Bundle Public Trust Board 7 October 2021

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19 Safe Staffing Report

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20 Walsall Together Partnership Board Report

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21 Care at Home Executive Report

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22 Work Closely with Partners Executive Report

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23 Winter Plan

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24 Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Report

23. Cover Sheet Trust Board 7 Oct - Annual EPRR Assurance Report 2021-22.docx

23.1 202109 Walsall Healthcare Annual EPRR Assurance Report 2021-22.docx

23.2 Appendix 1 - Walsall Healthcare Final Core Standards Self Assessment 2021-22.xlsx

23.3 Appendix 2 - Walsall Healthcare Annual EPRR Assurance 2021-22 Report.pdf

25 Audit Committee Highlight Report

24. Audit Commitee Highlight report for October 21 Board meeting.docx

26 Charitable Funds Committee Report

27 Update from the Black Country and West Birmingham Acute Provider Collaboration Programme

26. BCWB Acute Povider Collaboration Update Trust Board Paper October 2021 ACB.docx

28 Any Other Business

29 Questions from the Public

30 Date and Time of Next Meeting

Walsall Healthcare NHS Trust

MEETING OF THE PUBLIC TRUST BOARD

Held in public on Thursday 7 October 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	10.50
8.	COVID-19 Board Assurance Framework	Assure	Ned Hobbs	Enclosure	10.55
PATIENT STORY					
9.	Patient Story	Discuss	Introduced by Ann-Marie Cannaby	Audio	11.00
PROVIDE SAFE, HIGH QUALITY CARE					
10.	Quality, Patient Experience and Safety Committee Report	Assure Inform	Pamela Bradbury	Enclosure	11.15
11.	Safe High Quality Care Executive Report (including Board Assurance Framework and performance)	Assure Inform	Manjeet Shehmar Ann-Marie Cannaby Lisa Carroll	Enclosure	11.20
12.	Maternity Update	Assure Inform	Carla Jones-Charles	Enclosure	11.30
13.	Safeguarding Annual Report	Assure Inform	Fiona Pickford	Enclosure	11:40
USE RESOURCES WELL					
14.	Performance, Finance and Investment Committee Report	Assure Inform	John Dunn	Enclosure	11.50
15.	Use Resources Well Executive Report (including Board Assurance Framework and performance)	Assure Inform	Ned Hobbs Russell Caldicott	Enclosure	11.55
12.05 – 12.15 COMFORT BREAK					
VALUE OUR COLLEAGUES					
16.	People and Organisational Development Committee Report	Assure Inform	Junior Hemans	Enclosure	12.15
17.	Value Our Colleagues Executive Report (including Board Assurance Framework and performance)	Assure Inform	Catherine Griffiths	Enclosure	12.20
18.	Safe Staffing Report	Assure	Ann-Marie Cannaby /Lisa Carroll	Enclosure	12.30
CARE AT HOME					

#	Agenda Item	Purpose	Lead	Format	Time
19.	Walsall Together Partnership Board Report	Assure Inform		Enclosure	12.35
20.	Care at Home Executive Report (including Board Assurance Framework and performance)	Assure Inform	Daren Fradgley	Enclosure	12.40
WORK CLOSELY WITH PARTNERS					
21.	Work Closely with Partners Executive Report (including Board Assurance Framework)	Assure Inform	Ned Hobbs	Enclosure	12.50
22.	Winter Plan	Assure Inform	Ned Hobbs	Enclosure	12.55
23.	Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Report	Assure Inform	Ned Hobbs	Enclosure	13.05
GOVERNANCE AND WELL LED					
24.	Audit Committee Highlight Report	Assure Inform	Mary Martin	Enclosure	13.10
CHARITABLE FUNDS					
25.	Charitable Funds Committee Report	Assure Inform	Paul Assinder	Enclosure	13.20
CLOSING ITEMS					
26.	Any other business	Discuss	Steve Field	Verbal	13.25
27.	Questions from the Public	Discuss	Steve Field	Verbal	
DATE AND TIME OF NEXT MEETING					
Thursday 4 November 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
Mr Junior Hemans	Non-Executive Director; Chair of People and Organisational Development Committee
Mrs Mary Martin	Non-Executive Director; Chair of Audit Committee
Mr Paul Assinder	Non-Executive Director; Chair of Charitable Funds 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

Name of Lead	Position of Lead
Ms Catherine Griffiths	Director of People and Culture
Mr Ned Hobbs	Chief Operating Officer
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 – 7th October 2021			
Declarations of Interest			**AGENDA ITEM: 2**
Report Author and Job Title:	Keith Wilshere 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 September 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
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 Junior Hemans	Non-executive Director	Non-executive Director - Royal Wolverhampton NHS Trust
		Visiting Lecturer – University of Wolverhampton
		Director – Libran Enterprises (2011) Ltd
		Chair/Director - Wolverhampton African Caribbean Resource Centre
		Chair - Tuntum Housing Association (Nottingham)
		Company Secretary – The Kairos Experience Ltd.
		Member – Labour Party
		Mentor – Prince's Trust
		Spouse is a therapist at Royal Wolverhampton NHS Trust
Ms Mary Martin	Non-executive Director	Royal Wolverhampton NHS Trust - Non-Executive Director
		Trustee/Director, Non-Executive Member of the Board for the charity - Midlands Art Centre
		LTDTrustee/Director, Non-Executive - B:Music
		Director - Friday Bridge Management Company Ltd
		Non-Executive Director/Trustee - Extracare

Name	Position held in Trust	Description of Interest
		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 19th 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
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

Name	Position held in Trust	Description of Interest
Mr Russell Caldicott	Director of Finance and Performance	Member of the Executive for the West Midlands Healthcare Financial Management Association (HFMA)
Dr Manjeet Shehmar	Acting Medical Director	Company Director Association of Early Pregnancies Units UK
		Executive Member Association of Early Pregnancy Units UK
		Private Practice Health Harmonie ceased August 2021
Ms Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy ltd
		Chartered Institute of Personnel (CIPD)
Mr Ned Hobbs	Chief Operating Officer	Father – Governor Oxford Health FT
		Sister in Law – Head of Specialist Services St Giles Hospice
Mrs Lisa Carroll	Director of Nursing	Spouse - Royal College of Paediatrics and Child Health (RCPCH) Officer for Research
		Spouse - RCPCH Assistant Officer for exams
		Spouse - Chair of NHS England/Improvement Children and Young People's Asthma Effective Preventative Medicines Group
		Spouse - Consultant Paediatrician and Clinical Lead for Respiratory Paediatrics at University Hospitals of North Midlands NHS Trust (UHNM)
		Spouse - Guardian of Safe Working and Deputy Clinical Tutor UHNM
		Spouse - West Midlands National Institute for Health Research (NIHR) Clinical Research Scholar
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, 2ND SEPTEMBER 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
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
Prof David Loughton CBE	Interim Chief Executive
Prof Ann-Marie Cannaby	Interim Chief Nursing Officer/Deputy Chief Executive
Mr Ned Hobbs	Chief Operating Officer
Miss Catherine Griffiths	Director of People and Culture
Dr Manjeet Shehmar	Acting Medical Director
Mr Russell Caldicott	Director of Finance and Performance

In attendance

Mr Kevin Bostock	Advisory Director of Governance, RWT Support Team
Roseanne Crossey	Head of Business Development and Planning
Mr Matthew Dodd	Director of Transformation, Walsall Together
Lynn Fenton	
Aileen Farrer	Healthwatch Walsall
Tina Faulkner	Acting Head of Communications
Mrs Sophie Harris	Interim Senior Executive Assistant
Charlotte Hill	Medical Directorate Programme Lead
Mrs Carla Jones-Charles	Divisional Director of Midwifery, Gynaecology and Sexual Health
Mr Mike Sharon	RWT Strategic Advisor to the Board
Ms Amy Wallett	Head of Infection Prevention and Control (part meeting)
Mr Keith Wilshere	Interim Trust Secretary

Apologies

Mrs Pamela Bradbury	Non-Executive Director
Mrs Sally Rowe	Associate Non-Executive Director
Mrs Glenda Augustine	Director of Planning and Improvement
Ms Lisa Carroll	Director of Nursing
Mr Daren Fradgley	Director of Integration/Deputy Chief Executive
Ms Sally Evans	Director of Communications and Engagement

121/21	**Welcome, Apologies and Confirmation of Quorum**
	Prof Field welcomed everyone to the meeting and noted the apologies above.
122/21	**Declarations of Interest**
	No further interests were declared in addition to those published.
123/21	**Minutes of Last Meeting**
	The minutes of the meeting held on 5th August 2021 were approved.
124/21	**Matters Arising and Action Log**
	The Board received the action log and updates were noted.
125/21	**Trust Values and Nolan Principles**
	Prof Field brought the attention of the Board to the seven principles of public life (the Nolan Principles) and the Trust Values.

126/21	**Chief Executive's Report**
	Prof Loughton presented his report and highlighted that six new consultants had been appointed this month, three in dermatology services. He said that the International nurse recruitment had continued and a welcome session had taken place recently with a total of around 100 nurses attending. He said this would continue when flights had been re-booked following recent cancellations. He said that recruitment was a key area for the Trust in supporting reducing waiting lists for patients. He also referred to issues that had continued in relation to staff having to self-isolate as a result of COVID-19 'pingdemic' and this was expected to increase as a result of children returning to school in the coming weeks. **Resolved: that the Chief Executive's Report be received and noted by the Board.**
127/21	**COVID-19 Board Assurance Framework**
	Mr Hobbs presented the COVID-19 Board Assurance Framework that reflected the specific risks affecting maternity services, as requested previously by the Board. He noted that the risk score had increased to 12 due to the increased prevalence within community services and the resulting pressures within community and acute pathways with an increase in staff absences associated with isolating. He said that these factors had led to a very challenging summer. Mr Assinder requested an update on the current programme for staff COVID-19 testing. He had noted that there was a LAMP testing service available for asymptomatic staff provided through the Black Country Pathology service. Mr Hobbs said there was an opportunity for all Trusts to increase the uptake of staff testing and he was working with partners to achieve this. Prof Loughton said that all staff at the Royal Wolverhampton Trust had been auto-enrolled for LAMP testing and staff who did not wish to participate had had to opt-out. He said this had been discussed by the Executive Team and was to be implemented. Prof Field requested Mr Wilshere to register all Non-Executive Directors at both Trusts for LAMP testing. **Resolved: that the COVID-19 Board Assurance Framework be received and noted, and it be agreed that Non-Executive Directors at both Trusts be registered for LAMP testing.**
PROVIDE SAFE, HIGH QUALITY CARE	
128/21	**Quality, Patient Experience and Safety Committee Report**
	Mr Diamond presented, in Mrs Bradbury's absence, the Chair of the Quality, Patient Experience & Safety Committee report from the meeting held on 26th August, and noted the following: • The potential prevalence of infections and the predicted increase of Respiratory Syncytial Virus (RSV) was an area of concern as the Trust was experiencing higher rates than previous years along with an expected increase in Influenza cases, due to the lack of immunity in the community, was also a concern. • The predictions in relation to potential peaks in COVID-19 provided did not reflect the acuity of patients and the potential demand on critical care services, that had resulted inthe inability to reinstate the seventh operating theatre. • The committee received some reassurance on progress in clearing the backlog of serious incidents investigations and reports; however, they learnt there was more work to do to provide correct data and evidence of embedded learning from incidents. • Assurance was provided regarding the methodology used in the nursing workforce review. **Resolved: that the Board receive and note the highlight report from the Chair of the Quality, Patient Experience and Safety Committee.**
129/21	**Safe High Quality Care Executive Report**
	Dr Shehmar presented the Safe High-Quality Care Executive report that included the relevant BAF risk and the performance dashboard. She noted that a new group had been established to review clinical guidelines and some progress had been made in reducing the number of out-of-date guidelines. She advised that Venous Thromboembolism (VTE) performance had remained static with the national standard not achieved. She outlined that the VTE Group continued to review patients not assessed and continued to provide the regular report on healthcare acquired VTE.

Dr Shehmar reported that the number of reported falls remained below the national average at 4.78 per 1000 bed days in July, however there was a cluster of twelve serious incidents associated with falls that had been reviewed and reported through the serious incident group and root cause investigations was to be completed for all cases. She also highlighted that there had been two visits with the Getting it Right First Time (GIRFT) regional team that had focused on recommendations for dermatology and respiratory services. She said that evidence had been provided for a number of actions and the regional team had been pleased with the progress made. She further highlighted that an update had also been received in relation to the Emergency Department and the GIRFT team had reported good feedback in relation to progress with recommendations and the national benchmarking in place. She said the Emergency Department had been asked to share areas of good practice and pathwayswith other teams.

Dr Shehmar highlighted that manual audits had been put in place to monitor sepsis management and antibiotics being prescribed within an hour and this had demonstratedcompliance was above 95%. She said that the same level of assurance was not in placeacross the inpatient ward areas due to the lack of audits against the e-Sepsis tool, however,the matrons and ward managers were due to commence audits imminently. She confirmedthat a clinical lead had now been appointed and was working with the sepsis team to provide additional training and raise awareness across the Trust. She also highlighted that there was a new process embedded to review 104-day harms and overseen at executive level byreporting to the Quality, Patient Experience and Safety Committee (QPES).

Dr Shehmar referred to the mortality report and that there had been no deaths reported as a result of fractured neck of femur during July, an issue that the Trust had previously been an outlier for. She referred to further work required for completion of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) that had improved for patients who lacked capacity with 70% of patients who had received a stage two assessment. She added that further improvement was required in relation to documentation of discussions with families and the next of kin. She then referred to the division of Medicine and Long-Term Conditions (MLTC) where concerns had been raised in relation to the alleged poor behaviours of some staff within the Acute Medical Unit that reflected concerns raised by trainees in the department. She outlined that an external consultant had investigated these concerns and discussions had taken place to agree plans to tackle the issues.

Prof Field thanked Dr Shehmar for her report. He said he was impressed by the way she had taken on the role of Acting Medical Director and had helped to provide a better understanding of the current issues within the organisation. He said he was concerned by the number of out- of-date clinical guidelines and asked whether the Trust had a robust infrastructure to maintain the level of improvement and to prevent this from reoccurring. Dr Shehmar highlighted that an automated system to support tracking clinical guidelines was being explored and a case was being developed for the implementation that included the ability to flag guidelines that were due to expire. Mr Wilshere added that additional administration resource had been put in place this week to support in strengthening the policy, procedure and guidelines process which had also been revised to speed up the ratification process but that this would take some time before improvement was demonstrable and maintained.

Prof Field referred to the alleged poor behaviour of senior clinicians throughout the organisation and that any such behaviour must not be tolerated. He referred to the Health Education England (HEE) report that had also identified issues for junior doctors not being ableto contact their clinical professional leaders which was in his view unacceptable. He reiterated his support of Dr Shehmar, Prof Loughton and Prof Cannaby in resolving these issues. Dr Shehmar said that this was a professional issue and she was clear on the standards expected from senior clinicians. She thanked Prof Field and Prof Loughton for their support with sessions planned for all consultants to set out these expectations.

Mr Dunn requested an update on progress with actions following the MLTC CQC inspection and he noted that the division was working through their action plan and progress was

	monitored through a weekly oversight meeting alongside additional support provided by the governance team in collating evidence to provide adequate assurance. Mrs Baines thanked Prof Cannaby, Dr Shehmar and Ms Carroll for the very clear report. She raised her concern about the lack of quality assurance in relation to community services. Prof Cannaby said that work was underway to develop the Integrated Quality and Performance Report (IQPR) to include quality indicators for community services and aspects of Walsall Together to support future reporting. She said that the report required further work to identify trends, particularly with the Perfect Ward data, and had recommended the use of Statistical Process Control (SPC) charts moving forward. Prof Cannaby also pointed out that successful recruitment had taken place within the Health Visiting team and all vacancies had now been filled. **Resolved: The Board received and noted the Safe High-Quality Care Executive report.**
131/21	**Maternity Update**
	Mrs Jones-Charles presented the report and notified the Board that there was an increasing number of births that had reached the present cap level during July and exceeded it by 3 births during August. She said the wider position was variable across the region. Mrs Jones-Charles referred to the continuing recruitment of midwives and the high level of maternity leave which was causing some gaps. She said that the main focus for the service was to maintain the ability to provide safe 1-1 care in labour. She outlined in the report the percentage of planned absences during the holiday period and the steps taken to mitigate gaps. Mrs Jones-Charles highlighted that the final report from the recent CQC inspection was yet to be received and that the issues raised at the time of the inspection had been addressed. She said that work had taken place with the Pharmacy team regarding medicines concerns with spot checks taking place. She said a number of data requests had been submitted to the CQC and the final report was expected in the coming weeks. Mrs Jones-Charles said she was writing to all staff to remind them of their clinical responsibility in relation to safe medicines management. Prof Field recommended that an additional meeting take place with the Board when the final report had been received to ensure members were fully sighted on the outcome. Ms Martin raised concerns regarding the birth to midwife ratios and queried whether the current recruitment programme was sufficient to address the gaps in staffing in a timely fashion and whether there were adequate connections in place with local universities. Mrs Jones-Charles said that there was currently a national shortage of midwives but that a number of steps had been taken to increase recruitment in conjunction with the maternity service at the Royal Wolverhampton Trust. She added that the service had a low attrition rate and retained a high number of students with the current university links in place and midwives being offered the opportunity to complete a Master's degree through the clinical fellowship programme led byProf Cannaby. Mrs Jones-Charles confirmed that seven midwives had recently been successfully recruited with the recruitment process 'fast-tracked' to ensure no delays in midwives being able to give notice to their previous employer. She said that the current trajectory for recruitment expected that the department was to be fully staffed by January 2022 with discussions ongoing about how best to mitigate future maternity leave absences. Prof Cannaby highlighted discussions taking place relating to potential joint posts and with a local university the recruitment of a Professor of Midwifery along with the Deputy Director of Midwifery due to commence in post within the next month. Dr Shehmar advised the Board that the CQC had raised concerns regarding triage pathways and the prioritisation of patients. She said the Trust was working with a consultant from the Royal Wolverhampton Trust to implement a national triage pathway that she had developed. She added that another obstetrician was supporting the Trust in improving the related assurance and governance structures. **Resolved: that the Maternity Update be received and noted by the Board.**

132/21	**Mortality Report Q1 2021/22**
	Dr Shehmar presented the mortality report for quarter 1 and the Standardised Hospital Mortality Index for April 2021 at 81.11 and the Hospital Standard Mortality Rate on a downwardtrend at 103. She said that an external consultant who had supported at the Royal Wolverhampton Trust with its work on Mortality had also agreed to provide support in improving the mortality statistics and avoiding preventable deaths. Dr Shehmar advised the Board that there had been a total of 697 COVID-19 positive deaths in the hospital up to 8th July 2021, that all hospital acquired COVID deaths had been reviewed from 'wave one' and those from 'wave two' were being reviewed with mortality reviews completed and root cause investigations underway. Dr Shehmar highlighted that the fractured neck of femur pathway to reduce deaths was awarded a Trust Quality Improvement award and the Trust was leading regionally on apathway for head injuries with University Hospitals Birmingham on the district hospital review pathway. She added that Urology was an area of focus for reducing deaths from cancer and plans were in place for wider partnership working and service redevelopment. She also said that a 'virtual' multidisciplinary team meeting had been established with Birmingham Children's hospital to review complex medical cases to support with the expected increase in Respiratory Syncytial Virus Infection (RSV) cases. Mr Virdee noted that all tumour sites were meeting the two weeks wait standard for initial assessment and asked what the timeframe was between assessment and treatment. Dr Shehmar confirmed that cancer pathways were tracked within the organisation and reported through cancer performance reports. Mr Hobbs said that during June 2021, the Trust had treated 81.6 % of patients within 62 days of referral which was above average for the West Midlands and nationally. Mr Virdee also asked whether data was available in relation to ethnicity and socio-economic factors associated with learning from COVID-19 deaths. Dr Shehmar confirmed that this data was available through the mortality dashboard and she agreed to share a link with Mr Virdee outside of the meeting. Mr Hemans asked when the Board was to receive an update on the work being completed by the external consultant. Dr Shehmar confirmed that this was to be provided at the next meeting. Mr Diamond asked about the avoidability of deaths related to wider causes of ill health and socio-economic factors and the wider health inequalities work of the Walsall Together Board. Dr Shehmar advised that the Trust currently used a structured tool as part of the national programme for learning from deaths that focussed on the most recent admission and did not consider pre-morbid co-morbidities. She said that there was an intention to look at the issue more widely as part of the Integrated Care System (ICS) group that included the whole patient pathway. She said a Board Development session was planned looking into community and GP care and learning from mortality across the ICS and population health. Mr Dunn asked how changes to clinical practice and procedures as a result of the learning from deaths process had been embedded, monitored and recorded. Dr Shehmar confirmed that a thematic review of all structured judgment reviews had taken place for the top five pathways that had become the strategy for reducing avoidable deaths. She said a main focus had been lung cancer with an improvement programme in place which monitored clinical outcomes. She noted that data in relation to learning from deaths was to form part of the integrated performance and quality report in future, monitored by the divisional performance reviews. **Resolved: that the Mortality Report for Quarter 1 2021/22 be received and noted by the Board and it be agreed that an update on the work being completed by the external consultant be provided to the next meeting.**

133/21	**7 Day Services Assurance Report**
	Dr Shehmar presented the 7 Day Services report that outlined the results of an audit into emergency admissions undertaken during April 2021. She said the audit had looked at four core standards in relation to 7 days services and that 2 out of the 4 standards had not been fully met. She said that in relation to the standards not met: • Standard 2: Consultant review within 14 hours of emergency admission – She said that the Trust had achieved an overall compliance of 43% (against a standard of 90%) with further improvement was required to meet this standard. She said that areas of concern were identified in relation to the quality of record keeping, a common theme with other areas of non-compliance, and further work required to reduce clinical variation in relation to access and ward round standards that also formed part of the review of poor behaviours. • Standard 8: Ongoing consultant directed reviews – She said that all patients should be reviewed at least every 24 hours with evidence that a consultant had been involved in the plan. She said that Consultant job plans had been reviewed and space had been identified for consultant directed reviews, however, the Trust was only able to evidence 52% compliance with daily reviews. She highlighted that improvement was required regarding compliance with ward round standards and documentation, the need to strengthen policies and guidelines to support staff in completing consultant directed reviews. She added that further work was required to the medical workforce to understand the current establishments and gaps so rotas supported achievement of this standard. Prof. Field raised concerns regarding the outcome of this report and referred back to discussions about attitudes and behaviours of clinical staff that had to be addressed as a matter of urgency with support from the Board. Dr Shehmar concluded that she was clear on her expectations of improving the position. Ms Martin recognised that the assurance process would be repeated in Autumn/Winter; however, she asked for firm deadlines to be set for the improvement in compliance with the standards. Dr Shehmar said this was to be discussed at the Medical Advisory Committee and agreed for each division and care group along with a programme of pulse audits to monitor progress. Ms Wallett joined the meeting at 11:30am There was a further discussion regarding the eligibility of signatures in medical records and Mr Assinder said that this had been an issue at Russell's Hall Hospital and all consultants had been issued with stamps with full name and General Medical Council (GMC) registration number. It was agreed that stamps would be implemented for all clinical staff and incorporated into the relevant policy as a matter of urgency with feedback on progress of the implementationto the next meeting. **Resolved: that the 7 Day Services Assurance Report be received and noted and it be requested that an update on implementation of stamps for all clinical staff be provided in October.**
134/21	**Infection Prevention and Control Board Assurance Framework Update**
	Ms Wallet presented an update on progress with the Infection Prevention and Control (IPC) Board Assurance Framework for quarter two. She highlighted the maintenance of assurances related to COVID-19 internally as the national restrictions were eased. She referred to issues with screening on days 3 and 5 of admission with the IPC Committee looking into this. She also mentioned that the national learning was being embedded to increase LAMP testing compliance with a video to promote this. She referred to further work underway by the Black Country Pathology service and rapid testing for other infections on site that could pose a significant risk. She added that the Trust had seen the first positive norovirus case within the hospital recently and this had been very well managed. Ms Wallett advised that a further review had been undertaken by NHS England & NHS Improvement (NHSE/I) on 22 June 2021 which had resulted in an overall rating of red for the Trust. She said that whilst there had been improvements recognised in some areas, concerns remained in relation to cleanliness of equipment and an office environment in the Therapies department and as a result an action plan was being implemented and monitored by the IPC

	Committee with a further visit following in October 2021. Ms Wallett said that there had been no ward or bay closures as a result of Norovirus during quarter 2 and no full ward closures as a result of COVID-19. She said that at the time of reporting, there were 8 bay closures reported due to COVID-19 in July 2021. She said that these had been unexpected cases and patients had been streamed appropriately and tested negative on admission. Ms Wallet advised that nationally, there was a common theme of patients testing positive within the first few days of admission demonstrating the importance of day 3 screening. Ms Wallett said the Trust was on track with the *C.Difficile* trajectory, that the number of MRSA bacteraemia had exceeded the national target of 0 as 2 cases had been reported in the year to date. She added that a new national target had been set for the reduction in gram negative bacteraemia with a Health Economy Group set up to focus interventions in the community which was where higher levels of gram-negative bacteraemia were reported. Prof Field thanked Ms Wallett for attending to present the report and congratulated the teams on the management of the recent Norovirus case. Ms Wallett left the meeting at 11:47 **Resolved: that the Infection Prevention and Control Board Assurance Framework update be received and noted by the Board.**
USE RESOURCES WELL	
135/21	**Performance, Finance and Investment Committee Report**
	Mr Dunn, Chair of the Performance, Finance and Investment Committee presented the Chair's highlight report from the committee meeting held on 25 August 2021 and noted that: • Performance in relation to recovery and the constitutional standards remained strong. • Finances were on track to deliver the financial plan with continued imbalance in spends within some divisions. • A draft Integrated Performance and Quality report had been received. **Resolved: that the highlight report from the Performance, Finance and Investment Committee Chair be received and noted.**
136/21	**Use Resources Well Executive Report**
	Mr Hobbs and Mr Caldicott presented the Use of Resources Executive report. Mr Hobbs expanded on the risks associated with delivery of the emergency care standards and referred to the evidence that the Trust's performance with the 4-hour emergency access target remained strong when compared with other Trusts. He said that performance with ambulance handovers within 30 minutes also remained strong by comparison and the Trust continued to support neighbouring Emergency Departments in taking diverted ambulances to ensure that patients were not kept waiting. He advised the Board that a level of assurance could be drawnfrom the evidence. Mr Hobbs referred to the national waiting times reported across emergency care had been the worst on record in July 2021 and further deterioration was expected in August 2021. He said that the Trust had seen the highest demand record between May and July with higher bed occupancy throughout the hospital and challenges in discharging patients requiring domiciliary care. Mr Hobbs said he was concerned that these challenges had been experienced ahead of the other pressures associated with winter such as the expected increase in RSV cases, seasonal Influenza and suppressed levels of immunity within the population and norovirus cases emerging earlier than usual. He emphasised the importance of ensuring a robust winter plan was in place to support the safety of the emergency care pathway. He confirmed this would beavailable to the Committees of the Board in October 2021. He outlined that the elective care performance and diagnostic performance remained on track, the elective routine waiting time performance - 18-week referral to treatment standard

	remained stable and an improvement had been seen in cancer waiting time performance which was now ahead of the regional and national positions. Mr Caldicott said that the Trust was delivering to the financial plan year to date with a surplus of around £40k. He added that the MLTC division was currently overspending compared to plan largely driven by urgent and emergency care pressures. He outlined that the plan included £2.1m of elective recovery funds offset by a provision, however this was subject tothe Trust meeting gateways associated with the Sustainability and Transformation Partnership (STP) target for elective activity. Mr Caldicott noted that there was a surplus of £0.8m year to date within the overall provider sector. He said that the commissioning sector of the STP included a deficit of £1.5m for West Midlands Ambulance Service. He said there was low risk associated with the delivery of the H1 financial plan. Mr Caldicott said that there was more risk associated with the H2 financial plan as income allocations had still not been confirmed. He said that Trusts had been made aware that this was expected to be equivalent to H1 income allocation with less of an efficiency ask. He said that plans had to be considered for the 2022/23 financial year and an expected additional efficiency ask. Mr Caldicott advised that the Emergency Department development was now moving at pace. He said that the capital programme had been rated as amber and additional resources had to be secured to offset the refurbishment work within the ward areas. He referred to the first draft of the Integrated Performance and Quality Report (IQPR) that had been developed, following discussions with colleagues at the Royal Wolverhampton Trust, Walsall College and NHSEI. He said that this was to be populated for the next Performance, Finance and Investment Committee in readiness for sharing more widely. He advised the Board that progress was being made with the integrated procurement arrangements that had commenced as a service level agreement and had moved to a consortium arrangement. He said a further update would be provided to the Board at its next meeting. Prof Field congratulated the teams on the emergency performance, however he raised concern as to how this was impacting patient flow throughout the organisation and the abilityfor clinicians to assess patients once they are on the wards. He recommended that Mr Hobbs and Dr Shehmar work together to ensure that performance was maintained throughout the whole patient journey. Mr Hobbs agreed that there were opportunities to strengthen patient flow through the acute medical services and said that the use of same day emergency care instead of overnight admissions had supported Emergency Department flow. Mr Assinder asked whether the Trust would be planning to adopt a more flexible and sensitive approach to budget setting given the ongoing pressures faced by the MLTC Division as it seemed it was unlikely to be able to cope with the same budget allocated in H1 given the added pressures of winter. He asked what measures were in place to achieve the efficiency ask for H2 and into the next financial year. Mr Caldicott said that H2 budgets would be based on current expenditure trajectories and endorsed by the divisional teams. He said that the efficiency programme was due to be presented back to the next Performance, Finance and Investment Committee (PFIC) following concerns raised previously about the level of associated risk. Mr Caldicott accepted the recommendation to adopt a more flexible approach, however, he also emphasised the importance of setting expenditure run rates and trajectories based on the risks identified to hold individuals to account. Mr Hemans asked for an update on negotiations with other Trusts relating to the WestMidlands Ambulance Service deficit. Mr Caldicott said that the STP represented 23% ofambulance activity and that the deficit should be split by the level of service received. He said that there was an agreement for the deficit to be shared across all STP's into H2 and that negotiations were ongoing in relation to plans for the H1 share. Mr Caldicott noted that the £1.5m year to date deficit had been allocated within the STP financial position and was expected to decrease if negotiations were successful.

	Resolved: that the Use Resources Well Executive Report be received and noted. There was a break from 12.10pm to 12.20pm.
VALUE OUR COLLEAGUES	
137/21	**People and Organisational Development Committee Report**
	Mr Hemans, Chair of the People and Organisational Development Committee provided a verbal update following the committee meeting held on 26 August 2021 and he noted: • The committee had received a report on talent management and a description of the work underway to ensure the continued development of existing staff to aid retention. • An update was received on the Equality, Diversity and Inclusion (EDI) Strategy (approved by the Trust Board earlier in the year) and discussions had taken place about how to develop a talent pool of staff from ethnic minorities and diverse backgrounds. • Pride week was to take place during week 6 September 2021 and the Non-Executive Directors had been asked to support the activities. • The Trust continued to make good progress against the People plan that was due for an update. • The committee had been advised that furniture had been removed from the staff pods around the Trust with some being used as smoking shelters by staff and members of the public. • It was agreed that all individuals had to be reminded that the Trust was a 'smoke-free' organisation. • The committee considered increased liaision with Public Health colleagues regarding further resources and a campaign to support those who would like to stop smoking and to help with additional and refreshed signage. • The committee endorsed the Medical Revalidation report for approval by the Trust Board. **Resolved: that the verbal update from the Chairs Report of the People andOrganisational Development Committee be received and noted.**
138/21	**Value Our Colleagues Executive Report**
	Miss Griffiths presented the report. She highlighted trends in workforce metrics relating to staff turnover. She said that although the vacancy rate was currently stable, there remained risk in relation to 'the right staff in the right place at the right time'. She outlined that the transition to a fully established organisation was critical for staff wellbeing. She referred to work underway aimed at improving the recruitment of international nurses. She added that the ward refurbishments also boosted staff morale. She noted that the reliability of agency staff attending had also become an issue that resulted in staffing pressures. Miss Griffiths remindedthe Board of the importance of the need to ensure staff felt that the Trust cared about their wellbeing as reported in the recent pulse survey. She confirmed that the National Staff Surveywas to commence from 6 October 2021, closing end November 2021. Miss Griffiths reviewed the risk on the Board Assurance Framework relating to 'tackling poor behaviour and culture leading to bullying or discrimination'. She said that the work to improve talent management was a key part of this so staff had a clear route to career progression. **Resolved: that the Value Our Colleagues Executive Report be received and noted.**
139/21	**Safe Staffing Report**
	Prof Cannaby presented the Safe Staffing report. She said that it identified similar themes to those covered by Miss Griffiths. She said that July had been a difficult month for staffing levels due to sickness absence, vacancies and staff taking annual leave. Ms Martin asked for an update on the timeframe for the recruitment of international nurses, given challenges relating to transport and completion of OSCE's and the allocation of pin numbers. Prof Cannaby said the team were working very hard to get transport rebooked following cancellations and there was a robust bootcamp process in place for the completion ofOSCE's with a high number of recruits completing their OSCE's at the first attempt. She added that there were additional challenges relating to quarantine measures that would change as the COVID-19 restrictions eased for the hospitality sector. She said the team were

	very experienced in dealing with overseas recruitment for the whole of the Black Country and were on track to have recruits in post before the end of the calendar year as per the original plan. **Resolved: that the Safe Staffing Report be received and noted.**
140/21	**Medical Revalidation Report**
	Dr Shehmar presented the report. She highlighted that the annual appraisal programme led by the GMC had been suspended during the COVID-19 pandemic and a flexible programme supporting doctors with extended professional registration had been reinstated in October 2021. She noted that 76% of doctors had completed their appraisal, a reduction compared to previous years. She said there were five doctors who had unapproved reasons for not completing their appraisal and that each case was being managed on an individual basis and progress monitored on a monthly basis. Dr Shehmar advised that the Trust had reinstated the process to send letters to doctors prompting them to complete their appraisal, previously part of the GMC programme and returns were being tracked appropriately. She referred to two doctors due for revalidation prior to the GMC suspension of revalidation who had both been recommended for revalidation. She added that further work was required to support doctors in understanding their responsibilities regarding completion of their appraisal and revalidation despite the COVID-19 pandemic. Prompted by Dr Shehmar and Prof. Field, there was a discussion regarding unacceptable behaviours and the need to tackle these, including the use of the revalidation process to hold doctors to account for areas of non-compliance. Prof Loughton advised that in his view, the issues had been there for some time. He asked for discussions regarding potential sanctions in respect of individuals who continued to exhibit poor behaviour as this was impactingadversely on doctors in training. Prof Field said that had asked the Postgraduate Dean to ensure this situation was taken seriously. **Resolved: that the Annual Report for Revalidation and the statement of compliance be approved, confirming that the organisation, as a designated body, is compliant with the regulations.**
CARE AT HOME	
141/21	**Walsall Together Partnership Board Report**
	Prof Field advised that Mrs Baines was leaving the Trust at the end of September 2021 to join Birmingham and Solihull Mental Health Trust Board and this was her last Board meeting. He thanked Mrs Baines for all her hard work and commitment in leading the development of Walsall Together and support she had provided to colleagues with partnership working. He wished Mrs Baines the best of luck on behalf of the Trust Board. Mrs Baines thanked ProfField and said that she was sad to leave Walsall and the Black Country. Mrs Baines, Chair of the Walsall Together Partnership Board, presented the highlight report from the committee meeting held on 18 August 2021 and noted: • The partnership board viewed a patient story from a gentleman with a hearing impairment that had demonstrated that services struggled to provide effective access to services as a result of new ways of working prompted by the pandemic. • That concerns had been raised regarding pressure from staffing absences in a number of areas including social care, primary care and the private sector. • It was recognised that partners could work together differently within the community to recruit staff and respond to risks impacting on patients and service users. • The partnership board had been provided with reassurance that the Walsall Together senior management team was responding quickly to deal with these risks. • A bid for NHS charities monies had been approved for a Resilient Communities project focussed on supporting families and pregnant women in poverty with income generation. • Received a detailed evidence-based report from the Health Inequalities Working Group of Walsall Together regarding health inequality issues in Walsall. • A strategy was in development to be received by the Board for comment in November 2021.

	• Concerns was raised regarding the lack of progress across the Black Country with the implementation of the Integrated Shared Care Record. • The partnership board had recommended that the timeline associated was maintained by all Black Country organisations. **Resolved: that the Chair of Walsall Together Partnership Board be received and noted.**
142/21	**Care at Home Executive Report**
	Mr Dodd presented the Care at Home Executive report. He highlighted the residual pressures with vacancies alongside increased demand. He said that recruitment had taken place, including the implementation of Trainee Nurse Associates and interim measures to manage the additional capacity using admission avoidance, rapid response and Integrated AssessmentHub pathways. He said that the main area of concern was demand for packages of care that was a risk as a result of sickness, annual leave and lack of retention of staff. He said that the delays for patients waiting for packages of care had started to have an impact on the numberof patients medically stable awaiting discharge in the hospital. He outlined that there had been a collective response with support from adult social care including care home beds to discharge patients to whilst waiting for packages of care. He said that further work was to take place with commissioners to review rates of pay and any further flexibilities that might be available. He noted that the Board Assurance Framework had been shared and the risk score had been increased because of the challenges outlined. Prof Field thanked Mr Dodd for the report. He added that he had agreed with the Chief Executive at Walsall Council that a joint appointment was to be considered for the recruitment of a new independent chair of the Walsall Together Partnership and that a review of the job description and terms of reference was to be undertaken with a Non-Executive Director from the Trust included in the membership and that meanwhile, there would be Interim arrangements for the October 2021 meeting. Mr Virdee asked what the data showed regarding the uptake of the COVID-19 vaccination amongst BAME communities. He also asked for sight of the Health Inequalities report action plan. He asked how the shortage in supply of domiciliary care was to be managed when there remained vacancies within care homes. Mr Dodd said that care home beds with sufficient staff were being used to cover for the lack of domiciliary care. He said that care continued to be provided to patients in those beds resulting in a lower dependency of care required following discharge. He recognised that the care home market was subject to increasing staffing pressures. Mr Hobbs thanked all engaged in partnership working in respose to issues in domiciliary care. He emphasised the increasing level of risk associated with the increase of patients medically stable for discharge and the further impact this would have on the emergency care pathway in the winter period. **Resolved: that the Care at Home Executive Report The Board be received and noted.**
WORK CLOSELY WITH PARTNERS	
143/21	**Work Closely with Partners Executive Report**
	Mr Hobbs presented the report and highlighted that the Urology Integration proposal had been discussed at the Overview and Scrutiny Committees for Walsall and Wolverhampton and had been endorsed with conditions. He thanked Board members for their support with this proposal. He also noted that two pilot operating lists for trauma and orthopaedics at Walsall Healthcare had been successfully undertaken at Cannock Hospital in conjunction with colleagues at Royal Wolverhampton Trust. He said that discussions between both Trusts continued to try and maximise the use of capacity at Cannock Hospital. Ms Martin raised that Trusts were responsible for having a Board-approved 'Green Plan' and she recommended this be approached and developed across both Trusts and with the wider ICS and that it included benchmarking the starting carbon footprint. Mr Hobbs said there was limited sustainability expertise and he had discussed this with Simon Evans the Chief Strategy Officer at the Royal Wolverhampton Trust. He said they had agreed

	that the RWT expertise would be shared to lead on green plans across both Trusts, scrutinised by the Performance, Finance and Investment Committee prior to Trust Board consideration for approval including individual Trust and system-level responsibilities and actions. **Resolved: that the Working Closely with Partners Executive Report be received and noted.**
GOVERNANCE AND WELL LED	
144/21	**Audit Committee Highlight Report**
	Ms Martin, Chair of the Audit Committee, presented the revised Chairs highlight report from the committee meeting held on 26 July 2021 and noted the following: • The Trust had carried out an anti-fraud survey amongst staff which had resulted in a disappointing response. • The Counter Fraud team had advised that there was more opportunity for fraud to be committed due to home working arrangements in place. The committee had requested that steps be taken to raise awareness and that the survey be re-run to ensure maximum coverage. • The committee would be meeting on Monday 6 September 2021 to look at the final report from the external auditors on value for money in order to meet the deadline to publish the report. **Resolved: that the Audit Committee Chairs Highlight report be received and noted.**
145/21	**Board Assurance Framework/Corporate Risk Register**
	Mr Bostock introduced the Board Assurance Framework and Corporate Risk Register for information and confirmed that he, Mr Wilshere and Prof Cannaby would review the current position and agree the process for future in due course. Dr Shehmar advised the Board that risk 2610 regarding ligatures had been raised as a national safety requirement and she confirmed that ligature cutters had been purchased and training was being provided and as result the risk would be reviewed and the score reduced in due course. **Resolved: that the Board Assurance Framework and Corporate Risk Register be received and noted.**
CLOSING ITEMS	
146/21	**Any Other Business**
	Mr Virdee asked whether the Trust was involved in any planning for the support and relocation programme for Afghan refugees. Prof Field asked that the Trust seek an update from the Council. Prof Loughton said there was national programme in place using hotel groups across the country to accommodate refugees. He said that any required NHS support would start with Primary Care assessments. Mr Dodd confirmed that the Public Health Team were coordinating the response and had requested support from the health visiting service. He also confirmed that a lead primary care facilitator was to be identified.
147/21	**Questions from Public**
	Prof Field confirmed that there were no questions from the public.
	He confirmed that the next meeting was to take place on Thursday 7th October 2021.
	Prof. Field read the declaration of exclusion and the motion was passed.

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
	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	07 October 2021	*Update for the October meeting:* Engagement being undertaken with staff to explore options.	Open
127/21	02 September 2021	COVID-19 BAF	Non-Executive Directors at both Trusts to be registered for LAMP testing.	Interim Board Secretary	07 October 2021	Update for the October meeting: Registration details for LAMP tesing shared with all Non-Executive Directors.	Complete
132/21	02 September 2021	Mortality Report	Update on the work being completed by the external consultant to be provided at the next meeting	Acting Medical Director	07 October 2021	Verbal update to be provided at the October meeting.	Open
133/21	02 September 2021	7 Day Services Assurance Report	Update on implementation of stamps for all clinical staff to be provided in October.	Acting Medical Director	07 October 2021	Verbal update to be provided at the October meeting.	Open
146/21	02 September 2021	Any other Business	Update on the programme for relocating Afghanistan refugees was requested for the next meeting.	Director of Transformation, Walsall Together	07 October 2021	Verbal update to be provided at the October 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 fivestrategic objectives which combine to form theoverall ‘vision’ for the organisation.

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

“Caring for Walsall together” reflects our ambition for safe integratedcare, 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 visionof ‘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 CQCrating by 2022.

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

Work Closely with Partners;
We will deliver sustainable best practice in secondary care, through workingwith 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 andresponsibly.

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NHS Trust

Wa sa ealthcare NHS

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

Our values, coupled with individual behaviours, represent what wewish 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 fortheir wishes, beliefs and rights. • I understand my behaviour has an impact on people and striveto ensure that my contact with them is positive. • I embrace and promote equality and fairness. I value diversityand 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 themin 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 tomake 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 apart 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 – 7 October 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

1.0	**Review**
	This report indicates my involvement in local, regional and national meetings of significance and interest to the Board.
2.0	**Consultants**
	The following consultant was appointed this month: Occupational Health and Well being Dr Tamsin Radford
3.0	**Policies and Strategies**
	There were no policies approved this month.
4.0	**Visits and Events**
	• Since the last Board meeting I have undertaken a range of duties, meetings and contacts locally and nationally including: • Since Friday 27 March 2020 I have participated in weekly virtual calls with Chief Executives, led by Dale Bywater, Regional Director – Midlands – NHS Improvement/ England • Since Monday 3 August 2020 I have participated in weekly calls with the Black Country and West Birmingham Strategic Transformation Partnership (STP) on the co-ordination of a collective Birmingham and the Black Country restoration and recovery plan and COVID-19 regional update • 31 August 2021 – undertook a site visit to Occupational Health • 2 September 2021 – participated in the virtual West Midlands Acute Provider Network • 7 September 2021 – undertook a site visit to Adult Community Services • 9 September 2021 – led a virtual Senior Leaders Briefing session and met virtually with Dr Helen Paterson, Chief Executive – Walsall Council • 10 September 2021 – presented virtual the Long Service Awards and participated in the Walsall Proud Partnership (WPP) meeting • 23 September 2021 – participated in the Black Country and West Birmingham Strategic Transformation Partnership (STP) Quarterly Review meeting with NHS Improvement/ England and participated in the Black Country Acute Collaboration Board meeting • 24 September 2021 – undertook at site visit with Wendy Morton MP and participated in the Health and Well Being – Joint Strategic Needs Assessment (JSNA) Workshop

5.0	**<u>Board Matters</u>**
	There are no Board Matters to report on this month.

Latest Board/Committee/Group - 20/09/2021
Version V4.03

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 06 - COVID; This risk has the potential to impact on all of the Trust's Strategic Objectives.**
Risk Description:	The impact of Covid-19 and recovering from the initial wave of the pandemic on our clinical and managerial operations is such that it prevents the organisation from delivering its strategic objectives and annual priorities.
Lead Director:	Chief Operating Officer.
Lead Committee:	Trust Board
Links to Corporate Risk Register:	Title: • **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 = 16). • **2081** - Delivery Operational Financial Plan (Risk Score = 9). • **2082** - Future Financial Sustainability. (Risk Score = 12).
	Current Risk Score Movement: **Likelihood = 4 Consequence = 3 = 12 Moderate ↔** Forecasted Risk Score Movement for Q3: **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 positive that suggested a significant proportion of	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**	

					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, and 22/23 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 2020 peak. As of 15th September 2021 the Trust's Covid-19 positive inpatients are at 23.9% of the April 2020 peak or 16.7% of the January 2021 peak. Walsall borough's rolling 7-day average Covid-19 prevalence per 100,000 population is now in excess of 400/100,000 in September 2021 • 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 15/09/21). • The success of the vaccination programme has reduced the conversion of community cases into hospitalisations, however this has meant that community prevalence is sustained at higher levels, and therefore there is increased risk of staff absence as a result of being Covid positive or living with a Covid positive household member • The Trust has 45 Covid positive in-patients within the hospital (as of 15/09/21).			

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd 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.	• 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.

	• Enhanced Health and Safety/IPC Process in place in relation to Covid-19, with particular focus on social distancing, patient/staff, screening, zoning of Ward/Department areas, visiting guidance and PPE Guidance. • Daily risk assessment (RAG rating) of Community Locality teams to prioritise resource according to need. • 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. 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. Government Autumn and Winter Plan (21/22) that is unlikely to re-introduce social restrictions and thus community prevalence is likely to remain high resulting in significant staff members required to isolate due to being positive, or having a positive household member. • Increased fragility in the domiciliary care market resulting in higher bed occupancy in hospital, and compromised ability to optimally manage Infection Prevention and Control. • 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. • Vaccine hesitancy, particularly amongst younger people, resulting in unvaccinated COVID-19 positive pregnant women and evidence that Maternal COVID-19 infection is associated with an approximately doubled risk of stillbirth and may be associated with an increased incidence of small-for-gestational age babies. • Increased risk of complications for Pregnant women with COVID-19 coinciding with increased birth rate evident over Spring and Summer 2021. • High demand on key Covid-19 Community pathways including Community Pulse Oximetry monitoring (Safe at Home pathway) and Long Covid pathways. • Ability for neighbouring Trust's to manage demand from patients conveyed by ambulance resulting in additional ambulance patients being conveyed to Walsall Manor through WMAS Intelligent Conveyancing protocol. • National directives and mandates impact on the Trust's ability to make local decisions. • Ability of the Midlands Critical Care Network to successfully manage demand Critical Care demand across the region. • Unable to progress all elements of the improvement programme owing to capacity of senior leaders. • Comprehensive OD/Culture Improvement plan.		
Assurance:	• IPC Board Assurance Framework.	• Nosocomial Covid-19 infection rate in line with peer-reviewed published evidence. • Antibody positive staff rate in line with BCWB peers. • Financial top up requests in line (or lower) as a proportion of turnover than BCWB peers. • Faculty of Research and Clinical Education	• Elective waiting times best in the country for Diagnostics (DM01) and Top half nationally for routine elective treatment (18-week Referral to Treatment) in July 2021 national reported performance, out of 122 general acute Trusts. • GP referred Cancer treatment commencing

		evaluation of response to first wave. • 60-day readmission rate for Covid-19 patients in line with peer-reviewed published evidence.	within 62-days 67th (July 2021) out of 122 general acute Trusts. • Elective 52-week wait performance 4th best in the Midlands (July 2021). • 4hr EAS performance 34th best in the country (Aug 2021), and the 7th consecutive month in the Top 50. • Ambulance handover times (<30mins) best in the West Midlands for 7th consecutive month (Aug 2021). • CQC Assurance of the IPC Board Assurance Framework. • Productivity of Vaccination Programme compares favourably with other Acute Trusts. • Risk adjusted mortality rate (ICNARC) for Critical Care within expected range despite significant over-occupancy.
Gaps in Assurance:	• 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 Autumn 2021 and Winter 2021/22.
- Risk of further resurgence coinciding with RSV season, influenza season and norovirus season.
- Limited political appetite to re-introduce lockdown measures evidenced through Governments Autumn and Winter (21/22) Plan A.
- 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~~ Oct 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.	

MEETING OF THE PUBLIC TRUST BOARD Thursday 7 October 2021			
Patient Story			**AGENDA ITEM: 9**
Report Author and Job Title:	Caroline Whyte Deputy Director of Nursing	**Responsible Director:**	Ann-Marie Cannaby Interim Deputy Chief Executive / Chief Nursing Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The audio patient story reflects the positive experience of care provided to 'Jason' and the compassion shown towards his family by staff. Jason was a COVID patient in February 2021. Visiting restrictions were in place and as a patient on ICU it was difficult for family members who were unable to visit. Support was provided prior to intubation and this story highlights the efforts made by all those involved in Jason's care and the communication with his family especially when he was end of life. Learning is taken regarding the emphasis on communication and recognising the importance of the ReSPECT process. The use of ReSPECT ensured family members were understanding of the decision making involved and despite the distressing outcome were better prepared to support each other.		
Recommendation	Members of the Committee are asked to note the content of the report and actions being taken to learn from the concerns raised in this patient story.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 1: Safe, high quality care: We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Patient Story - Jason

A summary of key points raised by Jason's brother Garry is included below:

Background

Jason was admitted to the hospital via ambulance on the morning of the 11 February, initially he went through ED resus where his oxygen saturations were extremely poor. After some stabilisation of his condition he was transferred very swiftly to ICU. Jason remained on ICU until he sadly died on the 26 February.

What worked well

- Regular well informed updates from staff was provided
- Explanations were both empathetic and compassionate
- End of life care was dignified and provided space and comfort to those present in distressing circumstances
- Some staff went over and above what was expected and personal attention was given
- The Trust values were demonstrated

MEETING OF THE PUBLIC TRUST BOARD – 7th October 2021			
Quality, Patient Experience and Safety Committee (QPES) Highlight Report			**AGENDA ITEM: 10**
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 30th September 2021. Of note are: ▪ We received a short video of Garry Perry telling the story from a relative perspective of losing his brother who contracted Covid and died in our hospital. Garry is a well-respected member of the Trust and works tirelessly to improve patient and carer experience. This was a fitting tribute to his brother and the teams of people who looked after him during his short time with us. ▪ Acute service access – combined elective (overnight) and day case surgery has been restored to 108% YTD of 2019 activity. ▪ There remained a reduction of elective operating theatres from 7 to 6 during August due to the staffing requirements of Critical Care Unit, August 2021 saw 601 elective surgical procedures completed. ▪ In July, The Trust's 6 Week Wait (DM01) Diagnostics performance was reported to be the best in the country, however temporary staff absence within the ultrasound service during August (sickness, and self-isolation) have meant that performance has deteriorated in August with an anticipated recovery date of end of October. We will be monitoring the implications of this monthly at QPES. ▪ Despite cessation of routine elective services during the pandemic the Trust's 18-week RTT performance is stable with 70.27% of patients now waiting under 18 weeks at the end of August 2021. ▪ Committee approved the Urgent & Emergency Care Resilience Winter Plan, although it was noted that should the worst-case scenario be realised the plan is currently not sufficient to address potential demands from increased acuity of non-elective admissions, higher prevalence of flu/norovirus/covid and challenges in social care provision for MSFD patients. ▪ The Community update reported dealing with increased level of demand at a time when there remains high level of absence. ▪ The Care Navigation Centre continued to operate as an		

	escalation point for clinical deterioration in the community and the clinical teams supporting care homes were able to provide a full schedule of ward rounds within the homes. ▪ The numbers of patients who are medically stable for discharge continues to perform yet is under more pressure due to the package of care crisis, new services such as the Integrated Assessment Hub continued to have a positive impact in reducing numbers of admissions to Walsall Manor Hospital. ▪ Referrals into community pathways from Walsall Manor Hospital for patients with Covid increased during August. Referrals into the Long Covid pathway remained high; this has been exacerbated by strong numbers of weekly referrals from Primary Care since this was opened in May. ▪ The Trust target for Clostridium difficile 2021/22 had been internally agreed again at 29 cases and cases are in line with the trajectory. The national target has now been agreed and set at 33 cases. ▪ VTE compliance for August is 92.03%. Divisional teams are now reporting on their performance and plans to Patient Safety Group (PSG). ▪ The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department was 93.8%.The prevalence of timely observations is 88.14% and consistently is remaining above trust target. Nineteen clinical areas achieved more than 85% trust target, an increase from seventeen in July 2021. ▪ Falls per 1000 bed days was 3.76 in August 2021 and remains significantly below the national average of 6.1. ▪ Maternity update although it was reported that there was a high level of demand last month there is an active recruitment programme in place including the appointment of 2 new consultants. ▪ One serious incident was reported last month. There has been a rapid review of this incident and several actions taken. This including supporting the staff involved and a review foetal monitoring training. ▪ Monthly SI progress report, reassured to hear there have been two new significant appointments 1) Head of serious incident management that is overseeing the backlog that has previously being escalated and a patient safety specialist who will lead on SI process redesign and to support future divisional compliance with the SI process going forward. ▪ Good progress has been made to address gaps in the mental health service provision for adults, children and young people with engagement from the CCG and STP. This includes recruitment to a mental health team, infrastructure, training to

	staff with a resilient training programme and closer working with the Mental Health Trust and CAHMS. The next meeting of the Committee will take place on 28th October 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 7th October 2021			
Safe High-Quality Care Oversight Report – August 2021			**AGENDA ITEM: 11**
Report Author and Job Title:	Lisa Carroll Director of Nursing	**Responsible Director:**	Manjeet Shehmar Interim Medical Director Lisa Carroll Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report describes the continuing actions that are taking place to provide Safe, High Quality Care (SHQC) in the Trust. The report includes details relating to the Board Assurance Framework (BAF), the Corporate Risk Register and the Performance Report, relevant to SHQC.		
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 = 16). **2066** – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels. (Risk Score = 15). **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	Failure to deliver safe, high quality care may result in breaches of legal requirements under the Health and Social Care Act 2008		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

Provide Safe High-Quality Care – Executive Update

1. Executive Summary

The delivery of safe, high quality care remains a key priority for the Trust.

The associated Board Assurance Framework (BAF) and corporate risks have been reviewed and updated as required. Where there are gaps in control and assurance these are detailed in the monthly report to the Quality, Patient Safety and Experience Committee and actions taken and in progress are explained.

Projects within the Safe, High Quality Care Improvement Programme have continued to progress and some of the key highlights are:

- VTE compliance for August is 92.03%. Divisional teams are now reporting on their performance and plans to Patient Safety Group (PSG).
- The prevalence of timely observations is 88.14% and consistently is remaining above trust target. Nineteen clinical areas achieved in excess of 85% trust target, an increase from seventeen in July 2021.
- Falls per 1000 bed days was 3.76 in August 2021 and remains significantly below the national average of 6.1 as recognised as the Royal College Physicians.
- Nursing 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
- 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

2. CQC Inspections

Maternity Services

The Trust received the draft CQC inspection for factual accuracy checking in early September 2021 and the final report will be published on the 1st October 2021. The division have continued to develop the action plan that was started following the verbal feedback on the day of the inspection.

The maternity action plan will be incorporated in the Trust wide action plan which is led and overseen by the executive team.

All actions from previous inspections have been incorporated into this one Trust wide action plan.

3. Links to corporate risk register

The aligned corporate risks have been reviewed in month

208 - Failure to achieve 4 hour waits as per National Performance Target of 95%, resulting in patient safety, experience and performance risks. (Risk Score = 16).
2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels. (Risk Score = 15).
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).

Risk **2398** - Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care. (Risk Score = 12) has been de-escalated from the corporate risk register and moved to a divisional risk.

4. Performance Report

4.1 *Getting it Right First Time (GIRFT)*

A virtual deep dive into Emergency Medicine took place on 19 August 2021. This was well attended by Trust staff. The GIRFT team were impressed by the work undertaken by the team and the results supported the effort made to see patients in a timely and safe manner. The GIRFT team were updated with progress of the new A&E and associated services and requested that a face-to-face update is held when the build is complete. A recording of the deep dive is available on the GIRFT Futures Website.

4.2 *Falls*

The number of falls inpatient falls recorded for August is reported as 58, a reduction from 77 in July 2021. Work continues on the falls strategy aligned with the 'Key Performance Indicators' in the Safe High Quality Care Improvement Programme (SHQC).

The Trust had identified 12 historic falls that have not previously been investigated and have been identified as potential Serious Incidents (SI's). It has been agreed with the CCG that the Trust will investigate 10 of these falls as a cluster review and will be presented to the SI Group on completion.

4.3 *Tissue Viability*

The total number of Trust acquired pressure ulcers in August 2021 is 31. There has been a slight decrease in pressure ulcers since last month. All pressure ulcers of stage 3 and above and those that are unstageable have a Root Cause Analysis completed none met the SI criteria in August 2021.

4.4 *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 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.

4.5 *Venous Thromboembolism (VTE)*

VTE compliance for August 2021 was 92.03% which continues to be under the 95% target for compliance. Monthly reports continue to be sent to Divisions, in addition to the daily reporting to consultants.

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 will be reported in due course.

4.6 *104-day harm*

There were 3 patients identified in July 2021, 1 x haematology and x 2 urology. Harm is currently being evaluated. Figures for August 2021 are currently unvalidated, 3 patients will be discussed at the September's MDT.

4.7 *Sepsis*

A Trust sepsis team has been agreed and being recruited to. The newly appointed Trust Clinical Lead for sepsis, Miss Rushi Joshi, Clinical Director for Emergency Medicine commenced in this post on 1 September 2021.

The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department was 93.8% by manual audit and 65.6% by E-sepsis in August 2021. The inpatient adult E-sepsis compliance for August 2021 was 44.29%. The discrepancy in data is due to an IT configuration issue within the system. Work is being undertake with IT to understand and take the appropriate corrective action.

4.8 Clostridium *difficile*

The Trust target for 2021/22 had been internally agreed again at 29 cases; the national targets have now been released and have been set at 33 cases. There were 3 reported cases in August 2021 Following investigation two were deemed unavoidable and one avoidable due to a delay in taking the appropriate stool sample.

4.9 *Outbreaks*

There have been three COVID-19 outbreaks in the last month on wards 21, 1 and 3. Outbreak meetings have been held in accordance with Trust policy and there have been no new cases in the last fourteen days. Lessons learnt have been shared across the Trust through the IPC Committee.

4.10 *Percentage of observations undertaken within timeframe*

The prevalence of timely observations has decreased slightly to 88.14% in month from 88.26% in July 2021 but remains above the Trust target of 85% for the fifth month running and within normal variation

4.11 *Mental Capacity Assessment*

Audit for August 2021 shows that 71.05% of patients who lacked capacity had a stage 2 assessment undertaken; this is improved from 58.63% in July 2021. Discussion with patient's relatives or an attorney has increased to 57.81% (July 54.67%) of cases audited. The impact of minimal visiting on site has caused difficulties engaging with relatives at times

4.12 *Safeguarding, Prevent, DoLs, MCA and Dementia Awareness Training*

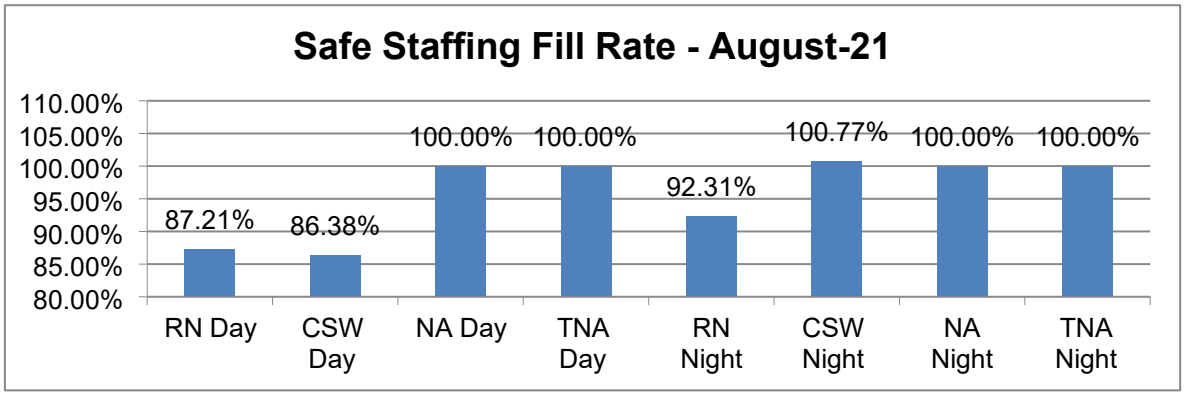
Safeguarding Adult and Childrens levels 1 and 2 training remain above trust target. Level 3 training remains under target for both adults and children.

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 achiveing compliance with level 3 training at the next Safeguarding Committee.

5. Staffing Update

The RN and Midwifery vacancy rate for August 2021 remains the same as July at just under 7%.

Rosters are designed to fill out of hours first and this is reflected in the fill rate as the lowest fill rate was seen in the CSWs on day shifts at 86.38%. This is a slight increase since last month. The overallfill rate for August (combined RN and CSW) was 91.66%, the same as the previous month.



75 overseas nurses have commenced working within the Trust and 42 of these have completed their OSCE. A further 22 have their OSCE's booked for September and 11 have their OSCE's booked for October 2021. A further 19 nurses are expected in September 2021

Pastoral care is being delivered by Team FORCE. The current expectation is that approximately 200 overseas RN will be recruited by the end of 2021.

Nine Trainee Nursing Associates have commenced the training programme in September 2021 and will be expected to qualify in November 2023.

End of Report

Latest Board/Committee/Group - 20/09/2021
Version V4.03

Walsall Healthcare NHS Trust

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 = 16). • **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 Q3:
		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								
	1st Line of Defence				2nd Line of Defence		3rd Line of Defence	

Controls:	• Clinical audit programme & monitoring. Clinical divisional structures, accountability & quality governance arrangements at Trust, division, care group & service levels. • Central staffing hub co-ordinating nurse staffing numbers in line with acuity and activity arrangements with staff re-deployed across clinical units and divisions as required to maintain safe staffing levels • 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	• 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.

	place, reporting to the People and organisational development 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.	• NHSI 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 tor 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.	NHSI re-inspection of cleanliness and IPC practice in maternity services	Director of Nursing	31/10/2021	NHSE/I 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 15.9.2021 - Action plan in place and monitored through IPC committee	
5.	Further develop processes to provide assurance that lessons learnt from adverse events	Medical Director/ Director of Nursing	31/10/2021	Scoping of new ward performance boards continues.	
6.	Development of Patient Engagement and Involvement Strategy	Patient Experience Lead / Lead for Patient Involvement	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 NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22 YTD	2021/22 Target	2020/21 YTD	SPC Variance	SPC Assurance
SAFE, HIGH QUALITY CARE												
No.	HSMR (HED) nationally published in arrears	104.24	83.37	115.04	112.8				100			
No.	SHMI (HED) nationally published in arrears	99.95	83.78	109.24					100			
No.	MRSA - No. of Cases	1	0	1	0	1	0	2	0	2		
No.	Clostridium Difficile - No. of cases	3	1	3	5	2	4	15	33	32		
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays	1.24	0.91	1.05	0.66	0.82	0.92					
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population	0.65	0.72	0.45	0.52	0.49	0.45					
Rate	Falls - Rate per 1000 Beddays	3.39	3.66	3.57	3.52	4.78	3.76		6.1			
No.	Falls - No. of falls resulting in severe injury or death	0	1	0	0	1	1	3	0	12		
%	VTE Risk Assessment	94.45%	94.34%	93.22%	93.50%	92.96%	92.03%	93.19%	95.00%	91.56%		
No.	National Never Events	0	1	0	0	0	0	1	0	0		
Rate	Midwife to Birth Ratio	34.4	29.3	30.4	32.0	36.0	35.2		28			
%	C-Section Rates	33.33%	30.82%	36.81%	32.42%	33.23%	30.45%	32.75%	30.00%	29.81%		
%	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	11.91%	11.46%	12.10%	11.93%	12.35%		11.96%	10.00%	13.44%		
%	Electronic Discharges Summaries (EDS) completed within 48 hours	83.34%	85.32%	86.71%	84.59%	83.50%	85.58%	85.13%	100.00%	85.75%		
%	Compliance with MCA 2 Stage Tracking	81.25%	64.29%	88.46%	70.59%	70.00%	71.05%	72.29%	100.00%	52.35%		
%	Friends and Family Test - Inpatient (% Recommended)	88%	87%	87%	87%	85%	84%		96%			
%	PREVENT Training - Level 1 & 2 Compliance	93.00%	87.21%	91.34%	92.81%	94.16%	94.84%		90.00%	93.00%		

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22 YTD	2021/22 Target	2020/21 YTD	SPC Variance	SPC Assurance
%	PREVENT Training - Level 3 Compliance	92.06%	94.48%	94.65%	93.09%	92.58%	92.69%		90.00%	92.06%		
%	Adult Safeguarding Training - Level 1 Compliance	95.48%	96.46%	96.23%	93.92%	94.43%	95.80%		90.00%	95.48%		
%	Adult Safeguarding Training - Level 2 Compliance	94.09%	93.01%	95.00%	95.56%	94.74%	95.51%		90.00%	94.09%		
%	Adult Safeguarding Training - Level 3 Compliance	81.22%	84.56%	85.30%	88.06%	88.41%	85.65%		92.00%	81.22%		
%	Children's Safeguarding Training - Level 1 Compliance	95.24%	97.04%	97.57%	94.45%	96.33%	97.07%		90.00%	95.24%		
%	Children's Safeguarding Training - Level 2 Compliance	92.14%	92.91%	92.40%	90.98%	91.64%	91.71%		90.00%	92.14%		
%	Children's Safeguarding Training - Level 3 Compliance	90.10%	90.09%	81.24%	83.25%	84.52%	85.35%		90.00%	90.10%		

MEETING OF THE PUBLIC TRUST BOARD **Thursday 7th October 2021**			
Divisional Director of Midwifery report			**AGENDA ITEM: 12**
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. • There is an active recruitment program Recruitment update • Medical update with 2 new Consultants due to start. • Maternity Serious Incidents • CQC 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

1.1 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
- Maternity Serious Incidents (SIs)

2.1 BACKGROUND

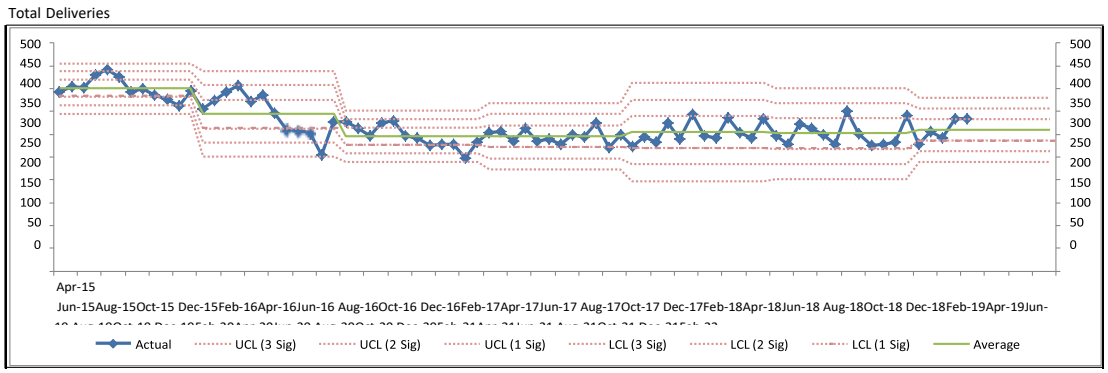
This report will update the on-going position on the key elements above by exception.

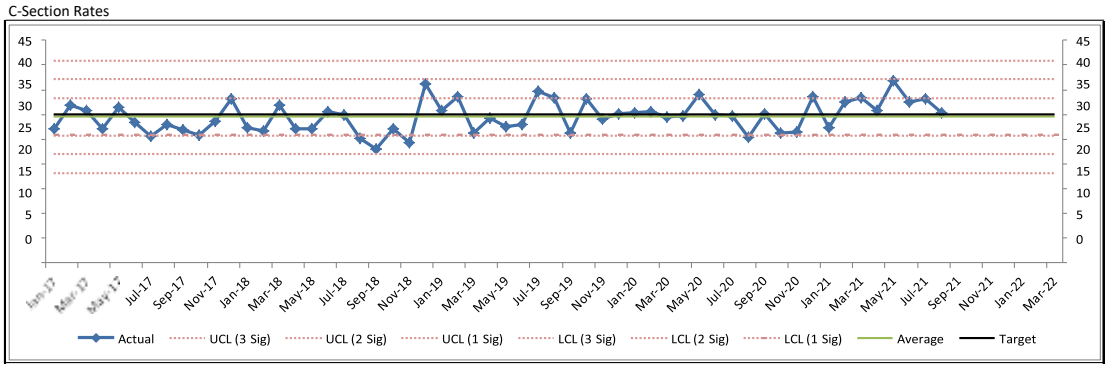
2.2 Activity within the Maternity Unit

Table one highlight the monthly activity within the Maternity Unit: table one is the total number of births per month and this activity is outlined in the SPC chart. The second SPC chart represents the total caesarean sections per month; this includes elective and emergency caesarean sections. There is a natural variation month on month depending on activity.
We are currently reviewing all emergency caesarean sections. This is being audited by the Delivery suite lead Consultant. Although we have seen a reduction this month we feel we are reviewing.

Table 1: Activity Aug 20 – Aug 21

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21
Births	299	279	351	301	276	279	285	342	279	307	293	334	337





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

Staffing is monitored daily and staffing deficits are manged using the maternity escalation policy. The current Trust uplift is 21%, this is to account for annual leave, sickness and training. The table below is a breakdown of absence for August 21.

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day
Women's Services	Delivery Suite -	15.9%	3.5%	7.2%	7.0%	1.0%	4.2%

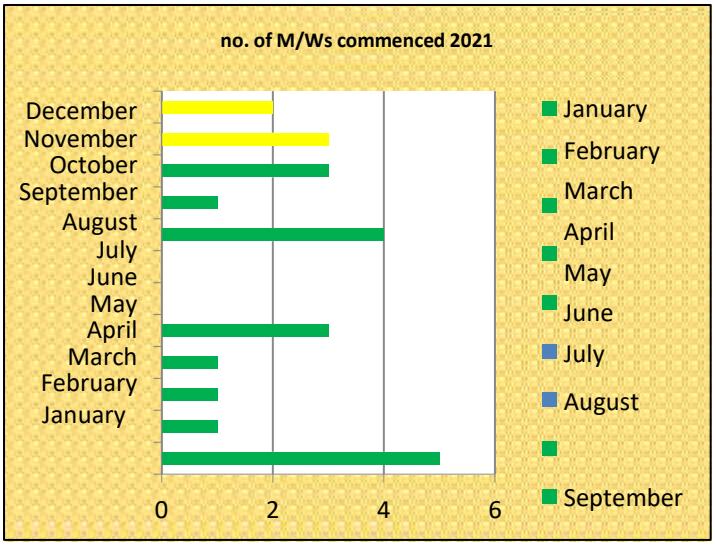
Acuity is monitored 6 times a day on the delivery suite and is used to assess staffing needs. The national recommendation is to strive to maintain an average acuity of 85%. The table below demonstrates average acuity over a period of a month. It illustrates that activity peaks against staffing. The service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

Table 2

	Aug-20	Sep-20	Oct-20	Nov-20	Dec - 20	Jan-21	Feb 21	Mar 21	Apr 21	May 21	June-21	Jul 21	Aug 21
Acuity	87%	84%	83%	87%	85%	85%	74%	76%	87%	60%	72%	66%	61%
1:1 Care in Labour	100%	98.5%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%

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

Recruitment update:
There has been 19 midwife starter's year to date with another 3 starting in October and 3 due to start in November and 2 in December. The service has appointed 7 of its 10 students. The 3 remaining student have chosen to return closer to their families. Of the 7 remaining 3 are awaiting completion of their course, some have been delayed due to the effects of the pandemic. The table below highlights the midwifery appointment year to date.



* The green bars are midwives in post
** The yellow bars are pending starts

3.2 Birth to Midwife Ratio

The national average birth to midwife ratio 1:28

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

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	June-21	Jul-21	Aug-21
Actual Ratio - Worked	30.8	28.3	37.0	31.4	28.9	27.2	29.1	34.4	29.3	30.4	32	36	35

4.0 Medical update

The service has one new Consultant starting on the 1st October who will take the role of inpatient lead and maternity safety champion and second consultant starting 1st November will be quality improvement lead clinician.
The service is undertaking a prospective audit on antenatal ward rounds over 2 weeks (primrose and foxglove ward). This is line with the national context for 7 day working. The results will be presented at monthly audit meeting and will be feedback to QPES.

5.0 Maternity Serious Incidents/ Health service Investigation Branch update.

There have been a total of 23 referrals to HSIB since April 2019 and of those 10 cases were accepted for investigation with 3 current cases awaiting final report, see table below.

Cases to date	
Total referrals	23
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	10
Total investigations completed	7
Current active cases	3
Exception reporting	MI-003333 will breach the 6-month deadline

6.1 CQC update

The service has had an unannounced CQC inspection on the 28th July 2021. The final report was published on the 1st October. The service rating has remained the same at 'requires improvement'. The service is actively working to develop an action plan although some immediate action has already been taken to ensure the on-going safety of our patients.
Some of these include –

- Working with pharmacy to correct concerns regarding medicine storage (completed)
- Weekly audit to demonstrate compliance
- On-going active recruitment
- Programme of work to support staff and develop an engaged culture to promote staff well-being
- Working with the estates team to ensure appropriate trained staff are availableamong housekeeping staff
- Supporting staff to raise concerns using the current Trust processes and guidelines.

7.1 RECOMMENDATIONS

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

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Thursday 7th October 2021			
Safeguarding Annual Report 2020 - 2021			**AGENDA ITEM: 13**
Report Author and Job Title:	**Jennifer Robinson** – Lead Named Nurse for Safeguarding Adults & **Lesa Robinson** – Lead Named Nurse for Safeguarding Children	**Responsible Director:**	**Lisa Carroll** Director of Nursing
Action Required	Approve ☒ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This annual summary report provides an update of Safeguarding activity in relation to activity from Q1 to Q4 2020 to 2021. The Board is asked to note and accept the contents of this report and to continue to support the work of the safeguarding team.		
Recommendation	The Board is asked to note the following: • There has been a review of the internal safeguarding committee with updated terms of reference; • Safeguarding Team shortages during Covid have impacted on attendance at some Walsall partnership meetings; • There has been a focus on providing additional safeguarding training across the Trust which has been well received; • There has been a review of S42 processes as a result of several complaints made during 2020. A safeguarding development plan has been implemented; • The Learning Disability agenda within the organisation will be reviewed during 2021-21		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The report refers to safeguarding team staffing deficits and embedding a more robust safeguarding culture.		
Resource implications	There are no resource implications associated with this report		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☒	

Walsall Healthcare NHS
NHS Trust

Safeguarding Annual Report

2020/21

Introduction

This report covers the period April 2020 to end March 2021. It seeks to provide information and evidence to the Trust of the continued commitment to good safeguarding measures. It refers to the details outlined in the Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs) and is aligned to national and local safeguarding standards including the requirements from CQC, Walsall CCG and Walsall Safeguarding Partnership (WSP).

The report aims to:

- Provide assurance to the Trust Board that the organisation is fulfilling its safeguarding obligations as defined within the assurance framework.

- Provide assurance to service commissioners and regulators (CQC and NHS Improvement) and partners (Walsall Safeguarding Partnership and Walsall Local Authority) that the Trust safeguarding activity over the year continues to develop.

- Appraise the Trust regarding the activity and function of the safeguarding team and the support it provides to operational and clinical service delivery.

- Ensure that patients, service users and carers know that the safeguarding of children and adults is a Trust priority.

- Outline the proposed areas of development for 2021 – 2022.

Safeguarding Legislation and Standards:

- Working Together to Safeguard Children (2018)

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff: RCN (2019)

- Domestic Abuse Act (2021)

- The Safeguarding Vulnerable Group Act (2008)

- The Mental Capacity (Amendment) Act (2005/2019)

- Deprivation of Liberties Safeguards (2009)

- CQC Fundamental Standards (2014)

- Children Act (1989/2004)
- Care Act (2014)
- Adult Safeguarding: Roles and Competencies for Health Care Staff: RCN (2018)
- Prevention of Terrorism Act (2005)
- Counter Terrorism and Security Act (2015)
- Walsall Safeguarding Partnership
- NHS Black Country and West Birmingham Clinical Commissioning Group- Walsall Place

Details of progress during 2020/21 are described against each section within the framework.

Section 1: Safeguarding Governance & Leadership
Health providers are required to demonstrate clear governance arrangements and that they have safeguarding leadership, expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, the Safeguarding Partnerships/and SABs priorities, and in regular monitoring meetings
With commissioners.

1.1 WHT Safeguarding Service Team Structure 2020/21
The current team structure provides assurance that the Trust is compliant with employing the Statutory Named Professionals for children – Named Nurses (NN), a Named Midwife (NM) and Named Doctor for Safeguarding Children.
(See Appendix 1. Team Structure 2020/21)

1.2 WHT Safeguarding Children and Adult Governance and Accountability Framework

All Staff: All staff within WHT has a commitment to protect children and adults at risk from harm and abuse and to work in accordance with all Trust policies and procedures.

The Director of Nursing: Is the nominated Director/Executive Lead responsible for coordinating the management of safeguarding and to ensure that the Board receives sufficient assurance on the effectiveness of the service. The Director of Nursing is the nominated chair of the Trust Safeguarding Committee (TSC).

Head of Safeguarding: Manages the Children and Adult Safeguarding Service and provides expert leadership on all aspects of the safeguarding agenda. The Head of Safeguarding is responsible for the development and implementation of systems and processes, working with partner agencies in line with local and national standards and legislation and ensures that there is appropriate implementation of relevant internal and external targets and standards, contributing to national and local inspections and assessments of safeguarding arrangements. The Head of Safeguarding provides assurance to the TSC and is the nominated representative on the Walsall Safeguarding Partnership. WHT had an Interim Head of Safeguarding from September 2019 until June 2021. The permanent Head of Safeguarding commenced in post August 2021.

WHT Named Doctor: There is a Named Doctor for Safeguarding Children. The post holder supports the Interim Head of Safeguarding and Director of Nursing. There is currently no Designated Doctor for Safeguarding Adults since the retirement of the previous designate and this remains a priority in 2021/22 for the Trust to seek a new Designate.

Named Midwife for Safeguarding: The Named Midwife post which was a part of the Safeguarding Team moved across to Maternity Services in Q3. Maternity Leads have reported that this resulted in the increased visibility of the Named Midwife in maternity.

- During 2020/21 The Named Midwife continued to lead on the Unborn Network meeting, which takes place fortnightly and actively contributed with the sharing of information and multi-agency discussion.

- The Named Midwife maintained attendance at the pre-birth bi –monthly meetings during 2020/2021.

- As part of the Named Midwife role, the audit programme has been continued during 2020-2021.

- The Named Midwife continued to update the FGM Enhanced Data Clinical Audit Platform for NHS Digital and developed and delivered bespoke training for the student Midwives at Wolverhampton University.

WHT Named Nurses for Safeguarding Adults, Children and Maternity:
The roles, responsibilities and competence of Named Nurses and support staff are set out in Safeguarding children and young people: roles and competences for health care staff (Intercollegiate Document 2019) and for Safeguarding Adult Intercollegiate Document (2018). The WHT Named Nurse/Professionals for Safeguarding have key roles:

- To provide an expert high quality support service to all health professionals working with children, adults and families within WHT.

- To be available to give safeguarding advice, guidance and support Monday to Friday 08:30-16:30hrs for Safeguarding Children and 09:00-17:00hrs for Safeguarding Adult.

- To represent the Trust at all appropriate sub groups or committees aligned to the Walsall Safeguarding Partnership.

- To contribute to planning / implementation across the organisation in respect of safeguarding children and adult concerns.

- To work collaboratively with multi-disciplinary and multi-agency teams including the Police and Social care. During 2020/21 the Multi Agency Safeguarding Hub (MASH) for children; Domestic Abuse Triage and adult safeguarding referral service continued to develop with involvement from WHT Safeguarding Service.

- To contribute to the Walsall Multi Agency Risk Assessment Conferences (MARAC) meetings, that is held fortnightly. WHT contributed to 100% of meetings either face to face or virtually.

- To work closely with Walsall CCG Designated Professionals for Children and Adults, this included the opportunity to access safeguarding supervision from them every 3months.

- To contribute to the delivery of the Trust safeguarding training programme as described in the Intercollegiate Document Guidance (Children 2019, Adult 2018). As part of this process to review the training programme annually minimally and in response to changes with national guidance and local and national learning from Reviews. This ensures training groups and delivery standards remain are up to date with new guidance and legislation.

- A cascade model of safeguarding children supervision is provided in WHT to practitioners working directly with children and families across all thresholds, including those children who are subject to a safeguarding plan. The Safeguarding Children Team provides safeguarding supervision to the Safeguarding Supervisors in the Health visiting service and the Health Visiting team leaders. The delivery of supervision is also provided by the team to key areas i.e. acute paediatrics and Emergency Department (ED).

- To provide specialist health advice and support to staff for court requirements, strategy meetings and case conference purposes.

- To participate in quality assurance work via the Trust and Partnership Multi Agency Audit programmes.

- Contribute to the Rapid Reviews, Child Safeguarding Practice Reviews; Safeguarding Adult Reviews and Domestic Homicide Reviews. Also to lead in internal safeguarding learning reviews and participates in Serious Incidents reviews in the Trust.

- To co-ordinate the Trust's statutory responsibility in response to Section 42 cause enquiries.

The roles, responsibilities and competence of Named Midwife for Safeguarding Children are set out in Safeguarding children and young people: roles and competences for health care staff (Intercollegiate Document for Children 2019) and for Safeguarding Adult Intercollegiate Document (2018). The key role entails:

- To ensure that knowledge is enhanced at all times to assist in the identification and management of gaps and be able to demonstrate a breadth of knowledge within the service; this will include cross-cover for the Named Nurse for Looked After Children.

- To ensure knowledge base is kept up to date and in line with current guidance, law, policy and procedure.

- On-going audits are completed to identify the current position and identify any current gaps in practice to then be addressed. This is the case across the Safeguarding Team.

- To participate in the completion of Individual Management Review (IMR) and Serious Case Review (SCR) processes as required. Ensuring dissemination of information post serious case review and application of learning.

- To participate in Clinical Governance activities including risk management, incident reporting, audit and research.

- To be responsible for ensuring commitment to maintaining a high quality of service to service users by continual development of practice in the light of research, evidence and audit against clinically relevant standards as an individual practitioner.

Safeguarding Team Administrator: During 2020/2021 the Safeguarding and Looked After Children (LAC) Administration Team worked across both the Safeguarding Children and Looked After Children Team. They were able to act as a knowledgeable resource in the following areas:

- Management of safeguarding referrals and queries from external sources
- Co-ordination of all incoming and external safeguarding enquiries
- Preparation of safeguarding paperwork, which includes induction packages for new starters in the Team; training packs; IT systems /Child Protection database/Information access
- Oversight of patient databases to flag safeguarding concerns
- Maintained the various databases that capture the safeguarding children and LAC activity

1.2 WHT Safeguarding and Quality Assurance Process 2020/2021

Safeguarding reports have been written by the Interim Head of Safeguarding and although provided an over sight of the safeguarding agenda, there was recognition during Q4 that WHT had not adopted the Black Country and West Birmingham (BC&WB) STP Safeguarding Assurance Framework for Commissioned Services and this will be used for reports moving forward.

1.3 WHT Trust Safeguarding Committee 2020/2021

The oversight of the Trusts safeguarding arrangements has been undertaken by the Trust safeguarding committee. The committee has been re-established with revised terms of reference and meets on a Bi – monthly basis. Attendance has shown an improvement throughout the year with representation from the divisions.

Members of the Board had not received annual safeguarding training since 2017 and this is required to ensure additional knowledge-based competencies by virtue of their board membership or non-executive safeguarding director as per Intercollegiate Document. This has now been prioritised to be delivered during Q2.

WHT is a member of the Walsall Safeguarding Partnership and therefore commitment to attend a number of partnership meetings and associated sub groups. WHT have attended Walsall Safeguarding Partnership (including Multi Agency Safeguarding Hub) meetings and respective subgroups as required (and as indicated as part of the terms of reference for each group). Attendance is monitored and reported on an annual basis as part of the WSP annual report. Going forward, attendance will be reported within the Safeguarding quarterly report.

- The Safeguarding Team Leads attended many of the Walsall Safeguarding Partnership meetings, however, the team has acknowledged that capacity within the teams have impacted on the consistency of representation and attendance of some meetings. As a result a review of all the partnership groups will be undertaken during Q1 to ensure that groups get the appropriate representation.

- WHT have continued to attend all MARAC meetings on a bi-weekly basis during 2020/21. All cases have been researched by the safeguarding team, and information sharing has been robust.

- During 2020/21 WHT have attended the regional Learning Disability Mortality review (LeDeR) Steering Group (100% attendance). During this period, WHT has made 14 notifications in relation to adults with a learning disability who have died in the Trust. Eight of these deaths were COVID 19 related and each underwent a Rapid Review in addition to the routine structured judgement review. The rapid reviews did not identify any discrepancies or challenges around care and treatment.

- WHT acute learning disabilities Nurse (1.0WTE) continues to be provided by Black Country Healthcare Trust. The service provision will need some further review and discussion between WHT Head of Safeguarding and the Black Country Healthcare Trust during

2021/22 to enable effective strategic direction to ensure the needs of the adults with a Learning Disability are met. The national and local requirements reinforce the need to ensure that adults with a learning disability have equal access to health and social care services, more recently the Learning Disability Improvement standards for NHS Trusts published in 2018 by NHS Improvement.

- At the start of 2020/21 WHT received a 'whistleblowing' concern relating to the care and treatment of patients on one of the designated elderly care wards. The concern also highlighted concerns around the professional conduct of a registered practitioner. This facilitated a focused enquiry into the concerns and resulted in the development of an improved greater engagement and oversight by both the Clinical Commissioning Group (CCG) and the local Authority (LA). The outcome of the report identified some concerns regarding the process of and outcomes of the review, as a result WHT commissioned an External Review by an Interim Safeguarding Consultant in March 2021. In response to the whistleblowing concern and the on-going review a Safeguarding and Quality Steering Group was instigated by the CCG and LA to support WHT to provide the assurances that the concerns raised were effectively reviewed. These meetings will continue to take place every two weeks with a review in Q1 to review evidence that will enable the CCG and LA to have assurance around the embedding of safeguarding across WHT.

- During Q4, the Safeguarding Adult team commenced monitoring compliance against concerns raised that met the s42 enquiry criteria (as per the Care Act).This was in response to the recognition that Section 42 caused enquiry reports were not always responded to within the agreed timescales. This led to concerns from the Local authority as it had a direct impact on their ability to make a decision around the outcomes of the safeguarding concern and the conclusion of the safeguarding enquiry. The team have seen an increase in the number of requests for S42 Caused enquiries, with 2 during Q1, 7 during Q2, 19 during Q3 and 29 during Q4. A review of the completion of S42 caused enquiries will be undertaken to engage with the clinical leads to take responsibility for completion with the safeguarding team providing oversight and assurance.

- In order to develop safeguarding practice across the organisation, Safeguarding Champions were launched at the Mental Capacity Act seminar in July 2020. Each ward area has been asked to nominate a 'champion' whose role will be to drive the safeguarding agenda within their respective areas and this will also include Mental Capacity Act (MCA) and Deprivation of Liberties safeguards (DoLs). This will ensure consistent messages and learning are disseminated. They have been supported by the Named Nurse for safeguarding Adults. See Appendix 2

Actions for 2021/22:

- To continue to develop the STP Safeguarding Dashboard to enable monthly reporting and address any data shortages.

- Provide assurance to the Safeguarding and Quality Steering Group with implementation and progress of the safeguarding development plan.

- To increase the frequency of the Trust Safeguarding Committee meetings to monthly and chaired by the Director of Nursing.

- Terms of reference and membership of the Trust Safeguarding committee to be reviewed.

- Review of the reporting processes to ensure that any safeguarding related reports are presented to the Trust Safeguarding Committee prior to Quality and Patient Experience Steering group, Trust Board and Clinical Quality Review Meeting.

- For WHT to continue to attend partnership meetings and fully engage with information sharing and agency responses as per Walsall Safeguarding Partnership request for each group.

- To continue to attend Walsall MASH Management Group meetings and to escalate any operational issues which require action across the Partnership.

- To ensure all WHT Board members have received safeguarding training by the end of Q3.

- To review the current Learning Disabilities provision within the Trust.

- To undertake the Section 11 and the Care Act compliance audit for adults as directed by the safeguarding partnership Performance Quality and Assurance sub group.

- To embed Safeguarding Champions throughout the Trust.

- To review the safeguarding adult team administration provision.

Section 2: Safety
All health providers are required to have effective arrangements in place to safeguarding Children and adults at risk of abuse or neglect; are compliant with the Counter-Terrorism and Security Act 2015, and to assure themselves, regulators and their commissioner that these are working. These arrangements include: Safe recruitment standards, safeguarding practices, safeguarding policies, safeguarding team and effective arrangements for engaging and working in partnership with other agencies.

2.1 Safer Recruitment

WHT recruitment process remains compliant with the NHS Employment Check Standards which requires: Identity checking processes, requirement to ascertain references and details of employment history, requirement and process for applying for and reviewing DBS checks and a procedure for checking professional registrations and qualifications, this is reflected in the recruitment policy.

- During Q4 2019/20 the Lead Nurse for Safeguarding Children was recruited the induction period spanned over Q1 2020/21.

- In the Safeguarding Children and Looked After Team Administrator the Band 4 post has been vacant, which has resulted in a reduced capacity in the Administration Team.

- During 2020/21 there has been staff absence in the Safeguarding Children and LAC Team Administration team and in Named Nurses team due to staff sickness and maternity leave. See table below:

Staff absences	Period of time off work
Band 3 Team administrator	Q2 to Q3
Band 3 Team administrator	Q4
Band 3 Team administrator	Q4 to present
Band 7 Named Nurse	Q1 2019 to Q1 2021

During staff absences there was limited impact on Named Nurse function, absence due to maternity leave was covered by the appointment of a fixed term Named Nurse. The impact on the reduced staffing in the administration team resulted in delay is some aspects of their work, for example the typing up of team minutes. In addition the absence of administration support in the Safeguarding Adult Team continued throughout 2021/21.

- The Paediatric Liaison Nurse (PLN) post which is linked to safeguarding was recruited to in Q1 and in Q3 the post moved across to acute paediatrics.

- Funding from the CCG was secured to appoint a fixed term part time MASH Health Administrator in Q4. The aim of the post is to support the named nurses with providing the essential rapid information gathering function from electronic systems prior to strategy meetings.

2.2 Safeguarding Practice

During this period the Safeguarding Children's team completed and maintained a safeguarding situation and risk report (Sit Rep) to advice of the local COVID 19 plan for the Team. See appendix 3.

The Team maintained visibility both in the acute and community through 2021/21 and all appropriate COVID 19 risk and home working assessments were completed. The Team also adhere to the COVID 19 guidance from NHS England and had access to the Trust guidance via the Intranet. See appendix 4.

2.3 Safeguarding Policies

There is evidence to suggest the organisation did not always manage allegations against staff in line with WHT policies and the Safeguarding Partnerships. The External review into a specific ward made recommendation that 'policies and procedures must be implemented at all times when allegations are made against members of staff for the protections of patients, the alleger and the individual against whom the allegations were made'. A person in positions of Trust policy has been developed and this is planned for consultation during Q1.

- There were a number of policies that were out of date and were awaiting ratification at the end of Q4.The other policies have been prioritised for review and ratification during Q1

Policy Title	Status
The Female Genital Mutilation Policy	reviewed and consulted
Safeguarding Adult Policy	updated and ratified
Mental Capacity Act Policy	review scheduled in Q2
Deprivation of Liberty Safeguards (DoLS) Operational Policy –	review scheduled in Q2
PREVENT Policy	updated and awaiting ratification
Safeguarding Supervision Policy (for Adults and Children)	New policy awaiting approval at the Trust Policy Group.
Restrictive Intervention and Restraint Policy	updated, ratified and waiting to be uploaded onto the Trust Intranet

2.4 Partnership Working

- The Lead Nurse Safeguarding Adults continues to undertake the role as the Prevent Lead for WHT. Attendance the Walsall Prevent steering group has been maintained. WHT will continue to maintain a focus on the agenda and have planned to host a 'Prevent Seminar' in Q3 2021/22 with support from local partners.

- WHT have attended all meetings in regard to the Prevent activity agenda. Overall activity remains unremarkable. Referrals from Health across the borough have been low; the majority have been submitted by the Mental Health Trust. Whilst there has been no direct scrutiny this is something that needs to be monitored to gather some greater understanding and assurance that practitioners are able to recognise and refer as necessary.

- The mandatory NHSE returns have been completed and submitted as required with support from Information Services and workforce intelligence. See appendix 5

- The Safeguarding Children Team has seen a continued period of instability during the course of the past 4 years. Changes to the management structure and increase in workload, particular in the MASH (Multi-agency Safeguarding Hub) and the introduction of the Domestic Abuse Daily Triage in Q1 have seen significant challenge for the Team. At the end of Q4 it was acknowledged that a review was required in terms of the current resources in light of the focus WHT has on providing resources for the MASH and Domestic Abuse Daily Triage (non-statutory) has resulted in significantly reduced capacity for the safeguarding service to often carry out its full statutory role and functions (training, supervision, advice and policy development). The team have demonstrated resilience during this persistent challenging period, and remained committed to the overall delivery of the safeguarding children agenda.

- Safeguarding Children Team maintained a daily active presence in MASH. See appendix 6.

- Requests for mental health information continued to be undertaken by the Named Nurses during this year, as the mental health providers and CCG is yet to have mental health representation within the MASH. The Team have highlighted the risks associated to not having this expertise in the room to support the identification and analysis of the mental health information. WHT; Black Country Healthcare NHS Foundation Trust (BCHCFT) and the Local Authority are working together to address.

- The Safeguarding Children Team has fully engaged with Daily Domestic Abuse Daily Triage the year. See appendix 7.

- The significant IT challenges that have been present since Walsall MASH commenced in 2015 were resolved in Q1, which resulted in the improved time in which health information was being returned.

Actions for 2021/22:

- Additional resources and team structure proposed in readiness for a business case to be developed by the Head of Safeguarding during Q3.

- To review WHT MASH Service Level Agreement and resources required to meet the needs of MASH and Domestic Abuse Daily Triage from WHT perspective with LA/CCG.

- Discussions to continue with LA and CCG in regard to the funding model and contracting arrangements to support future work for the All Age Exploitation Hub.

- To work with the Local Authority (LA) and BCHCFT to develop a process for LA request for mental health checks to go directly from the LA to BCHFT and for the mental health information to be returned directly to the LA. This will increase capacity in the Safeguarding Children Team. The new process to be implemented in Q2.

- To continue to work with the CCG to secure funding to recruit a full time substantive MASH Health Administrator.

- Safeguarding Supervision model for adults to be agreed and safeguarding policy (children and adults) to be completed and ratification process to be completed by Q3 2021-22.

- A review of all policies is required to ensure the full suites of policies are up to date and available for staff to access. Policy proforma to be developed and for oversight of this within the local governance meetings.

- WHT to review processes to ensure effective and on-going communication and support for individuals who have had allegations made against them by developing a stand-alone Managing people in positions of Trust policy based on the West Midlands procedures.

- In addition to the advice calls capture and report on the advice request received via email and non-advice calls.

- To establish WHT Policy Group dates and to ensure any outstanding safeguarding policies are processed and concluded during Q3.

- The Lead Nurse Safeguarding Adults and Lead Nurse Safeguarding Children to work together with the Safeguarding Champions to incorporate and embed a think family approach to safeguarding across the Trust (E.g. children aged 16yrs and 17yrs that are admitted to adult wards). Progress with planning the Prevent seminar to be scheduled during Q3.

- Discussion with the Medical Director to identify a suitable candidate to become the Named Doctor for Safeguarding Adult (Nominated Medical Lead for Safeguarding Adult post).

Section 3: Training
Health providers must ensure the effective training of all staff commensurate with their role and in accordance with updated intercollegiate competencies relating to safeguarding: including Safeguarding Adults, Safeguarding Children, Children and Young People in Care, Prevent, Domestic Violence, MCA and DoLS, Learning Disabilities.

3.1 Safeguarding Children and Adult Training progress from 2020/21

- The Safeguarding Children Level 3 training was the first training packaged in the Trust to be converted to and delivered via MS Teams. This has been received positively and has increased the numbers of delegates that can attend each session.

- WHT Workforce intelligence distributes weekly compliance training data reports to the Safeguarding team and to the Divisional teams. The purpose of this is to support staff compliance within the Trust. The divisions present their compliance to the safeguarding committee with actions that have been taken to improve their compliance.

- 2020/21 Safeguarding Training Compliance Report, see appendix 8 reflects the compliance for the Safeguarding Levels and training programmes. It is noted that the compliance for Prevent and Safeguarding Children Level 3 had reduced for a short time. However on reflection, this may have been attributed to the staff taking annual leave, and the impact of staff absence during COVID 19.

- WHT have reported training compliance data to the internal Trust Safeguarding Committee on a monthly basis throughout 2020/21.

- The Safeguarding Team and WHT training department continue to meet on a regular basis to ensure that staffs are aligned into the appropriate level of safeguarding training as per the Intercollegiate document framework for Children 2019 and Adults 2018.

- The current safeguarding training programme includes both children and adult courses at Level 1 – 3 (as outlined within both intercollegiate document frameworks for Children 2019 and Adults 2018). Level 1 and 2 is delivered via e learning (National Safeguarding Training Programme).

- From June 2020 Core Safeguarding level 3 training for both adults and children has been delivered virtually via Microsoft teams (due to COVID 19 restrictions). Two sessions are

delivered twice a month; the training is reflective of the partnership priorities and is adjusted to reflect any emerging themes from multi-agency audits or reviews.

- During Q1 the Safeguarding Children Team offered a specialist level 3 training domestic abuse training package, this was face to face learning once a month. However this ceased due to COVID 19 restrictions in relation to face to face training. There are plans to reinstate this in Q3.

- In addition to the core and specialist training, WHT also provided additional bespoke safeguarding children training to key areas: Paediatric Assessment Unit (PAU), Ward 21 (paediatric) and ED.

- Prevent training level 1 & 2 is also delivered and accessed via e learning. From June 2020 Prevent HealthWRAP, Level 3 training has been accessible via the approved E learning package.

- Whilst there has been no face to face Prevent HealthWRAP staffs have accessed the training via e-learning for those staff that are eligible.

- In addition, any information or briefings received from the Prevent lead in the local authority is disseminated through the Trusts communication channels.

- The Adult team routinely deliver face to face sessions to wards to update them on key subject areas: Mental Capacity Act legislation, application of DoLS. Sessions have also been delivered within the community teams.

- External visits and internal audit outcomes have identified that MCA is not sufficiently embedded within clinical practice across the Trust in response to this the Medical Directorate initiated a programme to review MCA compliance, resulting in a wide range of recommendations and actions. These included staffs being provided with credit card size MCA cards, MCA documentation was revised, and audits completed in relation to the decisions around DNAR/CPR and now auditing the RESPECT tool. The audits show an improved compliance with evidence of a mental capacity assessment for those adults who are deemed to lack capacity in relation to that decision.

- The MCA Task and Finish group met on a monthly basis and membership included, Medical Directorate Programme Lead, Deputy Medical Director, Interim Head of Safeguarding, and Lead Nurse Safeguarding Adults. See appendix 9.

- The Medical Directorates involvement in the MCA improvement project has now expired with a recommendation that progress is managed by the Safeguarding team to continue to build on the improvements made. Divisions will be responsible for managing and improving their compliance via the power bi dashboard and feedback into safeguarding committee as part of their exception reports.

- The existing Mental Capacity page on the Trust intranet has been updated to include educational resources to support staff in practice.

- The Trust hosted a Mental Capacity conference during Q2. This was supported by colleagues from the Local authority, CCG, NHS England and the Legal teams. It is anticipated that this will become an annual event which will be opened up to the wider safeguarding partnership.

- Compliance regarding Level 4 training is not currently captured and access to training at this level has been reduced due to COVID 19 restriction. This will be reviewed during Q2 and local and national training has been sought to address this.

- In addition to mandatory training the safeguarding team have continued to offer bespoke face to face training in targeted ward and clinical areas during 2020/21. This is in response to recommendations made within RCA's, internal audit findings and from individual requests.

- During Q3 and Q4 the CCG and Local Authority have both raised concerns regarding Trust's safeguarding procedures in the inconsistency of recognition in practice around safeguarding adults and the failure to escalate these concerns. As a result the safeguarding team developed and delivered be-spoke training for staff on the identified ward area but will also deliver sessions across other ward areas. To raise awareness and empower staff to identify, report and escalate.

- The Trust has a Practice Improvement manager. In September 2019 the WHT DON, Independent Chair of the Partnership and the LA Head of Safeguarding, agreed that WHT would host the Practice Improvement Manager on behalf of the Partnership. It took approximately 11 months from the initial discussion at the Board to the post holder commencing in the role. In Q4 this was reviewed and it was confirmed that there is no formal agreement in place to clarify what arrangements are in place to support this agreement and ensure the individual, WHT and the Partnership Business unit are aware of their individual roles and responsibilities.

Actions for 2021/22:

- To continue to monitor compliance against all safeguarding training and report via monthly Safeguarding Dashboard to CCG and Trust Committee.

- Review domestic abuse training and review the options for delivery via Walsall Domestic abuse Co-ordinator and Wolverhampton MARAC Co-ordinator and Walsall Safeguarding Partnership.

- The review the evaluation of training, to ensure that learning is being embedded and that staff are able to recognise their role within the safeguarding agenda. This work is being progressed as part of the work that will be cited within the Safeguarding Development plan. Establish a methodology to measure the impact of safeguarding training by the development of a questionnaire that can be distributed to a sample of those who have attended safeguarding training over the last 12 months to assess the impact of learning on practice.

- To continue to offer bespoke training regarding all safeguarding topics across the Trust, including Community, which is based on need and identification of gaps within practice.

- To continue to review Level 3 children and adult training to ensure it reflects service changes both locally and nationally.

Section 4: Safeguarding Team Supervision
Safeguarding Named Doctor/Nurse/Midwife/Named Professionals have access to advice and support and a minimum of quarterly supervision with Designated Professionals.

All WHT Named professionals are required to access supervision every 3 months. This supervision is predominately offered via the CCG Designated Nurse or an external supervisor.

Safeguarding Team Supervision Activity for 2020/21

WHT Named Professionals	Safeguarding Team Supervision Compliance Q1 – Q4 2020/21	Outstanding
Interim Head of Safeguarding	Compliant	Nil
Named Nurse/Professionals x 9	8 Staff have accessed supervision	x1
Named Doctor (Safeguarding Children) x 1	Compliant	n/a
Named Midwife x 1	Compliant	n/a

Dates have been arranged for staff to receive Safeguarding Adult Supervision Training in August 2021 this will enable work around to commence the work around embedding safeguarding adult supervision as this was recognised as a priority. It is anticipated that this will begin the work around embedding safeguarding adult supervision.

Action for 2021/22:

- All safeguarding staff to continue to receive their required safeguarding supervision.

- All safeguarding staff to access peer supervision quarterly.

- All safeguarding staff to receive psychological wellbeing support quarterly.

Section 5: Trust Supervision

Professionals supervising staff or working on a day to day basis with children and families should have child and adult protection supervision available to them appropriate to their role and responsibility in order to promote good standards of practice.

- The current mode of supervision for children is via a cascade model style approach (with Named Nurses/Professionals and other staff trained to deliver supervision within the Trust). Compliance figures indicate that this model appears to be successful in the 0-19 service.

- Safeguarding supervision has not been provided consistently by the safeguarding children Team due to capacity and resource in the team. However during the first wave of the COVID 19 supervision was provided to paediatric ward areas including Emergency Department, twice a month initially and then monthly. During this period there was fear and uncertainty, which left staff feeling overwhelmed and there was nervous anticipation at what may yet come to pass. The Safeguarding Team was there to provide reflection and to promote resilience amongst colleagues.

- Practitioners working within the Health Visiting service receive safeguarding supervision as minimum every 4 months individually by safeguarding children supervisors that are part of the Community Division and not Safeguarding.

- Acute and Community Midwives receive supervision every quarter via the Named Midwife or an experienced Midwife who has completed a recognised safeguarding supervision course. This is provided either by one to one or via group supervision. These sessions are supplemented by additional supervision sessions as necessary, depending on the need identified by the practitioner/supervisor.

5.2 WHT Staff Safeguarding Supervision Summary Q1 – Q4

Total number of Health Visitors identified to receive safeguarding supervision within timescale	**Total number of staff who attended within timescale**	**Total number of midwives identified to receive safeguarding supervision within timescale**	**Total number of staff who attended within timescale**
Q1 - 66	20 (30%)	**49**	29 (59%)
Q2 – 77	24 (31%)	**58**	41 (70.7%)

Q3 – 75	16 (21%)	**56**	46 (82%)
Q4 – 72	19 (26%)	**56**	40 (71.4%)

The above data demonstrates that there is overall a good compliance for staff receiving safeguarding supervision on a regular basis in both the health visiting and midwifery service within the required timescale. However, it is recognised that the team need to understand the reasons why staff were not able to attend within timescale and this will be explored in Q1.

Safeguarding Supervision to acute paediatric wards in currently under review as the take up was intermittent and on some occasions supervision did not take place. This was reported to be due to operational commitments. Safeguarding Supervision ceased for a short period in the acute but is due to recommence in Q2 2021/22.

- During Q3 the Safeguarding Children Safeguarding Supervision Policy was reviewed and the direction of the policy changed. It was agreed that a combined adult and children safeguarding supervision policy for the Trust was required. This will be progressed within the organisation during Q1/Q2.

- Dates have been arranged for staff to receive Safeguarding Adult Supervision training in Q2-August 2021.

- To commence the work around embedding safeguarding adult supervision.

- The safeguarding team (adult and children) have liaised with ward and community areas on a daily to respond to any safeguarding issues that require intervention, escalation or support. This will be reported more formally 2021/22.

- The Safeguarding Children Team provided group safeguarding children supervision to the Community Paediatric Nurses/PAU/Ward 21 and ED staff.

Actions for 2021/22:

- Ratification of the Safeguarding Team Supervision policy.

- To roll out via a communication briefing the details of the new combined supervision policy.

- For staff to complete any outstanding safeguarding supervision.

- For Safeguarding Teams to commence reporting on supervision compliance including bespoke support/supervision/or caseload management feedback every month. This will be reported by the Safeguarding Team to the safeguarding committee meeting.

- For Safeguarding Children and Adult team to continue to provide visible leadership to the ward and community areas to raise awareness of safeguarding and to offer support as needed.

- To develop a timetable to deliver group supervision for the Neonatal Unit (NNU) and Sexual Health service as part of an extended support process by the Safeguarding Children Team. The scoping of the NNU and sexual health team has been completed.

- To review the safeguarding children supervision with Allied Professionals working with children and families.

- To review the cascade model with the Trust.

- To review the safeguarding children supervision arrangements in the Health visiting service.

- For adult staff to attend safeguarding adult supervision training in August 2021.

Section 6: SCR/DHR/SAR
Health providers are required to provide chronologies and reports for Section 42 Enquiries, Child Practice Reviews, Child Death Reviews, Domestic Homicide Reviews and other learning reviews as required on time and in line with Safeguarding Partnerships, SAB's, Community Safeguarding Partnership Terms of Reference and Templates.
Section 6b: Recommendations and Learning from all types of learning reviews are distributed to relevant staff and there is evidence of practice change.

WHT Compliance 2020/21

- During 2020/21 WHT represented and aligned to all respective safeguarding case groups across the region. This covers work aligned to Section 42 Enquiries; Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR).

- The learning from the two published Child Safeguarding Practice Reviews (CSPR, previously referred to as Serious Case Reviews) see appendix 10, in 2020/21 has been disseminated. As part of the Safeguarding Development plan, the learning and/or gaps will be captured and reported to the safeguarding committee.

- During 2020/21 there was four Rapid Reviews initiated by WHT, one of which met the criteria for a local child safeguarding practice review. This has not yet been published. The single agency recommendations from this review will be added to the safeguarding team learning reviews single agency action plan and reported to the Safeguarding Committee.

- It is noted during 2020/21, WHT participated in the multi-agency review of one LeDeR case. The learning from this case will be disseminated following feedback from the LeDeR Strategic Group. It was a recommendation that the case be considered as a Serious Adult Review and the partnership practice review group has agreed that this progress to a Serious Adult review

- Panel meetings were still being held during 2020/21 in relation to one Domestic Homicide Review that was commenced during 2019/20. This was due for completion during 2021/21; delays were due to the complexities around criminal proceeding and uncertainty around the alignment of the DHR process.

- There were no SARS initiated during 2020/21 and one Rapid review was held. The Learning has been translated into a multi-agency and single agency action plan.

- Three requests for SAR consideration were received by the Practice Review group during Q4 2020/21, scoping documents have been submitted.

Section b

- The learning from these reviews were shared in the safeguarding children level 3 training and cascaded to all staff member via a 7 minute briefing which detailed the child's lived experience and the learning for practitioners regarding connected carer's**.**

- The recommendations and learning from all types of learning reviews and are embedded in to training and supervision.

Actions for 2021/22:

- WHT single agency action plans are to be developed by the representative who will be representing the Trust at the Practice Review Group.

- To ensure WHT continue contribute to all enquiries as part of their role within the Walsall Safeguarding Partnership Group and other external safeguarding panels.

- Consider the development of in internal Trust PRG, the group will have TOR and be responsible for monitoring the implementation of the action plans (from PRG to WHT) and to ensure that communication processes in regard to wider learning is robust.

- Progress work to collate the details regarding the cases, to collect outstanding data and to conclude any case action plans that remains outstanding by working with the WHT PRG group representative.

- To attend WSP Practice Review Group and all related meetings that require Trust representation on request and ensure this is feedback to internal groups including the safeguarding committee.

- To ensure key staff within WHT have expertise in regard to completing IMR or Chronologies during 2021/22.

- Await the decisions regarding SARs referrals and contribute as necessary.

Section 7: Safeguarding Activity and Process
Health providers are required to provide evidence that patient assessment processes within The organisation identifies appropriate risk and need, and result in an appropriate response; including where the criteria for statutory enquiries are not met.

There are a number of key area activities in the safeguarding team, which include

7.1 On Call Advice service
During 2020/21, the safeguarding children team managed 308 advice calls through the advice and support on-call system. Each call is logged on the safeguarding children database, which captures the origin, volume and nature of the calls received. The advice calls have been varied i.e. practitioners have requested support with escalation of cases to CSC and poor parental engagement. See appendix 11.

7.2 Court Reports
During 2020/21 the Safeguarding Children supported 87 practitioners to complete court statements requested by Legal Services. The Health Visiting, School Health Service and Neonatal Unit received the majority of the requests for statements from the Courts.

7.3 MASH and Domestic Abuse Triage
The WHT Named Nurse for Children continues to provide cover within Walsall MASH for safeguarding children referral activity and for Domestic Abuse Triage, this covers Monday to Friday as per MASH requirements. WHT have provided 100% cover throughout 2020/21. See appendix 6 & 7.

7.4 MARAC
WHT have contributed to the domestic abuse agenda through their input into Domestic Abuse Daily triage and the MARAC process by scoping relevant victim information on targeted case systems covering both adult and children activity. During 2020/21, attendance at MARAC was via MS teams and undertaken by the Safeguarding Children Team (see appendix 12). Work is continually undertaken to raise the profile of domestic abuse in view of isolation and restrictions placed on vulnerable people during Coronavirus. Domestic Abuse will remain a focus for the Trust during 2021.

The Safeguarding Children and Adult team have routinely undertaken 'floor walk' leadership activity on the wards at Walsall Manor, which has been welcomed. The focus of this work is to ensure that the safeguarding agenda is embedded across the Trust. Feedback from WHT service has been positive.

It is noted during Q1 that WHT Safeguarding Adult Team raised awareness of safeguarding and risk within the Trust through the joined up work in regard to concerns raised by the partnership. This resulted in enhanced support from the Walsall CCG Designated Adult Professional who provided useful oversight (with them) of ward staff activity and ability to escalate safeguarding issues. Part of this work included undertaking a safeguarding questionnaire with staff to establish their knowledge base. Overall it was concluded that staff had a reasonable understanding of the safeguarding agenda and their role. This ward based oversight is continuing during Q2/Q3. A full report will be prepared for the Trust Committee in 2021-2022.

Safeguarding Incidents have been referred to the safeguarding team for their perusal.

8.3 **Deprivation of liberty safeguards**

- WHT submitted 291 DoLS applications during 2020/21 none of which were authorised compared to 219 applications during 2019/20, of which 4 were authorised

- The highest numbers of applications received were received from Ward 16 (Gastroenterology ward). During 2020/21 the safeguarding team have continued to support ward areas with the completion of the DoLS applications. The monthly audits undertaken show themes around staff engagement with carers in relation to the application and the quality of the application forms.

- The safeguarding team continue to have weekly correspondence with the DoLs team within the local authority to review the applications that have been submitted.

- The DoLS register is part of the Trust electronic system and enables the safeguarding team to monitor DoLs applications. The register is reviewed and revised with the support of the Trust informatics team. See appendix 13.

Actions for 2021/22:

- To review the Safeguarding Children Team arrangements within MASH.

- To continue to monitor activity across the safeguarding agenda for children and adult activity.

- There are 5 outstanding 'historical' incidents documented on Ulysses, the Trust Incident reporting system, these are currently under review and will reviewed and concluded by Q3.

Section 8: Audit
Health providers are required to provide evidence of incremental improvement of processes over time through; regular evaluation through audit, leading to required improvements in the light of their efficiency, effectiveness and flexibility.

- During 2020/21 WHT Safeguarding Children Team participated in a multi-agency case file audit to consider the impact of 'Neglect' with a focus on: agency recognition, impact, agency response, stakeholder engagement, communication pathway and the voice of the child. A multiagency action plan is being developed as a result (see appendix 14).

- During 2020/21 WHT Safeguarding Adults Team participated in a multi-agency case file audit to consider- self neglect, caused enquiries, quality of care, financial abuse. A multiagency action plan and 7 minute briefings are developed after each audit. See appendix 15.

- The safeguarding adult's team continue to undertake monthly audits in relation to Dols and DNAR/CPR. Compliance reports in relation to Partnership performance measures have been undertaken: MCA, Making safeguarding personal.

- During Q3 the Safeguarding Children Team including the Named midwife were co auditors in the Multi -agency Audit on Domestic Abuse.

Action for 2021/22:

- WHT will continue to monitor safeguarding audit and action plans through the Trust Safeguarding Committee.

- Safeguarding Children to commence Team audit schedule for 2021/22. See appendix 16.

- WHT will continue to participate in partnership audit processes as requested.

- The Safeguarding Children and Adult service will be developing a joint audit programme for 2021/22.

Section 9: National Reports and Inquiries
Health providers are required to report on the implications of recommendations made in the inquiries on their specific organisation and the resulting action plan with subsequent updates.

There has been one focused visit to Walsall Metropolitan Borough Council children's services during 2020/21. Inspectors looked at the Local Authority's arrangements for contacts and referrals in the multi-agency safeguarding hub (MASH), thresholds for children in need and child

protection, and arrangements for children and families stepping down to early help and to the Initial Response Service (IRS) for social work assessment. Inspectors considered a range of evidence, including case discussions with social workers and children's case records. They also reviewed the Local Authority performance management and quality assurance information. See appendix 17.

Action for 2021/22:

- WHT to ensure that relevant reports or inquiries are processed and any resulting action plans developed.

Appendix 1	Appendix 2	Appendix 3	Appendix 4	Appendix 5	Appendix 6
Structure Chart Safeguarding Team (	Role of the safeguarding champi	26.04.2020 Safeguarding Risks C	Home Working Guidance and help du Home Working Guidance and help du	Copy of PREVENT_Summary_	Safeguarding Children MASH Data
Appendix 7	**Appendix 8**	**Appendix 9**	**Appendix 10**	**Appendix 11**	**Appendix 12**
Domestic Abuse Daily Triage Q1 - Q4	Safe Safeguarding Training.pdf	Project plan and actions.xlsx	WHT CSPR.docx	Safeguarding Children Advice call D	MARAC Cases discussed 2020 21.do
Appendix 13	**Appendix 14**	**Appendix 15**	**Appendix 16**	**Appendix 17**	
Dols annual report 2020.2021.pptx 7 Minute Briefing - Dols applications Key	Children's MAA plan 2021-22.docx	MAA Adults.docx	Audit Plan Safeguarding Childre	Walsall_Focused_visit_of_local_authority_	

Supplementary information					
Pie chart to demonstrate total od	Total number of children subject to a	Total number of children under a child	Pie chart to demonstrate the total	Pie chart to show how many children a	Pie chart to show how many children a

Graph to show how many children are su	2020.2021.pptx ~~Safeguarding adults~~ data 2020.21	Audit Plan 2021 2022 v1.pdf			

MEETING OF THE PUBLIC TRUST BOARD – 7th October 2021			
Performance, Finance & Investment Committee (PFIC) Highlight Report			**AGENDA ITEM: 14**
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 29th September2021. Of note are: • The Financial position of the Trust has moved into a £0.3m deficit at month 5, forecasting a trading deficit of £0.95m at close of H1 (September 2021). The Division of Medicine and Long-Term Conditions exceeding resource plans the key driver in the deteriorating financial position, with high temporary workforce costs in servicing increased Urgent and Emergency demand. The Trust has invoked the risk share within the STP owing to the costs being driven through supporting the response from the system to high Emergency demand. The Trust to receive a funding allocation of £0.95m to offset this trading deficit, the result being for the Trust to forecast delivery of H1 financial plan. • Members reviewed the financial modelling undertaken for H2, developed through modelling of the Operational plans for the second half of the financial year (to include Winter, Nursing and theatres support delegated by Board). Members received confirmation on impacts on the expected efficiency ask and details of potential mitigations (ERF earned if received an example) to deliver financial balance. Excluding efficiencies, the Trust would have a potential c£4m deficit for H2 and the 2021/22 financial year (should the efficiency be 3% of H1 allocation).		

	However, the STP is still to receive confirmation of income allocations, as such members endorsed the recommendation for an extra-ordinary meeting to be held to review the financial plans upon confirmation of income allocations. As the income envelope was (and at time of writing this report remains) unknown a full discussion regarding the Theatres Establishment Business Case, Nursing workforce and other developments was also deferred to the Extraordinary meeting of the Committee, when income allocations and efficiency plans are expected to be known. Members noted required efficiencies compared to plans developed was low, with this aspect key to delivery of plan and an enabler for further investment, enhanced focus within this area was requested for the next meeting. The Executive are then to present the recommended operational and financial plans from PFIC to Board for endorsement, this results in a month delay in Trust Board endorsement of financial plans. • Formal approval was sought for the Theatres Insourcing plan amounting to £352k during H2 2021/22, as per the delegated authority from Trust Board and this was approved. • Restoration and recovery efforts in both the acute and community are on track. Members received an update that the 7th elective theatre stepped down during July has servicedsome activity during September. It was also highlighted to Committee that there is a risk that the extent of pressure on theurgent and emergency care system could jeopardise ability to deliver elective recovery. In the community a return to group activities and recruitment to vacancies has seen an improved position, but the risk to Community estate was highlighted. • Operational performance is strong, despite pressure in both Acute and Community (particularly in Urgent and Emergency Care Pathway) and with reduced capacity for packages of care in the Community. Committee received an update on the vaccinations programme which has now exceeded 150,000

	vaccinations. Committee commended the exemplary partnership working demonstrated in achieving this. • Committee received a report detailing the Winter plan for 2021/22. This was commended for being a comprehensiveplan for mitigation of Urgent and Emergency care pressure, but assurance was sought as to contingencies in the worst-case scenario. This was agreed to remain as a standing agenda item. • A business case for the introduction of a Safety and Quality management system was presented to Committee (the award required to commence from 14th October 2021 to deliver in year). Approval given to resource the c£147k annual licencefor two years, set up costs and Trust backfill of officers (a financial envelope of c£400k over two years). Further analysis of benefits modelling for this case is to be presented at a futuremeeting of Committee. This additional spend will require modelling within the H2 forecast position presented earlier in the meeting. • A business case for the introduction of a Medical and Clinical Fellowship infrastructure to replace the existing SLA was presented. This shows a return on investment for each post appointed to through the programme and was approved by Committee. • Members wanted to record their thanks for the significant contribution of Mrs Baines and Mr Fradgley (this being their last meeting of PFIC for the Trust) and wish them success in their future ventures. The next meeting of the Committee will take place on 27th October 2021, as noted above an additional Extraordinary meeting of the Committee will take place before this date.
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 7th OCTOBER 2021			
Use Resources Well Executive Report			**AGENDA ITEM: 15**
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, a result of the impact of the COVID-19 pandemic. Board members receiving an update on financial performance following formal adoption of the financial plan for April to September 2021 (Horizon 1 – H1). The Trust has moved into a deficit in August 2021 of £0.3m (month 5 of 2021/22) and is forecasting a trading deficit to plan of c£0.95m for H1. The forecast trading deficit centres upon the Medicine and Long-term Conditions Division exceeding planned resource allocations. The drivers of this adverse variance centre almost entirely upon the Urgent & Emergency Care demands that the Trust is experiencing from increased attendances and ambulance conveyances (supporting the STP in emergency care) contributing to high levels of temporary workforce. As the forecast deficit is driven by increased emergency activity, the Trust has invoked the risk share agreed within the sustainability and Transformation Partnership (STP) resulting in the Trust securing additional income of £0.95m. This offsets the forecast		

	trading deficit and results in the Trust revising its forecast back to break-even for H1, maintaining the success in delivery of a surplus for the previous two financial years. The report then focuses upon plans being developed for October to March 2022, Horizon 2 (H2) income expected to be comparable to H1 less an efficiency requirement. Delivery of H2 Operational plans within resource envelopes will be challenging. The primary risks to delivery of 2021/22 financial plans in H2 being (a) additional costs to be incurred for winter, (b) H2 actual income allocations yet to be confirmed (at the time of writing) (c) the need to deliver efficiencies to offset an expected income reduction and enable further investment. The National and Regional teams of NHSEI have confirmed funding allocations are known. However, the STP is yet to receive confirmation of allocations and as such it has not been possible to present the H2 financial plan for endorsement to Board colleagues. A paper presented to the Executive Team, Trust Management Committee and the Performance, Finance and Investment Committee (PFIC) detailed current financial modelling undertaken with Operational teams, key risks being income confirmation and delivery of efficiencies to service developments. The recommendation being for an extra-ordinary PFIC to be held to review expenditure plans against resource allocations (onceincome allocations are known). In addition, the income allocations for the 2022/23 financial year are expected to further reduce. The current run rate is 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 to live within its means. However, the provider base for the NHS would face a similar challenge. As such, whilst the Trust awaits formal guidance on allocations, the focus remains on identifying baseline (normalised) expenditure exit run rate for March 2022 for when we enter 2022/23 (this will be a key area for debate within the extra-

	ordinary meeting of PFIC). The report identifies continued strong operational performance. It highlights exceptional constitutional standard performance in the DM01 6 week wait diagnostic standard with the seventh consecutive month of waiting times amongst the Top 10 general acute Trusts in the country, and the Trust now ranked 1st (of 122 reporting general acute Trusts) in the country (July 2021) for diagnostic waiting times. However, it notes temporary staff absence within the sonography service during August that will effect Diagnostic waiting times during August, September and October. 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 seventh consecutive month. It notes increasing pressure on the Trust's 4-hour Emergency Access Standard performance associated with record high levels of Type 1 Emergency Department attendances,increasing numbers of ambulances received that have been intelligently conveyed away from neighbouring Emergency Departments due to excessive ambulance handover times, andwith higher hospital bed occupancy associated with increased numbers of Medically Stable For Discharge patients as a result of challenges in the domiciliary care market. It notes that the country as a whole has delivered the worst 4-hour Emergency Access Standard performance on record in August 2021, and that Urgent &Emergency Care systems are under unprecedented strain. For this reason the Trust's Winter Plan (under separate agenda item), is vital to ensure sufficient resilience in Urgent & Emergency Careover the Winter Period. 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 fifth 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 significantly better than the West Midlands average and in line with the national average (July 2021), and both suspected cancer and Breast Symptomatic 2 week wait

	performance have also improved. The report notes that the Trust is providing mutual aid to TheDudley Group NHS Trust for the suspected Skin Cancer pathway,to The Royal Wolverhampton NHS Trust for long waiting patients needing Urology surgery 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 forecast to deliver plan, with STP additional allocation** • Income for Horizon 2 is yet to be confirmed, the Trust has developed a run rate model based on H1 less an efficiency (to include winter costs and Nurse investment) efficiency attainment will be key. • **PFIC are to hold an extra-ordinary meeting to debate H2 financial plan and investment prioritisation, the plan then to be endorsed by Board at the next meeting (in line with national requirements for submission of H2 financial plans in November 2021)** • The Trust is developing exit run rate models to understand expenditure baselines for 2022/23, when income allocations are known the Trust can then develop plans for 2022/23. • The Trust is seeking additional capital allocations to off-set the risk to the capital programme for much needed ward infrastructure works. A further central capital allocation has been made available for 2021/22 nationally, the Trust has made bids to mitigate this risk and further support a number of schemes. • The Trust's Winter Plan is before Board for approval, under separate agenda item.
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: *We will deliver optimum value by using our resources efficiently and responsibly* - 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 trading deficit of £0.3m to August 2021 of the financial year (month 5 of 2021/22). The Trust forecasting a trading deficit of £0.95m that has been mitigated through securing additional income from the Sustainability and Transformation Partnership (STP) and is therefore forecasting 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 best performance of 122 reporting general acute Trusts in the country. It highlights strong relative performance in emergency care with the Trust's ambulance handover times (within 30mins) the best performing in the West Midlands for the seventh consecutive month, and 4-hour Emergency Access Standard performance in the Top 40 performing Trusts in the country for the sixth consecutive month. However, the report notes the increasing pressures on Urgent & Emergency

Care services and the critical importance of the Trust's Winter Plan in maintaining access to safe, timely emergency care. The report highlights the Trust's stable 18-weekReferral To Treatment waiting time standard performance, which is mirrored by the Trust having the fifth 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 in line with 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:

- 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 service the plan and 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 in advance of the September Committee meeting. The review noting risks articulated centring upon a lack of clarity on income envelopes, uncertain demand for urgent and emergency care and delivery of winter plan initiatives within a reduced resource allocation from H1 (H1 less an efficiency ask) combined with a need to attain efficiencies to offset reduced income but also enable investment in services.

The conclusion of the review was for the risk to remain as reported, owing to the significant uncertainties regarding income to be received for H2 and the level of efficiencies that can be generated to offset income reductions and serviceinvestments.

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 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 a trading deficit at month 5 of 2021/22's financial plan, attaining a £0.3m deficit to August 2021. The Trust forecasting a trading deficit against the H1 overall plan of £0.95m. However, the Trust has secured a further income allocation to offset this deficit forecast of £0.95m, and as such is forecasting delivery of the H1 financial 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 planned resources by £1.4m year to date and is driving the Trust overall deficit. The drivers of this adverse variance centre almost entirely upon the Urgent & Emergency demands the Trust is experiencing from increased attendance and ambulance conveyance (increased urgent and emergency care demand).

  However, as the forecast deficit is driven by increased emergency activity including from neighbouring boroughs as a result of West Midlands Ambulance Service Intelligent Conveyancing to Walsall Manor ED due to shorter patient handover times, the Trust has invoked the risk share agreed within the sustainability and Transformation Partnership (STP) resulting in the Trust securing additional income of £0.95m. This offsets the forecast trading deficit and results in the Trust revising its forecast back to break-even for H1.

  The cost exposure driven through the Urgent and Emergency demands has been modelled within the H2 financial planning.

- **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 5 to deliver a c£2.2m 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 performance needed to trigger payment against historic activity thresholds increasing in future months. STP members are accruing out the benefit from ERF potential income on a comparable basis, owing to the uncertainty regarding actual receipt. If receivablethis will be available therefore to support financial planning in H2.

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

The Trust has entered a risk share with the STP, essentially indicating nomember 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 deficit at month 5 of c£0.2m (year to date). However, this position for the STP includes a reported year to date deficit of c£1.7m for West Midlands Ambulance Service (WMAS).

This WMAS reported position will be mitigated through escalation to regulators as the STP is reporting the entire deficit (when only representing 23% of the activity serviced) as the service covers activity from outside of the STP boundary (the full cost impact reported owing to the STP hosting the partner organisation).

It is expected that the STP will only offset 23% of the WMAS deficit and thus this would move the STP into surplus overall. It is of note all other members are forecasting attainment of break-even for H1 of 2021/22 and agreement has been reached for Walsall to receive c£0.95m from the risk share to offset the forecast trading deficit.

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 ERF estimated to total c£19m). The STP potential adverse impacts from the risk share managed, all partners on plan to deliver break-even for H1 with Walsall to receive additional funds (WMAS deficit escalated with NHSEI and neighbouring STP's and the 23% share of the deficit off-set within the STP through an additional allocation also).

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

Income allocations for H2 have not been released (at the time of writing), this remains a key uncertainty in production of financial plans for the latter 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 reduction for efficiency

The development of run rate modelling with the Operational teams to 'live within the expected income allocations' for H2 has resulted in a need to move expenditurebetween Divisions, off-setting the increased ask of urgent and emergency care servicesduring winter (c£4m increase on H1 run rate) and in addition, reducing overall costs 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 primary risks to delivery of 2021/22 financial plans are:

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

The results of the Operational Plans have been modelled, with run rates presented to the Executive, Trust Management Committee and Performance Finance and Investment Committee. However, the modelling identifies a key risk associated with the
(a) delivery of efficiencies over the H2 period of the financial year, and as such (b) a shortfall in servicing developments, current modelling including Winter Plan, Nursing and insourcing.

In addition, the National and Regional teams of NHSEI have confirmed funding allocations are known. However, the STP is yet to receive confirmation of allocations and as such it has not been possible to present the financial plan for endorsement to Board colleagues.

The Operational Plan presented to PFIC recommending an extra-ordinary PFIC be held to review expenditure plans against resource allocations (once income allocations are known). This would enable debate over investment prioritisation and articulation of the level of efficiency that can be secured for H2 and thus outturn, also giving clarity on normalised expenditure in readiness for the debate on 2022/23 financial plans.

The result is for the Trust to enter October 2021 without an endorsed Operational and Financial Plan through Trust Board, though the production and adoption of the plan in October will enable endorsement to occur prior to the national timetable for submission of plans in November of 2021.

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 than historically, and whilst an element of this cost will be expected to reduce as Covid-19 subsides and (or 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 (though noting one off mitigations exist in the form of ERF income if receivable).

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 on 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 thesecommitments and balance the programme accordingly.

An additional source of capital resource has been made available to the NHS, with very tight timeframes for bidding for this resource (co-ordinated through the STP). The Trust has made applications that if successful would mitigate the in-year risk to the programme from the ward refurbishments, and give a separate route to resourcing investments within areas such as Tele-tracking.

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:

The Trust has maintained statistically significant improvements in the percentage of patients triaged within 15 minutes of arrival to the Emergency Department (ED) with 9 consecutive months above the mean average, and continues to deliver the best Ambulance Handover times (<30 minutes) in the West Midlands for the seventh consecutive month in August 2021. This has been achieved despite sustained high number of Type 1 ED attendances through August 2021, 6.1% higher than August 2019, and whilst supporting neighbouring Trusts with mutual aid through receipt of 96 ambulances intelligently conveyed away from neighbouring Trusts with prolonged ambulance handover times during August 2021.

4-hour Emergency Access Standard performance in August 2021 has deteriorated further to 79.37% of patients admitted or discharged within 4 hours of arrival to ED, but the Trust was still ranked 37th nationally out of 113 reporting Trusts. The deterioration in 4-hour Emergency Access Standard performance has been in part due to increased bed occupancy as a result of a significant increase in the number of Medically Stable For Discharge (MSFD) patients in hospital due to challenges discharging patients who require domiciliary packages of care. The detail and actions to address this are included in the Care at Home section, and are important given that timely emergency care is crucial given the clear association between prolonged duration of stay within EDand both increased mortality for admitted patients, and worse patient experience. Giventhe worst access to emergency care ever recorded at national (England) level inAugust 2021, it is vital that additional resilience is built in through formal adoption of theTrust's Winter Plan which is before the Board under separate agenda item.

Elective Care:

The Trust's 6 Week Wait (DM01) Diagnostics performance was the best in the country (July 2021 reporting), out of 122 reporting general acute Trusts. However, temporary staff absence within the ultrasound service during August (sickness, and self-isolation) have meant that performance has deteriorated in August as a result and will take until the end of October to recover. Recovery of access to ultrasound diagnostics is important to ensure that serious disease that needs urgent treatment is detected and acted upon promptly, and to ensure GP and other community clinicians have access to timely diagnostic information to support the management of patients in community settings.

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 70.27% of patients now waiting under 18 weeks at the end of August 2021, and is 55th nationally (out of 122 reporting Trusts) for July 2021 performance. In addition, the Trust's 52-week waiting time performance is 5th best in the Midlands (out of 20 Midlands Trusts). The Trust now has 523 patients waiting in excess of 52-weeks as at the end of August 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. The Trust is about to commence mutual aid to The Royal Wolverhampton NHS Trust to support reductions in the longestwaiting Urology patients.

In July 2021, for 62-day Cancer performance the Trust was materially better than West Midlands average (60.5%) and in line with the national average (72.1%), with 72.04% of our patients treated within 62 days of GP referral. Patients referred by their GP on 2 week wait suspected cancer and Breast symptomatic pathways both have had improved access again. Mutual aid to the Royal Wolverhampton NHS Trust for Breast Cancer pathways has now ceased following reduction in Wolverhampton waiting times. The Trust is now providing mutual aid to The Dudley Group NHS Foundation Trust for patients with suspected skin cancer, however. 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 (Q1 2021/22 – Model Hospital).
- Average Length of Stay for elective admissions rolling 6 months below peer and national median (Q1 2021/22 – Model Hospital)
- Average Length of Stay for emergency admissions rolling 6 months below peer and national median (Q1 2021/22 – Model Hospital)
- Average late starts in Operating Theatres better than peer and national median (August 2021 – Model Hospital)
- Touchtime Theatre utilisation better than peer and national median (August 2021 – Model Hospital)

A report to the Performance, Finance & Investment Committee in September 2021 from the Chief Operating Officer and Director of Integration recognised that the altered operating environment of the Covid-19 pandemic means that the majority of the operational productivity improvements have not been cash-releasing cost improvements, and the block contract environment similarly means that they are not PbR income generating improvements either. Further work is required to define the opportunity for additional H2 and 22/23 Efficiency Programme savings. The additional H2 saving opportunity review will feed into the final version of the H2 financial plan. Theexisting Effective Use of Resources Improvement Programme will be re-orientated overH2 into a Financial Improvement Programme targeting cash releasing efficiency savings. This will have a defined Efficiency target for each Division (clinical and corporate), based on the final H2 Planning Guidance.

5. RECOMMENDATIONS

Members of the Trust Board are asked to:

- Note the contents of the report.
- Note the following actions;
    - **H1 forecast to deliver plan, with STP additional allocation**
    - Income for Horizon 2 is yet to be confirmed, the Trust has developed a run rate model based on H1 less an efficiency (to include winter costs and Nurse investment) efficiency attainment will be key.

- **PFIC are to hold an extra-ordinary meeting to debate H2 financial plan and investment prioritisation, the plan then to be endorsed by Board at the next meeting (in line with national requirements for submission of H2 financial plans in November of 2021)**

- The Trust is developing exit run rate models to understand expenditure baselines for 2022/23, when income allocations are known the Trust can then develop plans for 2022/23.
- The Trust is seeking additional capital allocations to off-set the risk to the capital programme for much needed ward infrastructure works. A further central capital allocation has been made available for 2021/22 nationally, the Trust has made bids to mitigate this risk and further support a number of additional schemes.

APPENDICES

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

Latest Board/Committee/Group - 20/09/2021
Version V4.03

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 05 - Use Resources Well; We will deliver optimum value by using our resources efficiently and responsibly.**
Risk Description:	The Trust's financial sustainability is jeopardised if it cannot deliver the services it provides to their best value. If resources (financial, human, physical assets & technology) are not utilised to their optimum, opportunities are lost to invest in improving quality of care. Failure to deliver agreed financial targets reduces the ability of the Trust to invest in improving quality of care, & constrains available capital to invest in Estate, Medical Equipment & Technological assets in turn leading to a less productive use of resources.
Lead Director:	Chief Operating Officer.
Lead Committee:	Performance, Finance, & Investment Committee.
Links to Corporate Risk Register:	Title: • **208** - Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks (Risk Score = 16). • **665** - Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation (Risk Score = 15). • **1005** - Insufficient capital funding for the estate 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 = 8). • **2081** - Delivery Operational Financial Plan. (Risk Score = 16). • **2082** - Future Financial Sustainability. (Risk Score = 9). • **2398** - Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care. (Risk Score = 12).
	Current Risk Score Movement: **Likelihood = 3 Consequence = 5 = 15 High** ↔
	Forecasted Risk Score Movement for Q3: **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	Evidence of risk control • 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. • Improved Cost per WAU, and operational productivity indicators (Model Hospital) Evidence of risk gaps in control • 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 remains, whilst international nurse recruitment • West Midlands Ambulance Service Intelligent Conveyancing protocol resulting in significant out of borough ambulances conveyed to the Trust, forecast to equate to circa £1.5m of ED attendance and non-elective admission activity during 21/22. • Formal Month 5 submission to NHSEI Midlands/ICS re-forecast to a £952k adverse variance to H1 plan. • Increasing general risk in the UEC system due to high demand on EDs, and compromised domiciliary care market resulting in excessively high hospital bed occupancy. • Lack of credible capital plan to fully address backlog maintenance requirements, despite 5-year Capital Programme in place. Evidence of planning uncertainty • 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.	Likelihood:	2	31 March 2022
Consequence:	5			5		Consequence:	5	
Risk Level:	**15 High**			**15 High**		Risk Level:	**10 Moderate**	

					• Significant uncertainty still associated with H2 (Q3 and Q4) 2021/22 financial arrangements.			

Control & Assurance Framework - 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Financial position reported monthly via Care Groups, Divisions, Divisional Performance Reviews and Executive Governance Structures. • Revised financial governance in place for COVID-19 through the Trust's Governance Continuity Plan. • Board Development session for the Improvement Programme with identified 3-year targeted financial benefits.	• Performance, Finance & Investment Committee in place to gain assurance. • Audit Committee in place to oversee and test the governance/financial controls. • Adoption of business rules (Standing Orders, Standing Financial Instructions and Scheme of Delegation). • Use Resources Well work stream of the Improvement Programme has Governance infrastructure in place.	• Externally benchmarked Financial and operational productivity performance data, particularly (but not exclusively) through Model Hospital.
Gaps in Controls:	• Business planning processes require strengthening. • Accountability Framework has been approved however needs 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 1st 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.	

Walsall Healthcare NHS
NHS Trust

Use Resources well

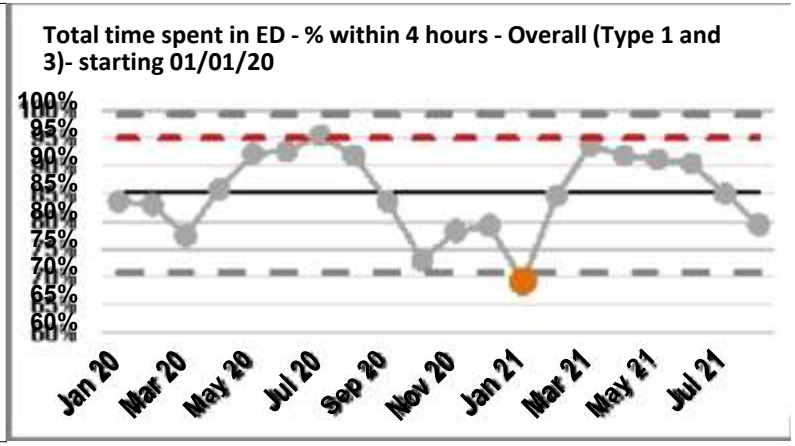
Caring for Walsall together

Use Resources Well - Performance

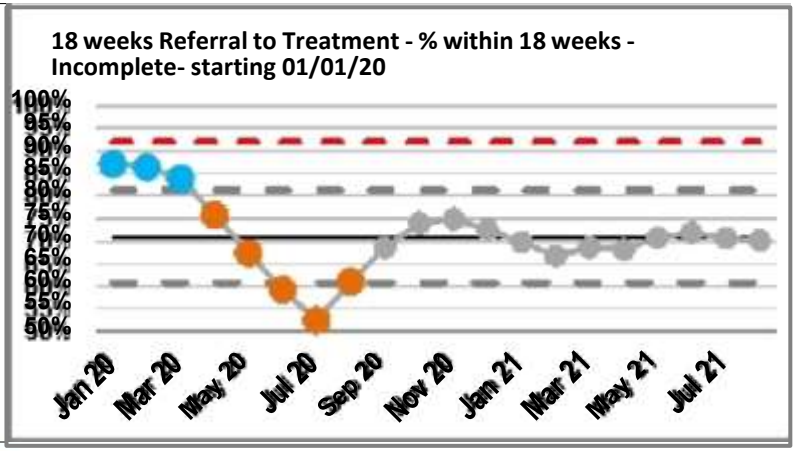
SPC Key

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

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



18 weeks RTT – Incomplete Pathways



Narrative (supplied by Chief Operating Officer)

Emergency/Urgent Care

The 4-hour Emergency Access Standard (EAS) performance achieved 79.37% of patients admitted or discharged within four hours of arrival to the Emergency Department for the month of August 2021. This is a deterioration in performance from the July position of 84.96%. These waiting times are not acceptable for our patients and this mirrors pressure being seen across the West Midlands patch.

Commencing 30th August the hospital commenced a cross Divisional 'Perfect Pathway Fortnight' to attempt new ways of working to improve the standard of Emergency Care. This featured interventions ranging from extended Urgent Treatment Centre, Direct Streaming, an Integrated Single Point of Access and extended front door therapies. The data from this fortnight will be evaluated with a view to introduce the beneficial interventions soon to address the continued UEC pressure.

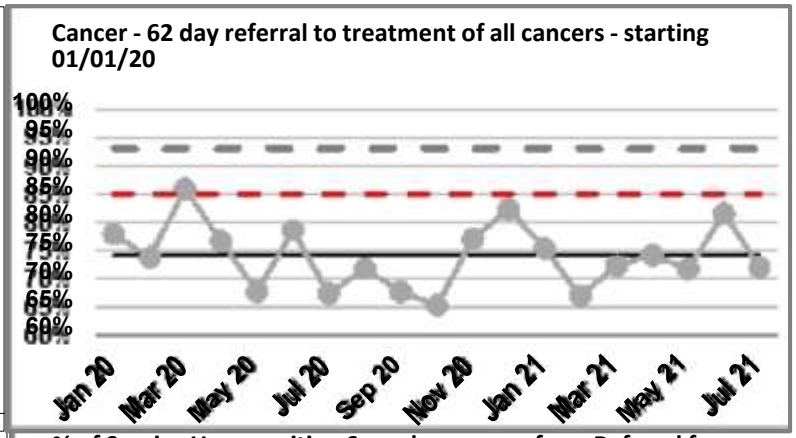
RTT (18 weeks Referral to Treatment)

In August 2021, 18 week RTT incomplete performance is in line with the forecast with 70.27% of patients waiting less than 18 weeks, relative to a trajectory of 69%. July 2021's performance sees the Trust placed 55th (out of 123 reporting general Acute Trusts) across the NHS and 6th in the Region.

Use Resources Well - Performance

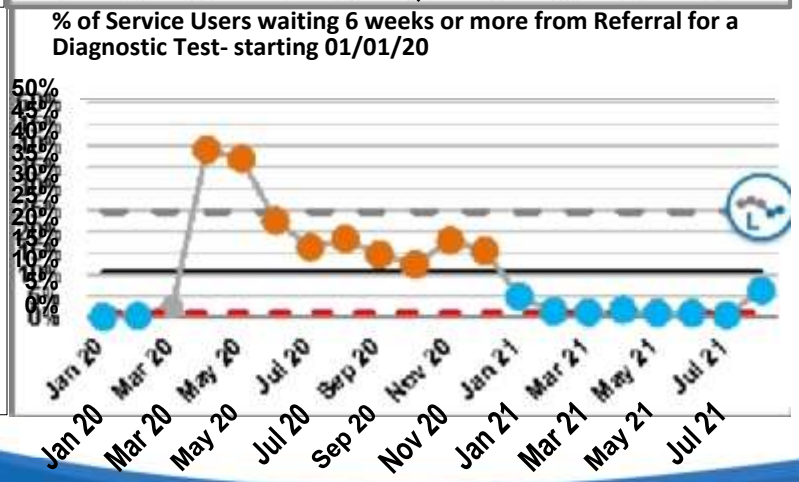
Mean | Measure
Process limits - 3σ | Special cause - concern
Special cause - improvement | Target

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 July's performance 72.1%. The Trust's national position, which now places the Trust 67th of 123 general acute Trusts reported against the constitutional standard and 20th for 62 day upgrades.

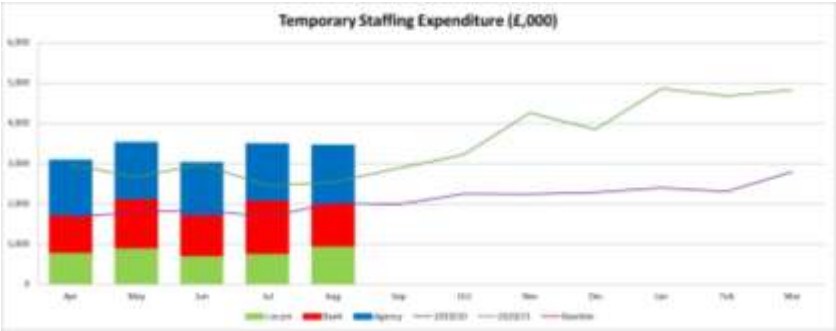
Diagnostic waiting times (DM01)



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 5)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Income			
Healthcare Income (Inc. Vaccs)	131,751	136,326	4,575
Other Income (Education&Training)	3,510	3,220	(290)
Other Income (Other)	2,854	3,681	826
Subtotal Income	**138,116**	**143,227**	**5,112**
Pay Expenditure			
Substantive Salaries	(71,493)	(71,902)	(409)
Temporary Nursing	(6,503)	(7,645)	(1,142)
Temporary Medical	(5,985)	(5,825)	160
Temporary Other	(2,214)	(1,821)	394
Vaccination Programme	(3,036)	(1,550)	1,486
Subtotal Pay Expenditure	**(89,231)**	**(88,741)**	**490**
Non Pay Expenditure			
Drugs	(7,414)	(8,290)	(877)
Clinical Supplies and Services	(6,845)	(7,509)	(665)
Non-Clinical Supplies and Services	(6,048)	(6,998)	(950)
Other Non Pay	(21,104)	(23,621)	(2,517)
Vaccination Programme	0	(282)	(282)
Depreciation	(3,598)	(3,564)	34
Subtotal Non Pay Expenditure	**(45,009)**	**(50,265)**	**(5,256)**
Interest Payable	(3,935)	(4,089)	(154)
Subtotal Finance Costs	**(3,935)**	**(4,089)**	**(154)**
Total Surplus / (Deficit)	**(59)**	**132**	**191**
Donated Asset Adjustment	84	(435)	(520)
Adjusted Surplus / (Deficit)	**25**	**(303)**	**(328)**



Financial Performance

- The Trust has a deficit position at the end of August 2021 of £0.303m, a deterioration from plan of £0.328m (planned surplus £0.025m) with a trading deficit forecast of £0.95m to Horizon 1 (H1) which closes end of September 2021
- The deteriorating position has been driven by high levels of temporary staffing spend particularly in areas of increased activity, the main driver being temporary nurse staffing as a result of increased Urgent and Emergency Care activity in ED, ICU and also Maternity
- The Trust has secured additional resources from the Sustainability and Transformation Partnership (STP) to offset this financial risk to H1 and is therefore forecasting achievement of breakeven for H1.
- The Trust has included an assumed ERF receipt of £2.172m YTD. Inclusion of these funds has been requested by NHSEI in the YTD position. However, the Trust has provided for the risk associated with receipt of these funds (underperformance against targets from other providers in the STP or STP 1 or more of the 5 Gateways) and thus if receivable in full this receipt would improve the financial position in future reporting months.
- The Trust has included additional non pay costs to negate the impact 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, £10m of other expenditure and £1.1m to support PFI Lifecycle (total of £28.5m).
- Capital expenditure totals £5.136m 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.
- Further national capital allocations have recently been made available to providers to bid for, the Trust seeking to mitigate this risk referred to above and secure further capital resources for investment. Upon confirmation of award further information will be shared with members

Cash

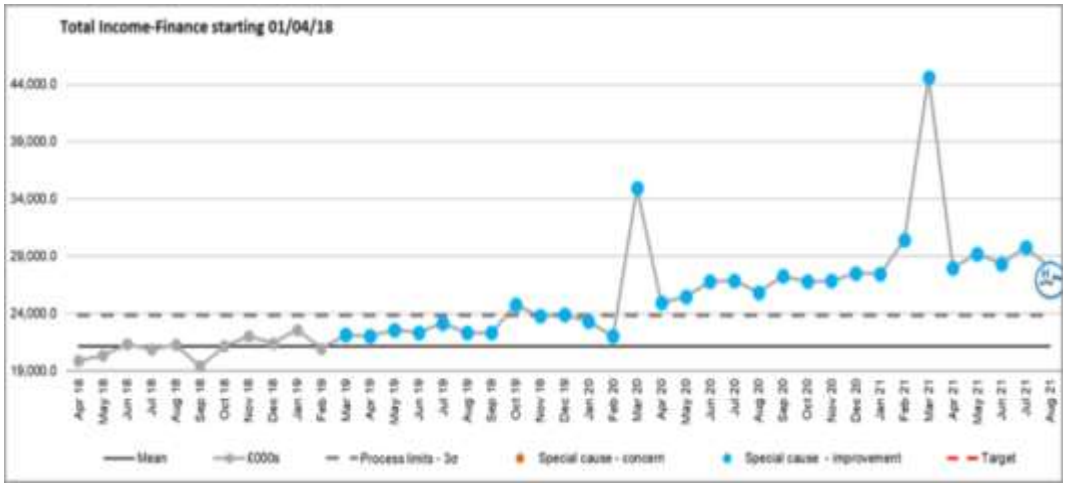
- The Trust continues to maintain a positive cash holding, the balance on account totalling £45.5m as at 31st August 2021.

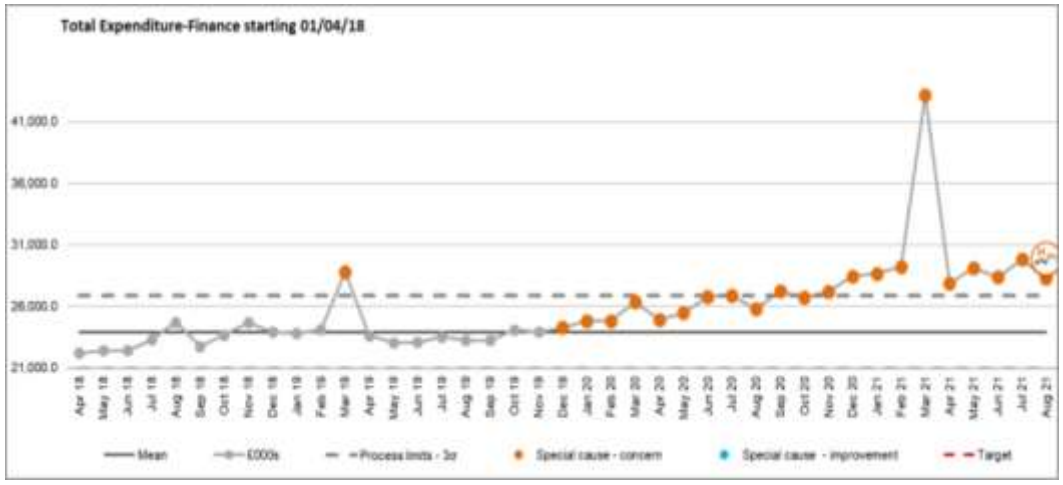
Efficiency attainment

- Development of Improvement Programme initiatives that offer cash releasing efficiencies is key to ensuring financial sustainability moving forwards combined with creation of headroom to support investment priorities.

- Performance, Finance and Investment Committee have sought further assurance over plans, this being a key risk to financial standing.

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.
- In March 2021 the Trust received non recurrent income - £3.2m for annual leave accrual, £4.5m to offset the value of Push stock, £3.7m Digital Aspirant funding, £0.6m in respect of donated equipment.

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
- Costs increased in support of COVID-19, with June and July seeing these costs increase further for elective restart and provision for EPR, Clinical Excellence Awards impacts on cost base, noting a reduction in expenditure in August due to the non recurrent nature of these. Spend increased again in September due to back dated Medical Pay Award, increased elective activity and non recurrent consultancy spend and increased further in Q4 20/21 driven by the additional pressures of a second wave of COVID activity.
- March 21 spend includes non recurrent items such as Annual

leave accrual, adjustments for Push stock, and non recurrent spend on the Digital Aspirant Programme offset by income.

Cash Flow Statement & Statement of Financial Position (M5)

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending August 2021	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	4,221
Depreciation and Amortisation	3,564
Donated Assets Received credited to revenue but non-cash	(608)
(Increase)/Decrease in Trade and Other Receivables	(1,927)
Increase/(Decrease) in Trade and Other Payables	7,952
Increase/(Decrease) in Stock	(99)
Increase/(Decrease) in Provisions	0
Interest Paid	(3,433)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	9,670
Cash Flows from Investing Activities	
Interest received	**0**
(Payments) for Property, Plant and Equipment	**(5,970)**
Receipt from sale of Property	**0**
Net Cash Inflow/(Outflow)from Investing Activities	**(5,970)**
Net Cash Inflow/(Outflow) before Financing	3,700
Cash Flows from Financing Activities	(1,692)
Net Increase/(Decrease) in Cash	**2,008**
Cash at the Beginning of the Year 2021/22	43,532
Cash at the End of the August	45,540

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending August 2021	Balance as at 31/03/21	Balance as at 31/08/21	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Property, plant & Equipment	161,995	164,262	2,267
Intangible Fixed Assets	6,417	6,330	(87)
Receivables greater than one year	561	147	(414)
Total Non-Current Assets	**168,973**	**170,739**	**1,766**
Current Assets			
Receivables & pre-payments less than one Year	11,075	13,416	2,341
Cash (Citi and Other)	43,532	45,540	2,008
Inventories	2,951	3,051	100
Total Current Assets	57,558	62,007	4,449
Current Liabilities			
NHS & Trade Payables less than one year	(35,179)	(40,743)	(5,564)
Other Liabilities	(284)	(2,494)	(2,210)
Borrowings less than one year	(4,058)	(2,367)	1,691
Provisions less than one year	(96)	(96)	-
Total Current Liabilities	(39,617)	(45,700)	(6,083)
Net Current Assets less Liabilities	**17,941**	**16,307**	**(1,634)**
Non-current liabilities			
Borrowings greater than one year	(111,956)	(111,956)	-
Total Assets less Total Liabilities	74,958	75,090	132
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	-	132	132
Total TAXPAYERS' EQUITY	74,958	75,090	132

Walsall Healthcare NHS

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22 YTD	2021/22 Target	2020/21 YTD	SPC Variance	SPC Assurance
SAFE, HIGH QUALITY CARE												
%	Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)	93.72%	91.78%	91.18%	90.42%	84.96%	79.37%	87.57%	95.00%	85.01%		
%	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	59.86%	60.73%	67.02%	60.43%	58.09%	56.65%	60.68%	100.00%	64.34%		
No.	Ambulance Handover - No. of Handovers completed over 60mins	1	11	1	3	9	26	50	0	177		
%	Cancer - 2 week GP referral to 1st outpatient appointment	73.74%	78.27%	74.37%	75.51%	82.60%		77.73%	93.00%	83.49%		
%	Cancer - 62 day referral to treatment of all cancers	72.37%	74.24%	71.76%	81.58%	72.04%		74.69%	85.00%	72.18%		
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	68.72%	68.24%	70.89%	71.91%	70.76%	70.27%		92.00%			
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	768	554	445	433	473	523		0			
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnostic Test	1.12%	1.72%	1.04%	0.96%	0.53%	6.30%	2.19%	1.00%	14.92%		
No.	No. of Open Contract Performance Notices	0	0	0	0	0	0		0			
CARE AT HOME												
%	ED Reattenders within 7 days	7.04%	6.66%	6.84%	7.53%	7.42%	7.18%	7.14%	7.00%	7.85%		
RESOURCES												
%	Outpatient DNA Rate (Hospital and Community)	11.74%	10.82%	11.37%	12.52%	12.35%	13.22%	12.06%	8.00%	10.63%		
%	Theatre Utilisation - Touch Time Utilisation (%)	49.63%	52.43%	66.37%	59.26%	64.44%	63.98%	60.90%	75.00%	53.18%		
No.	Average Number of Medically Fit Patients (Mon&Thurs)	29	30	33	32	49	47					
No.	Average LoS for Medically Fit Patients (from point they become Medically Fit) (Mon&Thurs)	3.00	3.00	4.00	4.00	4.00	5.00					
£	Surplus or Deficit (year to date) (000's)	140	96	152	103	39	-303					
£	Variance from plan (year to date) (000's)	4010	135	132	71	-7	-328					

		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22 YTD	2021/22 Target	2020/21 YTD	SPC Variance	SPC Assurance
£	CIP Plan (YTD) (000s)											
£	CIP Delivery (YTD) (000s)											
£	Temporary Workforce Plan (YTD) (000s)	35600	3125	6196	9189	11961	14702					
£	Temporary Workforce Delivery (YTD) (000s)	4200	3078	6596	9610	13096	16547					
£	Capital Spend Plan (YTD) (000s)											
£	Capital Spend Delivery (YTD) (000s)	21800	130	1240	2742	3761	5136					

MEETING OF THE PUBLIC TRUST BOARD – 7th OCTOBER 2021			
People and Organisational Development Committee (PODC) Highlight Report			**AGENDA ITEM: 16**
Report Author and Job Title:	Catherine Griffiths Director of People and Culture	**Responsible Director:**	Junior Hemans (Non-Executive Director and Chair)
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	The report provides the key messages from the People and Organisational Committee meeting on 30TH September 2021. Of note are: • The Committee noted good progress with the accreditation towards the Race Code and noted the joint work with the Royal Wolverhampton Trust. The action plan to improve Board effectiveness and assurance relating to race was endorsed by the Committee with a recommendation for approval at Trust Board. The Equality, Diversity and Inclusion group will monitor progress on the actions on a monthly basis and will report on a quarterly basis to the People and Organisation Development Committee for assurance to Trust Board. • The People and Organisation Development Committee noted the Safer Staffing report and commended the programme of international recruitment which is on track to achieve all appointments planned by the end of the calendar year. The Committee noted the extremely positive feedback on the buddy scheme. The Committee noted with concern that recent use of off framework agency use is an issue, however noted plans to review and control this. • The People and Organisation Development Committee received an update on the Gender Pay Gap reporting and noted that all statutory reports had been reviewed by the Committee in August 2021. • The Guardian of Safe Working Quarterly Report for November 2020 to January 2021, which is also before the Board, was received by the Committee who noted reported improvement in redeployment however access to senior support remains under review.		

	• The Freedom to Speak Up Guardians' Quarterly Report for April to June 2021 (Q1), which is also before the Board, was received by the Committee who noted the guidance and nationalrequirement to include a report detriment as a result of speaking up. • The Women's, Children's and Clinical Support Services were present at committee to provide a detailed assurance on the Division and workforce performance, this item was deferred as the meeting was no longer quorate at the point of presentation. Instead, the October meeting of the committee will hear directly from the Division as to their plans to improve workforce performance metrics. The Committee heard a staff story from Pharmacy presented by the Director of Pharmacy Mr Gary Fletcher, the committee commended the excellent work on organisational development led by Mr Fletcher which led to significant improvements in the service and resolved to present this staff story for learning to a future Trust Board. • The Committee noted the Board Assurance Framework risks, which encompass three separate risks and are included on the agenda of this meeting. The next meeting of the Committee will take place on 29th October 2021.	
Recommendation	Members of the Trust Board are asked to note the report and the escalations for its attention.	
Risk in the BAF or Trust Risk Register	BAF S04 – Culture (lack of an Inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care)	
Resource implications	There are no new resource implications associated with this report.	
Legal, Equality and Diversity implications	This Committee supports the Trust's approach to delivering equality, diversity and inclusion for the benefit of the patient population and staff who work for the Trust and who live in Walsall. .	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

MEETING OF THE PUBLIC TRUST BOARD – 7th October 2021			
Value our Colleagues – Executive Update			**AGENDA ITEM: 17**
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 taken last month 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 sustained Registered Nurse vacancy rate below 7%. The international nursing programme will meet its recruitment target by the end of the calendar year, with very positive feedback on the buddy scheme and pastoral support.

   The programme for recruiting Clinical Support Workers and other clinical support services locally as part of the anchor employer approach continues with success in filling entry level vacancies.

   The Trust leads system work on retention as part of the Workforce Supply work-stream of the People Board. The aim is to improve the experience of our people so they choose to say within the NHS. The Trust has secured a place on the national Flex for the Future programme as a pilot site to develop the organisation culture to attain the benefits of flexible and agile working which has a positive evidence based impact on retention[1].

2. <u>Progress on Staff Experience and Engagement</u>

   The National Staff Survey 2021 was launched last week within the Trust and the Divisional Oversight Group is working with the Communications team to promote uptake.

[1] CID Coronavirus (COVID-19): Flexible working during the pandemic and beyond – 30th September 2021

The last Pulse Survey reported to Trust Board in July had a response rate of 53.45%. The most significant improvement was in reported health and wellbeing with over 87% of colleagues reporting the organisation takes positive action on health and wellbeing. This must be maintained particularly with the Q1 trend of increased sickness absence.

Health and Wellbeing support is being expanded all the time based on feedback on staff experience and requested support.

The first cohort of 60 leaders received their Leading an Empowered Organisation (LEO) accreditation during September, leaders and managers have a significant impact on those reporting to them and the success of the LEO approach has a national evidence base for successful positive impact on organisation culture[2].

The Faculty of Medical Leadership and Management will complete their leadership development programme in November, this covers the Divisional teams of three and care groups to promote multi-disciplinary and team working, the evaluation to date has been very positive.

The CDs will also benefit from a joint leadership Boot Camp, led by RWT who are providing a comprehensive leadership development approach across the Trust.

The training, learning and development on restorative and learning culture is supporting a second leadership cohort with the accredited Northumbria and Merseycare programme, this specifically addresses the Trust Board priority on tackling bullying and harassment, with an approved action plan following diagnostic work.

The People and Organisation Development Committee has scheduled deep dives into the people metrics for each division to support assurance against the Board Assurance Framework for the following three elements of the Organisation Development Plan:

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

[2] Jones, K (2014) Lea ing an Empowered Organization (LEO): does the course work? *British Journal of Community Nursing* 10 (2) pp 92-96

	3. <u>Progress on the Race Code and supporting action plan</u> There has been good progress with the accreditation towards the Race Code as part of the joint work programme with the Royal Wolverhampton Trust on Equality, Diversity and Inclusion. The supporting action plan for the Trust will improve Board effectiveness and assurance relating to race, the plan was endorsed by the Committee with a recommendation for approval at Trust Board at appendix one for information.
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 the joint work with the Royal Wolverhampton on reaching accreditation on the Race Code, and approve the action plan and approach for monitoring progress. 2. Members of the Trust Board are asked to note the update on the health and wellbeing program, the leadership development work in progress and note the start of the National Staff Survey 2021.
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk Value our Colleagues (appendix two) in order to provide positive assurance the mitigations in place to manage this risk and the related corporate risks. In particular the risk of tackling the reported bullying and harassment and achieving an improved organisation culture.

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.	
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 equalityof 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 – Organisation Development Plan and 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 agreed the pledge remained current and following diagnostic work and report to private board from the Royal Wolverhampton support team in August 2021, the Trust Board has prioritised eliminating bullying and harassment within the workplace such that colleagues can feel and see the difference. The Pulse Survey reported in July 2021 offered further insights on the qualitative metrics measuring staff experience and the degree to which the pledge is achieved by directorate and department level. The Pulse Survey Workforce Tool provides the ability to focus in on workforce demographics by ethnicity, age, disability, sexuality, disability. The Workforce Equality Tool provides data and evidence on the outcomes achieved at directorate and department level on the ambitions and actions within the Equality, Diversity and Inclusion Strategy. The work on the Race Code seeks to ensure the board assurance and governance is robust, the plan of action was approved at the People and Organisation Development Committee and is at appendix one for information.

The purpose of the Value Our Colleagues Organisation Development Plan 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 experienceand 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.

2. BOARD ASSURANCE FRAMEWORK

The People and Organisational Development Committee has a schedule of accountability reviews with each Division to allow a deep dive into the qualitative and quantitative people metrics within the Board Assurance Framework (BAF) risk mitigations (appendix two) which have been 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

In this way, the committee can provide more detailed assurance to the Trust Board.

3. ORGANISATION DEVELOPMENT PLAN AND IMPROVEMENT PROGRAMME

The People and Organisation Development Committee reviews the plan and holds toaccount on the outcomes and benefits defined within the Value our Colleagues organisation development plan.

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 sustained Registered Nurse vacancy rate below 7%. The international nursing programme will meet its recruitment target by the end of the calendar year, with very positive feedback on the buddy scheme and pastoral support.

The programme for recruiting Clinical Support Workers and other clinical support services locally as part of the anchor employer approach continues with success in filling entry level vacancies.

The Trust leads system work on retention as part of the Workforce Supply work-stream of the People Board. The aim is to improve the experience of our people so they choose tosay within the NHS. The 'Looking After Our People (LAOP) – Retention Programme' brings together national and local experience and expertise to offer information, tools and practical support (including funding) for systems and organisations to help deliver the NHS People Promise.

In addition the Trust has secured a place on the national Flex for the Future programme as a pilot site to develop the organisation culture to attain the benefits of flexible and agile working which has a positive evidence based impact on retention[3].

[3] CID Coronavirus (COVID-19): Flexible working during the pandemic and beyond – 30th September 2021

Progress on Staff Experience and Engagement

The National Staff Survey 2021 was launched last week within the Trust and theDivisional Oversight Group is working with the Communications team to promote uptake.

The last Pulse Survey reported to Trust Board in July had a response rate of 53.45%. The significant improvement in reported health and wellbeing with over 87% of colleagues reporting the organisation takes positive action on health and wellbeing must be maintained particularly as the current workforce pressures are significant, (national increases attendances for urgent and emergency care, recovery programme for elective work) and a significant increase in quarter one sickness absence within the Trust.

Stress-related sickness is currently showing an increasing trend with significant impact; some of the actions being taken to support the workforce are highlighted within this report.

Work continues to ensure the offers available for colleagues and managers is fully utilised within the Trust. Including the investment in Mental Health First Aid trained individuals (47) who can provide early support and signposting. The Occupational Health team ensure swift response to management referrals and can offer same day referral when required, in addition the Black Country Mental Health Trust provide specialist services directly to colleagues within the Trust.

The intranet pages have a dedicated Health and Wellbeing area that managers and colleague can use for support including a range of support and guidance on wellbeing conversations which are supported by the People and Culture team.

https://themanor.xwalsall.nhs.uk/teampages/teampages/staff-health-and-wellbeing.aspx

The Health and Wellbeing support to colleagues is being expanded all the time based on feedback on staff experience and requested support. Currently managers have access to psychologist led ‘Restore and Recover’ sessions to help them with offering direct support to colleagues. Schwartz Rounds are established with a full programme ofmonthly rounds scheduled, the September round received exceptional evaluation from colleagues. The Wellbeing Champion network and training on Mental Health and Wellbeing continues to expand and Staff Networks and Councils, Cultural Ambassadors,FTSU Guardians and Confidential Contact Links as well as Staff-side leads all provide valuable support to colleagues.

In addition, the leadership and management development programmes help leaders at all levels to improve their own impact on others and help leaders to increase health and wellbeing support within teams. The first cohort of 60 leaders received their Leading Empowered Organisations (LEO) accreditation during September, leaders and managers have a significant impact on those reporting to them and the success of the LEO approach has a national evidence base for successful positive impact on organisation culture[4]. The Faculty of Medical Leadership and Management will complete their leadership development programme in November, this covers the Divisional teams of three and care groups to promote multi-disciplinary and team working, the evaluation to date has been very positive. The CDs will also benefit from a joint leadership Boot Camp, led by RWT who are providing a comprehensive leadership development approach across the Trust.

The training, learning and development on restorative and learning culture is supporting a second leadership cohort with the accredited Northumbria and Merseycare programme, this specifically addresses the Trust Board priority on tackling bullying and harassment, with an approved action plan following diagnostic work, the board can be assured the actions are on schedule, however the impact is not yet evidenced, the People and Organisation Development Committee have scheduled Divisional DeepDives into the performance on people metrics, the cultural heatmap for the Division and performance against the accountability framework. The Board Assurance Framework (BAF) risk mitigations are 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

<u>Progress on the Race Code and supporting action plan</u>

There has been good progress with the accreditation towards the Race Code as part of the joint work programme with the Royal Wolverhampton Trust on Equality, Diversity

[4] Jones, K (2014) Leading an Empowered Organization (LEO): does the course work? *British Journal of Community Nursing* 10 (2) pp 92-96

and Inclusion. The supporting action plan for the Trust will improve Board effectiveness and assurance relating to race, the plan was endorsed by the Committee with a recommendation for approval at Trust Board at appendix one for information only following review at the People and Organisation Development Group. The Equality, Diversity and Inclusion group will monitor progress against the actions on a monthly basis and will report on a quarterly basis to the People and Organisation Development Committee in order to provide assurance to Trust Board on delivery.

4. RECOMMENDATIONS

1. Members of the Trust Board are asked to note the report and in particular note the activity and progress on the joint work with the Royal Wolverhampton on reaching accreditation on the Race Code, and approve the action plan and approach for monitoring progress.

2. Members of the Trust Board are asked to note the update on the health and wellbeing program, the leadership development work in progress and note the start of the National Staff Survey 2021.

APPENDICES

Appendix One – Race Code Action Plan for information.
Appendix Two – Board Assurance Framework for information.

ANNEX A Race Equality Code Action Plan- MUST Do's

Race Equality Code ref	Action to be taken	Accountable Officer	Target date	Outcome /Measure
R1 Make sure there is reporting on the board and executive team composition as part of annual reporting	As part of the EDI Annual Report which is due to be published in November ensure ethnic monitoring of the Board composition is included and published	Talent Inclusion and Resourcing Lead	10th November 2021	EDI annual report contains information on ethnic composition of the Board and has been published.
R2 Publish ethnic gap reporting as best practice	Establish a template to report on ethnicity pay gap taking into account best practice from the private sector	Talent Inclusion and Resourcing Lead and Workforce Intelligence Team	March 2022 Deadline for report to be published - actions being worked on from March 2022- March 2023	Ethnicity pay gap report publicised on external pages and actions being taken to address gaps clearly identified and being actioned.
R3 Ensure more explicit annual reporting on work that is being done on the EDI Strategy and actions around EDI	Ensure actions being completed to progress the EDI Programme of work is incorporated into the Trust' annual report	Talent Inclusion and Resourcing Lead	10th November 2022 and annually	Progress with EDI actions being explicitly reported as part of the Trust's annual EDI reporting schedule.
A1 More work to do with the Employee Service Records Team to improve reporting rates	As part of the ESR Improvement Project work with the ESR team to increase declaration rates by 10% year on year for the following protected characteristics: Disability increase baseline data from 2.4 % to 10% by October 2022 Sexual Orientation increase baseline data of 1.8% to 10% by October 2022 Address the gaps within religion and belief reporting currently at around 65% reporting rate.	ESR Manager HR Operations Team Talent Inclusion and Resourcing Lead	31st October 2022 31st October 2023 31st October 2024	Year on year 10% increase in declaration rates on ESR for disability, religion and belief and sexual orientation.

A2 The Trust has identified (individuals)a board level sponsor for Race however there is a still a requirement to look at the ToR and examine implementation and reporting patterns	Review Trust Board ToR and ensure an objective around improving race equality is explicit within the ToR and is clearly referenced. As part of the annual Board evaluation process ensure there is an opportunity to review progress against the ToR with a specific focus on progress towards race equality at the Trust.	Board Secretary /Director of People and Culture	1st December 2021 and annually as part of Board evaluation process	ToR reviewed Board level objectives for Race included within ToR Progress against race equality objectives included as part of annual Board evaluation process.
A3 Use Divisional Performance Reviews to push accountability. Include specific EDI objectives for divisional/departments	Clear reports which contain EDI Metrics with recommendations on actions divisions should be taking to improve the culture in relation to EDI being discussed and actioned.	Workforce Intelligence Lead Deputy Director of People and Culture Talent Inclusion and Resourcing Lead	January 31st 2022 and then quarterly reporting and progress updates through DPR structure and through to PODC	Transparent reporting of EDI data with clear recommendations for improvement. Actions being taken by Divisions to improve EDI data specifically related to perceptions of race discrimination and any areas of under representation across the protected groups

Race Equality Code ref	Action to be taken	Accountable Officer	Target Date	Outcome Measures
A3 Once the PDR Framework, Workforce Intelligence Team and talent management initiatives gather the data re: career progression etc. the Trust will see who from a protected characteristic perspective is getting the right kinds of opportunities to progress. Use the Divisional Talent Forums to explicitly report this data into Pod C. They will demonstrate what and how they are monitoring on a biannual basis	Data on talent management outcomes from the PDRs to captured into a talent profile for each divisional area with actions being taken to progress colleagues career aspirations. Divisional Talent Forums to report into PODC bi annually.	Workforce Intelligence Team Talent Inclusion and Resourcing Lead Divisional Talent Forum chairs	31st December 2021	Talent profiles developed for each divisional areas. Staff career development aspirations are being discussed and actioned at Divisional Talent Forums
A4 Devise a mechanism for how well the board is doing on diversity objectives. Overarching reporting by the board to include board evaluation against those diversity objectives as a measure directly linked to performance collectively and individually	Mechanism to be developed to capture information on how well the Board is doing on its diversity objectives as part of the Board ToR. Process to be developed as part of Board appraisal process to capture review how each Executive Director has improved diversity within their portfolio of responsibility. Executive Directors to each have a personal objective for EDI	CEO Board Secretary Director of People and Culture	31st December 2021	Mechanism developed to capture information on progress against Board Diversity Objectives. Clear plan in place for Board evaluation linked to progress against race equality.
A5 Continue with launch of the Elisabeth Garrett Anderson leadership programme, and apprentice programme; launch a programme to support BAME nurses, and set targets for progression to senior position (reciprocal mentoring)	Following the review of the disparity ratio exercise by each divisional area targets to be set by each divisional area to address area of under representation and report to PODC on actions being taken bi annually. Launch reciprocal mentoring programme and ensure Executive and Board buy in	Talent Inclusion and Resourcing Lead Divisional Talent Forum chairs	31st December 2021	Clear targets in place to support career progression of under- represented groups. Target set at divisional level are being progressed and achieved. Reciprocal Mentoring programme in place with take up from the Executive Team.

Race Code ref	Action to be taken	Accountable Officer	Target Date	Outcome /Measures
Look at the cultural implications within the Trust and ensure they support the initiatives being rolled out Develop a targeted approach to uncover areas of underrepresentation (i.e. Divisional Talent Forums) then devise specific actions linked to the data generated	Embed Talent Forums across divisional areas. Develop talent profiles across each divisional area disaggregated by staffing group and linked to the nine protected characteristics and at care group level for discussion and action.	Talent Inclusion and Resourcing Lead	March 2022	Initiatives to improve areas of under representation using the disparity ratio tool are underway and being actioned . e.g secondments / stretch opportunities /positive action initiatives./leadership development courses
C2 Capture targets that go beyond BAME as a homogenous group and look at specific groups within area of Race in more detail.	Using the NHSE/ Disparity ratio tool carry out a deep dive exercise of BAME ethnic groups and where they sit within the pay bands- report this information to Divisional Talent Forums with clear recommendations on actions to be taken for each divisional area to close the gap.	Talent Inclusion and Resourcing Lead Workforce Intelligence Lead	1st December 2021	Clear profile of ethnic groups in relation to areas of under representation developed and published for each divisional areas with actions and targets agreed to improve amongst specific BAME staff representation and owned by each divisional area.
C2 Determine the brave, courageous and bold decisions that need to be made to ensure all the work around EDI is underpinned by the Strategy and supported. Identify clear actions to put in place as a response to the data.	As part of the data capture exercise review the outputs from the Race Disparity ratio exercise and identify clear actions for divisional teams to implement as part of Divisional Talent Forum discussions with reporting into PODC. Support HRMs to have courageous conversations with divisional areas based on the data and identify areas where improvement targets are required.	Talent Inclusion and Resourcing Lead and Workforce Intelligence Lead Operational HR Managers	31st January 2022	Clear actions identified as part of the race disparity ratio tool and being actioned with demonstrable progress /improvements in BAME representation.
C2 Have critical conversations and continuous reflection on performance targets to ensure they are relevant	Link Divisional Talent Forum targets as part of overall Board Diversity objectives to track	Director of People and Culture	October 2022	Evaluation of the success of Divisional Talent Forum objectives to be explicitly linked

and tie into the board's TOR and to ensure that the board is evolving and not losing any gains made	progress in relation to Model Employer targets for the whole organisation and improvements in staff perception pertaining to Race discrimination			to overall Board objectives

Race code ref	Action to be taken	Accountable Officer	Target date	Outcomes and Measures
E1 Update the D&I training to include a specific module on Race	Incorporate the A-Z of Black Lives Matter resource pack as part of induction /Managers Framework and EDI development programme	Talent Inclusion and Resourcing Lead	1st November 2021	A specific module on Race has been incorporated into induction and the EDI development programme and is accessible for everyone to access. Individual knowledge and understanding about race equality significantly improved measured by evaluation methods.
E2 Carry out a more comprehensive look at induction in terms of content and effectiveness	A review of our current induction programme to be undertaken by 31st December and updated with specific modules on Race (the A-Z of Black Lives Matter)	Workforce Training Manager Talent Inclusion and Resourcing Lead	1st November 2021	Induction programme will be updated to incorporate a module about race taken from the A-Z of Black Lives Matter with monitoring and evaluation to understand the impact of the module
E3 Relook at education for the wider workforce to ensure it challenges attitudes and behaviours Carry out a deep dive to ensure the entire workforce is educated into the benefits and need of EDI	Send out a targeted questionnaire to service managers and heads of department to identify any specific challenges they have in relation to their understanding of Race equality specifically and EDI generally. Put in place targeted support to address any gaps in	Talent inclusion and Resourcing Lead.	1st December 2021	Gaps in knowledge in relation to EDI identified. Targeted support and interventions in place with measurable outcomes in terms of improvements in understanding of EDI its importance and the benefits linked to a robust and an

	knowledge to ensure interventions and initiatives are tailored within the right areas.			evaluation of the impact of initiatives.
E4 Measure the impact of the EDI initiatives; ensure they are aligned to the EDI strategy and corporate plan Consider how to ensure people are leading in the right way in terms of compassionate leadership, civility and inclusive leadership	For each EDI initiatives rolled out across the Trust linked to the EDI strategy ensure these are evaluated with clear outcomes on the impact of initiatives based on the needs and requirements from Managers in relation to the EDI survey to understand any gaps	Talent Inclusion and Resourcing Lead	1st November 2022 and annually	Gaps in knowledge in relation to EDI identified. Targeted support and interventions in place with measurable outcomes in terms of improvements in understanding of EDI its importance and the benefits linked to a robust and an evaluation of the impact of initiatives.

Walsall Healthcare NHS
NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 04 - Value our Colleagues;** We will be an inclusive organisation which lives our organisational values at all times. • 04a - Leadership Culture & Organisational Development.
Risk Description:	Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care.
Lead Director:	Director of People and Culture
Lead Committee:	People & Organisational Development Committee
Links to Corporate Risk Register:	Title: • **2489** - Poor colleague experience in the workplace. (Risk Score = 16, Consequence 4 x Likelihood 4).

Current Risk Score Movement:
Likelihood = 4 Consequence = 5 = 20 High ↔
Forecasted Risk Score Movement for Q3:
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	*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.* <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	Likelihood:	2	31 March 2022
Consequence:	5			5		Consequence:	5	
Risk Level:	**20 High**			**20 High**		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 - August 2021</u> • Leadership offer with RWT in place. • Divisional Talent Forums scheduled (WCCSS took place in September 21). • Secondment with legal partner to support conclusion of outstanding Employment Relations cases agreed (due to commence September 2021). • Annual leave Policy, employment Break Policy, Retirement Policy, Flexible Working Policy all under active review with trade unions. • Case Advisory Group Pilot (to review potential cases in line with RJLC principles) commenced.			

Control & Assurance Framework - 3 Lines of Defence

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

	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.	assurance to the Board. • Monthly monitoring of Employee Engagement and Experience Oversight Group progress and actions via PODC. • Comparative performance against organisational workforce and culture indictors available via Model Hospital. • Joint Race Code action plan with RWT in place.	
Gaps in Controls:	• Limited capability and capacity to provide depth and breadth of leadership development for leaders / people managers across the Trust. • Workforce policies require review and update. • 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% [20190 to 52.3% [2020 NSS]. • Turnover has decreased from 11.64% in 2019 to 8.66% in 2020 against Trust target of 10%. • WRES indicator 2; recruitment improved from 2.73 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 and above roles from 18.81% to 19.17%	• 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.
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	Divisional Talent Forums scheduled.	
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	~~31/07/2021~~ 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	Completed - Presented to PODC in August 2021.	
8.	WRES and WDES national data submission	Catherine Griffiths	31/07/2021	Completed.	

Walsall Healthcare NHS Trust

Risk Summary

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

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• **2072** - Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency. (Risk Score = 16, Consequence 4 x Likelihood 4).	**Likelihood = 4 Consequence = 5 = 20 High ↔** Forecasted Risk Score Movement for Q3: **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	*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 actionsin greater detail.* <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.	Likelihood:	2	31 March 2022
Consequence:	5			5		Consequence:	5	
Risk Level:	**20 High**			**20 High**		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 - August 2021</u>: • RN turnover remains 7% for second consecutive month. • Temporary enhancement to midwifery bank rates agreed. • Collaborative bank between RWT and WHCT proposal under development. • 68 overseas nurses due to complete OSCE by end of September. • Mandatory & Statutory compliance above 90%for three consecutive months. • ESR Programme to cleanse establishment data (staff details in each department) 73% complete and on track to complete by 30 September 20201. • Nurse establishment review completed. Business case to increase establishment by 80 wte RN supported at PODC, PFIC and QPES and proceeds for formal approval at Trust Board in September.			

Control & Assurance Framework - 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Participating in STP Acute Collaboration to enable movement of staff via MOU and identify vacancy hotspots. • ESR data cleanse work stream supported by Informatics Team in place to accurately reflect organisational hierarchies. • International nurse recruitment programme in place supported by Regional NHSIE and RWT Clinical Fellowship Scheme. • Partnership with Walsall Housing Group,	• People and Organisational Development Committee in place to gain assurance. • Education and Steering Group in place and reports through to PODC for assurance. • Use of temporary staffing and ambition to eliminate agency staff by end of December monitored via PFIC and QPES for assurance.	• ICS 2021/22 priorities and operational plan. • Annual Internal audit of financial controls and payroll. • Annual ESR Data Quality Audit carried out by ESR. • Assessment of activities in line with requirements of National NHS People Plan and BCWB STP People Plan. • Participant of STP collaborate bank proposal.

	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.		• 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% [20190 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 Hospital data • Clinical Support Worker (CSW) vacancies reduced to 0 as of 31 Mach 2021. • 21/98 nurse vacancies filled by 10 May 2021.	• Implementation of Anchor Institute Recruitment Campaign • Associate Director of AHP appointed and commenced in role [May 2020].	• Work with education organisations and Health education England. • NHSIE central and regional team oversight of progress against NHS People Plan. • Quarterly deep dive of key workforce metrics by CCG.

Gaps in Assurance:	• There is a lack of workforce planning capability across leaders within the Trust. • Lack of ability to meet local and national professional clinical staffing models / guidelines.

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~~ 31/10/2021	Delayed	
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	Complete.	
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	Complete. 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	Complete. Outline paper to identify opportunity and what would be required to formalise collaborative approach due for joint HRD consideration. Progress towards Acute collaborative bank continues. Outline paper completed and submitted.	

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 04 - Value our Colleagues;** We will be an inclusive organisation which lives our organisational values at all times. • 04c - Making Walsall (and the Black Country) the Best Place to Work.
Risk Description:	Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care
Lead Director:	Director of People and Culture
Lead Committee:	People & Organisational Development Committee
Links to Corporate Risk Register:	Title: • **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).
	Current Risk Score Movement: **Likelihood = 4 Consequence = 5 = 20 High ↔** Forecasted Risk Score Movement for Q3: **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	*Level of BAF risk previously assessed on single BAF framework. From May 2021 the BAF has been divided into three distinct areas to assess, understand and monitor impact of mitigating actions in greater detail.* Evidence of risk gaps in control. • 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.	Likelihood:	2	31 March 2022
Consequence:	5			5		Consequence:	5	
Risk Level:	**20 High**			**20 High**		Risk Level:	**10**	

					• Sickness absence levels were 5.3% excluding Covid-19 related absence against target of 4.5% [30 June 2021]. <u>Evidence of risk control - August 2021</u>: • Weekly flu vaccination programme planning meetings in place. • Flu plan submitted to CCG. • Health and Wellbeing CHATS conversation framework launched. Pilot with ITU and E&F underway. • Health and Wellbeing conversation (CHATS Framework) management and staff resources drafted and train the trainer sessions have commenced. • Health and Wellbeing Champions appointed. • Assessment against updated NHSEI Health and Wellbeing framework underway – due to be completed end of September.			

Control & Assurance Framework - 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Schwartz rounds have been implemented in accordance with Point of Care Foundation license. • Internal Mental First Aider network established, accredited training complete and network contact details and support available to staff promoted. • Detailed project improvement programme plans for; *Health & Wellbeing Strategy*, *Achieving SEQOSH accreditation* and *Enhancing Flexible Working*. • Calendar of Black Country career events in place to attract and recruit to health and social care employment opportunities(NHS, Social Care and Voluntary Sector) • Development of system workforce metric. • Digital passport (improving education and training and mobility of workforce) • Anchor employer • Implementation of BMA Facilities and Fatigue Charter.	• 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 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.	• Achievement of SEQOHS accreditation and rolling improvement plan in Occupational Health • Assessment of activities in line with requirements of National NHS People Plan and BCWB STP People Plan. • Improved outcomes from annual NHS Staff Survey which match sector average scores. • Externally benchmarked people performance data, particularly (but not exclusively) through Model Hospital. • Leading STP (BCWB) Workforce Supply Programme Delivery Group. • Members of STP (BCWB) Work • Leadership & Culture • 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:	• More colleagues require training to apply the CHATS Framework when undertaking HWB conversations • 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% [20190 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. Interview took place 13 September 2021 – conditional offer made.	
2.	Complete gap analysis on Health and Wellbeing offer – for completion by end August 2021- to shape HWB strategy	Catherine Griffiths	31/08/2021	Completed - Document now supporting completion of National HWB Framework.	
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	Deep dive review of sickness absence at divisional level	Catherine Griffiths	17/09/2021	Workforce data and narrative from HR Advisory team under development.	
6.	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 completed. Roll out plan under development.	
7.	Formally bring OH and HWB services together as one team.	Catherine Griffiths	30/09/2021	Complete.	

MEETING OF THE PUBLIC TRUST BOARD Thursday 7th October 2021			
Safe Staffing Report			**AGENDA ITEM: 18**
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 August 2021 is just below 7%, this is unchanged from July 2021. • 75 overseas nurses have arrived in the Trust. 42 of those have completed their OSCE examination. A further 19 overseas nurses are due to arrive in 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 August 2021 to 1374 hrs, in July we used 1046.25 hrs. • The lowest fill rate for August 2021 was for the CSW day shift at 86.38%. The overall fill rate (combined RN and CSW) was 91.66%. This is unchanged from July 2021. • In August 2021, before consideration of escalation to Off Framework Agency, Matrons redeployed 1323 hours of substantive RN and 686 hours of CSW time during the twice daily Staffing Hub meetings. • The staff experience audit score was 82% with 11 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 disproportionally 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. August 2021 has seen 56 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 50 last month.

Nurse Staffing Update

1.1 Vacancy Position

The RN and Midwifery vacancy rate for August 2021 remains the same as July 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)

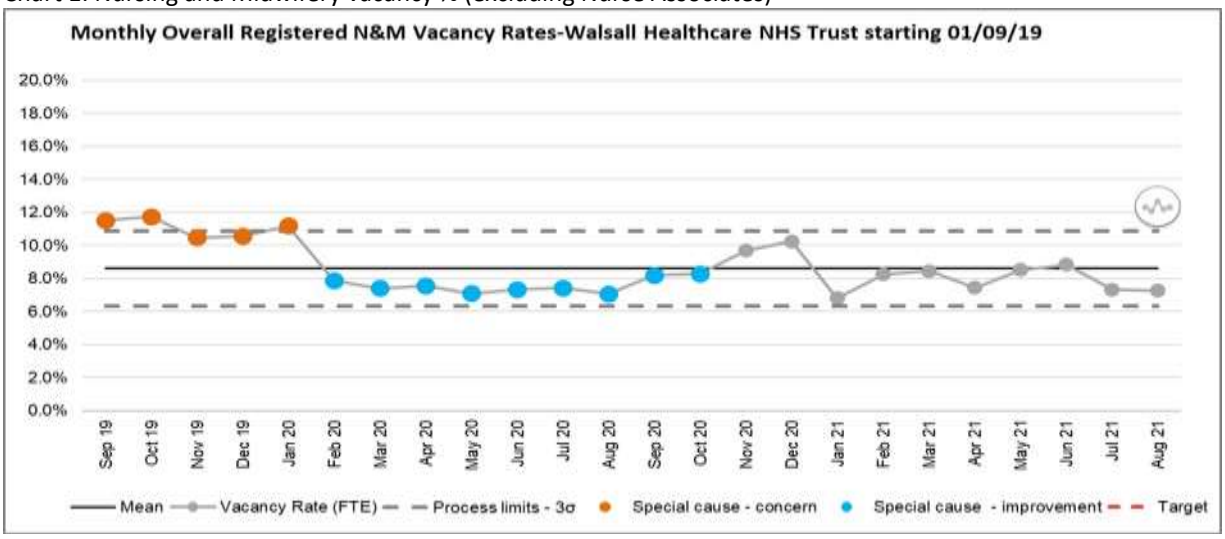


Chart 2: MLTC Vacancy position (information via ESR)

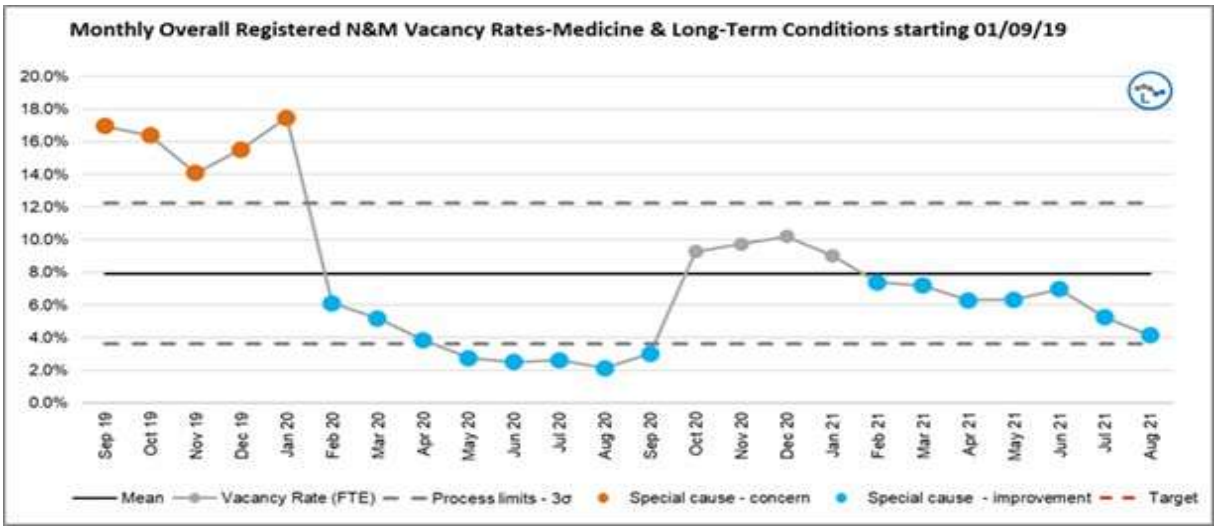


Chart 3: Surgery Vacancy position (information via ESR)

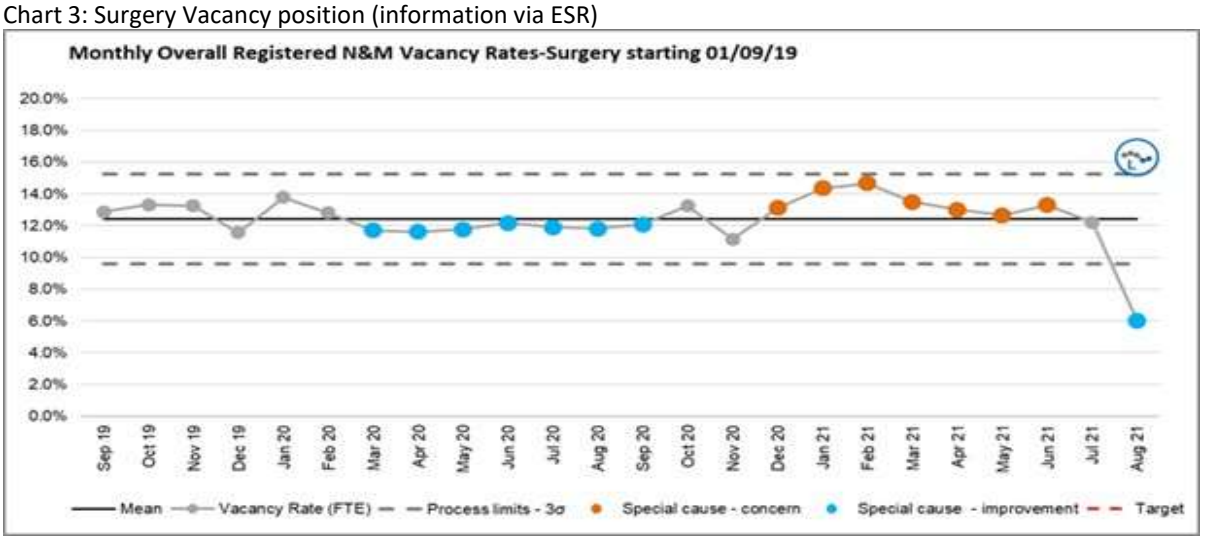


Chart 4: Community Vacancy position (information via ESR)

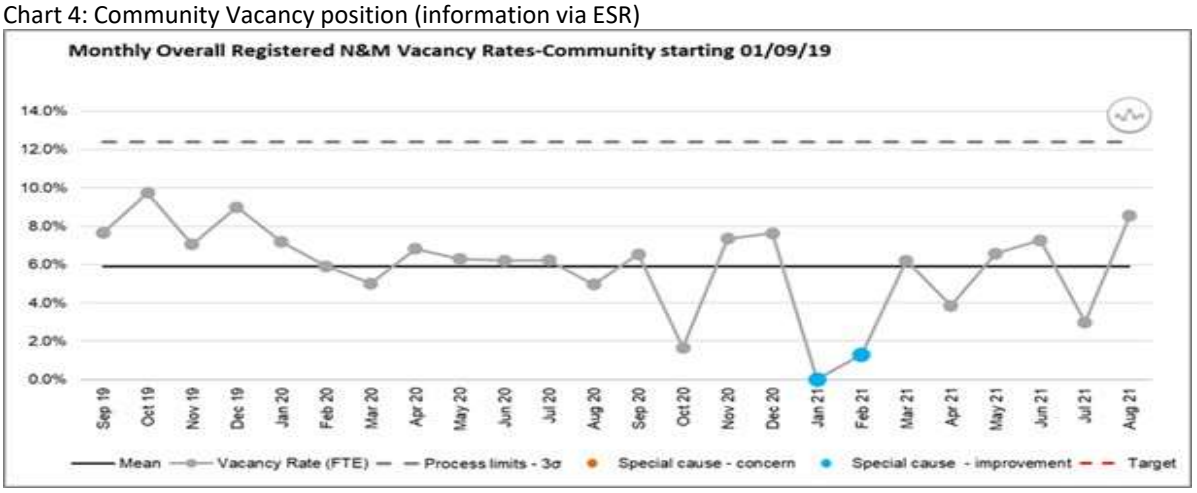
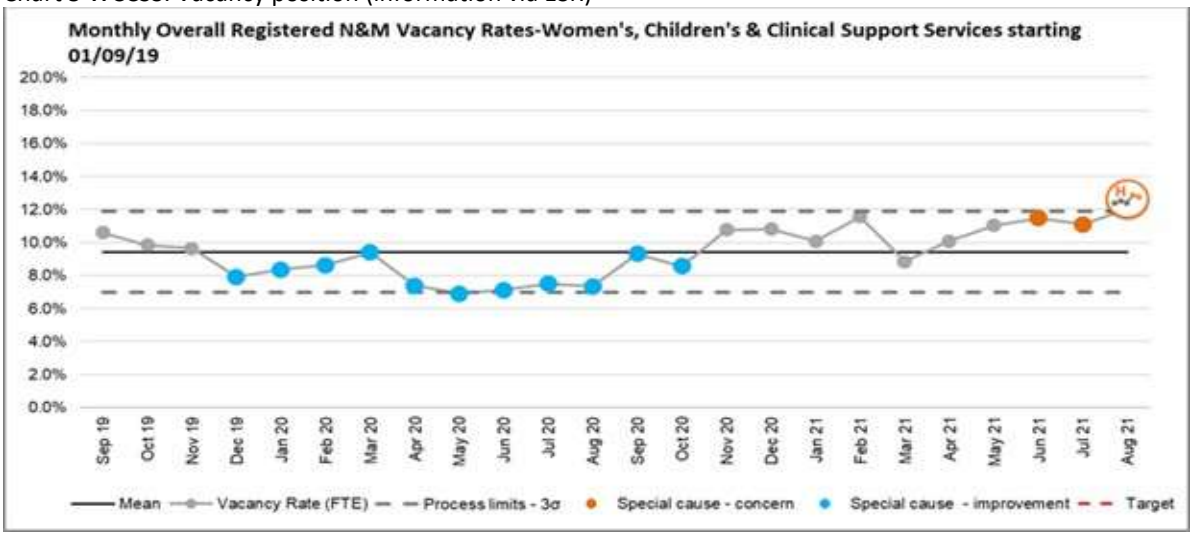


Chart 5 WCCSS: Vacancy position (information via ESR)



1.2 Overseas Recruitment

75 overseas nurses have commenced working within the Trust and 42 of these have completed their OSCE. A further 22 have their OSCE's booked for September and 11 have their OSCE's booked for October 2021. A further 19 nurses are expected in September 2021

Pastoral care is being delivered by Team FORCE. The current expectation is that approximately 200 overseas RN 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, thirty eight are Trainee Nursing Associates and forty four are CSWs undertaking either a level 2 or level 3 programme.

1.4 Nursing Associate Recruitment

Thirteen Trainee Nurse Associates (TNAs) are expected to qualify in December 2021 and be registered with the NMC by January 2022. A further 10 are expected to qualify in June 2022 and another 7 in November 2022.

Nine TNAs are commencing the training programme in September 2021 and will be expected to qualify in November 2023.

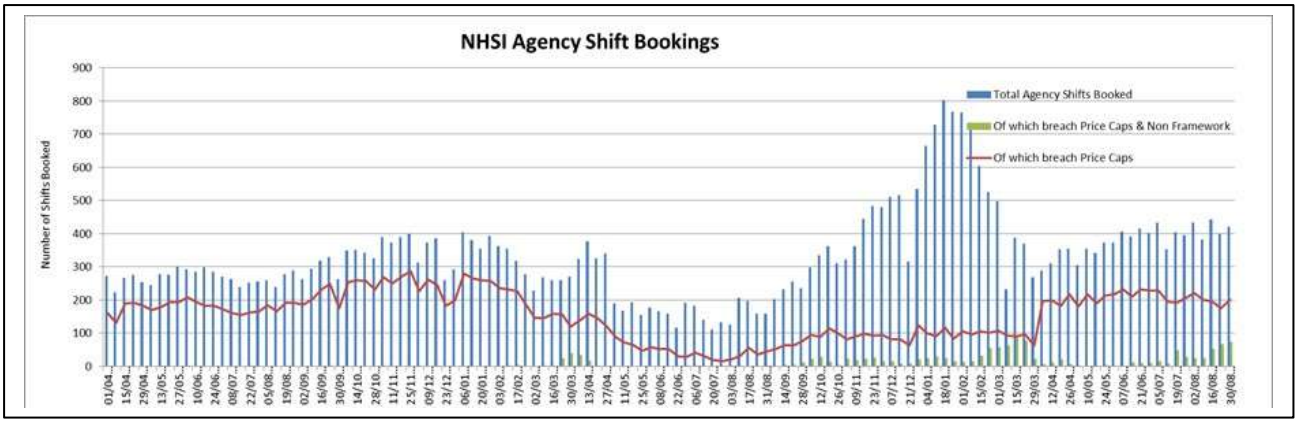
1.5 NHSI Agency Cap Breaches

NHSi Agency Cap Breaches (Chart 7) have continued to be reported weekly to NHSi and have increased slightly on the previous month (822 shifts in July and 792 shifts in August).

Off framework use has increased during August and has been used to support ICU (942 hours), NNU (196.5 hours), Delivery Suite (69 hours), A&E (46 hours), Ward 4 (46 hours), AMU (17 hours) and single shifts on Wards 2, 3, 7, 16 and 29 (11.5 hours each).

The Trust has continued to experience 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.

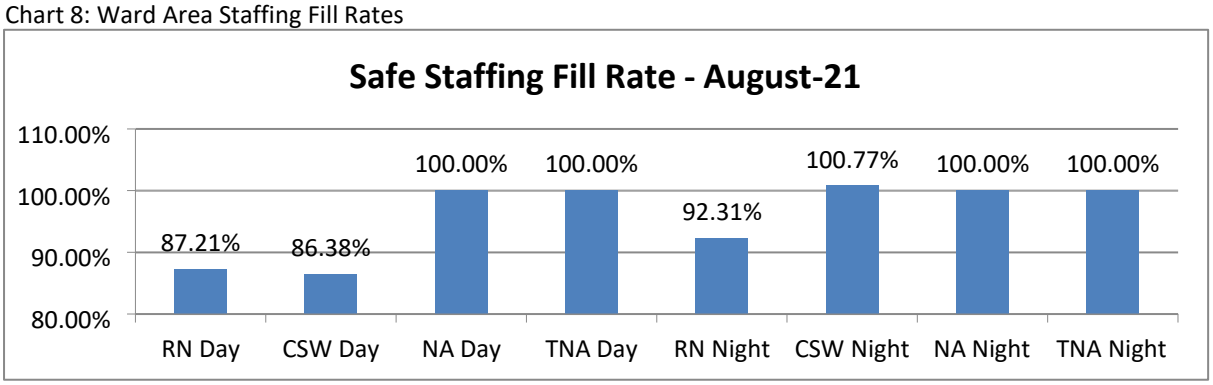
Chart 7: Agency Cap Performance



1.6 NHSI Model Hospital Staffing Fill Rates

The lowest fill rate for August 2021 was for CSWs on day shifts at 86.38%. This is a slight increase since last month. The overall fill rate for August (combined RN and CSW) was 91.66%, the same as the previous month.

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 riskscannot be mitigated. Through the safe staffing meetings 1323 hours of RN and 686 hours of CSW were re- deployed across the trust in August 2021. This is an increase overall since July 2021 when 1095 hours of RN and 492 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 August 2021 there were 209 Red Flags that were raised and 58 were resolved and mitigated during the safe staffing meeting. For the 151 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	August= 1221 hrs (increase since previous month-July 21)
CSW	August = 1319.75 (increase since previous month-July 21)

In August 2021 the temporary staffing bookings to cover for sickness and Covid-19 related absence for RN's was 3853 hrs less than the actual hours of absence recorded. For CSWs there were 4739 hours fewer hours booked than hours of absence recorded. There was an overall increase in sickness/Covid-19 related absence in August 2021 compared to those recorded in July 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	9741 hours	5887.75 hours
CSW	8638 hours	3899.42 hours

In August 2021 there were 2189 fewer RN hours of temporary staff booked compared to the actual hours of maternity related absence. For CSWs there were 1017 fewer hours of temporary staff booked compared to the actual hours of absence (Chart 11). The levels of absence for Maternity leave significantly increased in August 2021.

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	4464 hours	2275.67 hours
CSW	2330 hours	1313.08 hours

1.9 Allocate System Roll Out

Forty Six departments have now attended Roster Manager training for Allocate and are linked to the live payroll. The six departments that provide predominantly Monday-Friday services but do use bank staff will all be live in Allocate by the end of September 2021. Theatres and Imaging are the only two areas remaining that need to move to Allocate and this will be completed by 30th September 2021.

The RPC system licence has been extended until September 2021 to enable full roll out of the Allocate system.

In addition to the training delays Allocate have updated the user interface (version 11). 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 but planning will be the next priority. Extended support from Allocate is in place to support the continuation of use of v10.

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 August 2021 the staff experience audit score was 82% with 11 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 7th October 2021**			
Walsall Together Partnership Highlight Report			**AGENDA ITEM: 19**
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 22nd September 2021. The key points for the attention of the Trust Board are: • The Partnership Board received a story **from** a First Contact Practitioner working within Walsall. The presentation demonstrated the positive outcomes and benefits of getting new roles into primary care in leading to earlier treatment and reducing pressure on general practice. The challenges around workforce development and recruitment & retention were discussed by the Board. The Walsall Together Workforce & OD group were requested to use the FCPmodel to learn how to support the development of staffing models for other areas of service need. • The Board considered the systems pressures within Walsall which were affecting all partners. Particular attention was paid to staffing pressures within care agencies which were reducing the number of packages of care that could be delivered and leading to delays in discharge pathways. The work that was being done within the partnership to increase the number of providers of domiciliary care and seek alternative interim discharge arrangements was outlined, but this remains on the risk register for the partnership. It was noted by the Board that despite these pressures, the Walsall health & social care economy was recognised as having greater resilience than some other places within the region, which was manifesting itself in aspects such as ambulance turnaround times • The Board was informed that £700,000 has been allocated by the ICS for Walsall to help support the urgent community response, enhanced care in care homes and anticipatory care to help people stay well. A set of schemes was presented to the Board which included the expansion of the Care Navigation Centre (CNC), some additional support for the Intermediate Care Service and expanding the rapid response resource. These proposals were approved by the Partnership Board and were to be submitted to the Trust		

	Performance & Finance Committee (PFIC) on 29/09/21 • A presentation was given to the Board on the digital programme update after a request at the last meeting to detail the challenges faced by the programme and to provide assurance that the necessary actions are being taken to ensure delivery. The Board were assured that delays were due to requirements and standardisation at system rather than local level, however it was emphasised that any delays should be escalated through to Board rather than accepted by the project team. • There are 3 risks currently rated at 16 (major) and another 4 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); and workforce capacity and appropriate skill mix.
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 7th October 2021**			
Care at Home Executive Report			**AGENDA ITEM: 20**
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 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

October 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 have abated slightly for Community Services (7,491 hours of demand compared to 8,027 in July), although the Care Navigation Centre had its highest number of calls in month.

2.2. Capacity

Concerns remain about the capacity of providers to respond to demand. Despite the drop in demand, Community Nursing was unable to respond to 26% of its demand within localities, while Care Agencies continue to report staff shortages which adversely impact on their ability to provide packages of care to people in their own homes. As reported last month 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. Consequently the total number of MSFD patients and the LOS on the MSFD list increased during July and August. 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):

A response is being coordinated within Walsall Together which involves:

- Use of interim care home beds and dedicated staff to support these people as required
- Reduction of demand for packages of care through support with the Bedside Mobility Assessment Tool and accelerated discharge at the Manor Hospital
- Recruitment of additional providers by Commissioning teams
- Greater flexibility within the contracts for provision of packages of care
- Offer to care agencies for support with recruitment

The aim has been to keep the number of MSFD at Walsall Manor at 50 patients and with specific regard to the August bank holiday, not to exceed the previous year's levels. The average number of MSFD in August was 47 patients with the bank holiday performance within the range of last year, as shown in the table below:

MSFD	Mon before	BH Sat	BH Sun	BH Mon
2020	33	57	57	49
Predicted 2021	38	65	65	56
Actual 2021	38	55	57	53

In September the number has increased and up to 26/09/21, was at an average of 53 patients.

Planning in response to System Pressures:

Walsall has been allocated £700,496 by the Integrated Care System to support three areas: [1] urgent community response services; [2] enhanced health in care homes; [3] new service models for anticipatory care. A spending plan has been developed for this, which provides a system response to current and predicted surges in demand. There is a focus on increasing admission avoidance activity through the Integrated Assessment Hub and the Care Navigation Centre. The plan was reviewed and

approved by the Walsall Together Partnership Board on 22/09/21 and was scheduled to be considered at PFIC on 29/09/21.

3. BOARD ASSURANCE FRAMEWORK

The BAF is appended and reflects an in-month risk score of 12 incorporating the following risk themes:

- Continued 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. This risk is expected to be reflected in the refreshed Joint Strategic Needs Assessment and a new Health & Wellbeing Strategy, both due to be published by the Health & Wellbeing Board imminently.

The BAF also incorporates the associated controls, assurances and actions, which reflects 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. As reported in September, the focus is currently on the transition of services already provided by Walsall Healthcare community services. In recent weeks, several meetings regarding the transition were suspended in part due to annual leave commitments and in part whilst we await the national publication of the final ICP contract and its associated guidance.

Progress continues to be made on the outcomes framework and with the development of a Population Health and Inequalities Strategy. The priorities for Walsall were discussed at the Clinical & Professional Leadership Group in August and an implementation plan for the partnership is expected to be presented for approval by the Partnership Board in November.

5. IMPROVEMENT PROGRAMME

The work to identify the principles upon which financial benefits are measured and transacted across the acute and community boundary is progressing well and is scheduled for initial review by divisions in early October.

Once the work is complete, the Board will need to consider a future investmentstrategy 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.

Latest Board/Committee/Group - 20/09/21
Version V4.03

Walsall Healthcare NHS Trust

Risk Summary

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

- 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:
  - 2370 - *Population Health Management* (Risk Score = 16).
  - 2628 - *Funding for ICS beds* (Risk Score = 16).
  - 2626 - *COVID vaccinations* (Risk Score = 16).
  - 2625 - *WHT investment in Community/WT services in scope* (Risk Score = 20).
  - 2624 - *Primary Care demand and capacity* (Risk Score = 20).
  - 2641 - *Delayed discharges for MSFD patients as a result of low availability of packages of care* (Risk Score = 20).

Current Risk Score Movement:

Likelihood = 4
Consequence = 3
= 12 Moderate
↔

Forecasted Risk Score Movement for Q3:

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			
	1st Line of Defence	2nd Line of Defence	3rd 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-19. • 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	Director of Integration	July 21	Work is underway to confirm maintenance of transformation funding for the diabetes and care home services into	

	provision.			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	

Walsall Together Partnership Operational Update: September 2021

Matthew Dodd
Director of Transformation

Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 0

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	Aug-21		
Workforce: Anchor institutions	No. staff employed by WHT via scheme											
	% staff still in post after 3 months											

[Emergent] Score Card for WT Tiers – Tiers 1

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-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	5945.25
	Hours cancelled by Locality teams	>600	400-600	400<	473	305	623	1020	1453	1546
	% of hours demand unmet	>10%	5-10%	5%<	6.5%	5.1%	11.2%	18.3%	22.1%	26.0%
MDTs	No. MDTs held	<20	20-24	>24	29	19	19	27	25	26
	No. referrrals received	<100	100-200	>200	29	27	35	37	26	26
	No. cases reviewed	<100	100-200	>200	29	27	32	40	90	96
Adult Social Care	1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	<100%		100%		100.0%	100.0%	100.0%	100.0%	100.0%
	1E: Proportion of adults (aged 18-64) with learning disabilities in paid employment (NI 146).					2.8%	2.8%	2.9%	2.9%	3.1%
	1G: Proportion of adults (aged 18-64) with Learning Disabilities who live in their own home or with their family. (NI 145).					84.8%	85.5%	84.5%	84.9%	84.4%
	2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	<9.1		>= 9.1		1.2	2.4	3.0	3.0	3.0
	2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	<671.8		>= 671.8		69.3	142.6	186.1	229.7	257.4
	2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	<85%		>=85%		79.0%	83.8%	77.6%	82.8%	85.6%
	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				449	478	494	550	553	617
	Care and Support Assessments and 3 Conversations Completed - Total				267	242	234	195	187	143
	Monthly Adult contacts completed by Team				1,122	1,030	1,010	1,094	1,025	1,061
	Total Initial & Subsequent Reviews Completed				388	223	235	230	163	105

[Emergent] Score Card for WT Tiers – Tier 2

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Tier 2: Specialist Community Services										
ASC Safeguarding Concerns	Concerns received				297	253	292	307	315	258
	Concerns progressing to s42 eqnuiry				72	79	84	83	88	66
	% of concerns progressing to s42 enquiry				24%	31%	29%	27%	28%	26%
	Safeguarding cases in progress				39	25	48	15	36	20
Care Homes	Care Home residents	1,503<	1,503-1,650	>1,650	1,258	1,267	1,259	1,285	1,294	1,330
	Vacancies	>291	144-291	144<	436	430	441	416	408	368
	% vacant beds	>15%	8-15%	8%<	25.7%	25.3%	25.9%	24.5%	24.0%	21.7%
	Total No of Care Homes	53<	53-56	>56	57	58	58	58	58	58
	Closed to admissions	>8	3-8	3<	14	7	8	8	2	10
	% of available homes closed to admissions	>10%	5-10%	5%<	24.6%	12.1%	13.8%	13.8%	3.4%	17.2%

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

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Tier 3: Intermediate Care, Unplanned Care & Crisis Services										
Care Navigation Centre	Calls received	316<	316-512	>512	550	580	691	747	821	840
Rapid Response Team	Referrals received	160<	160-247	>247	232	210	216	304	301	334
	% admission avoidance	73%<	73-86%	>86%	82.0%	88.0%	91.7%	89.5%	94.4%	94.3%
Medically Stable For Discharge	Average number of MSFD in WMH	>51	41- 51	41<	29.33	31.13	31.86	31.89	48.56	47.38
	Average number of days MSFD	>7.8	4.8 - 7.8	4.8<	2.7	2.7	3.6	3.9	4.2	5.1
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21 - 25	21<	30	27	29	N/A	N/A	N/A
	Domiciliary Pathways - Average service users				188	181	180	N/A	N/A	N/A
	Bed-based Pathways - Discharged ALOS	>36	24 - 36	24<	29	46	49	N/A	N/A	N/A
	Bed-based Pathways - Average beds in use				83	67	61	N/A	N/A	N/A
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	44	56	90	90	80	72
	Early Supported Discharge	40<	40-54	>54	52	51	106	43	48	47
	Assisted Discharge	35<	35-50	>50	75	62	71	63	103	61
	Prevent Readmission							63	60	62

Walsall Together

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	Comments
1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	Mosaic, H21 & Provider spreadsheets	1731	1899	1985	2038	2100	2188	2211	2245	2203	2193	2180									
	AACM	1895	1951	1954	2045	2100	2188	2211	2245	2203	2193	2180									
	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%**								**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	17								12	
	AACM	551	585	587	596	574	573	540	545	548	550	546									
	Jeanette Knapper	**1.1%**	**1.7%**	**0.2%**	**1.2%**	**2.4%**	**3.3%**	**2.8%**	**2.8%**	**2.9%**	**2.9%**	**3.1%**									
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	461									
	AACM	551	585	587	596	574	573	540	545	548	550	546									
	Jeanette Knapper	**85.8%**	**85.0%**	**86.0%**	**84.2%**	**86.1%**	**85.3%**	**84.8%**	**85.5%**	**84.5%**	**84.9%**	**84.4%**									
2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	7	11	22	10	24	18	2	4	5	5	5								15	
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	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**	**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 speadsheet.	271	309	311	329	301	311	35	72	94	116	130								335	
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	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**	**257.4**								**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	107									
	Provider Services	317	130	266	73	91	125	143	113	141	122	125									
	Matthew Dodd & Jennie Pugh	**80.1%**	**86.9%**	**82.7%**	**75.3%**	**83.5%**	**75.2%**	**79.0%**	**83.8%**	**77.6%**	**82.8%**	**85.6%**								**85.0%**	

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

- Volunteers are still being co-ordinated by the volunteer centre to the trust and to the vaccine buses across the borough. This is despite the summer period seeing a drop in volunteers this year (owed to eased restrictions at several leisure venues and holiday destinations compared to last year), although placements are still being made.
- Three organisations are being supported by the team with a collaborative bid to support children and families around mental health issues that are particularly affecting the child's education – either through behavioural issues in school or lack of attendance. A meeting with the Lottery to discuss this further will take place towards end of Sept. but will be looking for funding in the new financial year.
- Engage Walsall Unit is becoming a hub from which the VCSE can utilise the space for activities, service user support and meeting other like-minded organisations to share ideas etc and as such we have an extended lease until the end of December. Zebra, CAB and Rethink are now running regular sessions.
- Interest from local businesses in supporting local community projects continues to rise as part of their CSR. The team have been facilitating employee supported volunteering with several community groups in need across the borough.

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 .

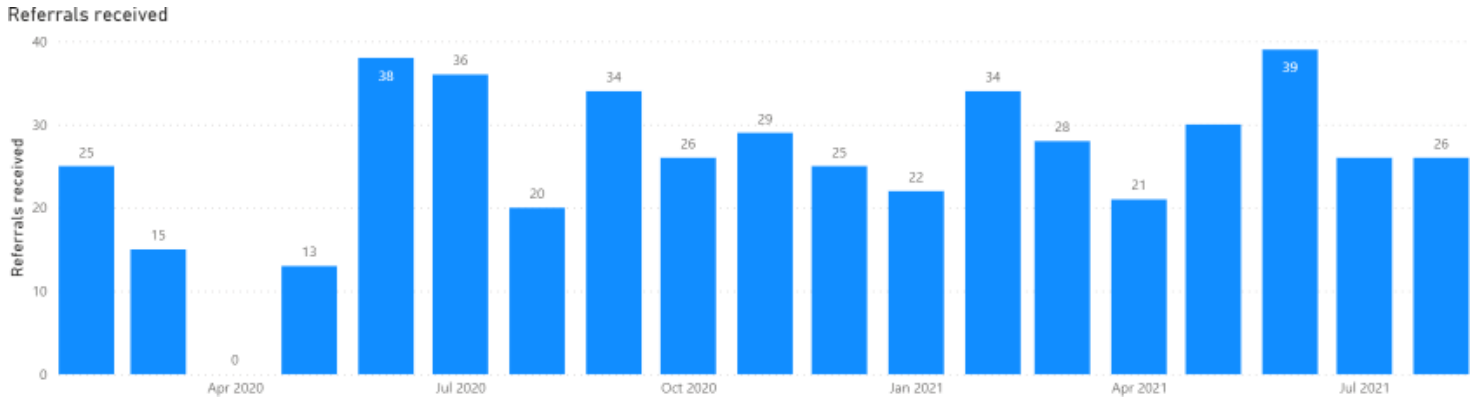
Early relationships were developed as part of an organised family day out . The Champion used the activity as a platform to build trust and buy into the programme .

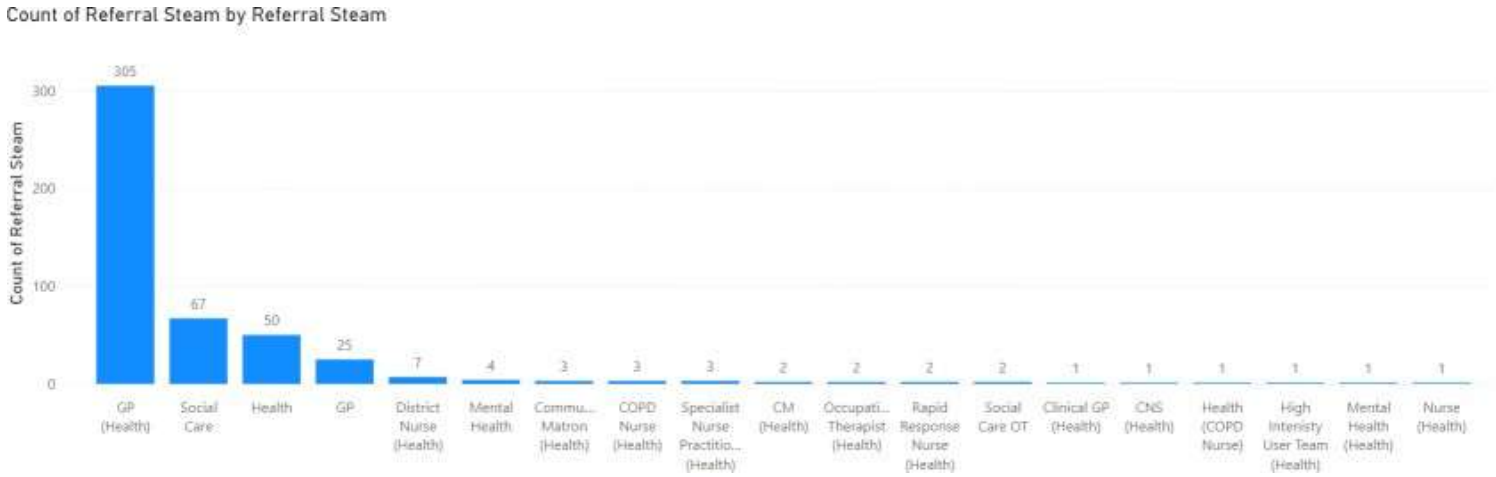
Their confidence increased and they progressed onto whg's Be The Best You Can Be programme . This is a positive psychology programme . This programme gave them a sense of their identity and untapped potential and was a catalyst to them taking up education completing ESOL Maths and English . Their increased 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





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 (June 2021)

- Black Country STP
  - ✓ 637,425 appts
  - ✓ 577,322 attended (90%) up 6%
  - ✓ 34,784 – DNA (5.45%) down 2.8%
  - ✓ 25,319 – Not Booked(3.97%) down 3.6%
  - ✓ X1 appt per 2.34 pt (appt vs patient)
  - ✓ Compared to Mar 2021 2.21 (appt vs patient)
- 55 % F2F appts compared to 50% in August 2020

CCG	Population	Number of Appts	Appt vs pt
BCC	**1,492,153**	**637,425**	**2.34**

Tier 1: Primary Care SOP

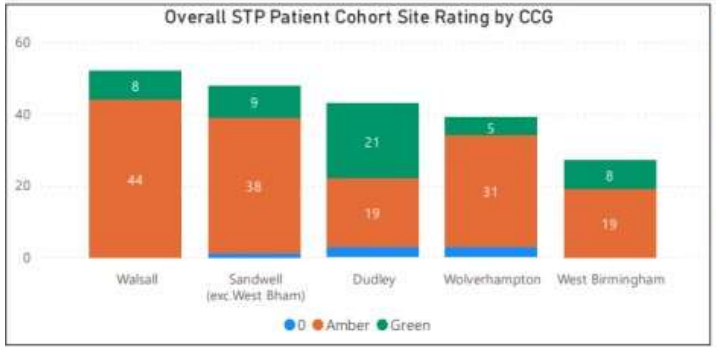
- Primary care operating telephone triage first – if patients require clinical face-to-face (F2F) examination they are invited in for an appointment
- Consultations are being completed via telephone, video consult, online and F2F

Current Pressures:

1. Access to appointments
2. Ongoing delivery of the Vaccine programme Phase 1- 3
3. Access to Out-patient services
4. Patient Demand
5. Blood Bottle Supply shortage

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

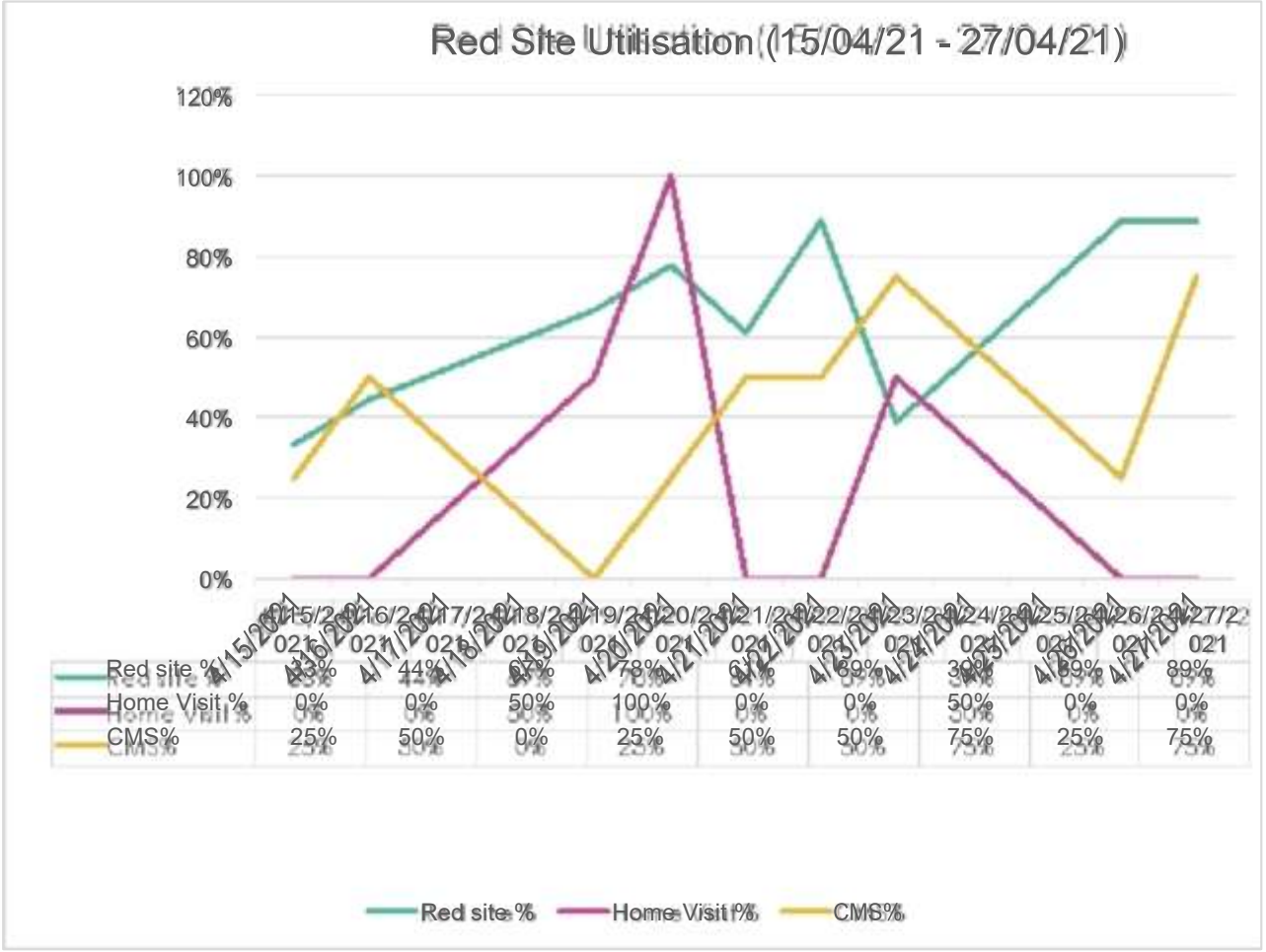


Total

CCG Name	Number Self isolating but unable to work from home	Number Off Sick - Covid Symptoms	Total Sick	Staff Down %
NHS Dudley CCG	18.00	7	24	4.04%
NHS Sandwell and West Birmingham CCG	23.00	30	86	6.19%
NHS Walsall CCG	25.00	13	38	6.86%
NHS Wolverhampton CCG	13.00	27	51	7.44%
Total	**79.00**	**77**	**199**	**6.07%**

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.
- Red sites are commissioned untill the end of September 2021
- Winter planning for COVID +ve patients in primary to be discussed

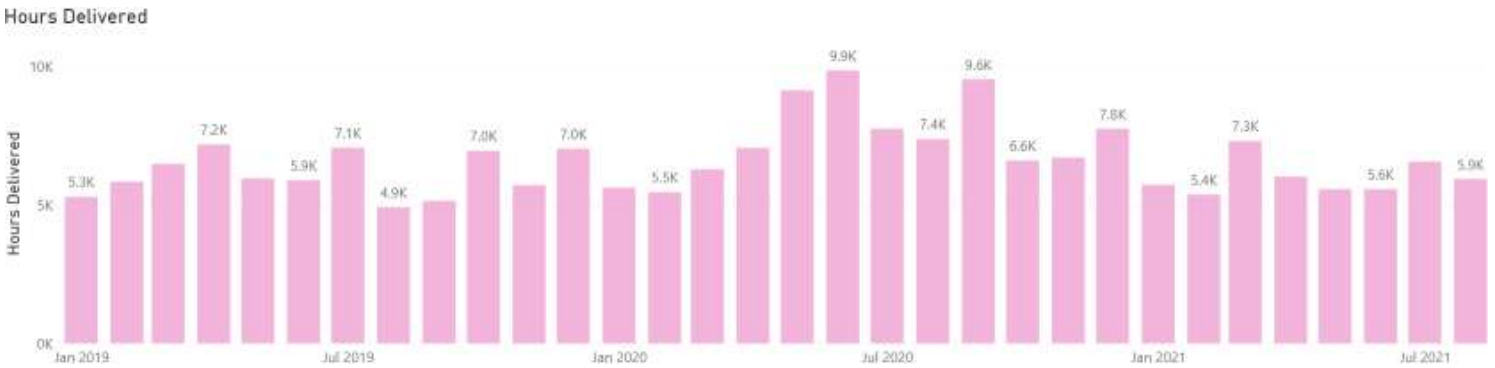


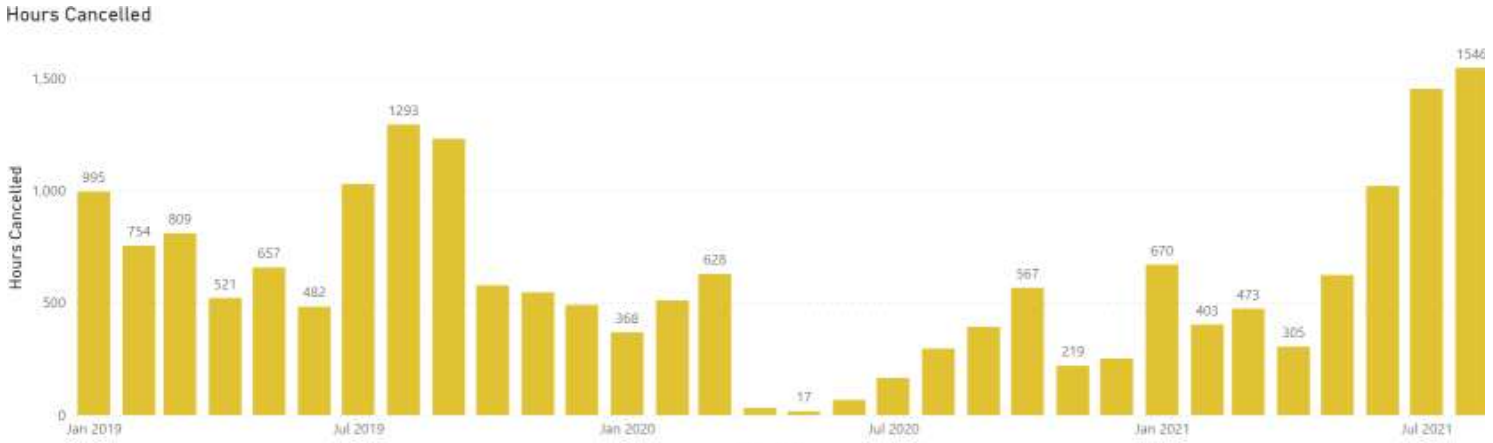
Tier 1: PCN – ARRS

- Currently 2 projects involving PCN ARRS and WT.
  - First Contact Practitioner (FCP)
  - Nursing Associates (NA)
  - Mental Health Practitioner
- 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
- Mental Health Practitioner recruitment has been challenging with x1 succsessful applicant - pilot to take place in East 1 PCN
- 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 August 2021, Community Services delivered less hours of care and cancelled more than in the previous month



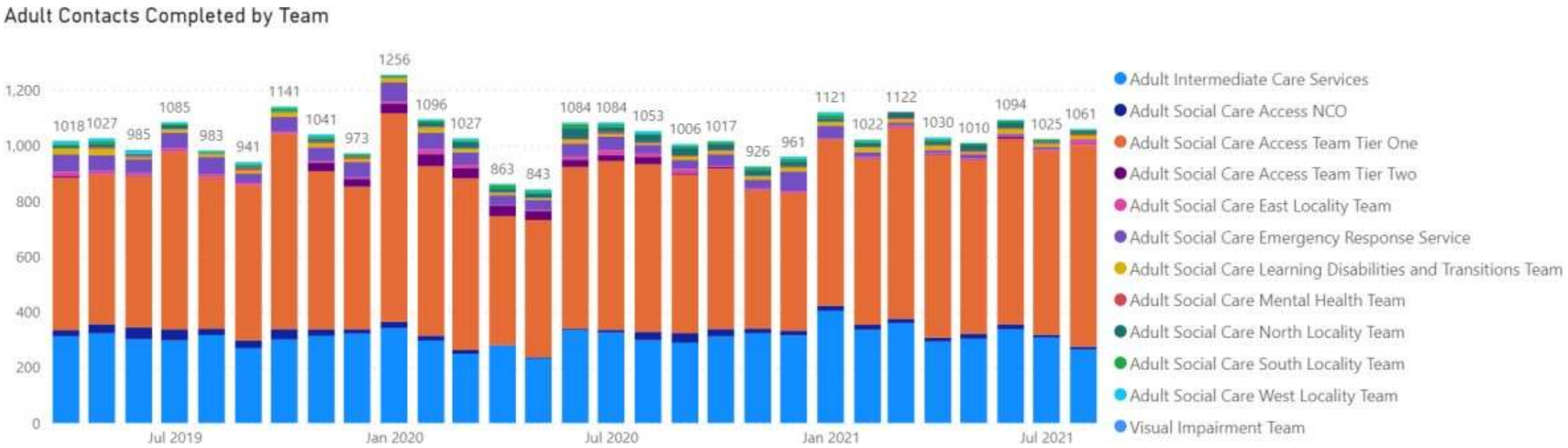


Absence levels within Community Services continue to be high throughout July. This combined with an increased number of staff on maternity leave and further staff leaving their posts within Locality Teams, this has impacted on the number of hours that have been cancelled. June has shown a significant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

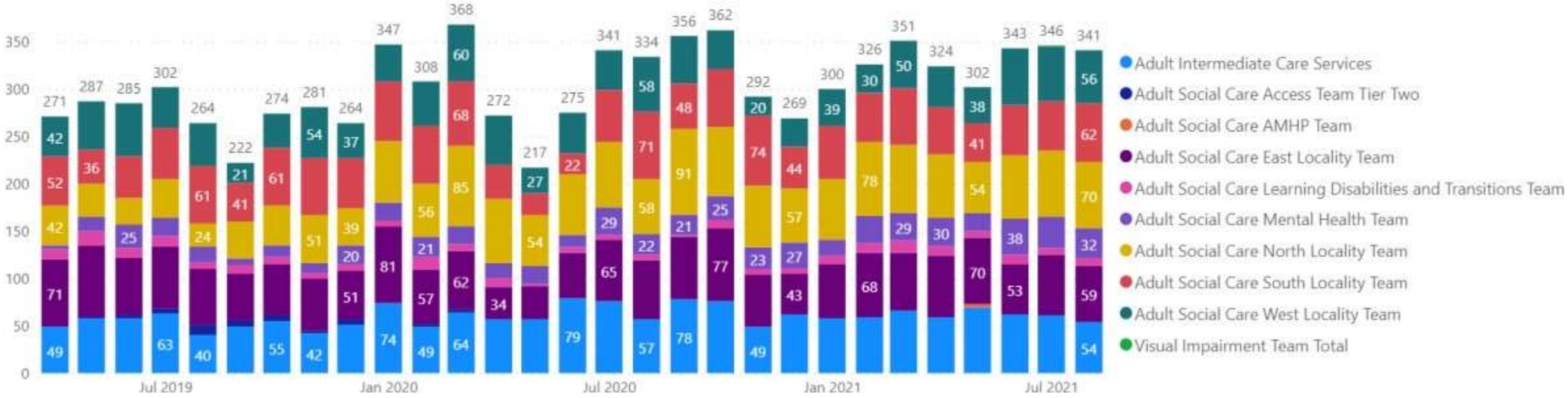
Tier 1:
Adult Social Care



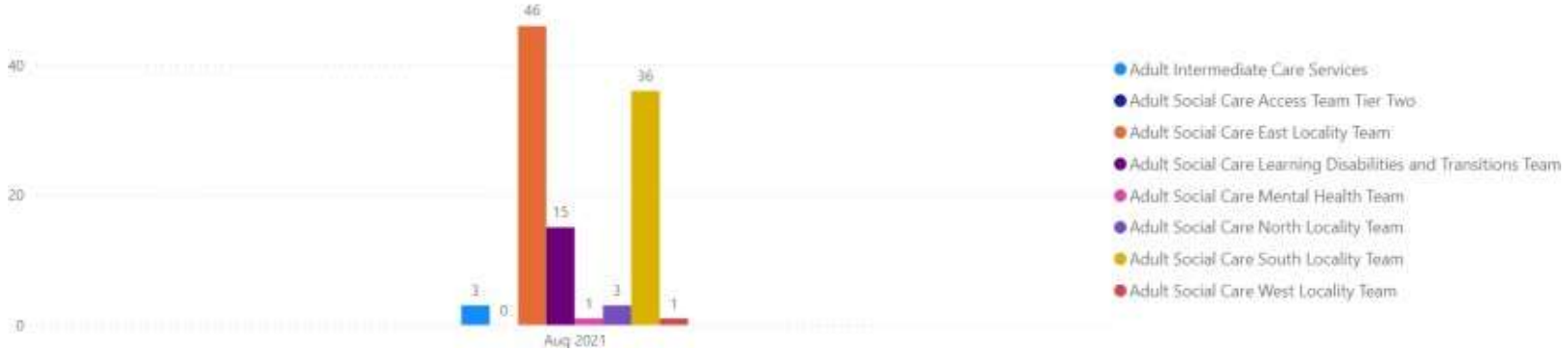
Demand coming into Adult Social Care was slightly higher in August than July. Annual leave, absences and redeploying some staff to ICS to support demand has resulted in reduced staffing capacity in our locality teams therefore we have continued to maintain normal activity for completion of Care Act assessments and prioritised out reviews to support individuals with change of need.

Walsall Together

Care and Support Assessments and 3 conversations completed

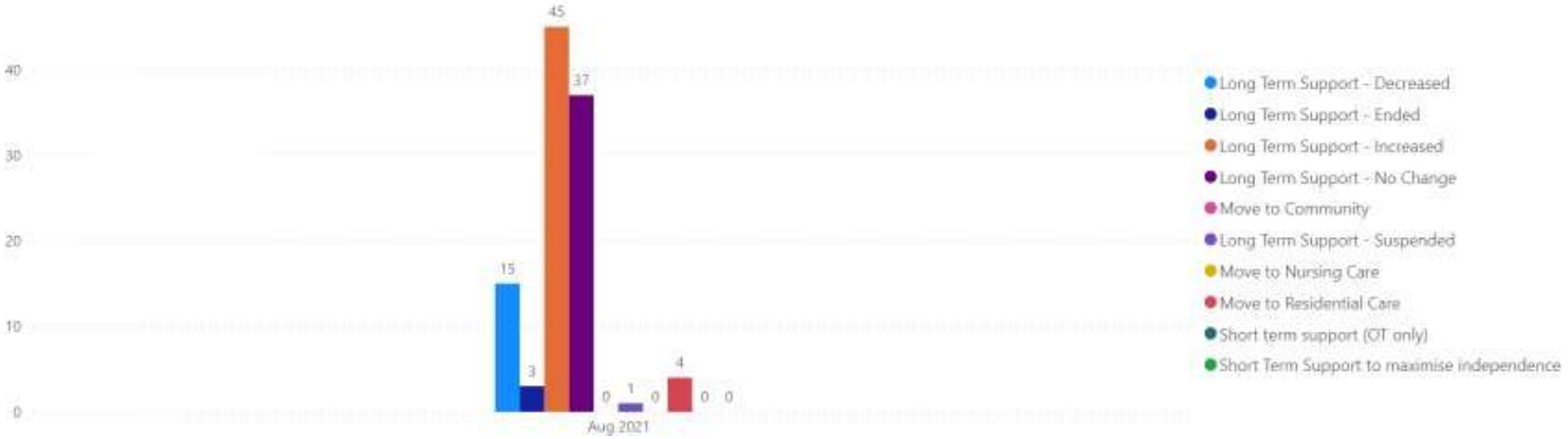


Initial and Subsequent Reviews Completed by Teams



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
Aug-21	105

Initial and Subsequent Review Outcomes



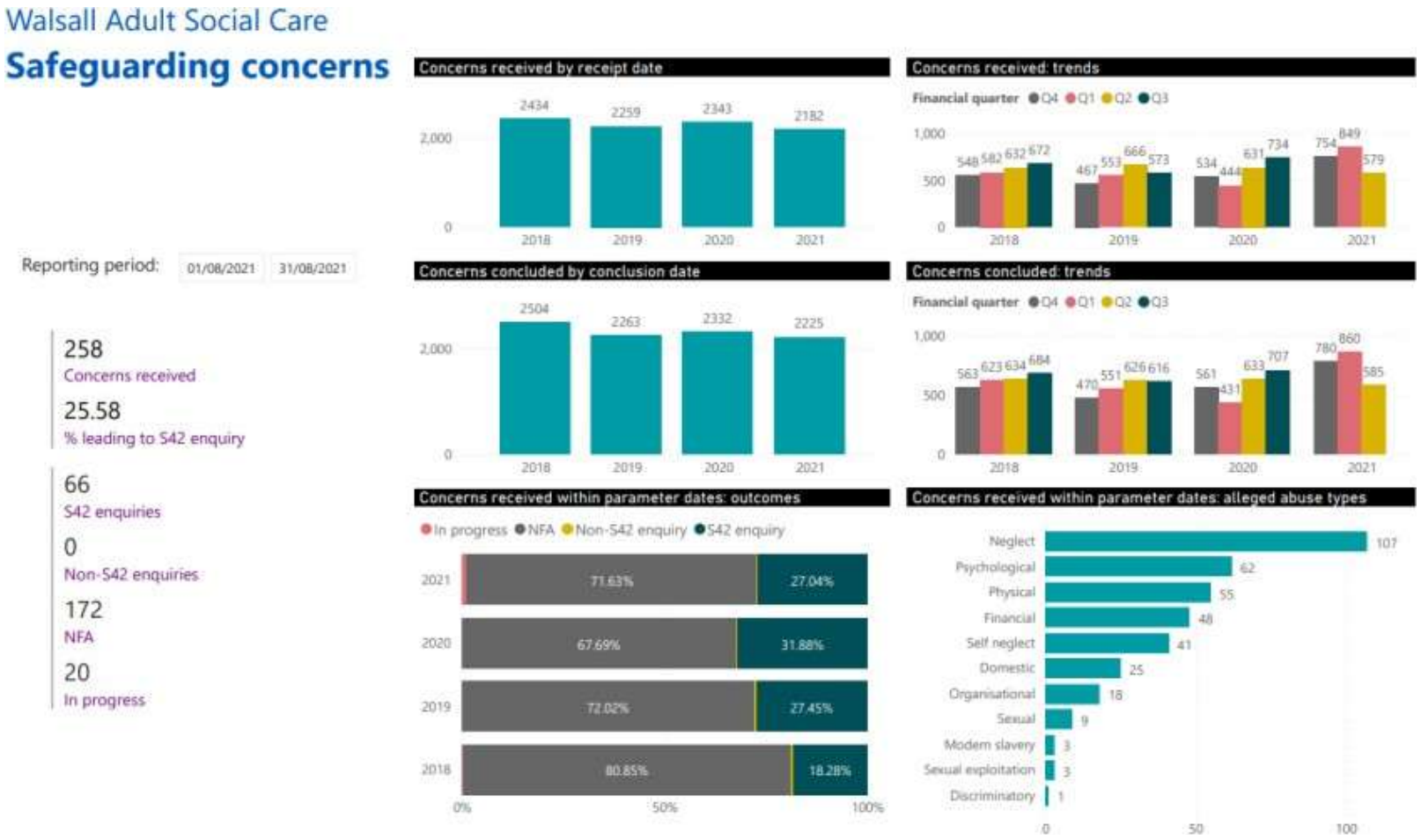
Tier 2:
Adult Social Care

ASC have received 258 concerns which is a reduction on the previous month. There is no indication of why there is a reduction but reflects the same data for this period in 2020.

The number of cases progressing to a s42 enquiry is a quarter of concerns received. This number has also reduced which would correlate with the reduction of concerns received.

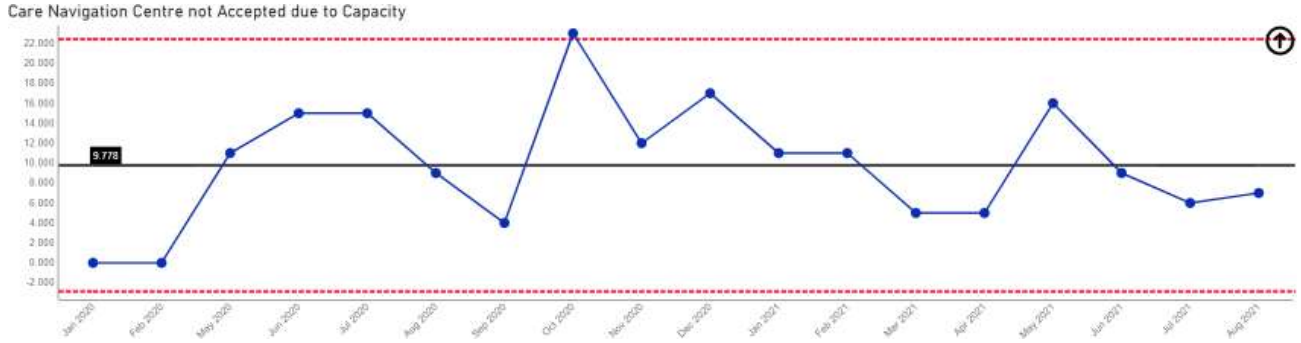
Safeguarding cases in progress have reduced with staff prioritising the timeliness of safeguarding enquiries and providing timely outcomes.

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



Tier 3:

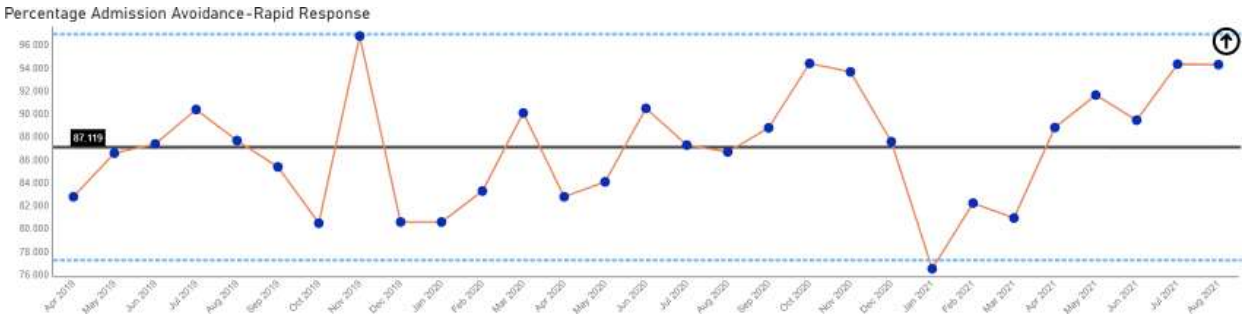
Care Navigation Centre: Hours of availability have increased (November 2020) and calls continue to rise



- 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

Gynae/ Early pregnancy services.

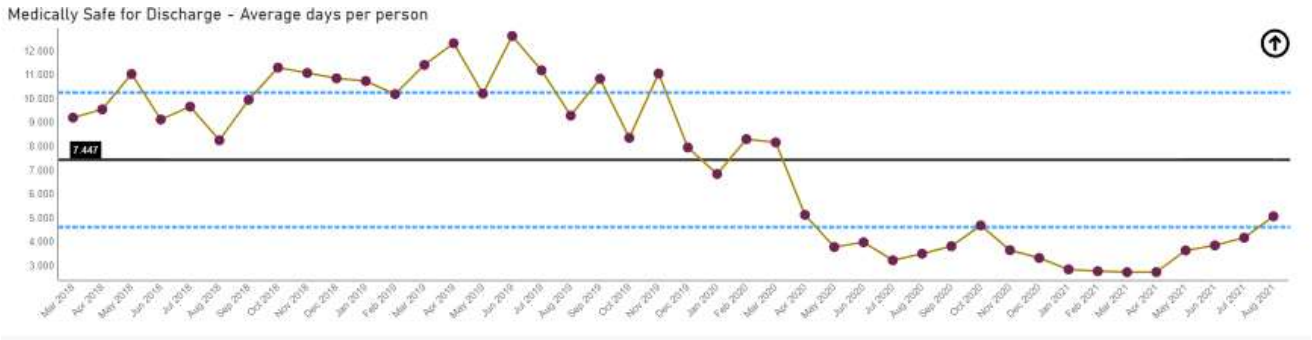
Tier 3: Rapid Response
The pattern of demand is changing [impact of CNC]



Referrals into Rapid Response have increased, while the percentage of admissions avioded has also climbed. The service 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.

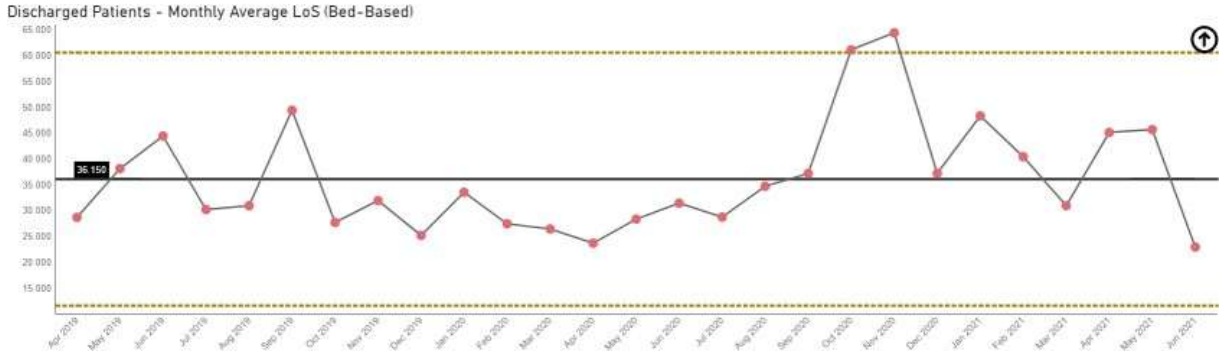
Rapid Response is now visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non-clinical referrals(non –clinical calls as 3 month pilot with 6 identified conditions).

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



- The number of MSFD patients and the LOS on the MSFD list increased during July and August
- This was linked to the reduced capacity in the system for provision of packages of care
- Walsall Together has coordinated a response which involves:
  - ☐ Use of interim care home beds and dedicated staff to support these beds
  - ☐ Reduction of demand for packages of care
  - ☐ Recruitment of additional providers
  - ☐ Greater flexibility within the contracts for provision of packages of care
  - ☐ Offer to care agencies for support with recruitment
- The aim has been to keep the number of MSFD at Walsall Manor at 50 patients

Tier 3: Domiciliary and Bed-Based Pathways



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

Tier 3/4:
Integrated Assessment Hub:

Recruitment is still in progress last B6 post

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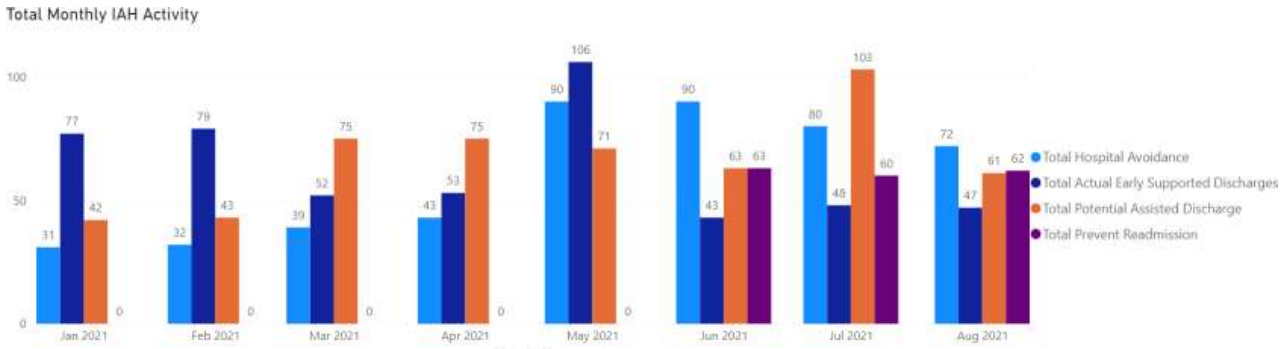

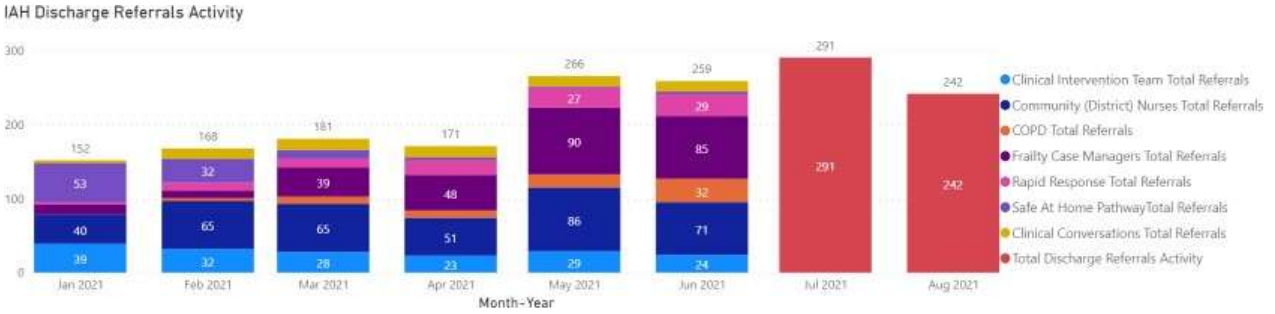

Awaiting Team level referrals activities from Total Mobile system configuration from July 2021

avoid readmission.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD – 7th OCTOBER 2021			
Work Closely with Partners			**AGENDA ITEM: 21**
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, Orthopaedics, Bariatrics, 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 ☐		


Safe, high quality care
Care at home
Partners
Value colleagues
Resources
Respect
Compassion
Professionalism
Teamwork

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 theRoyal 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. Despite good progress with the Urology partnership programme, it is likely that Phase 1 (integration of non- elective Urology services with RWT) will not now be able to be delivered until in to2022, as a result primarily of physical bed capacity constraints at New Cross Hospital.

Caring for Walsall together

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 has been endorsed at the Black Country & West Birmingham Urgent and Emergency Care Board, the Walsall Borough Council's Scrutiny Committee, and the City of Wolverhampton Council Health Scrutiny Panel.

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 now targeting implementation of phase 1 of the programme in early 2022, upon resolution of sufficient inpatient bed capacity at New Cross Hospital.

Mutual Aid between the 2 Trusts continues, with Walsall Healthcare scheduled to support 67 Urological surgery procedures by December 2021 to reduce the longest waiting times for Wolverhampton patients.

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 were 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. The pilot operating lists have been evaluated, and will become a timetabled, weekly, all-day operating list every Thursday commencing 21st October 2021.

Bariatric Surgery and weight management services

The Trust is working collaboratively with Black Country & West Birmingham partners to submit a proposal to commissioners to secure Walsall Healthcare as the dedicated tier 4 Bariatric Surgery hub in the ICS, supplemented by a Tier 3 specialist weight management service including the wider Multi Disciplinary Weight Management specialists such as Dietetics, Psychologists, Physiotherapists and Chemical Pathologists.

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. The two Estates & Facilities Divisional leadership teams are reviewing further opportunities to integrate the services.

Haematology

Formal project structure for integration is now in place between WHT and RWT, with monthly integration project meetings. WHT have confirmed budget for recruitment to 2 Clinical Fellows under the RWT clinical fellowship programme, and the two services are seeking to identify joint clinical leadership to lead an integrated service across the two sites.

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

Latest Board/Committee/Group - 20/09/2021
Version V4.03

Walsall Healthcare NHS
NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 03 - Working with partners; We will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System.**
Risk Description:	Failure to integrate functional and organisational form change within the Black Country will result in lack of resilience in workforce and clinical services, potentially damaging the trust's ability to deliver sustainable high quality care.
Lead Director:	Chief Operating Officer.
Lead Committee:	Performance, Finance, & Investment Committee.
Links to Corporate Risk Register:	Title: • There are no direct corporate risks associated with Partnership working. However increased partnership working provides a mitigation to the following Corporate risks; ▪ **2066** - Nursing and Midwifery Vacancies (Risk Score = 15), ▪ **2072** - Temporary workforce (Risk Score = 16).
	Current Risk Score Movement: **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. ▪ Health Overview & Scrutiny Committees for Walsall and Wolverhampton endorsed Urology integration proposal. ▪ 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 commenced in post. ▪ 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. ▪ Mutual aid provided to partner organisations including suspected Skin Cancer patients from SWBH, suspected Breast Cancer patients from RWT, and intelligently conveyed ambulances from multiple neighbouring Trusts. However, despite progress, integration plans are not all yet fully implemented and the sustainability of the Urology service prevents the score being reduced further at this stage.			

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Sustainability review process completed. • Regular oversight through the Board and its sub committees. • Improvement Programme to progress clinical pathway redesign with partner	• 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.	• Third line of control NHSE/I regulatory oversight. • Black Country and West Birmingham STP plan and governance processes in place.

	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. • Black Country & West Birmingham Acute Care Collaboration Programme Board established March 2021.	• West Midlands Imaging Network Board established with Trust Chief Operating Officer as voting member.	
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 and/or significant non-elective Winter pressures associated with a resurgence in Influenza, Respiratory Syncytial Virus and norovirus as well as 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.	

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Thursday 7th October 2021			
Urgent & Emergency Care Resilience: Winter Plan 2021/22			**AGENDA ITEM: 22**
Report Author and Job Title:	Ned Hobbs – Chief Operating Officer Kate Salmon – Director of Operations (Medicine & Long Term Conditions) Adam Townsend, Longacres Consulting	**Responsible Director:**	Ned Hobbs – Chief Operating Officer
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The winter of 2020/21 was dominated by the rapid spread of the delta variant of Covid-19, placing huge strain on Urgent & Emergency Care services and Critical Care services in December 2020 and January 2021 in particular. The Trust's ability to respond to the new variant was heavily supported by the underlying Winter Plan that the Trust Board had approved in October 2020. January 2021 will go down as one of the most challenging months in the history of the NHS, and it would have been far worse if it wasn't for the diligent planning from Divisional Leads in anticipation of Winter 2020/21. Winter 2021/22 is arguably an even more difficult prosect. We know that traditionally emergency care services face greater pressure during the winter months as a result of patients being more acutely unwell and thus staying in hospital longer. This year is likely to be even more challenging for the NHS and Social Care systems due to the unpredictability of Covid variants, higher than normal prevalence of Respiratory Synctial Virus (RSV) in children, winter influenza and noroviruses, high general non-elective demand, more acutely unwell patients due to undiagnosed or delayed diagnosis of conditions over the course of the pandemic, and significant challenges in the provision of domiciliary social care. This potentially toxic scenario comes on the back of the most challenging Summer and Autumn for Urgent & Emergency Care services on record in England with unprecedented delays for patients arriving by ambulance to be handed over to Emergency Departments and the worst ever recorded timeliness of care within Emergency Departments as measured through the 4-hour Emergency Access Standard in August 2021. Whilst the Trust's own ambulance handover times and 4-hour Emergency Access Standard performance has remained good in benchmarking terms		


Safe, high quality care
Care at home
Partners
Value colleagues
Resources
Respect
Compassion
Professionalism
Teamwork

	to other Trusts, it has deteriorated significantly since June in real terms meaning that more patients have waited for longer for access to Emergency Care. This means that our Winter Plan must have even greater resilience than previous years. In addition, the plan must enable a relentless focus on minimising the risk of nosocomial infection and reflect that this necessitates Covid, influenza and RSV segregation and streaming within the hospital setting which is acknowledged to make managing patient flow through hospitals more challenging. The 3 central tenets of the plan are as follows: 1. A strategic focus on interventions that improve quality ofcare and result in reduction in overnight hospital admissions, including an increase in same day emergency care (SDEC) services, interventions to get people better sooner (reducing inpatient length of stay), and interventions through the Walsall Together Partnership to avoid admissions, ratherthan simply opening more hospital inpatient beds. 2. Following the success of our targeted approach to managing the Festive period over the last two years, the same approach will be adopted for 2021/22 running from Saturday 18th December 2021 to Sunday 9th January 2022. Operational services over the key weekends and bank holidays will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges. Historically bed occupancy rises steeply overthis period as fewer patients are discharged over Christmas and the New Year period, and it is this risk which must be mitigated. 3. A strategic focus on the recruitment and use of substantive workforce, rather than reliance on temporary bank, agency and locum workforce to fulfil planned interventions. Getting this right is really important, and is a whole hospital, whole Trust, and whole health economy responsibility. It is important because if we don't get it right, patients will spend excessive time in the ED and will be at increased risk of contracting covid-19, influenza, RSV or other infections under our care. We know prolonged duration of stay in the ED for admitted patients is directly associated with an increased mortality rate of approximately 0.75% per additional hour in ED. We also know that emergency care services are high pressure environments, with a greater burnout rate for staff. In addition, the pan-West Midlands Stat-stress study highlighted that staff working


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	along the emergency care pathway in ED, wards and Critical Care were 40-50% more likely to report symptoms suggestive of Post-Traumatic Stress Disorder during the Covid-19 pandemic. This Winter Plan seeks to improve the resilience of the Trust's emergency care pathways for the benefit of the patients we serve, and also crucially to protect the wellbeing of hard-working staff working in highly challenging environments. The Winter Plan in 2021/22 is costed at £6.158m, with the two reasons for increased costs compared to last year (£4.697m) being £600k of CCG funded community/integrated care interventions, and the impact of the Paediatric RSV plan which is costed at £977k. These increased requirements are offset by much greater staffing through substantive and bank workforce, and significantly reduced Agency reliance resulting in less expensive costs for comparative interventions. As a consequence, the net increase in costs over H2 to deliver the winter plan is £4.191m compared to H1.
Recommendation	Members of the Board are requested to: - APPROVE the Urgent & Emergency Care Resilience Winter Plan. - NOTE that notwithstanding the extensive nature of this plan, it is not currently sufficient to address the reasonable worst case scenario for the coming Winter. The Urgent & Emergency Care Resilience Winter Plan was approved at the Trust Management Committee on 28th September 2021, approved at the Performance, Finance & Investment Committee on 29th September 2021, and endorsed by the Quality, Safety & Patient Experience Committee on 30th September 2021.
Does this report mitigate risk included in the BAF or Trust Risk Registers?	Risk 208 - Total time spent in ED BAF S01 – Safe, High Quality Care BAF S06 – Use of Resources


Safe, high quality care
Care at home
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Resource implications	The Winter Plan in 2021/22 is costed at £6.158m, with the two reasons for increased costs compared to last year (£4.697m) being £600k of CCG funded community/integrated care interventions, and the impact of the Paediatric RSV plan which is costed at £977k. These increased requirements are offset by much greater staffing through substantive and bank workforce, and significantly reduced Agency reliance resulting in less expensive costs for comparative interventions. As a consequence the net increase in costs over H2 to deliver the winter plan is £4.191m compared to H1. The costs are included within the Trust's H2 Financial Plan.	
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 ☒	


Safe, high quality care
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Compassion
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Walsall Healthcare NHS
NHS Trust

Urgent & Emergency Care resilience: Winter Plan 2021/22

Active Period
1st October 2021 to
31st March 2022

Version 1

Executive Lead

Ned Hobbs
Chief Operating Officer

Contributing Authors
Kate Salmon, Divisional Director of Operations, Medicine Division
Adam Townsend, Longacres Consulting

Walsall Healthcare NHS Trust
Trust Headquarters | Moat Road | Walsall | West Midlands | WS2 9PS

Section

1	**Foreword**
2	**Executive Brief**
3	**Purpose of this Document**
4	**Approach to planning for winter 2021/22**
5	**Winter plan modelling methodology**
6	**Modelling**
7	**Detailed plans & summary costings**
8	**Risks**
9	**External reporting arrangements**
10	**Appendices**

1.1 Foreword

The winter of 2020/21 was dominated by the rapid spread of the delta variant of Covid-19, placing huge strain on Urgent & Emergency Care services and Critical Care services in December 2020 and January 2021 in particular. The Trust's ability to respond to the new variant was heavily supported by the underlying Winter Plan that the Trust Board had approved in October 2020. January 2021 will go down as one of the most challenging months in the history of the NHS, and it would have been far worse if it wasn't for the diligent planning from Divisional Leads in anticipation of Winter 2020/21.

Winter 2021/22 is arguably an even more difficult prosect. We know that traditionally emergency care services face greater pressure during the winter months as a result of patients being more acutely unwell and thus staying in hospital longer. This year is likely to be even more challenging for the NHS and Social Care systems due to the unpredictability of Covid variants, higher than normal prevalence of Respiratory Synctial Virus (RSV) in children, winter influenza and noroviruses, high general non-elective demand, more acutely unwell patients due to undiagnosed or delayed diagnosis of conditions over the course of the pandemic, and significant challenges in the provision of domiciliary social care.

This potentially toxic scenario comes on the back of the most challenging Summer and Autumn for Urgent & Emergency Care services on record in England with unprecedented delays for patients arriving by ambulance to be handed over to Emergency Departments and the worst ever recorded timeliness of care within Emergency Departments as measured through the 4-hour Emergency Access Standard in August 2021. Whilst the Trust's own ambulance handover times and 4-hour Emergency Access Standard performance has remained good in benchmarking terms to other Trusts, it has deteriorated significantly since June in real terms meaning that more patients have waited for longer for access to Emergency Care. This means that our Winter Plan must have even greater resilience than previous years. In addition, the plan must enable a relentless focus on minimising the risk of nosocomial infection and reflect that this necessitates Covid, influenza and RSV segregation and streaming within the hospital setting which is acknowledged to make managing patient flow through hospitals more challenging.

The 3 central tenets of the plan are as follows:

1. A strategic focus on interventions that improve quality of care and result in reduction in overnight hospital admissions, including an increase in same day emergency care (SDEC) services, interventions to get people better sooner (reducing inpatient length of stay), and interventions through the Walsall Together Partnership to avoid admissions, rather than simply opening more hospital inpatient beds.

2. Following the success of our targeted approach to managing the Festive period over the last two years, the same approach will be adopted for 2021/22 running from Saturday 18th December 2021 to Sunday 9th January 2022. Operational services over the key weekends and bank holidays will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges. Historically bed occupancy rises steeply over this period as fewer patients are discharged over Christmas and the New Year period, and it is this risk which must be mitigated.

3. A strategic focus on the recruitment and use of substantive workforce, rather than reliance on temporary bank, agency and locum workforce to fulfil planned interventions.

Getting this right is really important, and is a whole hospital, whole Trust, and whole health economy responsibility. It is important because if we don't get it right, patients will spend excessive time in the ED and will be at increased risk of contracting covid-19, influenza, RSV or other infections under our care. We know prolonged duration of stay in the ED for admitted patients is directly associated with an increased mortality rate of approximately 0.75% per additional hour in ED.

We also know that emergency care services are high pressure environments, with a greater burnout rate for staff. In addition, the pan-West Midlands Stat-stress study highlighted that staff working along the emergency care pathway in ED, wards and Critical Care were 40-50% more likely to report symptoms suggestive of Post-Traumatic Stress Disorder during the Covid-19 pandemic. This Winter Plan seeks to improve the resilience of the Trust's emergency care pathways for the benefit of the patients we serve, and also crucially to protect the wellbeing of hard-working staff working in highly challenging environments.

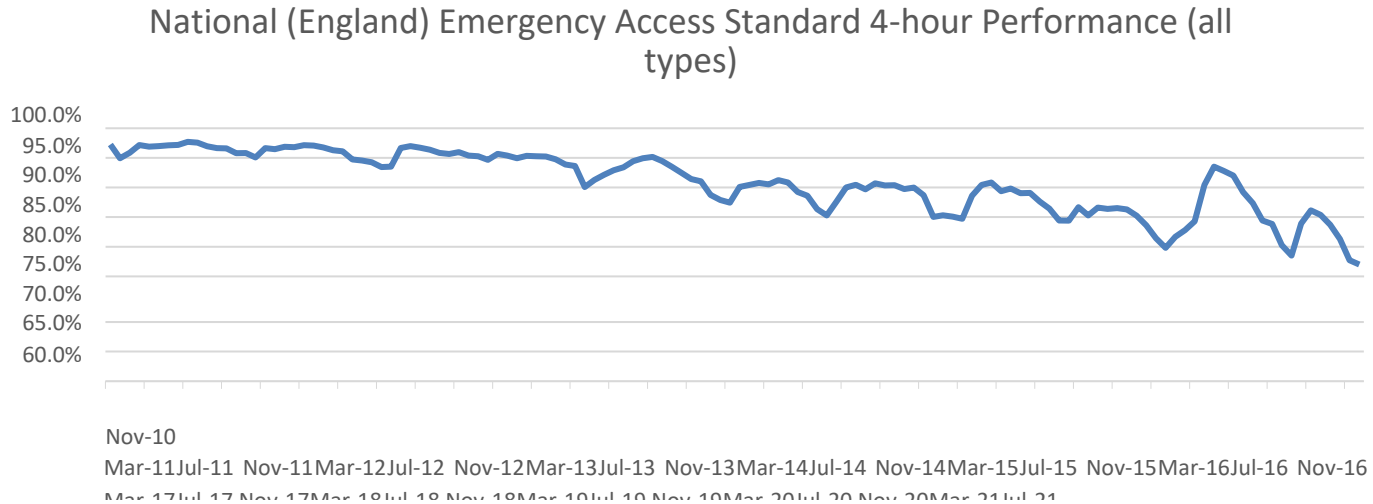
Thank you to all colleagues who played their part in delivering as safe a Winter as possible last year, thank you to all colleagues who have played such an invaluable role in keeping our patients and staff safe over the course of the Covid-19 pandemic, and thank you to all colleagues who have been involved in developing this plan. Just about every specialty or department in the Trust has a role to play to ensure we manage Winter as well and as safely as we can, and it is our collective responsibility to ensure that we do just that.

Ned Hobbs
Chief Operating Officer
Walsall Healthcare Trust

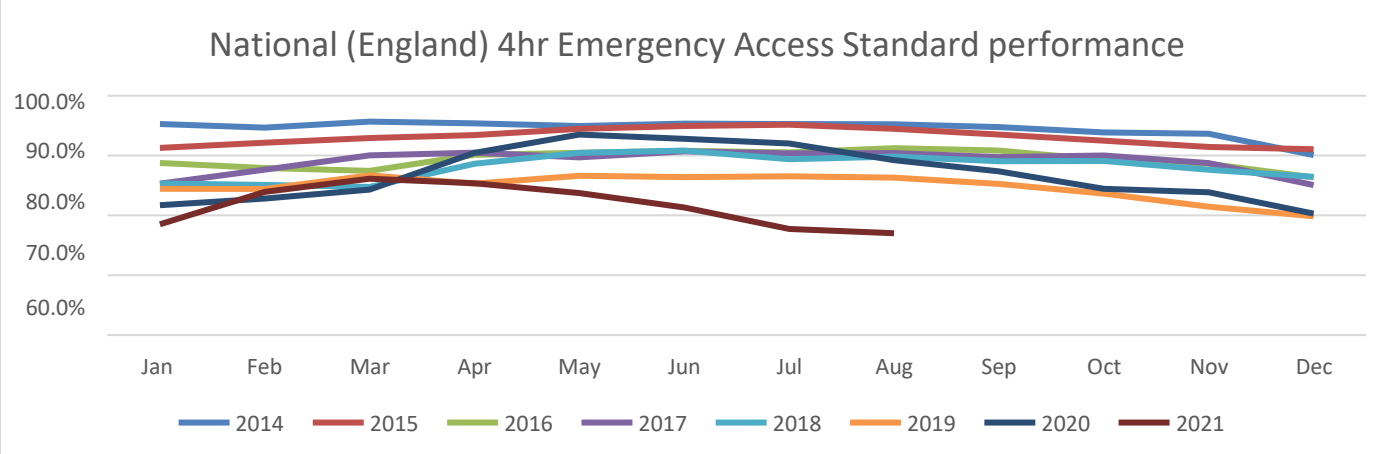
2.1 Executive Brief

Last year's Winter plan anticipated that the winter of 2020/21 would be the most challenging yet. Given the unpredictability of Covid variants, Respiratory Synctial Virus (RSV) in children, winter influenza and noroviruses, high non-elective demand, more acutely unwell patients due to undiagnosed or delayed diagnosis of conditions, and significant challenges in the provision of domiciliary social care, this winter is set to be even more challenging. The country enters this Winter with the Urgent and Emergency Care system in the most perilous position it has ever faced[1,2,3,4], and thus the importance of a resilient Winter Plan is arguably even greater than in previous years.

The Urgent and Emergency Care system in England has huge risks within it currently. As a proxy for the level of overcrowding in Emergency Departments, and the level of Exit Block (delayed admission for patients needing admitting from ED into the hospital), the country is delivering the worst 4-hour Emergency Access Standard performance on record currently[5]:

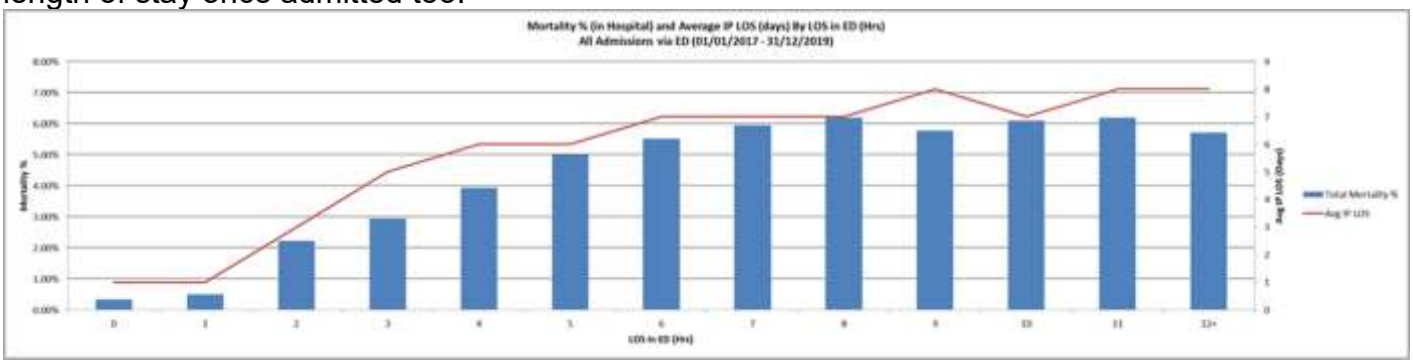


Moreover, as can be seen by the following chart the pressures experienced over Summer 2021, and into Autumn 2021 are unprecedented:



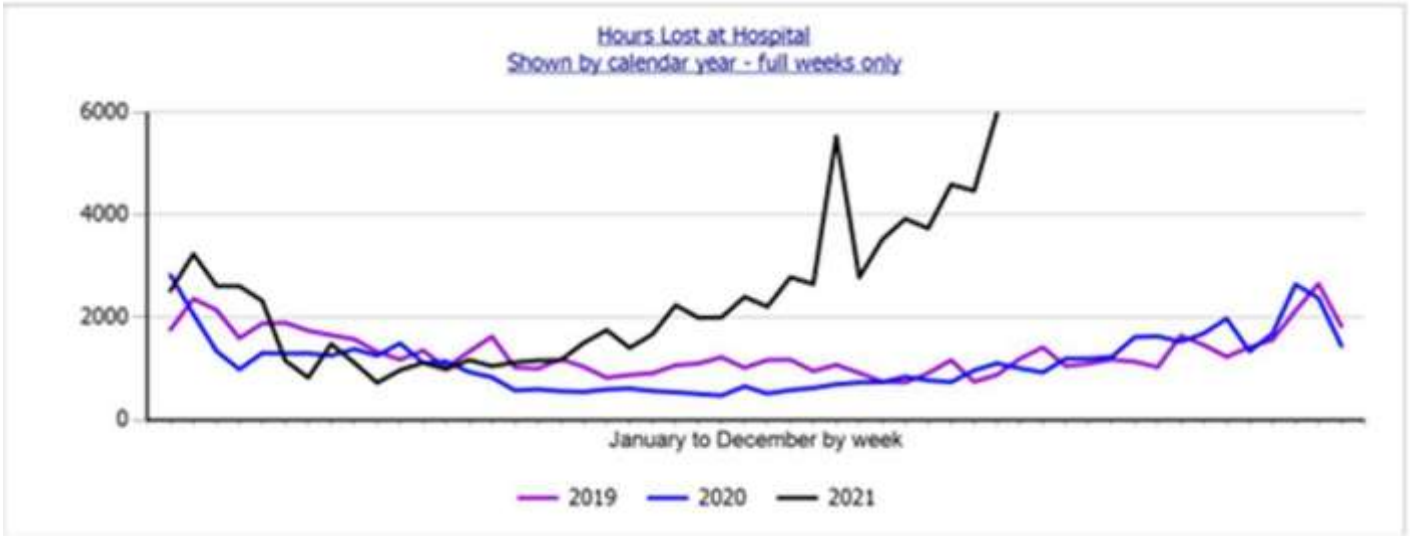
1. NHS Confederation (2021), *Winter in summer: the NHS at crunch point* , https://www.nhsconfed.org/publications/winter-summer-nhs-crunch-point
2. Society of Acute Medicine (2021), *Performance data shows dire state of affairs,* https://www.acutemedicine.org.uk/performance-data-shows-dire-state-of-affairs-sam-president/
3. Royal College of Emergency Medicine (2021), *RCEM Acute Insight Series: What's Behind the Increase in Demand in Emergency Departments?* https://www.rcem.ac.uk/docs/News/WhatsBehindTheIncreaseInDemandInEmergencyDepartments.pdf
4. Royal College of Emergency Medicine (2021), *Winter is a looming crisis; effective action must be taken before it's too late,* https://www.rcem.ac.uk/RCEM/News/News_2021/Winter_is_a_looming_crisis_effective_action_must_be_taken_before_it_s_too_late_RCEM_says.aspx
5. Health Service Journal (2021), A&E performance hits record low despite fewer attendances https://www.hsj.co.uk/quality-and-performance/aande-performance-hits-record-low-despite-fewer-attendances/7030860.article

The 4-hour Emergency Access Standard is a relatively blunt measurement. However, we know that each additional hour patients spend in the Emergency Department prior to admission to hospital, is associated with an approximately 0.75% increased risk of death, and with increased inpatient length of stay once admitted too:



The risks are not currently just within hospitals. Indeed some of the greatest risks are for patients in the community needing an emergency ambulance to attend to them[6]. West Midlands Ambulance Service is currently experiencing the worst ambulance handover delays at Emergency Departments on record, meaning crews are unable to be released to get to the next 999 call. Again, the delays are not only unprecedented, but indeed grossly unprecedented for Summer/Autumn period, causing significant concern for the Winter ahead:

West Midlands Ambulance Service lost crew hours to delayed handover at EDs



The CQC held an Emergency Care Quality & Safety summit on 15th September 2021 to gather Trust Executive leaders and Emergency Department clinical leaders together to review the current situation facing Urgent & Emergency Care services. This year's Winter Plan explicitly seeks to address the CQC's recommendations contained in Patient FIRST[7], the specialist support tool to reset standards of care in Emergency Medicine, namely;

6. College of Paramedics and Royal College of Emergency Medicine (2021*), Increased ambulance handover delays threatening patient safety, RCEM and College of Paramedics warn* https://www.rcem.ac.uk/RCEM/News/News_2021/Increased_ambulance_handover_delays_threatening_patient_safety_RCEM_and_College_of_Paramedics_warn.aspx
7. Care Quality Commission (2020), *Project reset in Emergency Medicine: Patient FIRST*, https://www.cqc.org.uk/sites/default/files/20201001-Patient-FIRST.pdf

***F**low* – interventions that optimise flow out of the ED over Winter for patients who require access to onward services such as admission to an inpatient bed, or a SDEC service.

***I**nfection Control* – a rigorous focus on rapid testing and then correct streaming of patients upon admission to minimise the risk of nosocomial transmission.

***R**educed patients in EDs* – an emphasis on access to alternative community services to prevent attendances to ED, and alternative acute services to prevent the need for patients to spend prolonged time in ED.

***S**taffing* – deliberate interventions to increase staffing in a targeted and planned way to manage predictable increases in the number and/or acuity of patients requiring care.

***T**reatment in the ED* – Enhanced access to senior decision-makers and diagnostics to ensure evidenced based time-critical emergency care treatment is delivered consistently in ED.

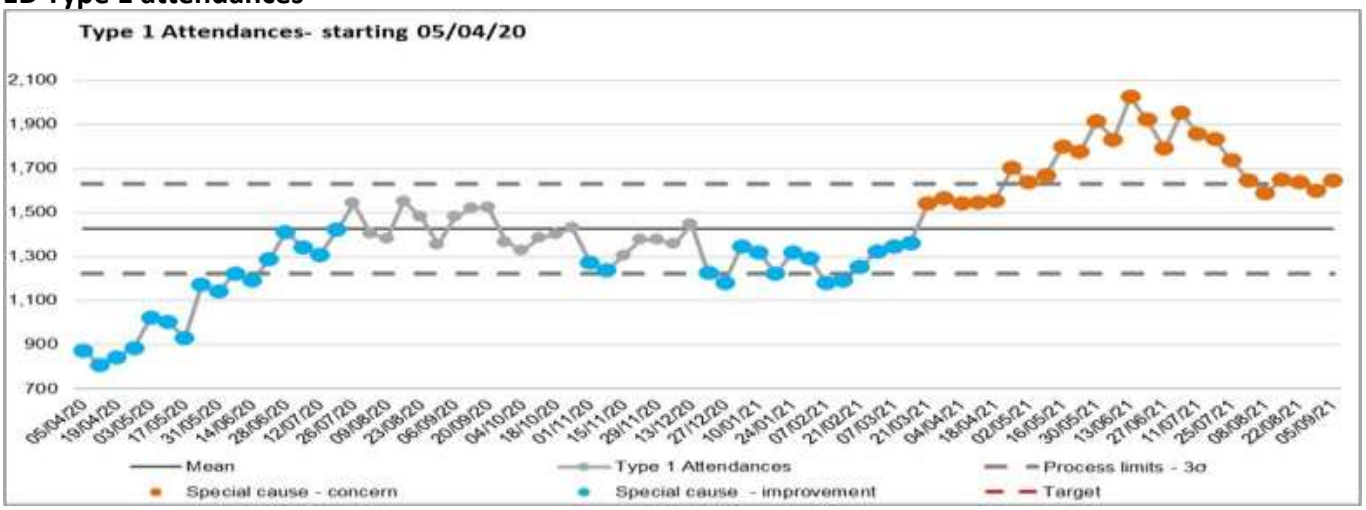
Our staff have continued to work tirelessly throughout this year. Due to the various lockdowns and restrictions on foreign travel, many staff members have not been able to take their usual holidays or catch up with friends and family members in the way they ordinarily would. Staff are tired and nervous about the Winter ahead and we need to ensure the Health & Well-being offeringscontinue throughout the coming Winter and that our Winter Plan is as resilient as it can be to both provide the best possible patient care, and the best possible working environment for staff.

A full review of the 2020/21 Winter plan was undertaken across all Divisions and departments, and once more the key themes, areas of good practice, improvement and successful interventions were identified and captured (see s.4.0). But this has been an unusual year; although the Medicine Division were able to close winter bed capacity weeks earlier than planned; many of the winter interventions have continued throughout the spring and summer months due to the continued prevalence of Covid-19 patients presenting to hospital, and due to the unprecedented levels of Type 1 ED attendances.

Worthy of mention was the specific benefit of receiving £4.1m of Department of Health capital investment awarded in Q3 2020 to ensure our Covid resilience. This included increasing ED waiting room capacity, creation of additional assessment unit capacity in Medicine and Surgery, additional cubicle capacity in ED and ensuring sufficient winter ward capacity through the relocation of the Frail Elderly Service into a newly refurbished unit. Due to the level of demand through attendances to ED, and the requirement to maintain Covid streaming this extra capacity has been required throughout the year, despite original plans to close at the end of March 2021.

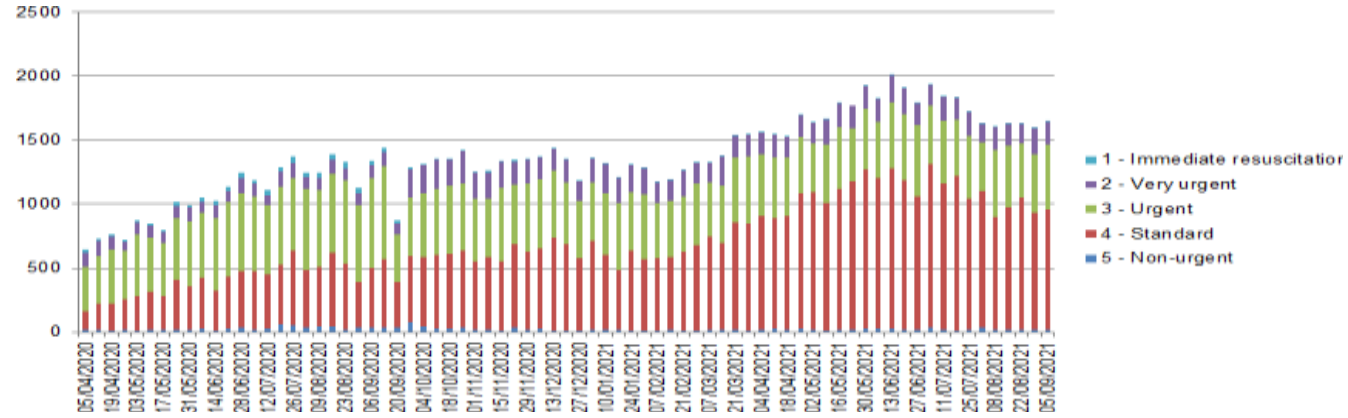
Although easing off slightly in the last few weeks, Type 1 ED attendances are still well over our normal demand, and we have seen an increase of circa 10-15% in ED attendances compared to pre-Covid levels over the past 6 months. This demand has been reflected across the West Midlands with many Trusts experiencing lengthy waits in ED and an inability to handover ambulance patients in a timely fashion.

ED Type 1 attendances



The increase in demand has been particularly seen in the Type 4 & 5 categories (lower acuity) due in part to patient's difficulties in accessing primary care and 111 services.

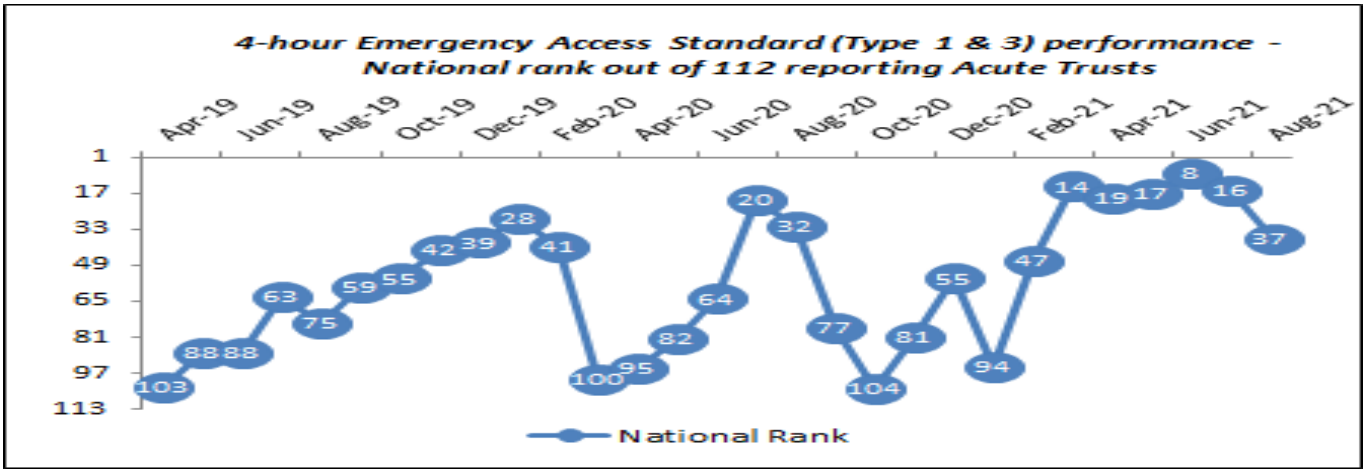
ED by Triage category



Despite our own pressures, WHT has continued to support neighbouring Trusts at times ofextremis by accepting ambulances intelligently conveyed by West Midlands Ambulance Service, and by accepting requests for ambulance diverts where possible and this was acknowledged in a letter of thanks from WMAS (see appendices). In the month of August WHT received 96 ambulances intelligently conveyed away from neighbouring Trusts Emergency Departments.

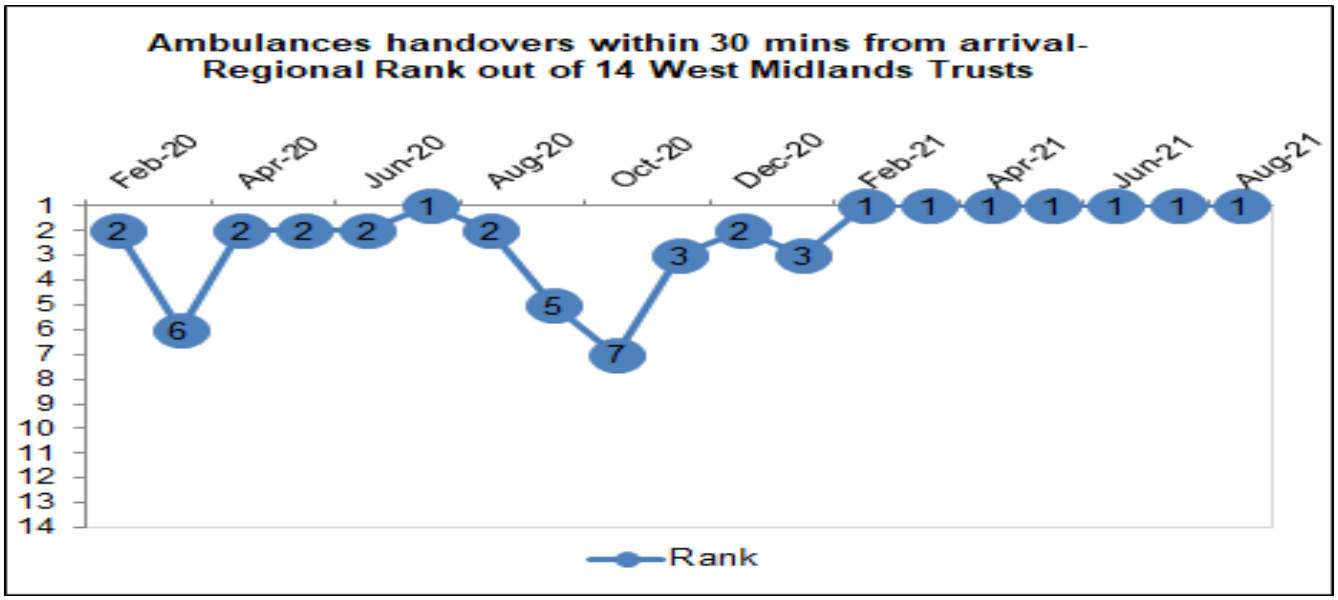
Despite these pressures over the past months, the Trust has been achieving some of its highest national rankings against the 4-hour emergency access standard and in June ranked 8th out of 112 reporting acute Trusts.

Emergency access standard performance – Types 1&3 national ranking



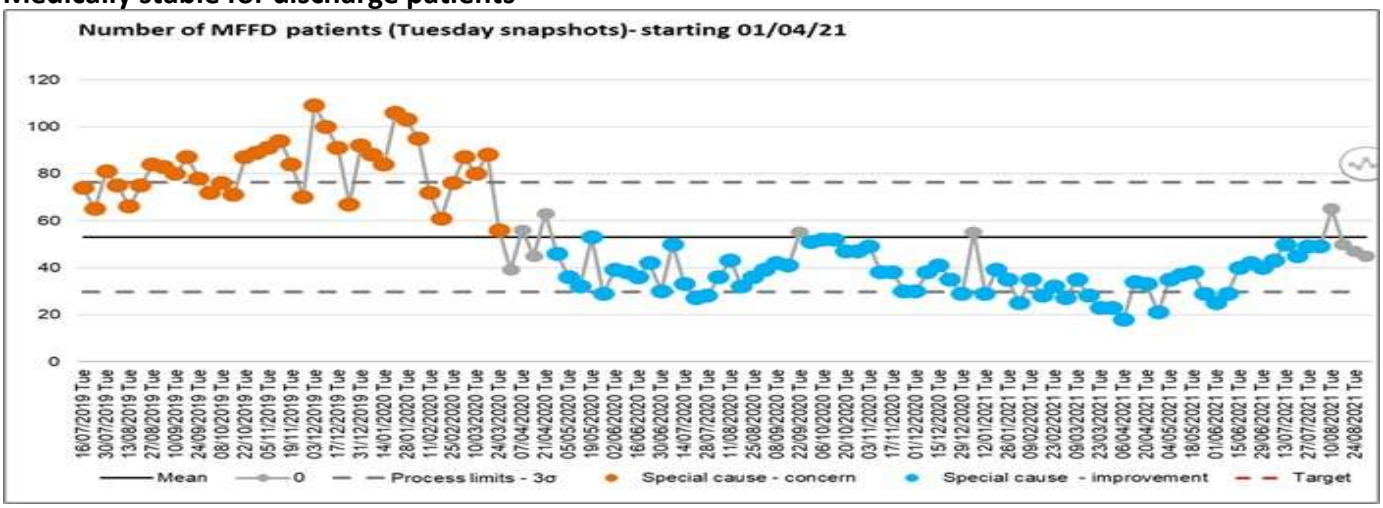
The Trust continues to rank number 1 in the West Midlands for the 7th consecutive month for ambulance handovers within 30 minutes of arrival.

Ambulance handovers within 30 mins from arrival



The Trust's ability to maintain flow throughout the hospital and thus avoiding exit block from ED has been greatly enhanced by the hard work of our Community colleagues and the management of our medically stable for discharge (MSFD) patients, although we have seen a rise in numbers of MSFD patients in hospital in recent months due to significant pressures in the domiciliary care sector. In addition, pathways established during Covid have continued; our 'Safe at Home' virtual ward for patients requiring oxygen monitoring has been nationally recognised for its good practice and impact on patient care and is a finalist at the Health Service Journal Patient Safety awards (September 2021).

Medically stable for discharge patients



This plan continues to build on the learning from previous years with many enhancements to the interventions that have worked so well to date, spanning acute and community health and social care.

The plan is subject to the following Governance approval process:

- Trust Management Committee (28/09/21)
- Performance, Finance & Investment Committee (29/09/21)
- Quality, Patient Experience & Safety Committee (30/09/21)
- Black Country & West Birmingham Urgent & Emergency Care Board (01/10/21)
- Public Trust Board (07/10/21)

3.1 Purpose of this document

3.2 The purpose of this Urgent & Emergency Care Resilience Winter Plan is to:

- Inform all relevant organisations and individuals of the way in which the system intends to manage Urgent and Emergency Care demand and provide resilience over the winter 2021/22
- Hold information on the approach taken to building the winter plan

3.3 The plan should be read by:

- Trust Board members
- Divisional Teams of Three
- Matrons
- Clinical Directors in all non-elective specialties
- Senior operational managers in the Trust
- All colleagues who are on an on-call rota.
- Senior operational managers in all system partner organisations
- Infection Control Leads
- Informatics Leads
- Black Country & West Birmingham Urgent & Emergency Care Board

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

- The appendices to this document
- Emergency Department Covid Escalation Policy
- Escalation policy – Full Hospital Protocol (2016)
- Covid-19 Contingency Plan (Version 3.3 June 2021)
- RSV Surge Plan (August 2021 and ongoing)
- Major Incident Plan (May 2019)
- Divisional, Enabling Departments and local Business Continuity arrangements
- Severe Weather Plan
- Walsall Council Severe Weather Partnership
- Walsall Council Local Covid-19 Outbreak Plan

4.1 Approach to planning for winter 2021/22

4.2 In previous years a formal 'After Action Review' has taken place with a final report presented to a number of committees and to Trust Board. This year Winter Plan reflections and lessons learned workshops were developed, co-ordinated and reported upon by the Head of EPRR. A detailed database of reflections, new ideas, areas that succeeded and interventions/arrangements that can be improved upon were documented. This report was shared to all Divisions and key departments and formed a strong foundation to fine tune arrangements for the winter ahead. Supplemented by strong and consistent datasets, both offered planners an excellent starting point for 2021/22 and were shared before and briefed at the initial planning meeting.

4.3 Divisions have produced strategic plans following similar principles to the previous winter based on the following:

- A strategic focus on interventions that improve quality of care and result in reduction in overnight hospital admissions, including an increase in same day emergency care(SDEC) services, interventions to get people better sooner (reducing inpatient length of stay), and interventions through the Walsall Together Partnership to avoid admissions, rather than just opening more inpatient beds.

- Following the success of our targeted approach to managing the Festive period over the last two years, the same approach will be adopted for 2021/22 running from Saturday 18th December 2021 to Sunday 9th January 2022. Operational services over the key weekends and bank holidays will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges. Historically bed occupancy rises steeply over this period as fewer patients are discharged over Christmas and the New Year period, and it is this risk which must be mitigated.

- A strategic focus on the recruitment and use of substantive workforce, rather than reliance on temporary bank, agency and locum workforce to fulfil planned interventions.

4.4 Planning has also been cognisant of the impact that greater pressures over the Winter period has on our staff. We know that emergency care services are high pressure environments, with a greater burnout rate for staff. In addition, the recent pan-West Midlands Stat-stress study has highlighted that staff working along the emergency care pathway in ED, wards and Critical Care were 40-50% more likely to

report symptoms suggestive of Post-Traumatic Stress Disorder during the Covid-19 pandemic. This Winter Plan seeks to improve the resilience of the Trust's emergency care pathways for the benefit of the patients we serve, and also crucially to protect the wellbeing of hard-working staff working in highly challenging environments. The Trust will take the learning from the Covid pandemic to continue to provide access to Psychological support and wellbeing facilities to promote the health and wellbeing of our staff over the Winter period, and the People & Culture Directorate have developed a set of further Winter interventions to relieve pressure on frontline clinicalleaders and staff.

5.1 Winter plan modelling methodology

The following methodology was used to calculate the expected impact/benefits of the planned interventions to produce a winter bed model included in s.6 below:

- Repeated methodology from 19/20 and 20/21 Winter Planning to inform forecast demand (ED attendances and non-elective admissions), accounting for Walsall Together interventions, particularly on admission avoidance.
- Repeated methodology from 19/20 and 20/21 Winter Planning to inform forecast acute hospital bed requirement (daily), accounting for MLTC and Surgery planned improvements in SDEC and inpatient LoS. Assumption that MSFD numbers remain at 50 or below.
- Take account of changed bed configuration i.e. no opportunity for non-elective surgical patients to occupy Wards 20a/20b, reduced opportunity for non-elective surgical patients to occupy ward 23, due to hard elective/non-elective segregation to minimise covid nosocomial transmission risk.
- Map Divisions' phased interventions and phased bed opening plans against best-case and worst case scenarios (s.5.1).

5.2 Reasonable best-case and worst-case scenarios have been developed:

Reasonable worst-case scenario:

- Increased acuity of non-elective admissions associated with delayed detection/acting upon serious pathology and/or comorbidity
- Assume higher prevalence of influenza and norovirus consistent than previous Winters
- Ongoing covid, influenza and norovirus demand increases number of beds unavailable due to infection control by 8% reflecting circa 40 empty, closed and inaccessible beds for IPC reasons
- Challenges in Social Care result in increased bed occupancy of MFSD by a further 15% of adult (General & Acute) beds, taking the number of MSFD patients in hospital to circa 110.

Reasonable best-case Scenario:

- Increased acuity of non-elective admissions associated with delayed detection/acting upon serious pathology and/or comorbidity
- Assume prevalence of flu and norovirus consistent with previous Winters

- Ongoing covid, influenza and norovirus demand increases number of beds unavailable due to infection control by 5% reflecting circa 25 empty, closed and inaccessible beds for IPC reasons
- Challenges in Social Care result in increased bed occupancy of MFSD by a further 5% of beds, taking the number of MSFD patientsin hospital to circa 50.

6.1 **Modelling**

Calculating the expected impact of planned interventions

Using the scenarios above the expected benefit calculations were completed (in a currency of bed day reductions). This benefit was then used to demonstrate the expected impact on demand that each intervention was committing to deliver in terms of reductions in bed demand through prevention of admission, reduction in LOS and improved ability to discharge to intermediate care pathways. These planning assumptions were used to forecast a daily bed demand model for the period Oct 21 – March 22

Modelling assumptions for LOS and admission rates

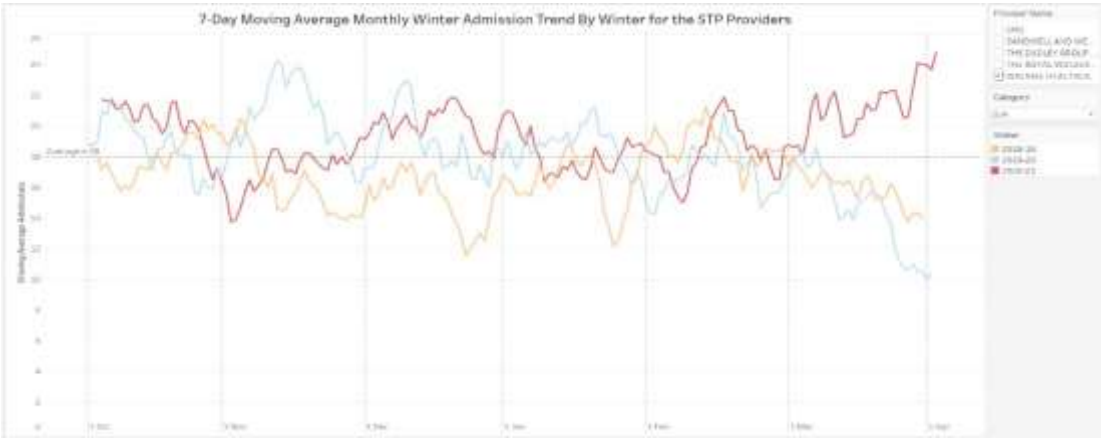
LOS Comparison Q1 2019 vis Q1 2021

Provider Name	Age Cate..	Q1 2019	Q1 2021
WALSALL HEALTHCARE NHS TRUST	75+	14.10	11.62
		805	732
	Adults	9.46	8.31
		888	825
	Peads	9.00	19.00
		2	2

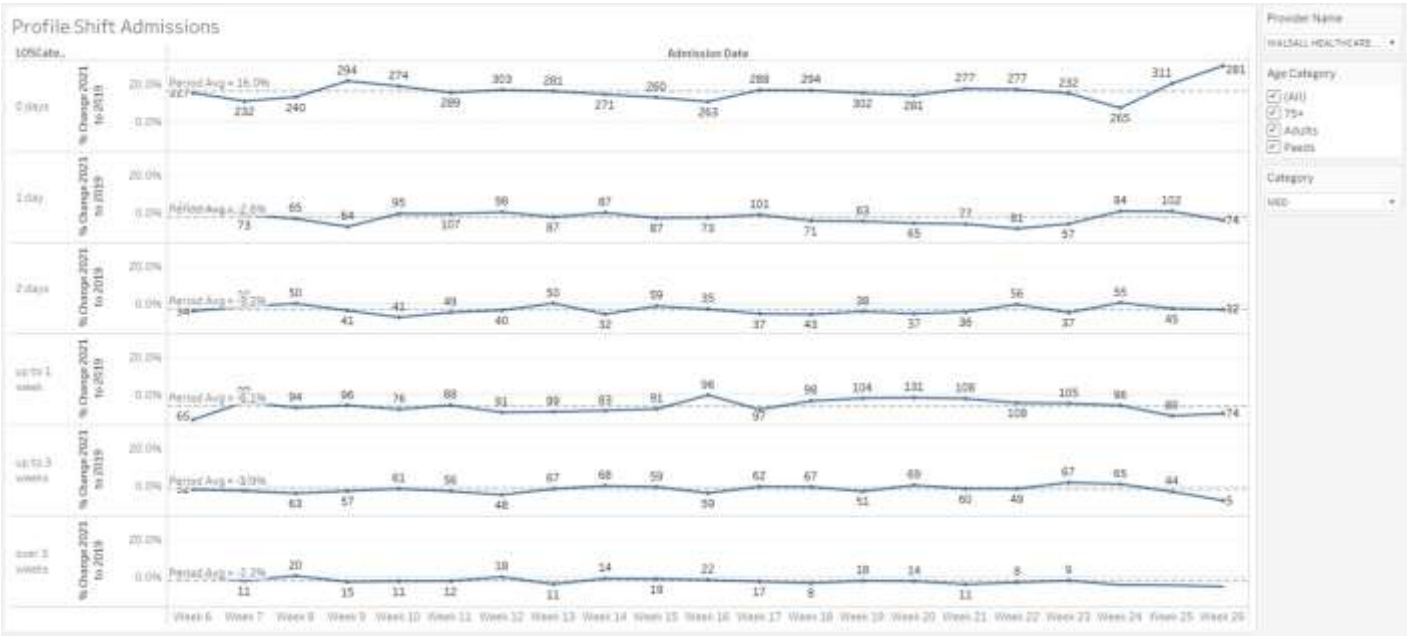
Walsall Healthcare has delivered significant reductions in Adult inpatient length of stay, most pertinently in the aged 75 and over age group, and in significant reductions in the number of patients spending over 3 weeks in hospital.

Provider Name	Age Cate..	LOSCategory	Q1 2019	Q1 2021
WALSALL HEALTHCARE NHS TRUST	75+	over 3 weeks	39.47	30.04
			151	93
		up to 1 week	4.76	4.98
			351	312
		up to 3 weeks	12.29	12.72
			303	327
	Adults	over 3 weeks	39.91	29.02
			67	58
		up to 1 week	4.53	4.50
			530	529
		up to 3 weeks	11.88	11.74
			236	238
	Peads	over 3 weeks		35.00
				1
		up to 1 week	7.00	9.00
			1	1
		up to 3 weeks	11.00	
			1	

Admission rates Q1 2019 vs Q1 2021 (Surgery)



Admission rates via ED Q1 2019 vs Q1 2021 (Medicine)



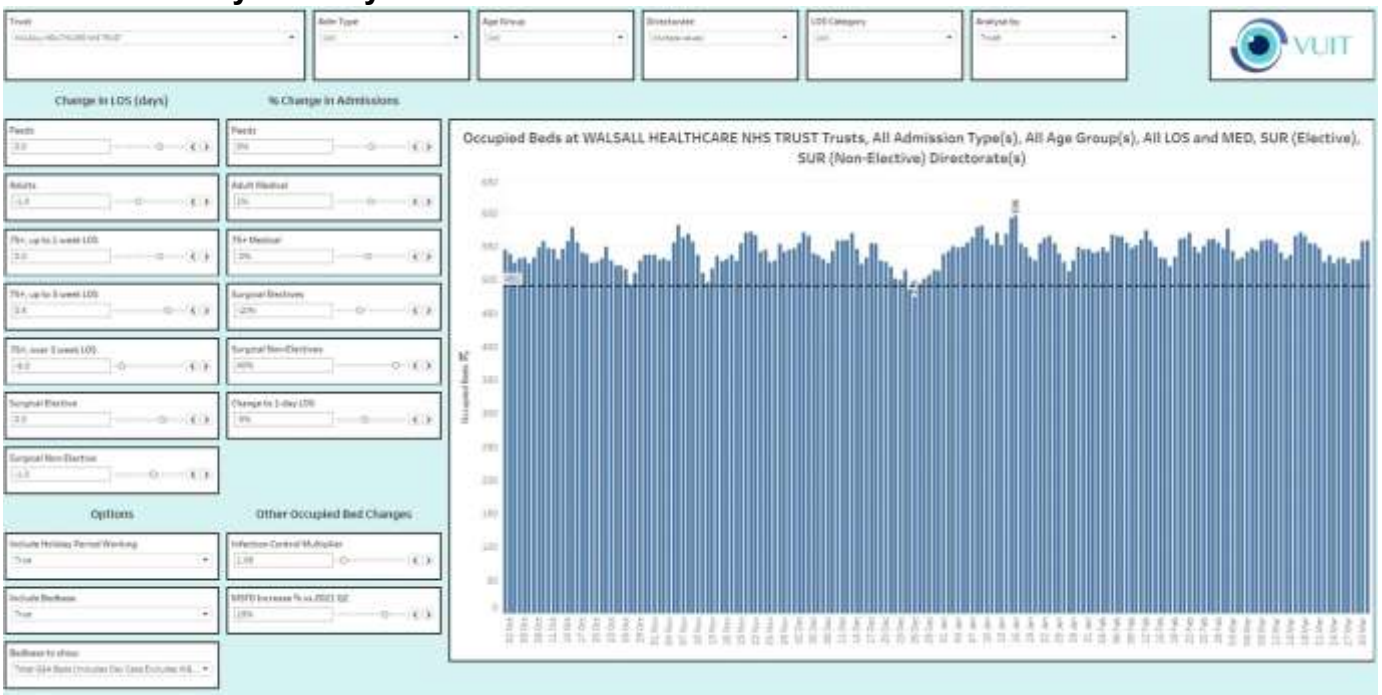
This modelled demand was then used to inform and agree a viable and deliverable operational plan for managing acute hospital bed stock through the winter period and, more specifically, identify times when the Acute Trust would need to consider opening additional medical andsurgical inpatient capacity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

The bed modelling evidences that both the final bay on Ward 4 (unfunded) and Ward 14 will both be required to meet anticipated medical bed demand, even after further SDEC and length of stay improvements. The bed modelling also suggests that at least 2 bays (12 beds) on ward 10 (will physically be on ward 9 post ward refurbishment) will be required for surgical beds.

Forecast Whole Trust (G&A) demand and bed base (core funded and additional beds) after mitigations – <u>Excludes</u> day case beds <u>excludes</u> Women's and Children's Division

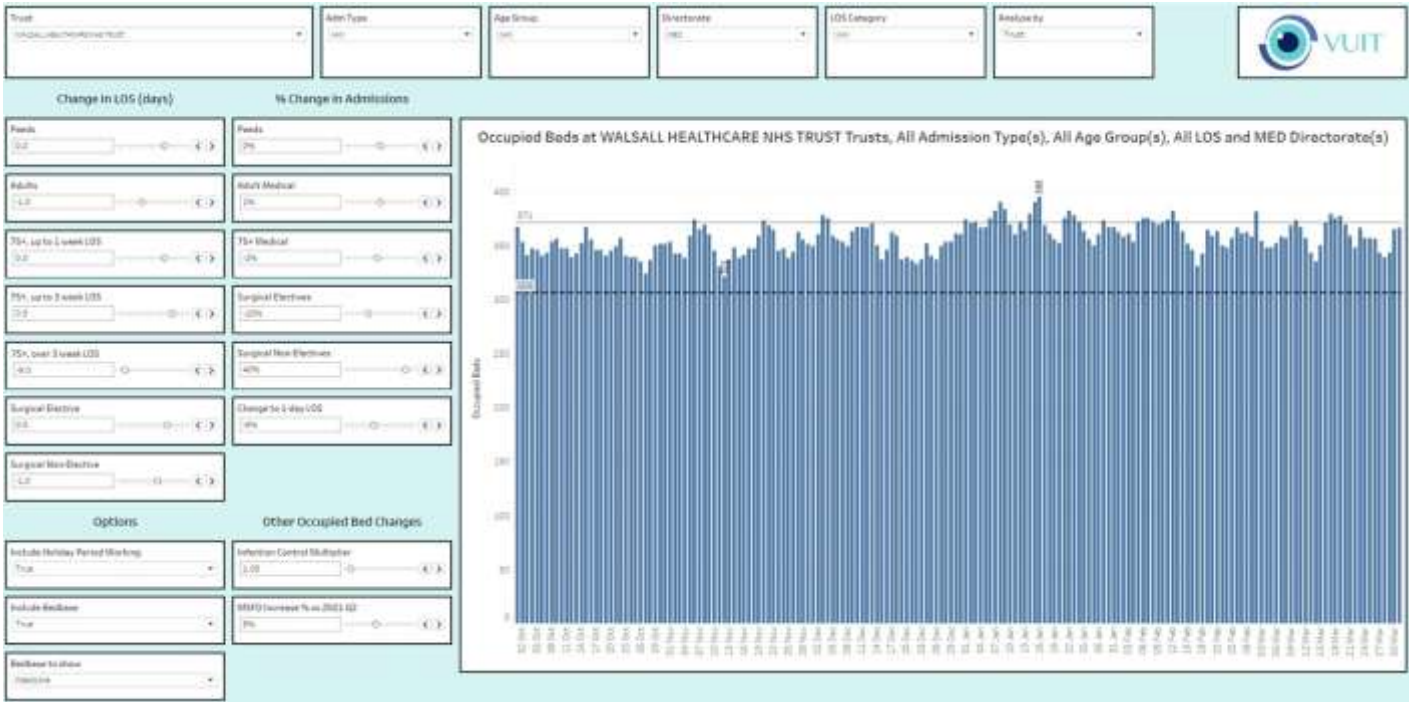
Reasonable Best Case Scenario – Moderate overnight bed deficits on peak days, with a maximum shortfall of 37 beds in early January

Reasonable Worst Case Scenario – Consistent deficit of circa 50 beds peaking at 105 beds shortfall in early January

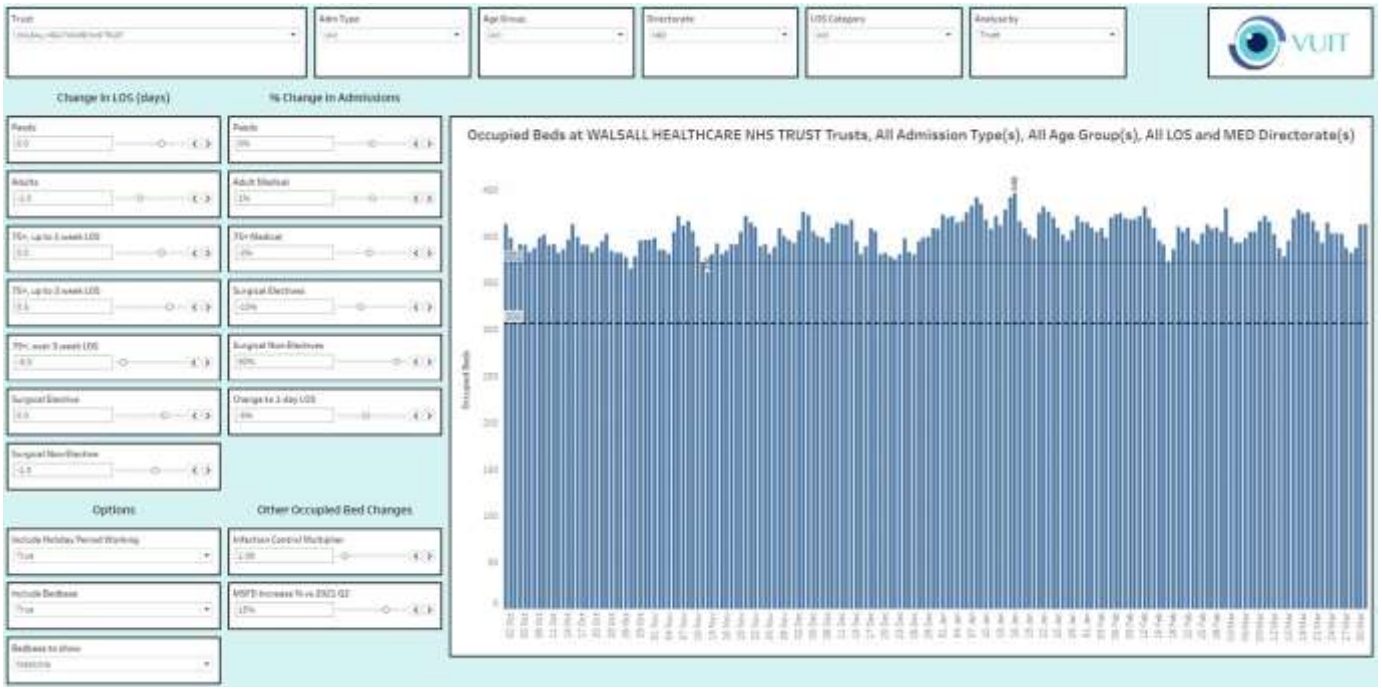


Forecast Medical demand and medical bed base (core funded and planned additional beds) after mitigations

Reasonable Best Case Scenario – occasional 10-20 overnight bed deficit peaking at 24



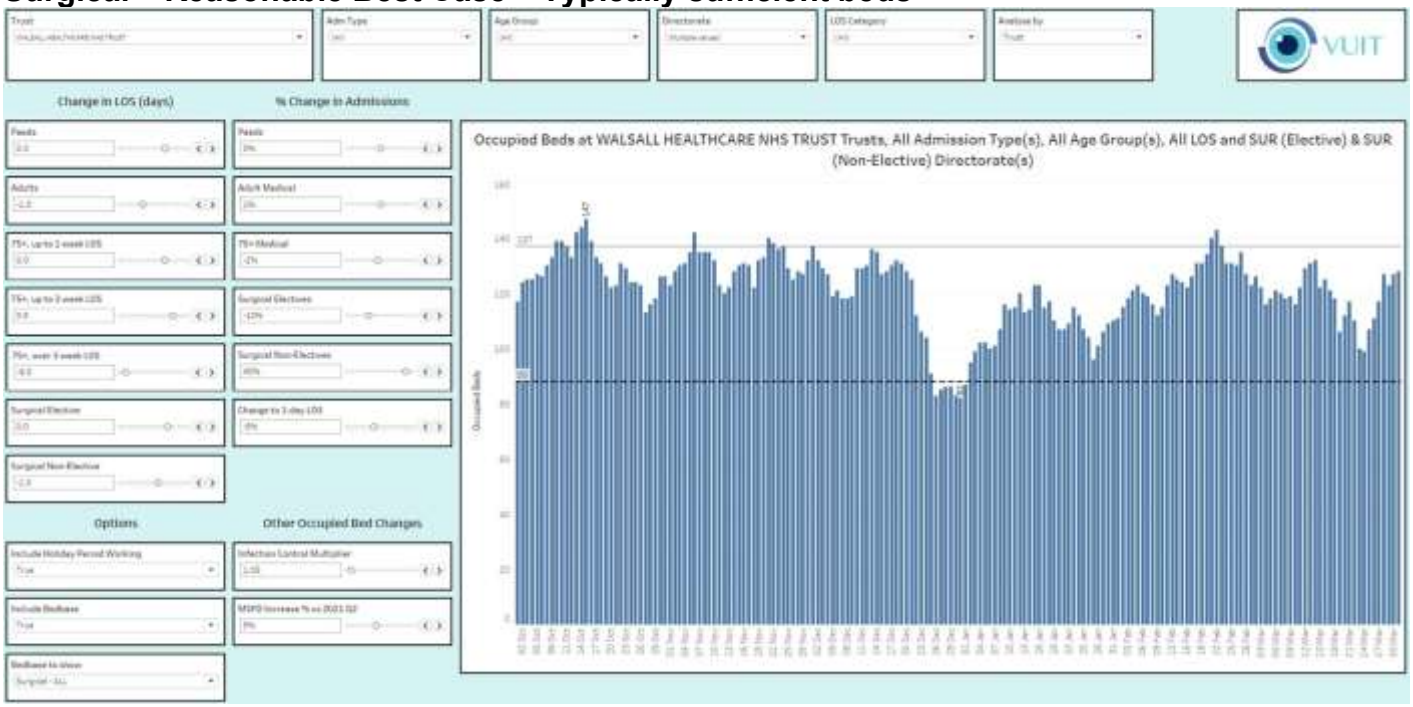
Reasonable Worst Case Scenario – Consistent circa 40 bed overnight bed deficit peaking at 75 bed shortfall



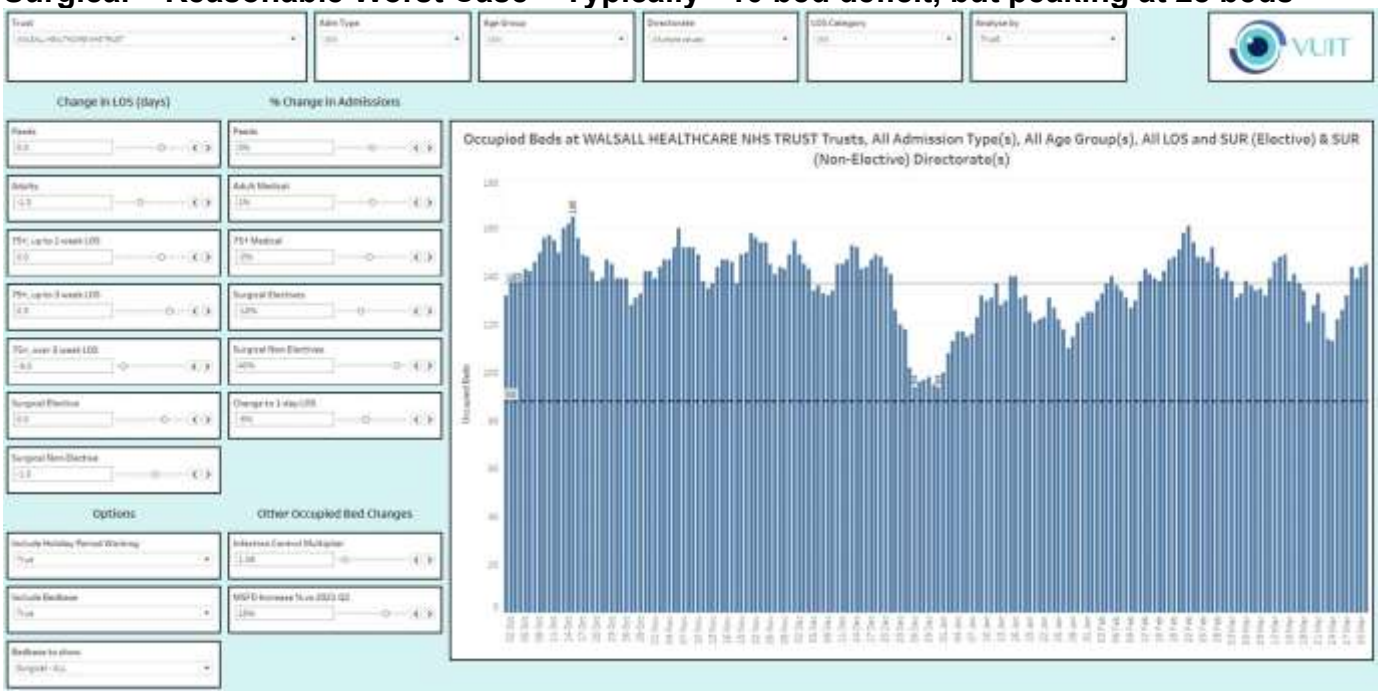
Forecast Surgical demand and Surgical bed base (core funded and planned additional beds) after mitigations

The model identifies the key risk, based on previous patterns of increased non-elective surgical bed demand over the Festive period of the non-elective surgical bed base being unable to manage demand in January and February, and without access to wards 20a and 20b for non-elective patients. Accordingly, the Surgical Division is adopting considerably stronger Festive Period arrangements (see below) this year to mitigate this risk.

Surgical – Reasonable Best Case – Typically sufficient beds



Surgical – Reasonable Worst Case – Typically <10 bed deficit, but peaking at 28 beds



Bed modelling conclusions

In summary the current plan is generally sufficient to manage the reasonable best case scenario of circa 50 MSFD inpatients in hospital and <25 beds closed and inaccessible due to Infection Prevention & Control reasons.

The existing plan is not sufficient to manage the reasonable worst case scenario where the Walsall UEC system would be overwhelmed. To mitigate against that risk the following actions have been taken:

a) The procurement of 9 Bioquell Pods to provide single room patient accommodation within the existing ward areas within Modular Ward Block has been prioritised as one of theTrust's top priority Capital Bids, submitted to the ICS on 17/9/21 for Winter Capital funding, to provide additional isolation facilities and mitigate the risk of significant bed closures dueto infection outbreaks.
b) The Community Division/Walsall Together leadership are developing a contingency plan to prevent the worst case modelled scenario of MSFD inpatients rising to 110. This includes an enhanced Hospital Avoidance offer for Winter including expanding the functions of key teams such as the Care Navigation Centre, Rapid Response and Integrated Assessment Hub in order to manage more patients in the Community and stream patients away from the Emergency Department and assessment units. Further, additional capacity for discharge in the form of maintaining a step-down facility for patients that are medically fit and the creation of a team to deliver 1000 hours of care per week to patients have been proposed.

In addition, whilst the surgical Division may have sufficient bed stock in totality, there is likely to be a risk that it has insufficient non-elective beds, and sufficient elective beds. In this scenario, the Division will risk assess the need to utilise more beds on ward 9 (formerly ward 10) in mitigation.

The Chief Operating Officer met with the Deputy CEO (Black Country & West Birmingham CCGs) and ICS Strategic Planning Lead to discuss mitigations to the shortfall of beds in the reasonable worst case scenario across the ICS on 17/9/21. The Deputy CEO (Black Country & West Birmingham CCGs) and ICS Strategic Planning Lead will attend the Black Country & West Birmingham Urgent & Emergency Care Board on 01/10/21 to consider necessary further actions to mitigate the risk of a Winter that is close to the reasonable worst case scenario.

Detailed plans & summary costings

The following winter initiatives show the planned interventions from each of the Divisions focussing on the strategies as outlined above which aim to reduce inpatient bed demand, increase same day emergency care and reduce length of stay. They typically add resources into existing UEC pathways to strengthen them and/or extend services so that they are available over longer periods(into the evening or at weekends for example). The additional interventions for the festive period are also included and are focussed on ensuring the weekends and bank holiday days run as closeas possible to a normal week day.

A high level summary of the costs of these interventions is below; please refer to the Appendices which provides the detailed phasings and costings.

7. 1 Financial summary

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	In Year
MLTC	210,146	343,604	511,707	505,637	434,506	310,846	**2,316,446**
Surgery	131,044	126,973	201,513	170,641	143,964	131,044	**905,179**
WCCSS	200,337	251,178	267,904	264,217	213,855	198,855	**1,396,346**
Community	63,850	68,274	76,233	75,283	67,768	73,952	**425,360**
Estates	45,750	60,021	76,950	76,846	67,335	55,948	**382,850**
Corporate	19,558	19,558	25,720	26,313	19,558	19,558	**130,266**
Winter Plan	**670,685**	**869,608**	**1,160,027**	**1,118,937**	**946,986**	**790,203**	**5,556,447**
Additional Bid Against CCG Monies: Community	100,325	100,325	100,325	100,325	100,325	100,325	601,953
Winter Plan Inc Additional Bid	**771,011**	**969,934**	**1,260,352**	**1,219,262**	**1,047,312**	**890,529**	**6,158,400**

Summary of Winter Plan 21/22					
	Winter Plan 20/21	Gross Plan 21/22	Variance to 20/21 Winter Plan	Included within H1 Run Rate	Gross Plan 21/22 Above H1 Run Rate
MLTC	2,911,603	2,316,446	(595,157)	654,032	1,662,414
Surgery	529,750	905,179	375,429	631,591	273,588
WCCSS	564,031	1,396,346	832,315	276,901	1,119,445
Comm	411,193	1,027,313	616,120	0	726,185
Estates	257,325	382,850	125,525	103,532	279,317
Corporate	22,792	130,266	107,474	0	130,266
	4,696,693	**6,158,400**	**1,461,707**	**1,666,056**	**4,191,216**

The Winter Plan in 20/21 was costed at £4.696m. 2021/22 is costed at £6.158m, with the two reasons for variance being £600k of CCG funded community/integrated care interventions, and the impact of the Paediatric RSV plan which is costed at £977k. These increased requirements are offset by much greater staffing through substantive and bank workforce, and significantly reduced Agency reliance resulting in less expensive costs for comparative interventions. This is primarily possible as a result of the international nurse recruitment programme in partnership with RWT. As a consequence the net increase in costs over H2 to deliver the winter plan is £4.191m.

7.2 Division of Medicine

Intervention	Expected benefit
Inpatient Ward Weekend Medical cover	Progressing patients care plans over the weekend to ensure timely, quality care and increased discharges over the weekend; to improve flow. Sunday ward rounds will be in place over the festive period.
ED Acute Physician	Acute physician working in ED to provide a timely senior review and confirmation of admission or discharge. Evenings and weekends.
AEC Extended Opening until 22:00	Increasing opportunities for same day emergency care, preventing inappropriate admissions, and decongesting ED at peak times (late afternoon and early evening).
Consultant Orthogeriatrician providing additional ward rounds	Provision of timely review of patients over the festive period to progress patients care plans and providing quality of care.
Inpatient Endoscopy weekends and BHs	To prevent patients waiting longer for their inpatient investigations particularly over the festive period, continuing to provide safe, timely care and freeing up inpatient bed capacity.
Extend FES Cover	Extending weekday hours and providing additional medical and nursing support over the weekend to ensure frail, elderly patients are seen and treated by specialists with the aim of avoiding unnecessary admissions and treated as same day emergencies. Relieving pressure in ED.
Weekend consultant ward rounds supported by Junior doctors	Junior doctors to support Saturday consultant ward rounds to progress patient's management plans and increase discharges. Bolstered further during the festive period with extended ward rounds on Saturday and Sunday
Junior Dr Sunday for EDS and Clerking	Additional doctor to ensure electronic discharge summaries are completed in time to support safe discharges on Sundays providing support to all medical wards. To ensure flow.
Additional ED consultant and middle grade shifts	To strengthen senior decision-making particularly at weekends and evenings/overnight to minimise time from arrival in ED to Doctor/practitioner review
Transfer team in ED	At times of surge and particularly during winter alongside the need to de-congest ED due to Covid segregation; a dedicated transfer team supports flow out of ED to free up cubicle capacity.
Extend Rapid Assessment and Treatment service (RATS)	Extended hours to manage times of peak demand and de-congesting ED.
Progress chaser & phlebotomist	Both posts relieve clinical staff ensuring the nursing team are dealing with clinical issues and are providing safe, timely care.
Alcohol Liaison Nurse	The alcohol liaison nurse will case manage patients in ED and assess the appropriateness of patients for ambulatory detox working alongside the community team. This would save hospital bed days, reduce ED attendances and educate staff (providing confidence) as to the available support and pathways in the community rather than admit patients for detox.
Medical winter ward capacity – 40 beds	Additional inpatient winter ward capacity to reduce exit block from ED due to lack of bed capacity. Contributes towards achieving 4-hour EAS standard which is a proxy for safe, timely care; patients should not be in ED any longer than necessary; it is well known it has an adverse impact on patient care. • 28 beds on Ward 14 • 12 general medical beds on Ward 4

7.3 Division of Surgery

Intervention	Expected benefit
Additional trauma capacity – introduction of 2nd Trauma Theatre lists both before and after Bank Holidays	No waits for non-elective Trauma surgery >24 hours. Aim to protect ring-fenced elective beds (and thus avoid a period without elective operating), unless additional ward-based staff are required for issues related to Covid-19. [NB: these sessions may come as a replacement of elective sessions for Anaesthetists and Surgeons]
Additional Emergency Theatre capacity – introduction of 2nd Emergency Theatre lists both before and after Bank Holidays	As above
Ward 9 (formerly ward 10, 6 – 12 beds) and Ward 12 (12 beds) bed capacity	Additional non-elective bed capacity within the acute zone of the hospital.
Dedicated SACU 24/7	Improvements in same day emergency care (SDEC), maintaining a minimum of 50% of emergency surgical admissions discharged same-day. Advanced Care Practitioners will also be introduced on SACU to improve early decision making and further improve surgical SDEC rates.
'Perfect Week'	We will run the 'Perfect Week' for a fortnight over the winter period with a whole Division focus on timely discharge and supporting flow. The operational team will support as ward liaison officers to help resolve issues and only essential meetings will take place.
Emergency Hot Clinics	SACU will continue to provide Hot Clinics, to provide specialist input for surgical patients not requiring emergency admission

7.4 Community Division

The following interventions are in addition to the £1.6m investment made in 20/21 into Walsall Together to sustain healthy communities and address existing health inequalities in the borough.

Intervention	Description	Expected benefit
Weekend & Festive cover on the Acute Site	Additional therapy staff to provide support to wards around assessment and discharge	Ensure timely interventions thereby reducing LOS Supports extended 7 day working This was implemented last winter and supported the enhanced Manor response
Hospital Discharge Teams: extended coverage OOH [ICS ; planners]	Additional discharge staff to support with discharge of complex patients	See above
Front door	Community nurses working in the	Ensures community pathways are

discharge nurses to extend operational hours	assessment & admission areas of the Manor to signpost patients onto community pathways	maximised Patients are discharged before they get referred onto in-patient units by offering care of equal quality at home.
Enhanced Care Home Team to extend operational hours to 7 days	Support to care homes from community nurses Maintaining weekly reviews of residents and will develop advanced care plans for them - the additional support will maintain an unplanned response for hospital admission for these case managed patients.	This provides clinical oversight of residents in care homes. Ability to detect any changes in condition and intervene early. Provides the opportunity to maintain more people to be cared for in their place of residence and reduce conveyance to hospital Implemented on a bigger scale during Covid – this will now extend to >30 care homes in the Borough
Rapid Response- additional capacity	Additional staffing through winter to deliver increasing capacity of the service between the new operational hours of 08:00- 00:00	c85% of patients treated by Rapid Response are able to stay at home and hospital conveyance is avoided Increasing the number of referrals dealt with, within the new operational hours will lead to reduced attendances at ED. This is a well-established model
Additional capacity within locality teams	More community nurses recruited for locality teams, thereby increasing the number and range of interventions that they are able to make	Additional capacity in the community should lead to more home-based care, greater resilience amongst clients and less referrals to hospital. This is a well-established model

A place-based Winter Plan for the full Walsall Together Partnership will be taken through the Partnership Board for approval, to complement this Walsall Healthcare NHS Trust Winter Plan. Details are as below:

Intervention	Description	Expected benefit
Enhanced Care Navigation Centre	Additional nursing, pharmacy and support staff to provide a winter expansion of the care navigation centre to maintain support for urgent care- Hospital avoidance and expedite hospital admission	Ensure timely response with community teams The service was implemented last winter and supported throughout the Covid response with new care pathways. Ability to scope further virtual pathways including long term condition management
	To provide CNC presence with WMAS to review cat 3 calls and implement a community response	As above
	To add Social Care Support into CNC to support a holistic approach to	As above

	hospital avoidance and open new pathways to avoid hospital attendance/ admission	
Disposition Teams from CNC	Described in Rapid Response and IFD in first Community table	
Community ICS capacity	Additional social workers, Mental Health nurses and Therapy staff to support community flow, in turn to ensure capacity and flow from hospital discharges	Assumption of expected expansion of care provision and block beds in care homes to support additional demand in ICS pathways to support whole systems approach
Team of CSWs to deliver Packages of care for ICS	Delivery assumption of 1000 hours per week based on recent knowledge of gap in capacity in local market of domiciliary care providers	Additional capacity in the community should lead to more home-based care, greater resilience amongst locality and less "social" referrals to hospital where care needs are essential to maintaining patients in their own homes Capacity to be used flexibility to meet unplanned demands

7.5 Division of Women's, Children's and Clinical Support Services

Paeds & Neonates

Initiative	Expected benefit
Increased HDU Capacity (Ward 21)	Based on last year's activity we will be increasing our staffing so we can provide this additional capacity for anticipated increase in children with high dependency needs as a result of a more significant RSV season. Benefits for patients as the sooner they receive this level of care, the better the clinical outcomes and a reduction in the patients LoS.
PAU Split Pathway for Children with direct ED admissions	We have divided PAU into two areas and will be streaming patients through accordingly. Additional Paediatric Consultant and Middle Grade cover will support with same day emergency care for the children, avoiding overnight admission where appropriate, and reducing he patients LoS.
Ward 26 surge capacity	In the event of the RSV season being at the upper end of NHSEI's predicted 20-50% increase above normal RSV seasons, ward 26 will be deployed as contingency surge capacity for Paediatric inpatients, but only after all previous interventions in the surge plan have been enacted.

Clinical Support Services

What are we doing	Description	Expected benefit
Weekend & Christmas cover	• Additional staff to provide support over festive period	Ensure timely interventions thereby reducing LOS. This was implemented last winter and supported the enhanced Manor response.
Additional capacity in Imaging	• Additional evening sessions for CT, US • Additional Weekend sessions	Ensure timely diagnostics thereby reducing LOS Reducing patient wait
Additional CMU Capacity	• Additional OP capacity - weekends, evenings	Ensure timely diagnostics thereby reducing LOS Reducing patient wait

Pharmacy

Initiative	Expected benefit
Move pharmacy resource to support completion of medicines reconciliation at the point of admission	Streamline discharges as there will be fewer drug queries to manage on day of discharge
Pharmacy opening until 7pm over Christmas and New Year period	Support for the higher level of discharges anticipated during the festive period
Set up of dedicated discharge team over the winter period	Will support the timelier discharge of patients and bring forward the time of discharge to earlier in the day (subject to EDS being available)

7.6 Corporate Services

Initiative	Expected benefit
Discharge lounge extended opening hours from 07:00-00:00	Discharge lounge has proven to improve flow early in the mornings and into the evenings. It will be open on Sundays and bank holidays during the festive period too. By opening later through the evening it will enable medically stable for discharge patients from ED to transfer to the discharge lounge, and patients awaiting discharge from AEC and FES/IAU too, giving greater confidence to SDEC services to continue to accept patients through the evening.
Operations centre will increase capacity coordinator cover through the twilight period, and add in trainee Clinical Site Practitioners to the twilight period,	Additional operational site support provides more robust management of the site, particularly during times of peak pressure. Increasing resilience during the Twilight period is as a direct result of feedback and review of last year's plan.
Infection, Prevention and Control	Strengthened evening and weekend IPC on-call cover to optimally manage the predictable increased prevalence of seasonal viruses including RSV, norovirus and influenza, as well as COVID-19.

8.1 Risks

8.2 It is recognised that the assumptions within this plan rely upon the availability of additional staff resource, particularly nursing and medical. The continued pressures from Covid-19, requirement to isolate and contact restrictions poses a risk to our ability to secure additional staff. The Trust has partnered with the Royal Wolverhampton Hospital Trust's international recruitment programme, and consequently is targeting elimination of general ward agency nursing staff by December 2021. The availability of medical staff may pose a greater risk than the availability of nursing staff as a result.

Risk Title	Current risk score	Risk description
Risk 208 Failure to achieve 4-hour emergency access standard resulting in patient safety, experience and performance risks.	16	Despite improvement in the Trust's national ranking for EAS performance, there remains a delay in patients being assessed in ED which will result in failure to achieve consistent wait to be seen times, time to treatment which will impact upon failure to achieve 4 hour EAS. This will lead to poor patient experience and risk of adverse clinical outcomes including mortality.

8.3 Command and Control.
Tactical Command will lead the Trust wide response to the winter UEC pressures, RSV and covid-19 challenges. Battle rhythm will be set by forecasted trends and the need to respond early to appropriate indicators and triggers set in various plans. Divisional leaders will ensure operational arrangements dovetail into the acute hospital Tactical Command tempo.

Strategic Command will offer strategic guidance and co-ordination for the same challenges and risks.

Site Safety Meetings will remain managing daily operational matters and will flex and enhance membership and tempo to meet the challenges as they present.

9.0 External Reporting

Early reporting of data that indicates emerging problems is seen as a key element in the effective management of winter. Trusts are required to use UNIFY2 for reporting local winter pressures. Clarity regarding SITREP contents will follow in due course, current expectations are:

- temporary A&E closures
- A&E diverts
- ambulance handover delays over 30 minutes
- trolley-waits of over 12 hours
- cancelled elective operations
- urgent operations cancelled in the previous 24 hours and those operations cancelled for the second or subsequent time in the previous 24 hours
- availability of critical care, paediatric intensive care and neonatal intensive care beds
- non clinical critical care transfers out of an approved group and within approved critical care transfer group (including paediatric and neonatal)
- bed stock numbers (including escalation, numbers closed, those unavailable due to delayed transfers of care etc.)
- and details of actions being taken if trust has considers that it has experienced serious operational problems

The additional Covid-19 reporting requirements are as follows:

- STP Covid Daily
- National Covid Daily
- Discharge Daily
- Mortuary Weekly
- PPE Weekly
- ICU Consumables Weekly
- Daily Update Submission - to be completed and returned by providers with a declared Covid-19 Outbreak

10.1 Appendices

Winter Plan phased interventions and costings

Winter Plan Costings 2122 v9.xls

Severe Weather Plan

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

RSV

Paeds Surge Plan September 21 ...

BW623 Winter Planning in Paediatric

Paed RSV Midlands ICS plans 230622.pdf

Thank you letter WMAS

Thanks to Richard Beeken CEO for hand

ED Covid Escalation Policy

WMH ED Escalation 24th Nov.pptx

MEETING OF THE PUBLIC TRUST BOARD **Thursday 7th October 2021**			
Annual Emergency Preparedness, Resilience and Response (EPRR) Assurance Report 2021-22			**AGENDA ITEM: 23**
Report Author and Job Title:	Mark Hart Head of EPRR	**Responsible Director:**	Ned Hobbs
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	It is a mandatory requirement for all organisations that receive NHS funding to carry out a self-assessment against the NHS England Core Standards for EPRR. An amended process that includes a detailed self-assessment of the seven EPRR domains, an organisational rating and a report to both Regional NHS EI and ICS leaders as well as the Trust Boards must be undertaken by early autumn. Walsall Healthcare is assessed "Substantial Compliance" with an associated Action Plan set out, which will be integrated into the annual EPRR work programme monitored by the EPRR Steering Group. The report highlights significant improvements, whilst meeting the response remit managing the covid-19 pandemic locally and sets a firm direction for the period ahead.		
Recommendation	Members of the Trust Board are asked to: • Approve our response to the Annual EPRR assurance process; • Note our approach for the next 12 months.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The EPRR work programme mitigates a number of corporate, divisional and departmental risks across the Trust as well as setting a course of implementing outstanding preparedness and response policies, plans, arrangements and culture.		
Resource implications	There are no resource implications associated with this report.		

Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	


Safe, high quality care
Care at home
Partners
Value colleagues
Resources
Respect
Compassion
Professionalism
Teamwork

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance 2021 - 2022

1. PURPOSE OF REPORT

The purpose of the report is to inform and assure that the Trust has professionally completed the annual assurance of EPRR required by NHS EI and offer an update that will set tone for the next 12 months.

2. BACKGROUND

It is a mandatory requirement for all organisations that receive NHS funding to carry out a self-assessment against the NHS England Core Standards for EPRR. Last year due to the national response to covid-19, it was recognised that the regular process would be excessive, so a bespoke framework was established and completed by the Trust. This year NHS EI aims to return some of the previous mechanisms to the original process, whilst acknowledging the previous 18 months, the changing landscape of the NHS and the uncertain 8 - 12 months ahead.

Furthermore, no wider review of the core standards process has taken place nationally, thus the traditional self-assessment toolkit with a very few standards removed (i.e. some training requirements) has formed the basis of this annual assurance remit.

Therefore by exception NHS EI directed an amended process that was communicated by letter on 22 July 2021. The assurance process is split into the following areas:

- Each organisation to undertake a self-assessment against individual core standards relevant to their type and role and rate their compliance for each.
- Each organisation to conduct a deep dive into the resilience of its internal piped oxygen system capacity, including a number of interdependent components to increasing volume and flow rates.
- Set an organisational rating.
- Develop Action Plans based in response to the activities of the EPRR annual assurance process and place them within their annual work programmes for the period ahead.
- Submit self-assessment against the 2021 amended core standards including a deep dive and report findings to:
    - NHS EI Regional Heads of EPRR and ICS Leaders by 31 August 2021
    - Trust Board when, most convenient but before 30 December 2021

3. OUTCOMES

The Head of EPRR co-ordinated the annual process under the auspices of the EPRR Steering Group and completed the main actions by late August 2021. The key outcomes are set out below.

Self Assessment

Head of EPRR submitted the Departmental self-assessment, rating the compliance for each standard to EPRR Steering Group on 9 August for initial scrutiny and then a separate challenge with the Accountable Emergency Officer (AEO) as part of a more robust and outstanding best practice process. The self-assessment included a deep dive, with support from the Estates & Facilities team and Pharmacy management. The final submission to regional NHS EI and ICS leaders is at Appendix 1.

- *Appendix 1 - Walsall Healthcare Final Core Standards Self-Assessment 2021-22.*

Organisational Rating

The overall EPRR assurance rating is based on the percentage of core standards the organisation assesses itself as being "fully compliant" with and is explained in detail in the Table below:

Organisational rating	Criteria
Fully compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Table 1 Core Standards Organisational Ratings and Criterial

The EPRR Department, EPRR Steering Group and AEO all assessed Walsall Healthcare as "Substantial Compliance".

Action Plan

As required and following the process, 5 core standards and one deep dive standard rated partially compliant in the self-assessment are placed in an Action Plan, reported accordingly and will be integrated into the EPRR annual work programme from October 2021. The new annual work programme is in draft and will be submitted to the EPRR Steering Group 11 October for approval. The Action Plan devised was reported to Regional NHS EI and ICS Leaders as required.

Reporting

The AEO submitted the final report to the Regional Head of EPRR and ICS Leaders on 19 August, which included the Self-Assessment and associated Action Plan; a copy of this report is at Appendix 2.

- *Appendix 2 - Walsall Healthcare Annual EPRR Assurance 2021-22 Report*

4. Detail

Summary of each core standard category is set out below:

Governance

Whilst now in good shape and underpinned with strong assurance and governance arrangements, 2 final areas will be refined and developed over the next 12 months:

- Dedicated Non Executive Board Member to have a dedicated EPRR role.
- Strengthening the resource underpinning EPRR across the Trust and partnership including proper financial arrangements and budgeting for EPRR, both as a dedicated department and within Divisions, particularly with the responsibilities held by the Emergency Department Team of Three within MLTC.

Duty to Risk Assess

Better placed, reported, shared and mitigated. Further work with external Walsall Resilience Forum colleagues to share and understand the local risks and hazards across Walsall Borough and the wider region including incorporating key events e.g. Commonwealth Games in 2022.

Duty to Maintain Plans

Whilst all plans are in place except shelter and evacuation, some plans require a refresh following learning from covid-19 and adjustments to reflect changes in operational practices, resources (new Incident Co-ordination Centre programme) and staff. Evacuation of a hospital is not just an Acute Trust activity; it requires wider regional and ICS engagement and support. This is currently lacking.

Response

Building on real and relentless response activity over the last 18 months our practices are in very good shape. However, training and exercising in more basic responses such as fire and floods will require a re-focus, as soon as other operational challenges allow staff the time to complete more traditional training and individual/collective exercising. Three significant exercises that will act as key headmarks in the EPRR response programme in the year ahead and support the ED New Build project are established and will reinforce our basic EPRR skill set and confidence across the Trust. A number of operational incidents including chemical spills, IT disruptions, armed police presence in ED and a Lockdown following an incident have all assured that our general response is valid, timely and effective, with debrief reports all submitted to the EPRR Steering Group and recommendations managed through the Trust EPRR Improvement Programme.

Warning and Informing

Excellent support and output from the small communications team continues to be valuable.

Co-operation

Despite very limited formal health partnership co-ordination, Walsall Healthcare EPRR footprint influences all ICS and regional response forums, the refreshed Walsall Resilience Forum that restarted this summer and informally meets with all Black County and West Birmingham EPRR colleagues each month.

Business Continuity

As an EPRR Steering Group priority despite the covid-19 response, excellent progress has been made and a clear policy led arrangement, with internal assurance, planning, testing and improvement established and building. With the foundations now well set, this work will guide and improve future preparedness and resilience thinking, resourcing and culture.

CBRN

Significant energy in this domain has resulted in a stronger capability, which will mature steadily in the 12 months ahead. Upgraded equipment, sound management of equipment, suits and their maintenance, training and testing are all in a better place. Embedding good practice and fine tuning plans and procedures will place this in a leading position regionally by 2022.

Deep Dive - Oxygen Supply

Planning before and accelerated in the early weeks of the covid-19 pandemic has quietly ensured that our oxygen supply arrangements have remained resilient, available

and reliable. The work by Estates & Facilities, supported by Skanska and other services/departments over the last 18 months should be commended.

5. SUMMARY

Whilst attention has remained focused on the covid-19 pandemic, supporting all Divisions and frontline teams day in day out, EPRR departmental core activities have remained guided by a pragmatic and ambitious work programme although some low priority activities remain outstanding. Significant improvements in business continuity, CBRN, improvement planning and assurance have all built capability and resilience, whilst in tandem managed an extraordinary response remit. This challenge has not diminished and the next 8 months ahead appear to be equally demanding with a different set of challenges and associated risks. Whilst recovery from early waves is ongoing and incomplete, our people start this autumn/winter with less energy and sharpness setting an even higher bar to lead the Trust through these next 8 - 12 months. The EPRR function, whilst growing and embedding deeper is in a good state to support the leadership in the year ahead. And the longer term process to build a resilient organisation, agile and robust to meet core business and any incident/emergency or disruption in parallel continues.

6. RECOMMENDATIONS

Trust Board:

- **Approve** our response to the Annual EPRR assurance process;
- **Note** our approach for the next 12 months.

Appendices:

1 Walsall Healthcare Final Core Standards Self-Assessment 2021-22.
2 Walsall Healthcare Annual EPRR Assurance 2021-22 Report.

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	Governance Leadership	Senior	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Ned Hobbs, Chief Operating Officer since July 2019	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training,Exercising etc.	Trust has an EPRR policy and BCMS policy in place that covers resource, business continuity, training and exercising. It also covers assurance, process, EPRR standards and responsibilities.	Fully compliant	EPRR policy currently being updated. Dedicated EPRR budget (outside COO budget) being set up.			
3	Governance reports	EPRR board	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	EPRR Steering Group meets monthly, reporting to Trust Management Board, Performance Finance & Investment Committee through to Trust Board. Board receives 2 formal EPRR reports annually and others by exception.	Fully compliant				
5	Governance Resource	EPRR	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policyhas been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Robust EPRR governance internally in place. One EPRR role plus recent secondment added June 2021 for 9 months. Resource enhancement currently being explored to better underpin EPRR performance, documentation and embedding culture across the Trust.	Partially compliant	Business case for enchanced resource being developed Q3.	Head of EPRR	Dec-21	
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Robust debrief, learning and improvement planning process and culture in place. EPRR Improvement Plan assured monthly by EPRR Steering Group.	Fully compliant				
Domain 2 - Duty to risk assess											
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on theorganisations corporate risk register	Regular Risk Assessment established by EPRR and shared for assurance monthly with EPRR Steering Group. Working with Walsall Resilience Forum to improve multi agency Risk Assessment.	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR Risk Management in place using Trust Wide Risk Management Safeguard System and briefed for assurance monthly at EPRR Steering Group.	Fully compliant				
Domain 3 - Duty to maintain plans											

11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust has adequate plans, and arrangements in place to respond to crictical incidents. Continuous response to Covid 19 and some crictical incidents has reinforced and offered confidence in arrangements.	Fully compliant				
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust has adequate plans and arrrangements in place to respond to major incidents. Whilst none have occurred in the last 12 months (apart from Covid 19) there has been less training and table top exercising than planned. Enhanced training and exercising underway and a priority in the next 12 months.	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Heatwave plan in place (May 2021) and activiated July 2021. Currently being refreshed following lessons and learning.	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Cold Weather Plan in place (November 2020) and debriefed with lessons in May 2021. Lessons being embedded in plan ready for November 2021.	Fully compliant				
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Mass Casualty Plan (June 2019) in place. Training and tabletop exercises have been limited in last 18 months. Significant focus and arrangements already in place culminating in live exercise Summer 2022.	Fully compliant				
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust has downtime paper process in place where all patients are given a sequential number taken from initial paperwork. This is completed at time of arrival by clinician triaging patient at ambulance doors. A clerical/reception team member assists the process to ensure accurate recording is taking place. Trust would like to explore major incident system in Careflow for a more robust system.	Partially compliant	Trust to explore major incident programme in Careflow system	Ed Care Group/ED EPRR lead	Nov-21	
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust has evacuation plans included in both fire and business continuity plans. Key areas such as ED are table topped. There is no site evacuation plan in place as this would be beyond the Trust's ability to manage; loss of any acute site would require regional response to redirect all activities.	Partially compliant	No site evacuation plan. Not feasible at Trust level.			
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Plan in place (July 2019). Currently under review following 2 incidents in the last 6 months and 2 yearly review point. Updated plan taken to EPRR Steering Group July 2021 and being further refined for final approval. Awareness training programme underway.	Fully compliant				
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Protected Individual Plan in place (October 2015). Refreshed plan drafted and with EPRR Steering group for approval in September 2021.	Fully compliant				
Domain 4 - Command and control											
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	Alerting, activation and notification arrangements in place and reguarly tested. Arrangements also exist for out of hours including a weekend and bank holiday SOP. Further work underway to improve resilience of switchboard capacbility, alerting communication to staff and building staff resilience out of hours.	Fully compliant				
Domain 5 - Training and exercising											
Domain 6 - Response											
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		Trust has a Main ICC, Alternative ICC (currently Covid Command Centre), Standby ICC and a Strategic Command Centre. Main ICC capability being refreshed and dedicated tactical training and exercising within main ICC planned. Standby ICC activated to co-ordinate a number of business continuity and a critical incident successfully. Alternative ICC operating since March 2020.	Fully compliant				

32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	New divisional business continuity plans as well as key enabling business continuity plans (estates & facilities, IT & digital services) completed. Procurement, HR and finance business continuity plans will be completed by October 2021. Formal rolling programme of operational business continuity plans in place and has been a priority during Covid 19.	Fully compliant				
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	Arrangements in place and regularly used. ICC Information Officer cadre fully trained and have conducted Sitreps internally and externally extensively.	Fully compliant				
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	• Guidance is available to appropriate staff either electronically or hardcopies		Fully compliant				
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	• Guidance is available to appropriate staff either electronically or hardcopies		Fully compliant				
Domain 7 - Warning and informing											
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform thedevelopment of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments ispart of a joined-up communications strategy and part of your organisation's warning and informing work	Commincations team fully integrated into EPRR arrangements and support training, exercises and incidents.	Fully compliant				
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience whenpublishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower thecommunity to help themselves in an emergency in a way whichcompliments the response of responders • Using lessons identified from previous major incidents to inform thedevelopment of future incident response communications • Setting up protocols with the media for warning and informing	Communications team have extensive tools to communicate with patients, visitors and the public and have used regularly in the last 12 months. Internal communication includes email, snap comms and alerts but better wider cascading of information to all staff continues to be improved. New App launched Aug 21 with EPRR component to be integrated	Fully compliant				
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform thedevelopment of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Communications team have sound arrangements to support all incidents and emergencies at tactical and strategic levels. Dedicated spokespersons identified and have regularly spoken to press/media.	Fully compliant				
Domain 8 - Cooperation											
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Trust efficiently integrated 24 military personnel through MACA arrangements January to March 2021. Covid 19 response highlighted significant regional mutual aid support in terms of stores, equipment and clinical transfers. Further work in 2021-2022 will look to formalise more local mutual aid arrangements (RWT) including mortuary resilience and EPRR expertise.	Fully compliant				
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs	Fully implemented during Covid 19.	Fully compliant				
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national healthaspects of an emergency	Fully implemented during Covid 19.	Fully compliant				
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.		Fully compliant				
Domain 9 - Business Continuity											
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Business Continuity Management System (BCMS) Policy approved by Trust Board November 2020. Fully aligned to ISO standard 22301 with external peer review completed.	Fully compliant				

48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competenciesand authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	BCMS Policy includes scope, aim and objectives, requirement, responsibilities, assurance, response, training and exercising. Awareness training has gradually built with increased number of BC Workshops and exercises underway and planned in the next 12 months.	Fully compliant				
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Statement of Compliance completed. EPRR work closely with Information Governance and all training and exercise requirement under DPST conducted.	Fully compliant				
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Business Continuity plans have become more standardised as new template rolled out across the Trust in the last 9 months. This programme continues with associated divisional and departmental resilient leads, associated workshops and EPRR expertise. Dynamic activation of numerous business continuity plans has taken place over the last 18 months which has significantly improved Trust wide understanding and application of business continuity.	Fully compliant				
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	BC audits currently being undertaken by new Head of EPRR with support from outside contractor. This has strengthened policy plans and arrangements whilst internal audit arrangements return to a healthier position after Covid 19.	Fully compliant				
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Updated EPRR improvement plan includes lessons and learning from business continuity incidents. All activation of plans are followed by debrief sessions. Currently many departments are refreshing own business continuity plans based on Covid 19 learning as well as new templates and means of crtically thinking abut reileince in their area of responsibility.	Partially compliant	Not all BC plans have been refreshed following the Covid 19 response and recovery as other activities have naturally been prioritised by divisions and departments. EPRR Steering Group is actively monitoring this programme of improvement to ensure all learning from the pandemic and other disruptions embedded.	Head of EPRR/Divisional and departmental resilience leads	Mar-22	
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	This was again reviewed at the start of Covid 19 and learning continues to be built in to appropriate business continuity plans.	Fully compliant				
Domain 10: CBRN											
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements		Fully compliant				
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process ofrecovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	CBRN/HAZMAT plan in place (March 2017). Review delayed due Covid 19. Number of areas for updating identified and updated version will be completed by November 2021.	Fully compliant				
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	ED risk assessment updated June 2021.	Fully compliant				

59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7	Decontamination shelter in place and serviced annually (June2021). Capability over 15 years old and approval gained to purchase a new decontamination shelter. Expected in place Q3 with old shelter being used for resileince and traning purposes. Surge training conducted spring and summer 2021 due Covid 19 postponement. Regular training formally established and 24/7 staff available. Live exercise planned March 2022.	Fully compliant			
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers -see guidance 'Planning for the management of self- presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Completed equipment inventories; including completion date	Full internal audit completed spring 2021 including WMAS visit. CBRNE audit successfully completed June 2021. Some minor decontamination shelter spares being ordered. All CBRN boxes refreshed. Await WMAS visit for CBRN planned inspection August 2021.	Partially compliant	Awaiting stores and outcome of WMAS CBRN inspection.	Head of EPRR/ ED CBRN Lead	Oct-21
62	CBRN	Equipment checks								
63	CBRN	Equipment Preventative Programme of Maintenance								
64	CBRN	PPE disposal arrangements								
65	CBRN	HAZMAT / CBRN training lead								
67	CBRN	HAZMAT / CBRN trained trainers								
68	CBRN	Staff training - decontamination	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	Routine inspections and audits in place. EPRR provide level of assurance for ED staff who maintain and conduct equipment checks. Head of EPRR manages PRPS suit inventory and maintenance schedule.	Fully compliant			
69	CBRN	FFP3 access	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, callbration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	• Completed PPM, including date completed, and by whom	Routine maintenance in place including support from Estates & Facilities and external bodies (WMAS, Private Sector Companies).	Fully compliant			

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART **Domain: Capability**										
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives(CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y						
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y						
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y						
H5	**HART**	**Protected training hours**	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y						
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans.	Y						
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered Paramedics.	Y						
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y						
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y						
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						

H12	HART	Commander competence	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y						
Domain: Administration										
H13	HART	Effective deployment policy	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H14	HART	Identification appropriate incidents / patients	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y						
H15	HART	Notification of changes to capability delivery	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y						
H16	HART	Recording resource levels	Organisations must record HART resource levels and deployments on the nationally specified system.	Y						
H17	HART	Record of compliance with response time standards	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y						
H18	HART	Local risk assessments	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H19	HART	Lessons identified reporting	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H20	HART	Safety reporting	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
H21	HART	Receipt and confirmation of safety notifications	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y						
H22	HART	Change Request Process	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
Domain: Response time standards										
			Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y						
			Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y						
H25	HART	Attendance at strategic sites of interest	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y						
H23	HART	Initial deployment requirement	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y						
H24	HART	Additional deployment requirement								
D										

H27	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y						
H28	**HART**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
H29	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y						
H30	**HART**	**Fleet compliance with national specification**	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y						
H31	**HART**	**Equipment maintenance**	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y						
H32	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y						
MTFA Domain: Capability										
M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y						
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y						
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y						
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y						
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y						
M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y						
M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.	Y						
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y						
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y						

M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y						
Domain: Administration										
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M14	**MTFA**	**Change Management Process**	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y						
M15	**MTFA**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y						
M16	**MTFA**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y						
M17	**MTFA**	**Recording resource levels**	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y						
M18	**MTFA**	**Local risk assessments**	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
M19	**MTFA**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
M20	**MTFA**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
M21	**MTFA**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y						
Domain: Response time standards										
M22	**MTFA**	**Readiness to deploy to Model Response Sites**	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y						
M23	**MTFA**	**10minute response time**	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y						
Domain: Logistics										
M24	**MTFA**	**PPE availability**	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y						
M25	**MTFA**	**Equipment procurement via national buying frameworks**	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y						
M26	**MTFA**	**Equipment maintenance**	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y						
M27	**MTFA**	**Revenue depreciation scheme**	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y						

M28	**MTFA**	**MTFA asset register**	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (includingany other records which must be maintained for that item of equipment).	Y						
CBRN **Domain: Capability**										
B1	**CBRN**	**Tactical capabilities**	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontaminationunits • Specialist Operational Response (HART) for inner cordon / hotzone operations • CBRN Countermeasures	Y						
B2	**CBRN**	**National Capability Matrices for CBRN.**	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y						
B3	**CBRN**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y						
B4	**CBRN**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y						
Domain: Human resources										
B5	**CBRN**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y						
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y						
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y						
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y						
B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y						
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y						
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y						
B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y						
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y						
Domain: administration										
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y						
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y						
B16	**CBRN**	**Identification of locations to establish CBRN facilities**	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y						

B17	**CBRN**	**CBRN arrangements alignment with guidance**	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y						
B18	**CBRN**	**Communication management**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y						
B19	**CBRN**	**Access to national reserve stocks**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y						
B20	**CBRN**	**Management of hazardous waste**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y						
B21	**CBRN**	**Recovery arrangements**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y						
B22	**CBRN**	**CBRN local risk assessments**	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y						
B23	**CBRN**	**Risk assessments for high risk areas**	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y						
Domain: Response time standards										
B24	**CBRN**	**Model response locations - deployment**	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y						
Domain: logistics										
B25	**CBRN**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
B26	**CBRN**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y						
B27	**CBRN**	**Equipment maintenance - British or EN standards**	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y						
B28	**CBRN**	**Equipment maintenance - National Equipment Data Sheet**	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y						
B29	**CBRN**	**Equipment maintenance - assets register**	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
B30	**CBRN**	**PRPS - minimum number of suits**	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y						
B31	**CBRN**	**PRPS - replacement plan**	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y						
B32	**CBRN**	**Individual / role responsible fore CBRN assets**	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y						
Mass Casualty Vehicles										
Domain: Administration										
V1	**MassCas**	**MCV accommodation**	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y						
V2	**MassCas**	**Maintenance and insurance**	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y						
V3	**MassCas**	**Mobilisation arrangements**	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y						
V4	**MassCas**	**Mass oxygen delivery system**	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y						
Domain: NHS England Mass Casualties			**Concept of Operations**							
V6	**MassCas**	**Mass casualty response arrangements**	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties*.	Y						

V7	**MassCas**	**Arrangements to work with NACC**	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y						
V8	**MassCas**	**EOC arrangements**	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y						
V9	**MassCas**	**Casualty management arrangements**	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y						
V10	**MassCas**	**Casualty Clearing Station arrangements**	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y						
V11	**MassCas**	**Management of non-NHS resource**	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y						
V12	**MassCas**	**Management of secondary patient transfers**	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y						
Command and control **Domain: General**										
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y						
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y						
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y						
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y						
Domain: Human resource										
C5	**C2**	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y						
C6	**C2**	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y						
C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y						

C8	**C2**	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y						
C9	**C2**	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y						
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						
Domain: Decision making										
C11	**C2**	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y						
C12	**C2**	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y						
C13	**C2**	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y						
Domain: Record keeping										
C14	**C2**	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y						
C15	**C2**	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y						
C16	**C2**	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y						
Domain: Lessons identified										
C17	**C2**	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y						
Domain: Competence										
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y						
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C21	**C2**	**Tactical commander competence - nationally recognised course**	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						

C23	**C2**	**Operational commander competence - nationally recognised course**	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C24	**C2**	**Commanders - maintenance of CPD**	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y						
C25	**C2**	**Commanders - exercise attendance**	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y						
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y						
C27	**C2**	**Assessment of commander competence and CDP evidence**	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y						
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y						
C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y						
C30	**C2**	**Loggist - training**	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y						
C31	**C2**	**Loggist - CPD**	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y						
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y						
C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y						
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y						

C35	C2	Control room familiarisation with capabilities	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y						
C36	C2	Responders awareness of NARU major incident action cards	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y						
JESIP Domain: Embedding doctrine										
J1	JESIP	Incorporation of JESIP doctrine	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y						
J2	JESIP	Operations procedures commensurate with Doctrine	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y						
J3	JESIP	Five JESIP principles for joint working	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y						
J4	JESIP	Use of METHANE	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y						
J5	JESIP	Joint Decision Model - advocate use of	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y						
J6	JESIP	Review process	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y						
J7	JESIP	Access to JESIP products, tools and guidance	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y						
Domain: Training										
J8	JESIP	Awareness of JESIP - Responders	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y						
J9	JESIP	Awareness of JESIP - control room staff	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y						
J10	JESIP	Awareness of JESIP - Commanders and Control Room managers / supervisors	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y						
J11	JESIP	Training records - staff requiring training	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y						
J12	JESIP	Command function - interoperability command course	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y						
J13	JESIP	Training records - annual refresh	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y						
J14	JESIP	Commanders - interoperability command course	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y						

J15	**JESIP**	**Participation in multiagency exercise**	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y						
J16	**JESIP**	**Induction training**	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y						
J17	**JESIP**	**Training - review process**	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y						
J18	**JESIP**	**JESIP trainers**	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y						
Domain: Assurance										
J19	**JESIP**	**JESIP self-assessment survey**	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y						
J20	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y						
J21	**JESIP**	**Exercise programme - multiagency exercises**	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y						
J22	**JESIP**	**Competence assurance policy**	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y						
J23	**JESIP**	**Use of JESIP exercise objectives and Umpire templates**	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y						

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Suuply**											
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	• Committee meets annually as a minimum • Committee has signed off terms of reference • Minutes of Committee meetings are maintained • Actions from the Committee are managed effectively • Committee reports progress and any issues to the Chief Executive • Committee develops and maintains organisational policies and procedures • Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) • Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate • The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	Medical Gases Committee in place. Meets every Quarter but since covid-19 has increased frequency to monthly and now every two months. Has Terms of Reference,minutes, Action Plan and covers all components expected as per Health Technical Memorandum.	Fully compliant				
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	• The organisation has reviewed and updated the plans and are they available for view • The organisation has assessed its maximum anticipated flow rate using the national toolkit • The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. • The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site • The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) • Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies • The organisation has breaching points available to support access for additional equipment as required • The organisation has a developed plan for ward level education and training on good housekeeping practices • The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	Have robust plans in place, which are regularly reviewed (currently 3 monthly). Max anticipated flow rate assessed and monitored daily. Plans in place with Skanska (PFI provider) and regularly reviewed. Pipework plans reviewed 6 monthly. New software installed that tracks all medical gases cylinders throughout the Trust. Excellent relationship with suppliers and stock levels maintained to meet requirement and resilience factors. SOPs in place and regularly updated. Breaching points known and system in place. Continually improving ward level education and working on a more comprehensive training programme, building on extensive learning.	Fully compliant				
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	• The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries • The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms • The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes • Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	BOC deliver at set intervals. No formal policy in place yet for calculation of gas consumption, but is being developed. Maintenance policy and arrangements established and implemented. Checklist utilised.	Fully compliant				
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	• Job descriptions/person specifications are available to cover each identified role • Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. • Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements • Medical gas training forms part of the induction package for all staff.	Y	Organisation has JD/PS for key roles and sufficient staff to maintain responsibilities at all times. Training and education in place. It currently does not form part of the induction for all staff.	Partially compliant	Induction training has been an ongoing issue for a number of years. Efforts remain ongoing to establish an assured process.	Heads of Estates and Facilities	Feb-22	
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	• SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds • Staff are informed and aware of the requirements for increasing de-icing of vaporisers • SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	Escalation plan in place and activated on numerous long term occasions. All De-icing arrangements firmly established and running. Continual learning and improvement culture in place.	Fully compliant				
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	• Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	Established and in place	Fully compliant				
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	• Organisation has a risk assessment as per section 6.6 of the HTM 02-01 • Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	Risk assessment in place and reviewed. Last review took place 22 Jun 21	Fully compliant				

Walsall Healthcare NHS Trust

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19 August 2021

EPRR Annual Assurance 2021 - 2022

References:

A. NHS England and NHS Improvement, Skipton House letter dated 22 July 2021(EPRR Annual Assurance Process for 2021-22).

B. NHS England and NHS Improvement, Midlands EPRR letter dated 23 July 2021 (EPRR Annual Assurance 2021-2022)

As requested, this letter submits Walsall Healthcare's self-assessment against the revised core standards.

Reference A from the National Director of EPRR, NHS EI set out the start of the EPRR assurance process and the initial actions for organisations to take as part of NHS England's statutory duty to seek formal assurance of both its own and the NHS in England's EPRR readiness.

Reference B from the Regional Head of EPRR set out requirement for submissions, self-assessment, an action plan and deadline for return.

Walsall Healthcare Rating is assessed as "Substantial Compliance"; the full self assessment is at Appendix 1 and subsequent Action Plan is at Annex A. The details have been scrutinised and challenged by our EPRR Steering Group on 13 August 2021 and by myself, the Accountable Emergency Officer separately on 18 August 2021.

Thereafter the self-assessment and an accompanying report will be presented to our Trust Board 7 October, prior to review by both the Trust Management Board and the Performance, Finance & Improvement Committee.

In sum, the Trust has utilised the full depth of our EPRR capability to continually respond to the covid-19 pandemic and recovery - with both elements ongoing. In tandem, the maintenance of priority p'reparedness and resilience activities to meet concurrent challenges, providing operational management assurance and ensure we are ready for the next threat has been maintained. Furthermore, we remain operating in a complex environment; restoring and delivering elective and emergency care, planning for RSV surge, monitoring and caring for covid-19 patients and playing a key pa'rt in mitigating a pressured regional UEC system. Winter planning is already facing unprecedented risks and requiring considerable planning and underpinning EPRR arrangements. This remains an extraordinary period, where the value of EPRR capacity and capability has been paramount.

Yours sincerely,

Chief Operating Officer

Copy:

Ash Canavan, Regional Head of EPRR
Nick Hardwick, Director of Performance
Jason Evans, Acting Chief Officer for Integrated Urgent & Emergency Care, West Midlands Region.

Annex

A. EPRR Action Plan

Appendix:

1. Completed Self-assessment including "deep dive"

Walsall Healthcare NHS Trust

Annex A- EPRR Action Plan

Standard	Detail	Organisational Evidence	Action to be taken	Lead	Timescale
EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Robust EPRR governance internally in place. One EPRR role plus recent secondment added June 2021 for 9 months. Resource enhancement currently being explored to better underpin EPRR performance, documentation and embedding culture across the Trust.	Business case for enhanced resource being developed Q3.	Head of EPRR	Dec-21
Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Trust has downtime paper process in place where all patients are given a sequential number taken from initial paperwork. This is completed at time of arrival by elfnician triaging patient at ambulance doors. A clerical/reception team member assists the process to ensure accurate recording is taking place. Trust would like to explore major incident system in Careflow for a more robust system.	Trust to explore major incident programme in Careflow system	ED Care Group/ED EPRR-lead	Nov-21
Shelter and evacuation	in line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Trust has evacuation plans included in both fire and business continuity plans. Key areas such as ED are table topped. There is no site evacuation plan in place as this would be beyond the Trust's ability to manage; loss of any acute site would require regional response to redirect all activities.	Whilst certain buildings and key areas have separate plans, no site evacuation plan exists. Whilst not feasible at Trust level to plan and respond further work with regional and system partners to be explored.	Head of EPRR	Feb 22

BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Updated EPRR improvement plan includes lessons and learning from business continuity incidents. All activation of plans are followed by debrief sessions. Currently many departments are refreshing own business continuity plans based on Covid 19 learning as well as new templates and means of critically thinking about resilience in their area of responsibility.	Not all BC plans have been refreshed foilowing the Covid 19 response and recovery as other activities have naturally been prio,ritised by divisions and departments. EPRR Steering Group is actively monitoring this programme of improvement to ensure all learning from the pandemic and other disruptions are delivered	Head of EPRR/ Divisional and Departmental Resilience Leads	Mar-22
Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx.	Full internal audit completed spring 2021 including WMAS visit. CBRNE self-assessment audit successfully completed June 2021-. Some minor decontamination shelter spares being ordered. All CBRN boxes refreshed. Await WMAS visit for CBRNE planned inspection August 2021,	Awaiting stores and outcome of WMAS CBRNE inspection.	Head of EPRR/ ED CBRN Lead	Oct-21

	• Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVDand other material: http://www.jesip.org.uk/what;.will-jesip- do/training/				
Deep Dive: **Medical gasses-workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	Organisation has JD/PS for key roles and sufficient staff to maintain responsibilitie.s at all times. Training and education in place. It currently does not form part of the induction for all staff.	Induction training has been an ongoing issue for a number of years. Efforts remain ongoing to establish an assured process.	Heads of Estates and Facilities	Feb-22

MEETING OF THE PUBLIC TRUST BOARD – 7th October 2021			
Audit Committee Highlight Report Meeting 6th September 2021			**AGENDA ITEM: 24**
Report Author and Job Title:	Mary Martin	**Responsible Director:**	Mrs Mary Martin, Chair of Audit Committee (Non-Executive Director)
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Alert			
Advise	The External Auditors had drafted their commentary on Value for Money which needed to be publicised on the Trust website by 19th September. They had one outstanding action which was a follow up conversation with NHSE/I. (Subsequent note, nothing further required to be included) The External Auditors confirmed that the Commentary had been completed under the new code and meets the required standards. The report provides a level of assurance concluding that there is no weakness in the financial control and reporting. The issues highlighted are around workforce with confirmation provided that the recommendations made are included in the Board Assurance Framework. The Committee suggested some amendments to improve understanding and also asked for the Commentary to be considered by the executive. The publication deadline was met.		
Actions	A final version was to be sent to all Board members on publication		
Approved			
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 Thursday 7 October 2021			
Update from the Black Country and West Birmingham Acute Provider Collaboration Programme			**AGENDA ITEM: 26**
Report Author and Job Title:	Simon Evans, Acting Chief Strategy Officer	**Responsible Director:**	Simon Evans, Acting Chief Strategy Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The paper covers programmes of collaboration including updates on priority works streams for diagnostics; clinical and back office updates as well as workforce and OD, governance, technology and data. New appointments have been made to the post of Chair to the Imaging Network and Danielle Joseph will commence her role as programme director for the collaboration in November.		
Recommendation	Members of the Trust Board are asked to note the key issues discussed at the Acute Provider Collaboration Programme Board held on 23rd September 2021.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There is a commitment from all organisations to commit resources in terms of time for key roles. As a minimum this includes the roles identified so far: CEO, Chair, CMO, CPO and CSO. A request for additional resource to support the PSs for the lead Chief Medical Officer post has been submitted for the next programme board.		
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 ☒		

Update from the Black Country and West Birmingham Acute Provider Collaboration Programme

1. PURPOSE OF REPORT

The purpose of the reports is to update the Board on the key issues discussed at the Acute Provider Collaboration Programme Board held on 23 September, 2021.

2. BACKGROUND

The Acute Provider Collaboration Programme meet regularly to agree and progress areas of mutually beneficial collaborative working programmes across the four Black Country NHS trusts. It has senior executive representation from each of the trusts.

3. DETAILS

3.1 Diagnostics Update

It was reported that Tim Cooper has been appointed as Chair of the Imaging Network, and this was welcomed by Programme Board members. Two priority workstreams have been identified – Digital and Workforce. Clinical Leads are being sought; programme board members agreed to encourage applications from member trusts.

3.2 Quality and Safety Update

Sally Roberts, Chief Nursing Officer, Black Country and West Birmingham CCG and ICS Nursing Lead, attended the meeting to share the proposed model for quality and safety assurance across the ICS.

Programme Board members requested that there is more provider input to developing the arrangements as we transition to the establishment of formal ICSs.

3.3 NHSEI Midlands – emerging commissioning architecture

Kiran Patel, Chief Medical Officer University Hospitals Coventry and Warwickshire NHS Trust, attended to share the emerging commissioning architecture across the Midlands, and in particular the establishment of the West Midlands Acute Provider Network. It was explained that the Network would bring providers together to respond to commissioning requirements from NHSE, however, the Network could also consider non-specialised services and how providers collectively respond.

3.4 Work Stream Updates

Clinical work stream – Dr Jonathan Odum and Diane Wake shared the themes from the previous clinical summit and shared plans for the summit to take place the following day. This would include a presentation on robotics, with a call for how we develop a robotics strategy across the Black Country collectively. It was also reported that 5 clinical leads have been appointed, for Orthopaedics, Ophthalmology, ENT, Gynaecology and Urology. Further leads will be appointed shortly, focused on breast, colorectal and skin cancer and adult critical care.
Following the clinical summit, work will be undertaken to prioritise clinical areas for change over the first phase of the programme. This will be captured in a clinical strategy and patient benefits case, which will then go through formal consultation processes.

Back Office - It was reported that progress with this workstream has been slow, partly due to the need to confirm the clinical priorities for change. It was agreed that the work stream lead should approach CEOs directly for information required to move forward.

Workforce and OD - The work stream lead reported that the proposed consistent fee for Waiting List Initiatives had been shared across all 4 organisations, with 2 still to respond. The Programme Board suggested that all 4 LNCs should be brought together to review, with a view to implement from 1st April 2022.
It was stressed that the MOU for staff passporting agreed at the previous meeting would not compel staff to work in different organisations, but would make cross-organisational working far easier.

Work had continued to develop the collaborative bank, with a request from Directors of Finance that different models are developed.

Governance and implementation - A summary of the recent guidance 'Working together at scale: guidance on provider collaboratives' was considered by the Board. It was agreed that the next programme board meeting should be used as a stocktake, to reflect on progress so far and confirm the future direction in the context of new ICS arrangements and how acute providers influence these, including those described for quality.

It was also reported that Danielle Joseph has been appointed as Programme Director and will start in post on 1st November 2021.

Digital, Data and Technology - It was reported that as agreed at the July Programme Board, a request for information was shared with the market to assess views from suppliers on how they would create insight to support a sustainable acute provider collaboration. This attracted 11 responses which have now been reviewed. Following further consideration, it has now been agreed that this should focus on cancer / elective programmes and a full tender will be issued.
Fortnightly acute provider CIO meetings have now been established.

3.5 Clinical reconfiguration – potential options

Work to identify a partner organisation to review how sites across the Black Country and West Birmingham are most effectively utilised has progressed. A tender document has been prepared and issued. The timescale for completion of this work will be by Christmas 2021.

3.6 Key Next Steps

The next Programme Board meeting will be held on 21st October 2021. As set out above, this will be a stock take meeting to review progress of the programme so far, andconfirm the direction for the future including priority specialties for change.

4. RECOMMENDATIONS

The Board is asked to NOTE the key issues discussed and decisions taken at the Acute Provider Collaboration Board held on 23 September 2021.