Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD TO BE HELD IN PUBLIC ON THURSDAY 8TH MARCH 2018 AT 10.00 A.M. IN THE LECTURE SUITE, MLCC, MANOR HOSPITAL, WALSALL

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A G E N D A

The Board of Walsall Healthcare NHS Trust has committed to undertake its Board Meetings in accordance with an etiquette that all Members have confirmed their agreement to. The purpose of the Etiquette is to enable the Board to make well-informed and high quality decisions based on a clear line of sight into the organisation.

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
1.	Staff Story: Community Services	Learning	Director of Nursing		**10.00**
CHAIR'S BUSINESS					
2.	Apologies for Absence	Information	Chair	Verbal	**10.20**
3.	Declarations of Interest	Information	Chair	ENC 1	
4.	Minutes of the Board Meeting Held on 1st February 2018	Approval	Chair	ENC 2	
5.	Matters Arising and Action Sheet	Review	Chair	ENC 3	
6.	Chair's Report	Information	Chair	ENC 4	
7.	Chief Executive's Report	Information	Chief Executive	ENC 5	
QUALITY AND RISK					
8.	Risk Management Update	Discussion	Trust Secretary	ENC 6	**10.30**
9.	Patient Experience Report	Discussion	Director of Nursing	ENC 7	**10.45**
10.	Serious Incident Report	Information	Director of Nursing	ENC 8	**10.55**
11.	Quality & Safety Committee Highlight Report and Minutes	Discussion	Committee Chair R Beale	ENC 9	**11.05**

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
STRATEGY AND PLANNING					
12.	Walsall Together Case for Change	Approval	Director of Strategy & Improvement	ENC 10	**11.10**
13.	Stroke Services Reconfiguration	Approval	Director of Strategy & Improvement	ENC 11	**11.30**
14.	Intermediate Care Update	Discussion	Director of Strategy & Improvement	ENC 12	**11.50**
15.	Trust Objectives Update	Discussion	Director of Strategy & Improvement	ENC 13	**12.00**
BREAK – TEA/COFFEE PROVIDED					**12.10**
PEOPLE AND CULTURE					
16.	People and Organisational Development Committee Highlight Report and Minutes	Discussion	Committee Chair P Gayle	ENC 14	**12.20**
PERFORMANCE AND FINANCE					
17.	Financial Performance Month 10	Discussion	Director of Finance & Performance	ENC 15	**12.30**
18.	Performance and Quality Report Month 10	Discussion	Director of Finance & Performance	ENC 16	**12.40**
19.	Performance, Finance & Investment Committee Highlight Report & Minutes	Discussion	Committee Chair J Dunn	ENC 17	**12.50**
GOVERNANCE AND COMPLIANCE					
20.	Use of Trust Seal	Information	Trust Secretary	ENC 18	**13.00**

21. **QUESTIONS FROM THE PUBLIC**
None received in advance of the meeting.

22. **DATE OF NEXT MEETING**
Public meeting on **Thursday 5th April 2018** at 10.00 a.m. at the Manor Learning and Conference Centre, Manor Hospital

23. **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).

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 1ST FEBRUARY 2018 AT 10:00 a.m. IN THE LECTURE SUITE, MANOR LEARNING & CONFERENCE CENTRE, MANOR HOSPITAL, WALSALL

Present:

Ms D Oum	Chair of the Board of Directors
Mr J Dunn	Non-Executive Director, Performance, Finance and Investment Committee Chair. Chair and Champion for the Emergency Department
Mr S Heer	Non-Executive Director - Chair of Audit Committee and Champion for Improvement
Mrs V Harris	Non-Executive Director – Chair of Charitable Funds committee NED Champion for Maternity and Neonatal Services
Professor R Beale	Non-Executive Director – Quality and Safety Committee Chair and Champion for Information and Computer Technology
Ms D Carrington	Non-Executive Director – Champion for Improvement, Staff Experience (including Duty of Candour, Freedom to Speak Up and Junior Doctors)
Mr R Kirby	Chief Executive
Mr R Caldicott	Director of Finance & Performance
Mr P Thomas-Hands	Chief Operating Officer

In Attendance:

Mrs P Furnival	Associate Non-Executive Director – Adult Community Care
Mr D Fradgley	Director of Strategy & Transformation
Ms L Ludgrove	Interim Director of Organisational Development and Human Resources
Mrs L Storey	Trust Secretary
Mrs B Beal	Interim Director of Nursing
Miss J Wells	Senior Executive PA (Minutes)

Members of the Public 0
Members of Staff 1
Members of the Press / Media 0

219/17 Patient Story

Mrs Sandra Gough attended the meeting to tell the story about her mother's experience when she was admitted to the hospital.

Mrs Gough explained that her mother, Zena, suffered with dementia, Type 2 Diabetes, was 85 years old when she was admitted and could not advocate for herself. Zena resided in a specialist dementia unit but following a seizure was admitted onto the Acute Medical Unit and was placed in a bay of 6 patients. Mrs Gough highlighted a number of issues that were encountered by both Zena and the

family:

- The busy environment caused Zena a sensory overload.
- Zena quickly forgot who people were therefore it would have been helpful for the staff to repeatedly introduce themselves at each contact and to explain what they were doing.
- A doctor wrote on Zena's notes that she was schizophrenic, making the assumption due to the medications prescribed to Zena.
- There was a lack of empathy and care.
- Dignity issues as Zena was not helped out of bed to eat her meals. The nurse stated that it was easier for her to stay in bed to eat.
- There was no management of visitors. The patient in the bed next to Zena had 5 visitors, 3 of which were children. This resulted in further sensory overload for Zena.
- The blue butterfly on the notes which was intended to alert staff to the fact that Zena suffered with dementia appeared to have no impact.
- Zena started to display signs of anxiety and distress.
- When the decision had been made to discharge Zena, her needs were not met within the Discharge Lounge. The staff response to Mrs Gough was that they were dealing with patients with more complex needs.
- Once Zena had arrived home it was found that a cannula had been left in situ. As the staff at the home were not skilled in removal, Walsall Healthcare were informed. A member of staff arrived at 0200hrs to wake Zena and removed the cannula. It took Zena 4 days for her sleeping pattern to return to normal as a result. Mrs Gough felt that given the time and the disturbance, it would have been beneficial to have removed the cannula the following morning.
- During that day, Zena had been in several different locations, finding the changing environment difficult to deal with.
- Medical history taking was very poor.
- Basic needs were not met.
- Staff lack of understanding.

Mrs Gough made a complaint to the Trust and asked for the GMC numbers of the medics and the NMC numbers of the nurses involved with Zena's care on the day of her admittance in order to try to make an impact upon their care and practice. Mrs Gough suggested that PALS ought to provide patients with staff numbers in order to take further action.

Mrs Gough was thankful that Zena could not remember the events of that day. Upon reflection Mrs Gough decided to leave her job in the NHS after 39 years working as a nurse.

<u>Questions and Comments</u>

Ms Oum thanked Mrs Gough for sharing her and Zena's poor experience with the Board which was distressing to hear.

Mrs Beal agreed that the experience was unacceptable and though the Trust could not change what had happened, lessons could be learnt. Mrs Beal advised that she would deliver feedback to the staff personally. Basic nursing including introductions and kindness were core to the role and Mrs Beal apologised for the failings in Zena's care. Ongoing dementia awareness for staff was underway but Mrs Beal welcomed Mrs Gough's assistance in using the story as a learning experience for staff training.

Mrs Gough understood that mistakes could happen but there was complete lack of care experienced throughout. Mrs Gough added that family members were being used like extra members of staff to order to keep patients in bed and suggested that Board members sat in A&E to observe procedures themselves.

Mr Khan was disappointed to learn of the poor experience and agreed that dementia patients suffered with changing environments and advised that the Trust were trying to provide support in patient's home rather than in hospital.

Mr Thomas-Hands advised he had had a similar experience, having a mother with dementia. Mr Thomas-Hands advised that the hospital was not a suitable environment for Zena and queried whether there were any positives that could be drawn from the experience. Mrs Gough clarified that the system as a whole failed on that occasion and that swifter clinical decisions were needed.

Ms Oum stated that that Mrs Beal and Mr Khan would review the areas of failure and would make the necessary changes to ensure that other patients did not encounter a similar experience. Ms Oum valued Mrs Gough's feedback and appreciated her offer of input into areas of training and awareness.

It was agreed that Mrs Beal and Mrs Gough would make contact the following day to set plans in motion to take up Mrs Gough's offer of feedback for staff training. **BB**

220/17 Apologies for Absence

Apologies were noted from Mr P Gayle, Non-Executive Director Champion for Patient Experience (including Ethics) and for Equality, Diversity and Inclusion.

221/17 Declarations of Interest

The Board received an updated Register of Directors' Interests with amended interests for Ms Oum and Ms Furnival.

Resolution

The Board received and noted the updated Register of Directors' Interests and noted that there were no declarations in respect of the agenda items.

222/17 Minutes of the Board Meeting Held in Public 7th December 2017

The minutes of the meeting held on the 7th December 2017 were agreed as a correct record.

Resolution
The Board approved the minutes of the meeting held on the 7th December 2017 as an accurate record.

223/17 Matters Arising and Action Sheet
The Board received the action sheet and it was noted that the red rated actions had agreed dates for committee review.

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

224/17 Chair's Report
The report was taken as read. Ms Oum gave the following additional updates:

The Board Meeting was Mr Kirby's last Board Meeting as Chief Executive of the Trust. Ms Oum thanked Mr Kirby for his contribution to the Trust during the last 7 years and wished him well for the future.

Mr Silverwood's term of office as a Non-executive Director had come to an end. Ms Oum noted the Board's thanks to Mr Silverwood for his contribution of his human resources expertise and wished him well for the future.

Ms D Carrington had been appointed as a substantive Non-Executive Director from 1st February 2018.

Resolution
The Board received and noted the Chair's report and update.

225/17 Chief Executive's Report
The report was taken as read.

Mr Kirby made reference to Mrs Gough's story heard at the beginning of the meeting and reiterated the Board's view that the unique presentation was very powerful and would be very helpful in delivering the messages to a wider audience.

Mr Kirby thanked all of the staff for their support and hard work and thanked the Board for its support and commitment during his time as Chief Executive.

Questions and Comments

Mr Heer queried how the Board could ensure a smooth transition following Mr Kirby's departure. Mr Kirby replied that Mr Beeken had already started to meet with teams and had been briefed on areas of particular focus. Mr Kirby noted that the Board held the corporate memory and explained that the more the Board worked with the Divisional Directors and teams on shared endeavours, the less likely that change in the executive team would have an adverse impact.

Ms Furnival referred to Accountable Care development and advised

that the business case would be reviewed at the Walsall Provider Board the following week, which was a significant development. Ms Furnival cautioned that considerable time, energy and commitment would be required to progress the work.

Mr Dunn queried the progress of the establishment of the Strategic Board Sub Committee where such issues as Accountable Care would be worked through. Mr Fradgley explained that the group had not yet been established but work would be undertaken to do this within the next two weeks. The terms of reference had been revised and initial membership would comprise of Ms Furnival, Mr Dunn, Mr Thomas-Hands and Mr Caldicott. One additional Non-executive Director would be required and it was anticipated that the first meeting would be held later in the month. Progress would be reported to the Private Part II session of the Trust Board Meeting in March 2018. **DF**

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

226/17 Patient Care Improvement Programme and Quality Commitment
Mrs Beal presented the report and highlighted the following:

- The Patient Care Improvement Programme (PCIP) sought to provide assurance that plans were in place to deliver against the recommendations from the December 2017 CQC report and how these fitted to the overall improvement direction of the Trust.

- It was critical that the quality commitment was mapped to the PCIP and previous actions from the PCIP had been included.

- The next phase of work would be to set out the themes identified and to link these to the Trust's strategic objectives.

- NHSI had informed of their intention to step down their oversight meetings and the actions relating to maternity services would transition into the new Maternity and Neonatal Services Taskforce Meeting.

- The PCIP would be managed through the Care Groups, Divisions, the Quality and Safety Committee for assurance and to the Trust Board.

- The key focus of the PCIP would be to make it business as usual as the Trust moved from a 'Requires Improvement' status to one of 'Good'.

Questions and Comments

Ms Oum noted the ambition to provide good services to the people of Walsall across a range of services and to provide outstanding services wherever possible. Ms Oum queried whether there would be external scrutiny from partners on the taskforce and was advised that the CQC would be included on the membership but in a different

relationship to previously.

Mr Heer noted the comprehensive action plan but raised concern at the lack of detail in relation to progress on actions to address regulation notices. Mrs Beal referenced attachment 2 to the report and explained that it related to the CQC regulations and actions to address the issues raised including how progress was fed back to the Board. Mrs Beal explained that assurance check meetings with the CQC took place to ensure that progress was being made. Divisions were being held to account through quarterly reviews. Mrs Beal added that a health-economy wide review of child safeguarding had taken place the previous week. Recommendations including training would be included in the plan.

Professor Beale noted the basis of a good plan which required further detail of the actions needed and additional evidence on progress.

Professor Beale noted that the report referenced the mapping of issues in the Quality Commitment and questioned if the approach was too detailed. Mrs Beal explained that there was a requirement to complete actions that were not completed and the focus was to make the plan focus on everyday business which was a cultural shift. Mr Kirby noted the requirement to ensure overlap between the CQC recommendations and the Quality Commitment and agreed with Mrs Beal that there was further work to do.

Mr Kirby noted that the plan that was presented at the Trust Quality Executive appeared to include more detail and Mrs Beal agreed to check the report and recirculate.

A proposal was made that the Board Walks should align to the plan as there was a requirement to use the intelligence gleaned in a more structured way. Mrs Beal agreed to review the approach to Board Walks with executive director colleagues. **BB**

The Board noted that further work would be undertaken on the action plan which would be brought back through the March Quality and Safety Committee and April Trust Board. **BB**

Resolution
The Board:

- **Received and noted the content of the report.**
- **Agreed a review of the Patient Care Improvement Programme and Quality Commitment alignment.**
- **An updated action plan would be reviewed at the March Quality and Safety Committee followed by the April Trust Board.**
- **Agreed an alignment of board walks to the PCIP and a review of the Board Walk structure and feedback processes.**

227/17 Safe Nurse Staffing

Mrs Beal presented the report and highlighted the following key

points:

- Data suggested that the level of nurses and aligned budgets were fairly tight.
- There were significant vacancies for Registered Nurses.
- The action plan was a critical piece of work that had been reviewed by the Trust Quality Executive and Quality and Safety Committee.
- The E-rostering system, if used properly and imbedded would be extremely effective in mitigation and managing the use of agency staffing.
- The Standard Operating Procedure had been put in place and would hold wards, care groups and divisions to account.
- Recruitment would be reviewed at the Trust Workforce Executive the following week.
- Overseas recruitment procedure changes meant that approximately 30 nurses might be recruited.
- Retention was poor and work was being undertaken to understand the reasons.
- Work with KPMG was progressing.

Questions and Comments

Ms Carrington noted the positive impact of actions from the verbal narrative provided and noted that it was not present in the report as it appeared that good work had been lost in translation. Mrs Carrington emphasised the need for the People Committee to be sighted on the work in order that it could pursue areas for further work. Ms Carrington echoed the comment in relation to retention and that there was more work to be done.

Mr Khan advised that retention was linked to career progression and asked if there was a process of benchmarking with neighbouring trusts in relation to nursing staff. Mrs Beal explained that further work was required on this.

Mrs Beal explained that the trainee Nursing Associates was an effective programme with the trainees mapped into the future plans for when they qualified. A further 26 trainees were due start which had progressed the forward trajectory for recruitment. Mrs Beal explained that the Trust was one of the leading Trusts offering the incentive, with good infrastructure and support. The current cohort would qualify in January 2019 and would be offered Registered Nursing posts where there were vacancies.

Mr Dunn was concerned that the Trust had seen similar predictions previously which had not lead to fruition. Mrs Beal replied that internal housekeeping in relation to e-rostering, managing proactively and compliance was key. Teams needed to work with procurement to manage agency through the framework. Assistance had also been sought from KPMG.

Ms Oum stated that recruitment and retention was a specific interest of the People and Organisational Development Committee along with the implementation of qualified nursing associates. The

Performance, Finance and Investment Committee would review the trajectories through KPMG worksteams. The Quality and Safety Committee would review the impacts.

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

228/17 Independent Patient care Review: Susan Hearsey

The Board received the independent patient care review for Susan Hearsey. Mr Kirby reminded the Board that the report had been discussed at the Private session of the Trust Board meeting in November 2017. Following that meeting the family of Susan Hearsey had requested that the report also be received at the Trust Board Meeting in Public. The Quality and Safety Committee had reviewed the report and the action plan.

Mrs Beal advised that the Trust had taken the complaint and concerns seriously with rigorous processes to understand and learn from the review and to ensure that action had been taken to implement the recommendations and actions.

Ms Oum underlined the importance for action to be taken, particularly with regard to patients who were vulnerable.

Mrs Beal advised that she visited wards during early mornings in order to meet with both night and day staff and gain intelligence. Areas of concern were known and issues were being addressed. Steps were in place to ensure the right staffing and that equipment was in place. Responsiveness in arranging support services and dealing with issues at the time were of high importance.

Questions and Comments

Mrs Harris reflected upon the report and the patient story earlier in the meeting and the need to provide universal care and understanding and noted that training focused on patients with learning disabilities and dementia required further work.

Ms Oum advised of the increasing number of vulnerable patients and the importance of ensuring that their needs were met appropriately.

Ms Furnival advised that there was a need for multidisciplinary training which was not currently available.

Mr Kirby stated it was clear that the Trust had clearly failed Susan Hearsey and had misunderstood the needs of her vulnerabilities. The ward in question had been opened at very short notice, under pressure and there were important lessons to be learnt. The report and action plan had been shared with the family. Mr Kirby apologised for the failings in care and assured that the Trust was taking action.

Mrs Ludgrove noted that the majority of patients the Trust's care were vulnerable. Pressures in the system and staff shortages were well known and staff should be supported in their ability to

demonstrate care and empathy when under pressure.

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

229/17 Violence and Aggression Toward Staff

As an additional issue to the published agenda the Board held a discussion on violence and aggression toward staff as it had been made aware of a number of recent incidents.

Mrs Beal reminded the Board that there was a duty of care to staff in relation to violent patients and in balancing support to staff alongside appropriate patient care. Ms Oum agreed that tolerance toward aggression needed to be reviewed.

Professor Beale advised that as Chair of the Quality and Safety Committee, he had been made aware of an incident recently of an incident of violence toward a staff member. The Trust needed to be clear that aggression was not acceptable, staff should be supported to report incidents and to work closely with police to pursue incidents fully.

Mr Fradgley advised that in relation to violence and aggression towards staff, the reporting process had been reviewed with Mrs Beal following a series of under reported incidents. The 'Respect Us' campaign was being refreshed to raise its profile to protect staff both on site and in the community.

Resolution
The Board noted the verbal update on violence and aggression toward staff.

230/17 Serious Incident Report

Mrs Beal presented the report and advised that there had been a decrease in the number of pressure ulcers reported during December 2017. A refresh and review was underway lead by the Deputy Director of Nursing and the Tissue Viability Team and reporting back to the Quality and Safety Committee.

Questions and Comments

Ms Oum asked for clarification regarding the review of pressure ulcers in the community. Ms Oum reminded the Board that she had previously asked for clarity on whether different communities were disproportionately represented in the increase in pressure ulcers and queried whether the review had looked at equality of outcomes. Mrs Beal replied that the review had not.

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

231/17 Mortality Report

Mr Khan presented the report which was taken as read.

Questions and Comments

Ms Furnival advised that the Divisional Directors of Medicine and Long Term Conditions had attended the Health and Care Scrutiny meeting and provided strong assurance in relation to mortality rates.

Professor Beale queried whether the figures reflected deaths within the hospital only or included the community following hospital contact. Mr Khan replied that they related to in-hospital patients. SHMI related to community patients up to 30 days from hospital discharge.

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

232/17 Quality & Safety Committee Highlight Report and Minutes

Professor Beale presented the highlight report from the most recent meeting held on 25th January 2018, together with the approved minutes of the meeting held on 21st December 2017. The following key points were highlighted:

- VTE still did not meet the 95% target. Mr Khan had assured that steps were being taken to improve but progress to date was of concern.
- The Maternity and Neonatal Taskforce was making good progress in terms of improvement. There had been an increase in C–Section rates in December but actions were in place to address this and daily morning review meetings were taking place.
- Safe staffing was reviewed. There needed to be focus on the use of tools and implementing them effectively.
- Surgery presented an update from the CQC report. A discussion regarding theatre utilisation would take place at the next meeting.
- The committee received assurance that all actions had been taken in relation to a recent Never Event.

Questions and Comments

Ms Oum expressed disappointment about the VTE position and asked that everything possible was being done in order to improve. Mrs Beal replied that the Deputy Director of Nursing had done a significant amount of work with nurses in key areas to support doctors. Mr Khan stated that a daily check of processes was taking place.

Mr Kirby advised that VTE figures had shown some improvement and were not far away from the target. The Trust was aiming to achieve the 95% in March.

Ms Oum suggested comparing the VTE figures of other sites in the local area to see if they were performing due to the importance for patients.

Ms Oum added that the increase in C-Sections was also

disappointing.

Ms Carrington replied that the Maternity Taskforce had received assurance that there had been a culture change with a move in the right direction for a sustainable service. Following a Board Walk earlier in the week, Ms Carrington felt assured by the reports received from staff that their understanding was not just focus on the Section 29 notice, and was about delivering the right kind of care. It was added that the rise in C-Section numbers had been discussed and appeared to have related to one particular locum. A review was under way in relation to this.

Mr Kirby shared his disappointment about the figures but was assured that VTE and C-Section rates were being monitored and actions taken. Signs showed that the Trust was improving.

Mrs Beal expressed her confidence in nursing staff meeting the needs of each patient and explained that daily reviews were taking place and submissions to the CQC had been sent weekly and would be moving to monthly.

A discussion was held in relation to the national media interest about the recent striking off of a doctor not associated with the Trust. The Board noted the complexities of the issue which had caused concern amongst doctors nationally. The Board recognise the importance of providing support to staff whilst ensuring that substandard practice was not tolerated.

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

233/17 Black Country Pathology Service Full Business Case Update

Dr Mark Livingston, Lead Clinical Scientist attended the meeting to present the business case update with Mr Khan.

Mr Khan advised that the business case had been reviewed by the Board in December 2017 where further information regarding the specification of legalities had been requested. Approval was now sought to progress to the transition phase.

Mr Khan highlighted the following key points:

- Forecast savings were £52 million over a ten year period which would be distributed to all partners using a cost sharing percentage.
- Any changes would be discussed at the Oversight Group and recommended to Trust Boards for approval.
- Recommendation to commit to fund the necessary enabling works and delegating the Oversight Group to manage the appropriate detail.
- The costs incurred to date totalled £795k which equated to £199k per Trust based upon a 25% split.

Questions and Comments

The Board recorded its support for the case in principle with the following request for clarification:

- That the risks be better clarified and their mitigation articulated.
- Further details would be required on governance processes.
- Clarification of process where there was dispute on consensus in relation to decision making.
- Greater clarity on benefits and sensitivity analysis.
- A requirement for an underpinning action plan to ensure that both clinical and financial benefits were achieved.

The Chair noted the important issues raised and sought clarification that the Board was in agreement to approve and support the business case with the proviso that the issues raised would be addressed. It was noted that the Private Part II session of the meeting would review this in further detail.

Resolution
The Board:

- **Received and noted the content of the report.**

- **Requested clarification on the following:**
  - **That the risks be better clarified and their mitigation articulated.**
  - **Further details would be required on governance processes.**
  - **Clarification of process where there was dispute on consensus in relation to decision making.**
  - **Greater clarity on benefits and sensitivity analysis.**
  - **A requirement for an underpinning action plan to ensure that both clinical and financial benefits were achieved.**

- **Approved the business case for the Black Country Pathology Service and agreed to progress to the transition phase including the initiation of the enabling HR plans immediately.**

- **Agreed to participate on the basis of the governance and commercial terms, as set out in the business case. If there are any changes that are recommended during the transition and due diligence phases these will be taken to the Oversight Group for consideration and approval.**

  Where the impact results in a change of the financial position, any proposed changes will be taken to the Oversight group and if approved there, will be recommended to Trust boards for approval.

- **Agreed to set up the BCPS as a shared Arms-Length Organisation, hosted by Royal Wolverhampton Trust.**

- **Gave commitment to fund the necessary enabling works, as**

contained in the FBC. Delegating the Oversight Group to manage the appropriate detail.

The approved costs incurred to date, were detailed in a paper presented to the Oversight Group, and amounted to a total of £794,909, which equated to £ £198,727 per trust, based on a 25% split.

- **Authorised continuation of design development.**
- **Appointed the substantive Clinical Director and Operational Manager.**

234/17 People and OD Committee Highlight Report and Minutes

Mrs Ludgrove presented the highlight report from the People and Organisational Development Committee meeting held on 18th December 2017 with the confirmed minutes of the meeting held on 20th November 2017. The report was taken as read, however Mrs Ludgrove added that the flu vaccination figure was currently at 61% of a target of 70%. In addition Mrs Ludgrove noted the outcome of the recruitment internal audit at substantial and congratulated the team on its achievement.

Resolution

The Board received and noted the content of the report.

235/17 Interim Director of Organisational Development and Human Resources Reflections Update

Mrs Ludgrove presented the paper which had been presented at the People and Organisational Development Committee in December 2017 and highlighted the following key points:

- Integration of the services within the directorate had been slow following the departure of a key manager which caused concern regarding a gap in resource to address equality, diversity and inclusion. A 6 month internal secondment was being considered followed by substantive recruitment.

- The management of change process had commenced in January.

- The process of coaching and developmental feedback to key members of staff was nearing completion and had been largely positive.

Questions and Comments

Ms Furnival asked whether the Trust would be publishing its gender pay statistics. Mrs Ludgrove explained that work was underway on this.

Resolution

The Board received and noted the content of the report.

236/17 Financial Performance Month 9

Mr Caldicott presented the Financial Performance report for Month 9 and highlighted the following key points:

- The Trust had a £20.3m deficit position in December 2017. The figure did not include asset sales which would be key to the plan.
- The Trust was moving away from plan at a rate of £1m per month.
- There had been considerable discussion on the position at the Performance, Finance and Investment Committee where it was emphasised that there was an urgent requirement to bring the Trust back to its £20.5m deficit plan.
- A further recovery plan had been created which included a review of temporary workforce staffing, the impact of additional bed capacity and pressure displacing elective capacity and income. The key message had been the requirement to stop spending and to improve patient flow and elective performance in the final quarter of the year.

Questions and Comments

Mr Dunn expressed concern that further work needed to be done within the plan to pin down weekly actions in order to see delivery. Mr Dunn emphasised that there were only two months of the year remaining and January's results were likely to be difficult and put further pressure on the plan. Mr Dunn explained that major engagement would be required and the plan appeared to be a plan for a plan with insufficient detail to provide assurance that delivery could be achieved.

Ms Oum advised a further level of detail was required and there was a lack of analysis as to why the original recovery plan had not delivered.

Mr Caldicott responded that the original plan had not delivered due to a large proportion of the plan being focussed on the improved utilisation of outpatients, theatres and elective income productivity which had not delivered. The new plan did indicate weekly cases for delivery and could therefore be monitored. Mr Caldicott further explained that the original plan had included a £300k to £400k reduction in monthly expenditure together with an increase in income which had not been delivered and the temporary workforce costs had not reduced sufficiently and had gone ahead of expenditure in previous months beyond historic levels.

The Chair requested a response from the executive directors in relation to the financial recovery plan and asserted that it was a recovery of the recovery plan and highlighted that the Board needed to know that the executive team was committed to its delivery to achieve the £20.5m deficit plan. The following responses were noted:

- Mrs Beal stated that all areas needed to assist with finance. Temporary workforce was problematic and all should be

committed to driving down expenditure whilst mindful of the need to support the operations team and extra capacity.

- Mr Khan confirmed his commitment and explained that the key issue was how quickly patient flow could be controlled as there was considerably more work to keep patients safe who were not in the right place. Mr Khan further explained that the biggest issue was the closure of beds and the requirement to look at different ways of working.

- Mr Thomas-Hands confirmed his engagement and advised that the Theatres and Outpatients plans were innovative but had been hit hard during winter pressures. KPMG were meeting with teams to review trajectories for the remainder of the year. There were considerable interdependencies to get the plan working and the clinical teams had signed up to this. Mr Thomas-Hands further explained that there had been huge pressure on the nursing resource and to keep areas safe.

- Mrs Ludgrove confirmed that the executive team met at the Performance and Finance Executive meeting twice a month with the clinical team where there was a significant enthusiasm and commitment from the teams to deliver the financial plan.

- Mr Fradgley confirmed commitment from his areas and explained that he was holding vacancies in the communications team. In addition there had been considerable work with the technical teams to support improvement in outpatients. Work was underway to look at better productivity through clinics and better visibility of data which would help to improve performance.

Professor Beale raised concern about confidence in the new plan as it did not appear to state anything different to previous plans.

Mr Kirby noted the importance of the views raised by the Non-executive directors and explained that at the beginning of November the Trust had been close to plan. Mr Kirby explained the need to recognise that the winter was much worse than planned which was why the Trust was currently struggling. Mr Kirby noted that the Trust had cancelled more elective work and opened beds earlier and there had been recognition in the national system about this. Mr Kirby stated that the Trust had been ahead of plan before winter and there was a requirement to close as many of the extra beds as soon as was safe to do so. The Board was advised that there was a programme week commencing the 12th February to clear a ward and to use the capacity released to improve elective capacity. It was explained that the unknown factor was whether emergency demand would return to normal for February and March which would make the plan achievable; if not Mr Kirby cautioned that it would be hard to make enough improvement in the time remaining. Mr Kirby advised that the Regulator was aware of the high risk and that there was no need at the current point to alter the forecast from the originally planned £20.5m deficit.

Mr Dunn advised that he would like to see a plan that was well monitored, controlled and delivering. The plan also needed to be shared at divisional level with the inclusion of governance. Further clarity of the cause and effect of winter would also be beneficial.

Ms Oum noted the commitment from the executive team about what needed to be done in order to achieve the plan. Ms Oum noted that there appeared to be a culture change in the willingness to be involved and requested that the Performance, Finance and Investment Committee closely monitor progress.

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

237/17 Performance and Quality Report Month 9

The Performance and Quality Report for December 2017 was received and the following key issues highlighted:

- A&E performance had improved slightly to 83.38% compared to November but remained below the trajectory of 87%.
- Cancer and diagnostic constitutional standards were delivered.

Questions and Comments

Ms Oum noted the maintenance of the cancer and diagnostic standards and noted that the 62 day consultant upgrade was consistently not met. Mr Kirby reiterated the importance of the measure for patient safety and explained that he had requested a similar level of operational progress on the measure. The CCG had agreed to set the same standard for that group of patients as the national standard. Mr Kirby explained that the number of patients in relation to the measure were small.

Mr Khan advised that the number of C-difficile cases had risen during December and there had been a norovirus outbreak. Figures remained within the trajectory but the gap had closed.

Mr Kirby noted that the RTT performance was slipping further from the target which was largely due to cancelled elective work and it was likely that other Trusts were in a similar position. There needed to be a prioritisation effect within operations to get emergency work under control, focus on cancer standards and controlling temporary staffing rates before efforts concentrated on RTT.

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

238/17 Winter Update

Mr Thomas-Hands presented the Winter Update Report and highlighted the following key points:

- Plans were in place and acted upon. Clinical engagement had

improved upon the previous year.

- Less medical beds were utilised than the previous year.
- During December both ward 12 and 14 were opened to a total of 56 beds which was earlier than planned. Snow also caused problems.
- National guidance was issued in early January. Emergency and cancer patients were not cancelled.
- Ambulance arrivals were significantly higher than the previous year.
- The length of handover rates with ambulates was lower than the previous year.
- Huge pressures were placed upon nursing and therapies.
- Focus had been on the discharge lounge and a higher number of discharges had been achieved during January than in previous months.
- During December 6/7 bays were closed due to norovirus.
- There had been no 12 hour breaches during the winter period to date.
- Good engagement at the bed meetings to understand risks and pressure.
- An extra medical team was introduced in November.
- Patient waits in ED had risen but extra staffing were provided during evenings.
- Infection control had been pragmatic.
- There were 279 attendances on Monday but everything was open. Extra doctors had been called in to assist with patient flow.
- ECIP were completing reviews.
- Ward 20C was about to be handed back to surgery the Starling ward closed.

<u>Questions and Comments</u>

Mr Dunn acknowledged the amount of work being done but queried what was different to last year, adding that he would like to see how volumes compared to the previous year along with changes and pressures and how they were planned for.

Mr Thomas-Hands replied that he had spent a considerable amount of time within A&E assisting and that the report included an update indicating tends and ambulance numbers.

Ms Carrington noted that the executive summary required a greater depth of detail than provided.

Mr Kirby advised that the Trust were experiencing an increase of 12-15% emergency admissions compared to the previous year. Half of the volume was due to pathway changes and the other was an increase of volume. More beds had been open and for longer periods.

Mrs Holden advised that the verbal assurance had been given rather than the content covered thoroughly in the paper.

Mrs Beal stated that she and Mr Thomas-Hands had been supporting staff and strengthening interfaces.

Mr Khan reiterated that the extra workforce had proved most helpful but cautioned that the winter was not yet over.

Ms Oum summarised that the verbal update was helpful and provided assurance of the level of commitment and engagement. Ms Oum suggested that the paper could be more analytical to include further updates for the Non-Executive Directors.

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

239/17 Performance, Finance & Investment Committee Highlight Report and Minutes

Mr Heer presented the highlight report from the Performance, Finance and Investment Committee held on 24th January 2018 with the confirmed minutes of the meeting held on 27th November 2017. Mr Heer highlighted the following key points:

- The financial performance for month 8 and 9 were reviewed with the forecast outturn for 2018/2018. Discussion took place regarding the agreed target of £20.5m deficit.
- The committee asked for action plans and mitigation. A weekly summary would be provided to Ms Oum, Mr Dunn, KPMG and the Executive Directors in order to understand the action being taken and implications.
- KPMG had been given objectives of delivering £20.5m deficit and run rate. It was felt that the pace had somewhat slackened and had therefore refocused going forward.

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

240/17 Questions from the Public

No members of the public were in attendance and no questions had been raised in advance of the meeting.

Date of Next Meeting

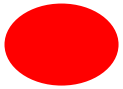
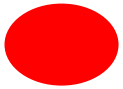
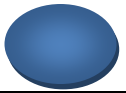
The next meeting of the Trust Board held in public would be on Thursday 8th March 2018 at 10:00 a.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

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

ENC 3

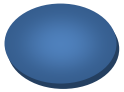
Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
150/17 07/09/2017 Emergency Preparedness Resilience Response	Compliance with Trauma Unit standards to be reviewed and reported through the Quality and Safety Committee.	Medical Director	~~02/11/2017~~ ~~07/12/2017~~ ~~01/02/2018~~ 08/03/2018	**Update** Trauma Network Revisit due in January. Report on compliance to be provided to February Quality & Safety Committee. Report deferred from February to March committee.	
160/17 07/09/2017 Questions from the Public: Ward Closures	Workforce impact assessment to be undertaken in relation to ward closures and reported back through the People and Organisational Development Committee.	Chief Operating Officer	~~02/11/2017~~ ~~18/12/2017~~ 19/02/2018	**Update** Philip is working with the Divisional team of three to provide this summary for People and Organisational Development Committee	
169/17 05/10/2017 Quality & Safety Committee Highlight Report	Feedback from a number of external reviews regarding Maternity would be due in two months and would be reviewed at the December Quality & Safety Committee.	Chief Executive	~~21/12/2017~~ 22/02/2018	**Update** Received at Quality & Safety Committee Meeting in February 2018.	
195/17 02/11/2017 Performance & Quality Report Month 6	Medical Director to liaise with Mr Thomas-Hands and report back outside of the meeting about concern raised in relation to the timely treatment of sepsis in emergency and acute areas.	Medical Director	07/12/2017	**Update**	
	The next report to show a clear distinction between patients on the Medically Fit for Discharge list that were awaiting Trust internal input and those that were waiting for external input.	Chief Operating Officer	~~01/02/2018~~ 08/03/2018	**Update** COO to work with Head of Performance &	

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

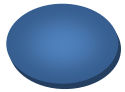
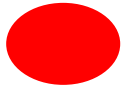
Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
				Strategic Intelligence for March Board report.	
	Discuss with executive director colleagues an approach to including in the report those actions in place to deliver trajectories but which were not having the expected impact. Report back to the Performance, Finance & Investment Committee.	Chief Executive	~~01/02/2018~~ 21/02/2018	**Update** In progress. Report at the next PFIC on 21.02.2018	
206/17 07/12/2017 Risk Management	Executive team to review the Corporate Risk Register to review the action required to address the large number of static risks.	Executive Directors	08/03/2018	**Update** Work under way – further work required. Focus on monthly basis as executive team.	
	Trust Secretary to work with the Executive Team to review the number of risks on the CRR and to provide greater clarity on the risk descriptions.	Executive Directors & Trust Secretary	08/03/2018	**Update** Work ongoing.	
	Review Board Assurance Framework to ensure the right challenges were articulated with a view to there being fewer BAF risks.	Trust Secretary	08/03/2018	**Update** Review commenced – proposals for changes for 2018/2019 to be discussed at Board Seminar session.	
21917 02/02/2018 Patient Story	Mrs Beal and Mrs Gough to make contact to set plans in motion to take up Mrs Gough's offer of feedback for staff training.	Interim Director of Nursing	08/03/2018	**Completed**	
225/17 02/02/2018 Chief Executive's Report	Update Board on progress of the first meeting of the Strategy Sub Committee.	Director of Strategy & Transformation	08/03/2018	**Update** Work plan agreed. Group to focus on Case for Change and	

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
				Sustainability Reviews. One to Ones held.	
226/17 02/022018 Patient Care Improvement Plan	Further work on the action plan to be undertaken and brought back through the March Quality and Safety Committee and April Trust Board.	Interim Director of Nursing	05/04/2018	**Not yet due**	

Key to RAG rating

 Action completed within agreed original timeframe	Action on track for delivery within agreed original timeframe
 Action deferred once, but there is evidence that work is now progressing towards completion	 Action deferred twice or more.

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date: 8th March 2018**
Report Title	Chair's Report			**Agenda Item: 6** **Enclosure No.: 4**
Lead Director to Present Report	Chair of the Trust Board, Danielle Oum			
Report Author(s)	Chair of the Trust Board, Danielle Oum			
Executive Summary	The report contains information that the Chair wants to bring to the Board's attention and includes a summary of the meetings attended and activity undertaken by the chair since the last Board meeting.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	The Board is recommended to NOTE the report for information.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>As above</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
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<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☐</td><td><u>Effective</u></td><td>☐</td></tr>
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<tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">BAF Risk No. 11 ‘That our governance remains “inadequate” as assessed under the Care Quality Commission Well-Led standard.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">There are no resource implications detailed within the content of the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">The 7 Principles of Public Life -Nolan Principles. 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.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The Chair reports monthly to the Trust Board.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The next report will be received by the Trust Board at its meeting on the 5th April 2018.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

CHAIR'S REPORT MARCH 2018

1. INTRODUCTION

The Chair's monthly report to the Board contains information that the Chair wants to bring to the Board's attention. It includes a summary of the meetings attended and activity undertaken by the Chair since the last Board meeting.

2. CHAIR'S ACTIVITY FEBRUARY 2018

Healthwatch Quarterly Meeting
Richard Kirby and I met with John Taylor and Simon Fogell from Healthwatch in a quarterly catch up.

Director of Governance/Trust Secretary Interviews
I chaired the interview panel for the Director of Governance/Trust Secretary vacancy. Following stakeholder events, two candidates proceeded to interview and an offer has been made.

Engaging with Colleagues
I met with a range of colleagues across the Trust, to discuss their work including Executive Directors, KMPG, ED Department and Simon Brake from Walsall CCG. I also met with Health Records during the Board Walk and attended the launch of the Quality Academy.

Non-Executive Director Changes
Deborah Carrington is leaving the Trust Board due to family commitments. I am sure that the Board will join me in thanking her for her work on behalf of WHT and wishing her well for the future.

3. RECOMMENDATION

The Trust Board is recommended to NOTE the report for information.

BOARD/COMMITTEE REPORT

Meeting	**TRUST BOARD**		**Date: 8th March 2018**
Report Title	**CHIEF EXECUTIVE'S REPORT**		**Agenda Item: 7** **Enclosure No.: 5**
Lead Director to Present Report	Richard Beeken, Chief Executive		
Report Author(s)	Richard Beeken, Chief Executive		
Executive Summary	It is with great pleasure and pride that I submit my first report to the Trust Board as Chief Executive of Walsall Healthcare NHS Trust. In my first three days in post, I have been meeting with my new Board colleagues, both collectively and on a 1:1 basis. I have also had the pleasure of joining the Medical Director on a visit to the Surgical Assessment Unit and Acute Surgical Unit, visited the Acute Medical Unit and Endoscopy Department with the Divisional Director of Nursing for Medicine. By the end of my first week I will have also met front line staff in Theatres and Outpatients and will have visited all of our inpatient ward areas, held a Q&A session with consultant medical staff as well as holding my first drop in session for Trust staff in the hospital restaurant area. In my second week, I will be hoping to meet staff in our community services at key locations and also spend time with colleagues in our Emergency Department. Of course, by virtue of joining the organisation at such a critical time of the year, I have also had to devote my time to the key issues of ensuring that our financial plan is delivered to the best of our ability by year end, as well as agreeing our approach to agreeing the contract activity values and expectations for 2018/19 with CCG colleagues. I am very keen to share with colleagues at the Trust how I intend to allocate my time in my first 100 days in post and the attached plan will be distributed to all staff to demonstrate that I will be constantly striving to get the balance right between my formal duties as accountable officer whilst also seeking to learn about the organisation through speaking with front line staff in their wards, departments and services.		
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	1. NOTE the Chief Executive's report.			

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<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Links to the financial and performance risks identified in the Board Assurance Framework.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">No direct resource implications.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">The Trust remains in special measures following our September 2015 CQC inspection and is in Segment 4 in NHS Improvement’s oversight framework.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">No previous consideration</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">No direct next steps</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
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Walsall Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD
8th March 2018

CHIEF EXECUTIVE'S REPORT

INTRODUCTION

My predecessor, Richard Kirby, set out in his last Board report, how the organisational priorities for quarters 3 and 4 were to be delivered and seen to conclusion. It is now vital that we look to the future and shape our priorities for the coming year. The Trust Board, at a lively and productive development session on my first day at the Trust, came to a quick consensus on those priorities and these will be reflected in consistent language in our Trust Plan for 2018/19:

1. Continue our improvement journey on patient safety culture and clinical quality, through a comprehensive improvement programme which focuses on patient outcomes

2. Continue to develop the culture of the organisation to ensure mature decision making and clinical leadership, underpinned by open and transparent deployment of our new Trust values and behaviours

3. Deliver the next stage of our journey of financial improvement, driven by improvements to services, processes and productivity through our improvement programme

4. Develop and deliver our clinical services strategy, through the implementation of integrated local care (Walsall Together) and increased acute hospital collaboration to ensure service resilience and sustainability for the longer term

It is imperative that we bring all our staff on this journey and include senior clinical and managerial leaders in the key decisions we need to take to deliver these Trust Board priorities. To that end, I will be shortly setting out how our Clinical Divisions will be systematically involved in this, through the creation of a Trust Management Board, which will ensure that not only are senior clinicians involved in such decisions, but also bind us all together to take collective responsibility for those decisions and their implications.

The Board is recommended to:

1. NOTE the Chief Executive's report.

Richard Beeken
1st March 2018

Walsall Healthcare NHS
NHS Trust

Richard Beeken
Chief Executive
@NHSBeeky

100 DAY PLAN

Hello, I am Richard Beeken, the new Chief Executive of Walsall Healthcare NHS Trust. I am honoured to be joining you at this key stage of the Trust's improvement journey to "good and outstanding".

I wanted to share with you how I will be spending my first 100 days with the organisation – search #Walsall100 on Twitter.

The Board has been very clear that I am to carry on the great work you started a couple of years ago, and with that in mind, I will focus on delivering in four key areas:

- Continue our improvement journey on patient safety culture and clinical quality, through a comprehensive improvement programme which focuses on patient outcomes
- Continue to develop the culture of the organisation to ensure mature decision making and clinical leadership, underpinned by open and transparent deployment of our new Trust values and behaviours
- Manage our resources effectively and improve the Trust's financial health through our improvement programme
- Develop and implement a clinical services strategy which will focus on integrated health and care provision with partner organisations in Walsall, as well as effective collaboration with other Trusts to improve the resilience and sustainability of our acute hospital services.

I am confident that together we can work towards getting to good and outstanding quality in all of our community and acute services and continue to work with our partners to ensure our services have a safe and sustainable future. I look forward to meeting with as many of you as possible in the coming weeks and months, and I will use the Chief Executive's briefing sessions to update you on our achievements, the milestones that we have reached and the feedback that I have received.

Week 1:		**Meet with the Chair and Executive Team**
26/2/18		**Weekly message and drop-in sessions for staff**
		Meet partner Chief Officers
		Walkabouts (SAU, ASU, AMU, Endoscopy, Theatres, Inpatients)
		Attend Senior Medical Staff Committee (wards)
Week 2:		**Trust Board**
5/3/18		**Weekly message and drop-in session for staff**
		Tour of our maternity services
		Weekly Executive Committee
		Review the results of the latest staff survey
		Announce leadership conference themes
Week 3:		**30 day update on four key priorities and colleague feedback so far**
12/3/18		**Chief Executive's Brief**
		Meet with our local provider partners
		Attend the ED Task Force Meeting
		Weekly Executive Committee
		Weekly drop-in session for staff
		Meet the teams
		Attend the Audit Committee
		Meet with some of our peer reviewers
Week 4:		**Quarterly review with our regulators – NHS Improvement**
19/3/18		**LiA Sponsor Group Meeting**
		Weekly message and drop-in session for staff
		Meet with our clinical leaders and union representatives
		Walkabout including evenings and weekends
Week 5:		Begin preparations for future CQC re-inspection
26/3/18		**Publish our Quality Improvement Plan**
		Meet with some of our community teams
		Weekly message and drop-in session for staff
Week 6:		**Present our Annual Plan and Accounts to Trust Board**
2/4/18		**Weekly message and drop-in session for staff**

Week 7: 9/4/18	Walkabout Chief Executive's Brief Meet with our divisional leadership teams Weekly message and drop-in session for staff
Week 8: 16/4/18	50 day update to our clinical leaders on four key priorities and colleague feedback so far Meet with our Black Country Partners
Week 9: 23/4/18	Weekly message and drop-in session for staff Walkabout
Week 10: 30/4/18	70 day update to Trust Board on four key priorities and colleague feedback so far Weekly message and drop-in session for staff Launch our Borough-wide celebrations of NHS70
Week 11: 7/5/18	Chief Executive's Brief Weekly message and drop-in session for staff
Week 12: 14/5/18	Weekly message and drop-in session for staff Walkabout Meeting with our clinical leadership teams
Week 13: 21/5/18	Leadership Conference Weekly message and drop-in session for staff Invite stakeholders to AGM
Week 14: 28/5/18	Walkabout Weekly message and drop-in session for staff
Week 15: 4/6/18	Report to Board on my first 100 days, and my recommendations of future actions Meet some of our Volunteers as part of Volunteer Week and NHS70 celebrations Weekly message and drop-in session for staff

Meet Richard
Open sessions, no agenda

Briefings
Invited staff groups

Meetings

Walkabout
A chance for conversations around the Trust

Communications
Information we share with you

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date:** 8 march 2018
Report Title	Risk Management			Agenda Item: 8 Enclosure No.: 6
Lead Director to Present Report	Trust Secretary, Linda Storey			
Report Author(s)	Trust Secretary, Linda Storey			
Executive Summary	The report provides an update on the Board Assurance Framework and Corporate Risk Register position at the beginning of March 2018 together with the forecast positions for Quarter 4 2017/18 and into 2018/2019. The BAF currently has 15 risks. The strength of the controls and assurances have been reviewed by the Executive Director leads. The actions to address gaps in both controls and assurances have also been reviewed. Appendix 1 shows the BAF Dashboard and supporting risk sheets. The Corporate Risk Register currently has 42 accepted risks. The risk detail including score movement since the last Board Report and forecast scores is shown in Appendix 2 which also includes narrative explaining what has changed on a number of the risks. Six new risks have been added to the risk register, two are pending acceptance, three have been either de-escalated or closed since the last Board report and three have deteriorated in score.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Board is recommended to DISCUSS the content of the report and make any recommendation for further action in relation to the risks. .			

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<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Embed an engaged, empowered and clinically led organisational culture</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Embed an engaged, empowered and clinically led organisational culture</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Embed the quality, performance experience improvements that we have begun in 2016/17</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☐</td></tr><tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☐</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">The report provides an update on the Board Assurance Framework and Corporate Risk Register risks.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">No resource implications identified within this report. Individual risk mitigations will include resource implications.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">No other regulatory implications identified within this report other than linkage to the Care Quality Commission Safe and Well Led Key Lines of Enquiry.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The report is a quarterly item at the Board.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The Trust Board will review the Board Assurance Framework risks in a Board Seminar early in 2018/2019 to refresh the framework taking into consideration the proposals and narrative from this report.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

RISK MANAGEMENT UPDATE

1. INTRODUCTION

The report provides an update on the current Board Assurance Framework and Corporate Risk Register position together with the forecasts for Quarters 4 2017/2018 and into 2018/2019.

2. BOARD ASSURANCE FRAMEWORK

2.1 Updates:

The Board Assurance Framework has been updated and the detail is shown at Appendix 1. The following key highlights are of note:

2.2 Score Movement Since December 2017 Board Report.

Of the 15 BAF risks:

- Two have improved in score.
- One has deteriorated in score.
- Twelve have remained static in score.
- Of those with a static score four are forecast to improve by the end of the financial year.
- A number of risks are proposed to be reworded, amalgamated or removed from the BAF for the new version in Quarter 1 2018/2019. The narrative for this is given in the section below.

2.3 Supporting Narrative and Proposals in Relation to the BAF Risks

The following narrative supports the current position (dashboard and detail at Appendix 1):

BAF No. 1: That the quality & safety of care we provide across the Trust does not improve in line with our Quality Commitment.
The current risk score is 4 x 3 = 12. This represents deterioration from that reported to the Board in December 2017 (3 x 3 = 9). The reason for the deterioration is a result of reassessment of evidence of assurance by the Interim Director of Nursing. The position is forecast to remain unchanged until Q3 2018/2019 following receipt of robust evidence of implementation of the new Patient Care Improvement Plan across the Trust.

BAF No. 2: That we continue to provide inadequate care for patients attending our Emergency Department (Static score to end of Q4).
As previously reported, the risk scoring shows the score 4 x 2 = 8 continuing for to the end of 2018/2019. This is because whilst improvements have been made, the physical limitations will remain until the capital scheme is concluded.

BAF No. 3: That we continue to provide "inadequate" care for patients of our maternity & neonatal services
The current risk score is 4 x 3 = 12. This represents a static position from that reported to the Board in December 2017. There are however, early indicators that suggest that improvement is being made e.g. NHS Improvement scrutiny was stood

down and merged into the Maternity and Neonatal Task Force. This remains under constant scrutiny and the Trust is awaiting reassessment of this service by the CQC. The forecast is to achieve the target score of 4 x 2 = 8 in Q2 2018/2019.

BAF No. 4 'Integration of community services fails to deliver the required reduction in acute admissions'.
The current risk score of 4 x 2 = 8 represents an improved risk score from that previously reported to the Board. It is proposed that for the 2018/2019 BAF refresh, the risk is removed and a new risk described relating to the delivery of new models of care e.g. 'If we are unable to agree and deliver new models of care with our partners then the local health economy will not be sustainable'.

BAF No. 5 'That our emergency care pathway does not improve resulting in continued delays for patients and poor flow through the hospital'.
The current risk score is 3 x 4 = 12. This represents a static position from that reported to the Board in December 2017. Due to the number of external stakeholders the delivery of the emergency pathway was variable across the year. An improved score of 3 x 3 = 9 is forecast from Q4 2017/2018 and for a steady hold across 2018/2019. The organisation is sighted on the issues and has been assisted by ECIP since January 2018, but is not yet delivering the constitutional standard.

It is proposed that the risk is reworded to the following in the new BAF:
'If improvements are not made to our emergency care pathway, there will be poor patient flow through the hospital, resulting in continued delays for patients & poor patient & staff experience'.

BAF No. 6 'Insufficient capacity leads to inability to deliver the elective national constitutional standards resulting in potential harm to patients'.
The current risk score is 4 x 4 = 16 which represents a static position from that reported to the Board in December 2017. The target score has been revised to reflect a reduced profile of 3 x 3 = 9. The Trust is aiming to achieve an 86% RTT position in the first quarter of 208/2019 as a result of better management of clinics and theatres and thereby improving capacity and the forecast score for the first quarter of next year is therefore an improved position of 3 x 4 = 12. It is forecast that the score will remain at 12 for 2018/2019.

It is proposed that the risk is reworded to the following for the new BAF:
'If there is insufficient capacity within the hospital, then we will not be able to deliver services in line with the national constitutional standards, resulting in potential harm to patients'.

BAF No. 7: 'That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff'.
The current risk score is 4 x 3 = 12 which is a static position to that reported to Board in December 2017. The risk is forecast to remain at 4 x 3 = 12 across 2018/2019 as the actions to address the risk will be longer term in coming to fruition as they are based on the new workforce models.

BAF No. 8: 'That we are not successful in our work to establish a clinically led, engaged and empowered culture'.
The current risk score is 4 x 3 = 12 which is a static position to that reported to Board in December 2017. The risk is forecast to remain at 12 until Quarter 4 2018/2019 when it is forecast that the target score of 4 x 2 = 8 will be achieved.

BAF No. 9 'That the Trust overspends compared to its agreed plan and is unable to deliver future financial sustainability'
The current risk score of 4 x 4 = 16 represents a static position to that reported in December 2017. The risk score has remained at 4 x 4 = 16 because temporary workforce costs remain high and are driving overspends within nursing and to a lesser degree the medical staffing. In addition, the Trust has seen a reduction in non-elective activity (births) and is below plan on outpatient activity. The Trust is yet to agree the 2018/2019 financial plan and the risks regarding delivery of this plan are therefore under review. A forecast position will be provided following agreement of the 2018/2019 plan.

BAF No. 10 'That we cannot deliver our planned programme of hospital estate improvement including ITUY, Neonatal Unit, 2nd Maternity Theate and a plan for the Emergency Department'.
The current risk score of 4 x 3 = 12 represents a static position to that reported to the Board in December 2017. It is forecast that the risk will remain consistent until Quarter 4 2018/2019 when it is anticipated that the full business case for the Emergency Department will have been approved by NHSI. Maternity and the ICCU are both approved and it is proposed that these elements remain on the BAF until capital works are concluded.

BAF No.11 'That our governance remains "inadequate" as assessed under the CQC well-led standard".
The current risk score of 3 x 2 = 6 represents a static position to that reported to the Board in December 2017. It is forecast that the risk will remain at this level until the substantive executive director posts are recruited to and the CQC Well Led inspection has been held.

BAF No. 12 'That the overall strategy does not deliver required changes resulting in services that are not affordable to the local health economy'.
The current risk score of 4 x 2 = 8 represents a static score to that reported in December 2017. The prosed changes in the local systems as outlined in the Case for Change take us a step forward in regard to our integrated service approach. Whilst this clearly complements of strategic delivery, the risk associated will only begin to move once the case for change is approved and the leadership team is established and beings to work through a credible program plan. It is anticipated that this plan will be constricted in early 2018 and form the basis for delivery through the remainder of the coming financial year. It is proposed that for the new BAF this risk is amalgamated with BAF No. 4. above.

BAF No 13. 'That the Service Improvement and Cost Improvement Programme does not deliver the financial impact planned resulting in non-delivery of financial plan'.
The current risk score of 4 x 4 = 16 represents a static position to that reported in December 2017. The outturn for 2017/18 is red due to delayed delivery of productivity (outpatients and theatres). The Trust is yet to agree the 2018/19 financial plan although indications are for the targeted delivery being £13m. Once agreed the forecast for the year will be shown and it is proposed that this becomes part of an overarching financial delivery risk for the new BAF in 2018/2019 thereby amalgamating this risk with BAF risk No. 9. above.

BAF No. 14 'New entrants into the market will succeed in attracting services resulting in income loss to the Trust'.
The current risk score of 4 x 2 = 8 represents a static position from that reported to the Board in December. The risk is now moving towards its target score as we establish an adopted case for change. This will reduce the risk of any additional new entrants into the local health economy as the Trust and its partners agree on a future delivery model together. It is proposed that an amalgamated partnership risk is articulated for the new BAF which will encompass this risk element.

BAF No. 15 'If the Trust does not agree a suitable alliance approach with local health economy partners it will be unable to deliver a sustainable integrated care model'.
The current risk score of 4 x 1 = 4 achieves the target score. Significant progress has been made in this area. A case for change is now being presented to Trust Board and partner organisations. If adopted, this will result in the Trust working towards an integrated system with other providers and commissioners in Walsall.

2.4 Next Steps – BAF

It is proposed that the Board hold a seminar session early in the Quarter 1 2018/2019 to refresh the BAF risk statements in line with the Annual Plan update and taking into consideration the proposals put forward in the narrative above.

3. CORPORATE RISK REGISTER

The Corporate Risk Register has been updated and the detail is shown at Appendix 2. The following key highlights are shown below including the key changes since last reported to the Board in December 2017.

3.1 De-escalation

No risks have been de-escalated since the last report.

3.2 New and Pending Risks

There is one new risk to the register:

- No. 1212 'Failure to successfully deliver the Patient Care Improvement Plan in response to the Care Quality Commission inspection findings'.

3.3 Improved Scores

The following four risks have improved their scores but have not yet been de-escalated:

- No. 201: 'Failure to recognise & respond to the deteriorating patient & those with early signs of sepsis leads to increased incidents of harm to patients including death'. The score has improved from a previous score of 5 x 4 = 20 (red) to 5 x 3 = 15 (red). The risk has been reviewed at the Sepsis / Deteriorating Patient Committee and additional actions identified regarding community training.

- No. 466: 'Non-compliance with Trust Medicines policy & UK law in relation to the supply, storage & recording of controlled drugs'. The risk has reduced in score

from a previous 3 x 5 = 15 (red) to 3 x 4 = 12 (amber). The improvement is a result of some improvements being noted in the controlled drugs audits.

- No. 244: 'Failure to recognise & learn from events that contribute to avoidable deaths & risk an increase in SHMI performance to above 10'. The previous score was 4 x 3 = 12 (amber) with an improved score of 4 x 2 = 8 (amber). The improved position is the result of the increased effectiveness of Mortality Group, and year to date SHMI and HSMR being below 100.

- No. 1009: 'Current gap in knowledge for formulation of medical staffing rotas'. The previous score was 3 x 4 = 12 (amber) with an improved score of 3 x 3 = 9 (amber).

3.4 New Risks

There is one new risk:

- No. 1212 'Failure to successfully deliver the Patient Care Improvement Plan in response to the Care Quality Commission inspection findings'. The risk has been scored at 3 x 2 = 6 (yellow). The target score for the risk is 2 x 2 = 4 (yellow).

3.5 Deteriorating Risks

One risk has deteriorated in score:

- No. 1163 'Increased risk of poor patient experience resulting in loss of trust and patient/ service user dissatisfaction. Increased risk of informal concerns/ complaints raised by patients/ carers as a result of poor experience and low expectation'. The score has deteriorated since the last reporting cycle 3 x 4 = 12 from 3 x 3 = 9.

4. PRIORITIES FOR THE NEXT QUARTER

The following are the key priorities for the first Quarter of 2018/2019:

- Board to hold a seminar session to review the BAF statements and agree changes.
- Dedicated resource to be considered for a review of the Corporate Risk Register.
- Develop the next steps of the Board's risk appetite work.

5. RECOMMENDATION

The Board is requested to consider the content and make any recommendation for further action in relation to the risks.

Appendix 1

WALSALL HEALTHCARE NHS TRUST

BOARD ASSURANCE FRAMEWORK 2017/2018

VERSION 4.0 TRUST BOARD MARCH 8 2018

REF	RISK STATEMENT	MONITORING BOARD COMMITTEE	EXECUTIVE LEAD	CURRENT RISK SCORE MARCH 2018	INITIAL RISK SCORE	TARGET RISK SCORE	MAY 2017 REPORTED SCORE	Q1 OUTTURN SCORE REPORTED AUGUST 2017	Q2 OUTTURN SCORE END SEPT 2017 REPORTED DEC 2017	Q3 OUTTURN SCORE	Q4 FORECAST SCORE	Q1 18/19 FORECAST SCORE	Q2 18/19 FORECAST SCORE	Q3 18/19 FORECAST SCORE	Q4 18/19 FORECAST SCORE	SCORE MOVEMENT DEC 2017 BOARD REPORT TO CURRENT
No. 1	That the quality & safety of care we provide across the Trust does not improve in line with our Quality Commitment.	Quality & Safety	Director of Nursing	4 x 3 = 12	4 x 5 = 20	3 x 2 = 6	4 X 4 = 16	3 x 3 = 9	3 x 3 = 9	4 x 3 = 12	4 x 3 = 12	4 X 3 = 12	4 X 3 = 12	3 X 3 =9	3 X 3 = 9	↑
No. 2	That we continue to provide inadequate care for patients attending our Emergency Department	Quality & Safety	Medical Director	4 x 2 = 8	4 x 5 = 20	4 x 1 = 4	4 X 3 = 12	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	→ ←
No. 3	That we continue to provide "inadequate" care for patients of our maternity & neonatal services.	Quality & Safety	Director of Nursing	4 x 3 = 12	4 x 3 = 12	4 x 2 = 8	4 X 2 = 8	4 x 3 = 12	4 x 3 = 12	4 x 3 =12	4 x 3 = 12	4 x 3 = 12	4 x 2 = 8	4 x 2 = 8	N/A	→ ←
No. 4	Integration of community services fails to deliver the required reduction in acute admissions.	Performance, Finance & Investment	Director of Strategy & Transformation	4 x 2 = 8	4 x 3 = 12	4 x 1 = 4	4 X 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	N/A	N/A	↓
No. 5	That our emergency care pathway does not improve resulting in continued delays for patients & poor flow through the hospital.	Performance, Finance & Investment	Chief Operating Officer	3 x 4 = 12	4 x 5 = 20	2 x 3 = 6	3 X 4 = 12	3 x 4 = 12	3 x 4 = 12	3 x 4 = 12	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	3 x 3 = 9	→ ←
No. 6	Insufficient capacity leads to inability to deliver the elective national constitutional standards (cancer, 18 weeks and diagnostics) resulting in potential harm to patients.	Performance, Finance & Investment	Chief Operating Officer	4 x 4 = 16	4 x 5 = 20	3 x 3 = 9	4 X 5 = 20	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	3 x 4 = 12				→ ←
No. 7	That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff.	People & Organisational Development	Director of Organsiatonal Devleopment & Human Resources	4 x 3 = 12	4 x 4 = 16	3 X 3 = 9	4 X 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	→ ←
No. 8	That we are not successful in our work to establish a clinically-led, engaged & empowered culture.	People & Organisational Development	Director of Organisational Development & Human Resources	4 x 3 = 12	4 x 4 = 16	4 x 2 = 8	4 X 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 2 = 8	→ ←
No. 9	That the Trust overspends compared to its agreed plan & is unable to deliver future financial sustainability.	Performance, Finance & Investment	Director of Finance & Performance	4.x 4 = 16	4 x 5 = 20	4 x 3 = 12	4 X 5 = 20	4 x 5 = 20	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16					→ ←
No. 10	That we cannot deliver our planned programme of hospital estate improvement including ITU, Neonatal Unit, 2nd Maternity Theatre & a plan for Emergency Department	Performance, Finance & Investment	Director of Finance & Performance	4 x 3 = 12	4 x 4 = 16	4 x 2 = 8	4 X 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 X 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 2 = 8	→ ←
No. 11	That our governance remains "inadequate" as assessed under the CQC Well-Led standard	Trust Board	Chief Executive	3 x 2 = 6	4 x 4 = 16	2 x 1 = 2	4 X 3 = 12	4 x 3 = 12	3 x 2 = 6	3 x 2 = 6	3 x 2 = 6	3 x 2 = 6	3 x 2 = 6	N/A	N/A	→ ←
No. 12.	That the overall strategy does not deliver required changes resulting in services that are not affordable to the Local Health Economy.	Trust Board	Director of Strategy & Transformation	4 x 2 = 8	4 x 3 = 12	4 x 1 = 4	4 X 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 2 = 8	4 x 2 = 8	4 x 2 = 8	N/A	N/A	N/A	→ ←
No. 13	That the Service Improvement and Cost Improvement Programme does not deliver the financial impact planned resulting in non-delivery of financial plan.	Performance, Finance & Investment	Director of Finance & Performance	4 x 4 = 16	4 x 4 = 16	4 x 1 = 4	4 X 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16	4 x 4 = 16					→ ←
No. 14.	New entrants into the market will succeed in attracting services resulting in income loss to the Trust.	Performance, Finance & Investment	Director of Strategy & Transformatoin	4 x 2 = 8	4 x 3 = 12	4 x 1 = 4	4 X 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 2 = 8	N/A	N/A	N/A	→ ←
No. 15.	If the Trust does not agree a suitable alliance approach with Local Health Economy partners it will be unable to deliver a sustainable integrated care model.	Trust Board	Director of Strategy & Transformatoin	4 x 1 = 4	4 x 3 = 12	4 x 1 = 4	4 X 3 = 12	4 x 3 = 12	4 x 3 = 12	4 x 2 = 8	4 x 1 = 1	4 x 1 = 4	4 x 1 = 4	N/A	N/A	↓

5 Year Strategic Objective: Provide safe, high quality care across all our services

2 Year Objective: Embed the quality performance & patient experience improvements that we began in 2016/2017.

STRATEGIC RISKS			CURRENT ASSURED LEVEL
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 5 = 20	
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12	
	TARGET RISK SCORE (Impact x Likelihood = Total)	3 x 2 = 6	

What is the strategic risk to be controlled?			
REF	**STRATEGIC RISK**	**EXECUTIVE DIRECTOR OWNER**	**BOARD COMMITTEE OWNER**
BAF No. 1	**That the quality & safety of care we provide across the Trust does not improve in line with the Patient Care Improvememnt Plan.**	**Director of Nursing**	**Quality and Safety Committee**

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	**POTENTIAL CONSEQUENCES OF THE RISK**	
	REF	*What are the key potential consequences (up to 4) of the risk?*
Failure to achieve at least 'requires improvement' on reinspection by CQC	PC1	Impact on ability to control organisation/enforced management changes
Failure to deliver safe, high quality care and experience to patients	PC2	Adverse impact on patient safety, outcomes and experience
Failure to engage staff resulting in poor morale and adversely affecting care	PC3	Adverse impact on staff morale and difficulties in recruitment & retention
IMPACT ON CQC CORE OUTCOMES	PC4	Adverse impact on finances i.e. increase agency costs etc
What are the Outcome Reference Numbers?		

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Failure to engage with staff regarding standards of care
O2	Normalising poor care and systems
O3	Over reliance on temporary staffing - medical and nursing
O4	Over reliance on central controls
O5	Poor preparation for increased activity from boundary changes
O6	Failure to manage risk within a robust governance structure
O7	Variable quality of leadership in some areas
O8	Poor provision of support staff
O9	Poor relationship with some stakeholders
O10	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Improve staff engagement via LiA toolkit and other means of listening
C2	Revised risk management processes
C3	Development of robust workforce plans and recruitment strategies
C4	Development of clinical leadership model and devolved management
C5	Delivery of planned leadership programmes and development
C6	Revised Quality Commitment and Plan
C7	Development of relationships with stakeholders
C8	Delivery of the PCIP and robust monitoring of progress
C9	Taskforce approach for high risk areas
C10	Patient experience strategy and plan

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R1	LiA sponsor group, Q & S Committee	Monthly
R2	Risk Management Committee, TQE, Q&S	Monthly
R3	Trust Workforce Executive, POD	Monthly
R4	Quality Committee monitoring and reports	Monthly
R5	POD	Monthly
R6	Monthly reports to Q&S	Monthly
R7	BCA, CQR, Healthy Walsall Partnership Board Reports	Monthly
R8	Report to Q&S	Monthly
R9	Maternity and ED Taskforces & reporting to Q&S & Divisional Confirm & Challenge Meetings on Quality	Monthly
R10	Reporitng to Q&S	Quarterly

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	PCIP reports monthly		✓		Q&S Committee Papers Jan 2018
A2	Workforce reports monthly	✓			Q&S Committee Papers Jan 2018
A3	Risk Management Committee reports		✓		Risk Mgt Committee Minutes, TQE Highlight Reports
A4	Outcome of Deanery Visit - removal of Level 4 status to a Level 2. (External)			✓	
A5	West Midlands Quality Review Service (External Assurance)			✓	ED, Maternity & Paeds - 13/10/2016 Patient Care & Medicines Mgt - 18/10/2016, Fractured NoF & Urology 01/12/2016, Respiratory 15/12/2016 completed
A6	Senior Nursing and Midwifery Advisory Group and Medical Advisory Committee		✓		Monthly reports.
A7	Reports from Trust Quality Executive Sub Committees		✓		TQE minutes and reports across year
A8	Trust Quality Executive Quality & Safety Committee agenda, papers and minutes		✓		Monthly
A9	Effective Managers Programme - content and attendance & reports to People & OD Committee.		✓		Content & attendance & People & OD Committee Minutes
A10	Organisational Development reports.	✓			People & OD Committee Minutes
A11	Learning culture reports.	✓			People & OD Committee Minutes
A12	Listening into Action reports	✓			People & OD Committee Minutes
A13	Quality Commitment Quarterly Report		✓		Report to Q&S March 2017 & Board April 2017
A14	Quality Account Report 2016-2017		✓		Draft report to Q&S April 2017 Completed
A15	Auditors report - qualified (VTE)			✓	Received June 2017
A16	CQC Visit and initial feedback			✓	CQC 01/06/2017
A17	CQC final report - move to requires improvement but remain in special measures			✓	CQC Inspectoin Report 01/12/2017
A18	NHSI Scrutiny meetings completed and moved into Maternity Taskforce from March 18			✓	Minutes & Reports from NHSi 01/02/2018
A19	CQC Monthly Engagement Meetings Continue			✓	Minutes & Reports from CQC 2018
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	Workforce plans not yet complete	Continue to work with Teams of Three (see workforce risk BAF)	End April 2018 in line with Annual Plan update
G2	Medical and Nursing, Staff recruitment and retention and agency use remains a risk.	Delivery of Safe Staffing, agency recovery plan, recruitment and retention plan as agreed at Executive Team Meeting and Performance, Finance & Investment Committee and Quality and Safety Committee.	Sep-18
G3	Lack of robust plan for VTE monitoring assurance	Medical Director has a recovery plan in place	31st March 18
G4	Lack of robust plan for sepsis monitoring and assurance	Medical Director has a recovery plan in place, and this is being enacted through the Infection Prevention and Control Committee	31st March 18
G5	Limited progress on urology improvement plan	Medical Director and DD for Surgery to review plan & report to Executive Team Meeting.	31st March 18
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Provide safe, high quality care across all our services

2 Year Objective: Embed the quality performance and patient experience improvements that we began in 2016/2017.

STRATEGIC RISKS				CURRENT ASSURED LEVEL (RAG)
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 5 = 20		
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 2 = 8		
	TARGET RISK SCORE (Impact x Likelihood = Total)	4 x 1 = 4		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 2	That we continue to provide "inadequate" care for patients attending our Emergency Department.	Medical Director	Quality & Safety Committee	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*
Failure to improve CQC ratings for ED and for the Trust.
Failure to improve patient experience in ED.
Failure to improve staff experience and morale in ED.
IMPACT ON CQC CORE OUTCOMES
What are the Outcome Reference Numbers?
TBC

POTENTIAL CONSEQUENCES OF THE RISK	
REF	*What are the key potential consequences (up to 4) of the risk?*
PC1	Poor patient experience for patients attending ED including long waits for admission and overcrowding.
PC2	Gaps in medical and nurse staffing resulting in high agency expenditure.
PC3	Failure to deliver agreed 4 hour wait improvement trajectory.
PC4	Potential poor care for children attending ED if these issues not addressed.

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Failure to recruit, retain and develop sustainable team of ED medical staff.
O2	Failure to recruit, retain and develop sustainable team of ED nursing and other support staff.
O3	ED environment small and poorly laid out for the number of patients currently seen.
O4	Lack of adequate environment and specialist staffing for children.
O5	Increase in ED attendances and especially increase in ambulance arrivals at the Trust.
O6	Poor co-ordination between ED and Out of Hours / Urgent Care Centre (provided by Primecare) at initial arrival.
O7	Lack of consistent focus by the team on key clinical processes (e.g. triage, pain relief, comfort rounds).
O8	
O9	
O10	

The risks are CONTROLLED by…

What are the key controls and actions (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	ED & Emergency Care Taskforce established and action plan for 2016/17 agreed.
C2	Workforce plan for nursing team in ED
C3	Trained paediatric nursing in place in ED & separate paediatric area established.
C4	ED team undertake regular audits of triage scores, pain relief, handover documentation and comfort rounds.
C5	Nurse delivered clinical streaming arrangements in place & agreed with Primecare and CCG.
C6	Response to data capture generated by electronic Friends & Family Test information.
C7	Plans for development of the Emergency Department have now been approved by the Trust Board
C8	
C9	
C10	

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R1	ED Dashboard at Taskforce. Taskforce report to Q&S.	Monthly
R2	ED Dashboard at Taskforce. Taskforce report to Q&S.	Monthly
R3	ED Dashboard at Taskforce. Taskforce report to Q&S.	Monthly
R4	Monthly audit of results to ED Taskforce, CCG & NHSI.	Monthly
R5	ED Dashboard at Taskforce. Taskforce report to Q&S.	Monthly
R6	ED Dashboard at Taskforce. Taskforce report to Q&S.	Monthly
R7		
R8		
R9		
R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	ED CQC Deep Dive report presented to Q&S Cttee and CQC Quality Oversight Group			✓	Q&S March 2016 Ref 317/15
A2	CQC Warning Notice Update presented to Q&S Cttee and Quality Oversight Group		✓		Q&S May 2016 Ref 29/16
A3	Monthly Taskforce progress report to Quality & Safety Committee		✓		Q&S Sep 2016
A4	Deanery visit (Medicine) resulting in de-escalation from Level 4 to Level 2 (External)			✓	Deanery Report
A5	Safety Round Audit Results		✓		Audit Results
A6	CQC pre-inspection by NHSI March 2017			✓	Report to Board April 2017
A7	CQC Initial Feedback from Re-inspection			✓	Initial verbal update
A8	ACP staff in place and reconfiguration of bed stock completed	✓	✓		Wards physically moved
A9					
A10					
A11					
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	Medical workforce plans agreed but being reviewed due to recruitment problems.	ACP's in place, A & E Business Plan for staffing to be presented to the March Task Force	Mar-18
G2	ED estate development plan & Strategic Outline Case.	OBC approved at the November Trust Board, approval received from NHSI & full business case to be developed for Trust Board approval.	May-18
G3			
G4			
G5			
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Provide safe, high quality care across all our services

2 Year Objective: Embed the quality performance & patient experience improvements that we began in 2016/2017.

STRATEGIC RISKS				CURRENT ASSURED LEVEL
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12		
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12		
	TARGET RISK SCORE (Impact x Likelihood = Total)	4 x 2 = 8		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 3	That we continue to provide "inadequate" care for out maternity and neonatal services	Director of Nursing	Quality & Safety Committee	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
	REF	*What are the key potential consequences (up to 4) of the risk?*
Failure to improve CQC rating for maternity	PC1	Safety and experience of women and neonates continues to be poor
Failure to improve quality, safety and experience for patients in maternity	PC2	Inability to recruit and retain staff leading to workforce gaps
Failure to improve staff experience in maternity	PC3	Reputational damage
IMPACT ON CQC CORE OUTCOMES		
What are the Outcome Reference Numbers?	PC4	Continued poor CQC rating

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Inadequate midwifery staffing levels
O2	Poorly led and developed midwifery service
O3	Largely medicalised model of maternity care
O4	workforce not engaged with wider Trust
O5	Poor communication between maternity leadership and Trust Board
O6	Inadequate paediatric and neonatal staffing levels, rotas and development
O7	Environmental constraints
O8	Increased service demand
O9	
O10	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	CONTROL	REF	REPORTING MECHANISM	FREQUENCY
C1	Maternity and neonatal taskforce and action plan (NHSi have stood down scrutiny meetings and merged membership into the Taskforce from March 2018	R1	Maternity dashboard reviewed at taskforce	Monthly
C2	Workforce Plan Midwifery	R2	Action plan reviewed at taskforce	Monthly
C3	Workforce Plan Paediatrics/Neonates (work to commence on new neonatal unit April 2018, including second maternity theatres)	R3	Estates Plan reviewed at taskforce	Monthly
C4	Capping' births in place	R4	Revised care model reviewed at taskforce	Monthly
C5	Normalising Strategy	R5	Maternity Taskforce	Monthly
C6	Additional midwives recruited	R6	Taskforce report reviewed at Quality and Safety Committee and Trust	Monthly
C7	Head of Midwifery, matrons and CD in post. New Deputy Head of Midwifery appointed on an initial 6 months secondment in December 2017 to provide additional midwifery leadership and support	R7	Staff Survery; CQC Engagement Meetings.	Annual; monthly.
C8	Organisational Development/Culture Change plan. Edgcumbe work has commneced	R8	External visits to maternity	Adhoc
C9	Plan for Specialist Midwives	R9	Internal visits to maternity/neonates	Adhoc
C10	New Clinical Director in post supported 1 day a week by senior clinician from BWH	R10	Maternity Taskforce	Monthly

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	Maternity CQC deep dive presented to Quality & Safety Committee and Quality Oversight Group		✓		Quality & Safety Committee - 31/03/2016 Minute ref 315/15
A2	NHS Improvement Visit (External)			✓	20th April 2016
A3	Section 29a Internal Review	✓			Q&S May 2016 Ref 29/16.
A4	Fortnightly Task & Finish Group Confirm & Challenge		✓		05/12/2016
A5	CQC Section 29a report to Quality & Safety Committee and Quality Oversight Group		✓		Quality & Safety Committee - 24/11/2016 Minute ref 179/16 Quality Oversight Meeting 13/12/2016 Minute ref Item 6. Update received monthly to Q&S via Maternity Taskforce Update
A6	Monthly taskforce report to Quality & Safety Committee, NHSi scrutiny committee has been stepped down and merged into Taskforce from March 2018		✓		Monthly report to Trust Board & Divisional Quality board
A7	CQC Walkabout 05/01/2017			✓	
A8	Maternity Dashboard received monthly at Taskforce meetings		✓		16/02/2018
A9	Development events taken place	✓			Edgcumbe work commmenced Dec 2017
A10	Visit for Zoe Penn, Obstetrician from Chelsea & Westminster Hospital			✓	07/12/2016
A11	WMQRS visits/Review completed.			✓	13/10/2016
A12	NHS Improvement Pre-CQC Visit			✓	Apr-17
A13	CCG Deep Dive / Stress Test			✓	Quarter 1 2017
A14	Monthly Oversight Committee			✓	Since early 2016
A15	Executive / Trust Board Visits	✓			Adhoc
A16	RCOG Review			✓	Visit took place Oct 17, Report Received Feb 2018
A17	Regional Head of Midwifery Peer Review Visit			✓	Visit took place January 2018
A18	Monthly CQC engagement meetings continue			✓	
A19	Section 29A Warning notice requirements previously reported weekly now stepped down to monthly by CQC from Jan 2018			✓	
A20	Secured funding for maternity support workers from HEE			✓	

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	CQC Revisit June 2017 lack of progress	Revise action plan monitored monthly through Maternity Taskforce	Jul-18
G2	Gaps in workforce -> staffing levels impact	Plan to mitigate risk - closure of MLU, shift and leave cover, backfill midwives. MLU remains closed in line with review undertaken Jan 2018 supported by CCG and reported to CQC and NHSi , for review end April 2018	May-18
G3	Negative culture remains	OD plan to be revised, Edgcumbe work implemented, awaiting feedback	Mar-18
G4	Neonatal Network Review undertaken Jan 2018 raised serious concer with staffing against BAMF)	Action Plan in progress	Mar-18
G5	RCOG report received, whilst shows some progress outlines further actions required	Recommnedations being added to maternity inmprovement plan	Jun-18
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Care for patients at home whenever we can:

2 Year Objective: With local partners change models of care to keep hospital activity at no more than 2016/2017 outturn.

STRATEGIC RISKS				CURRENT ASSURED LEVEL (RAG)
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12		
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 2 = 8		
	TARGET RISK SCORE (Impact x Likelihood = Total)	4 x 1 = 4		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 4	Integration of community services fails to deliver the required reduction in acute admissions.	Director of Transformation and Strategy	Quality & Safety	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
Care Closer to home potential not being realised and implemented	REF	*What are the key potential consequences (up to 4) of the risk?*
Community/acute teams working in isolation	PC1	Patients being admitted into acute care who could have been safely treated at home resulting in unnecessary demand on acute
Risk Stratification - Failure to meet challenges of growing demographic needs	PC2	Patients length of stay in community bedded areas increasing
IMPACT ON CQC CORE OUTCOMES	PC3	Potential to miss the most at need population for case management
What are the Outcome Reference Numbers?	PC4	Community demand exceeding clinical capacity available
TBC		

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Consultant outreach minimal
O2	Financial challenges prevents investment in technology
O3	Engagement from key stakeholders internally and externally
O4	Reduced bed flow through community beds
O5	Poor knowledge base of high users of the acute services
O6	Lack of awareness by hospital teams of community pathways available
O7	Estate availability to be able to develop integrated locality teams
O8	No Single point of access for community services
O9	Failure to deliver integrated record with partners
O10	Recruitment into community posts challenging, capacity not meeting demand

The risks are CONTROLLED by…

What are the key controls and actions (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Community Care Group Clinical Lead appointed which adds GP dimension (skillset) to MDTs.
C2	Integrated dashboard across all partners.
C3	Walsall Together partnership, workstreams.
C4	Integrated teams, Community Care Group, FES pathways
C5	Development of 7 Place Based Teams for Walsall serving population 30,000 to 50,000.
C6	Dedicated pathway for frail & elderly patients.
C7	Deployment of phased mobile technology to locality teams.
C8	
C9	
C10	

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R1	MDTs	Monthly/fortnightly
R2	Programme Group	Monthly
R3	WT Integrated dashboard	Monthly/fortnightly
R4		
R5	MDTs with local health economy partners. KPIs to Performance & Finance	Monthly
R6	Admissions avoidance distributed to Executive Team & CCG	Daily
R7	Update to Finance & Performance Executive & PFIC	Monthly
R8		
R9		
R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	CQC rating Good for community services			✓	CQC REPORT
A2	WMQR Frailty - positive outcome, no concerns			✓	WMQR REPORT circulated 2016.
A3	Programme dashboard - Place Based Teams	✓			DASHBOARD & programme pack for Walsall Together.
A4	Continued investment into community services from CCG 2013/14 - 2017/2018 e.g. £800k for mobile technology.		✓	✓	December 2016 Board reports.
A5	Walsall Together Partnership Board		✓	✓	Trust Board reports & Partnership Board Reports.
A6	Walsall Together Provider Board			✓	Monthly Meeting Pack
A7	Sustainability & Transformatoin Plan.			✓	March 2017 Board Report.
A8	Community and partnership updates to Trust Board	✓			Various board reports in 17/18
A9	Work plan to commence primary care MDT's	✓			Partnership Board Report
A10	Intermediate care model commened with Local Authority and	✓	✓		Exec Committee and Trust Board papers
A11					
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	Community estates - capacity for integrated working	Review completed on the suitability of estates for placed based team - $ site are not able to accommodate large scale teams - Discussion ongoing with options with the Local Estates Forum	May-18
G2	Whole system MDT arrangments with GP's	There has been resistence to adopting whole system MDT's in primary care. To this end we are undertaking 7 pilot MDT's to provide a line of sight to the benefits and establish a clear audit trail of what works and what doesn't before the next roll out is proposed.	May-18
G3	Not all admissions are pt's that are known to the community teams	Audit underway to understand what proportion of acute addmissions are known to locality teams. From this data we can they assess the opportunity from the community program	May-18
G4			
G5			
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Provide Safe High Quality Care Across All Our Services
2 Year Objective: Embed the quality performance & patient experience improvements that we began in 2016/2017
5 Year Strategic Objective: Working Closely with Partners in Walsall and Surrounding Areas
2 Year Objective: With local partners change models of care to keep hospital activity at no more than 2016/2017 outturn.

STRATEGIC RISKS				
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 5= 20		CURRENT ASSURED LEVEL
	CURRENT RISK SCORE (Impact x Likelihood = Total)	3 x 4 = 12		
	TARGET RISK SCORE (Impact x Lielihood = Total)	2 x 3 = 6		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 5	That our emergency care pathway does not improve resulting in continued delays for patients and poor flow through the hospital	Chief Operating Officer	PFIC	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
Failure to improve CQC ratings in relation to Emergency Department and medical wards	REF	*What are the key potential consequences (up to 4) of the risk?*
Fai to improve patient experience in the Emergency Department, Assessment Units and wards	PC1	Poor patient experience - long waits in emergency department
Failure to meet constitutional standards	PC2	Poor staff experience linked to operational pressures on wards, assessment units and the emergency department
IMPACT ON CQC CORE OUTCOMES	PC3	Reliance on additional capacity which has cost, staff and potential safety risks associated with opening these areas
What are the Outcome Reference Numbers?	PC4	Failure to meet service transformation fund 4hr emergency care trajectory.

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Lack of robust capacity and demand planning to underpin service models in hospital and across health system
O2	Historic staffing issues, especially vacancies and reliance on bank/agency medical, nursing and therapy teams
O3	Discharge processes weak; low discharges early in the day and at weekends
O4	Increasing demand trends
O5	Whole system pathways not responding to variations in demand
O6	High numbers of medically fit for discharge patients (but have relatively low formal delayed transfers of care)
O7	Discharge to assess model not robustly established
O8	Cultural response to implementation of initiatives
O9	Higher than planned length of stay
O10	Insufficient recognition Trust wide that flow is everyone's responsibility - inconsistent approaches in place

The risks are CONTROLLED by…		The REPORTING mechanisms are…		
What are the key controls (up to 10) that are in place to mitigate these risks?		*What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.*		
REF	CONTROL	REF	REPORTING MECHANISM	FREQUENCY
C1	Whole health system recovery plan, sponsored by the A&E Delivery Board	R1	A&E Delivery Board	Monthly
C2	Weekly meeting including Social Care and CCG to monitor & manage medically fit list.	R2	Medically fit for discharge list to Chief Officers of Local Health Economy.	Twice per week
C3	Daily bed management meetings to oversee flow of patients through the hospital & continued use of new bed management structure.	R3	Bed State & Daily Plan to Chief Operating Officer.	Daily
C4	Bi-monthly divisional performance review.	R4	Dashboard to Executive Team.	Bi-monthly
C5	Red & Green days on all wards - supported by NHS England Team	R5	Performance Report to Board	Monthly
C6	Emergency Care Improvement Plan written to achieve key targets for 17/18	R6	Weekly review with team and DoS and COO	Weekly
C7	Discharge to assess model agreed across the local health economy for September implementation and staff integration implemented in November.	R7	A+E Delivery Board	Monthly
C8	Winter funding secured via STP to the value of £581,272	R8	A+E Delivery Board	Monthly
C9	Weekly executive meeting.	R9	Performance Dashboard	Weekly
C10	ECIP supporting Trust from January 2018	R10	A & E Delivery Board	Monthly

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	WMQRS visit in November 2016 & review of all systems & provision of advice			✓	
A2	CCG ED joint audit of admission avoidance & admissions joint working			✓	WMQRS Report
A3	NHSI safety visit on 27/11/2017			✓	NHSI summary
A4	Daily monitoring of LOS and discharges	✓			Daily reports
A5	ECIP Feedback to Trust Executive Meeting 20/02/2018			✓	Executive Team Minutes
A6					
A7					
A8					
A9					
A10					
A11					
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	SAFER bundle implementation plan is not delivering the outcomes as expected	Review with ECIP for action plan relaunch.	Feb-18
G2	Robust plan for change in Discharge to Assess model not yet in place - led by Social Care on behalf of A&E Delivery Board	Business case drawn up by Local Health Economy Project Director for A&E Delivery Board but not yet seeing benefits. Being reviewed by ECIP.	Feb-18
G3	MFFD was not consistently below 80	Community teams and IDT integrated with Director Intermediate Care	Nov-17
G4			
G5			
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Provide Safe High Quality Care Across All Our Services

2 Year objective: embed the quality performance & patient experience improvements that we began in 2016/2017

5 Year Strategic Objective: Working Closely with Partners in Walsall and Surrounding Areas

2 Year objective: with local partners change models of care to keep hospital activity at no more than the 2016/2017 outturn.

STRATEGIC RISKS				CURRENT ASSURED LEVEL
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 5 = 20		
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16		
	TARGET RISK SCORE (Impact x Likelihood = Total)	3 x 3 = 9		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 6	**Insufficient capacity leads to inability to deliver the national constitutional standards resulting in potential harm to patients.**	Chief Operating Officer	PFIC	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
Fail to improve quality of service to patients	REF	*What are the key potential consequences (up to 4) of the risk?*
Fail to meet constitutional standards	PC1	Patients have risk of harm linked to delays in receiving care
Offer poor patient experience	PC2	Delays offer poor patient experience
IMPACT ON CQC CORE OUTCOMES	PC3	Failure to meet service transformation fund requirements
What are the Outcome Reference Numbers?	PC4	Financial/contractual implications from not achieving relevant standards

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Historic migration to new patient administration system
O2	Poor processes to manage to data quality
O3	Staff knowledge/understanding of RTT 'rules'
O4	No specialty level capacity and demand plans using best practice models
O5	Multiple historic recovery plans based upon poor data
O6	Booking processes lead to high levels of DNAs
O7	Inconsistent processes to manage patient tracking lists (RTT & Cancer)
O8	Poor processes to support the management of outpatient clinics, e.g. delays in out coming patients
O9	
O10	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Elective Access Performance Group established with the Local Health economy & NHSE to monitor recovery actions
C2	Weekly meeting of Directors of Operations reporting on performance to Chief Operating Officer.
C3	Weekly PTL meeting managed by Director of Operations with divisions.
C4	
C5	
C6	
C7	
C8	
C9	
C10	

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R1	Detailed reporting of dashboards to Elective Access Performance Group	Monthly
R2	Update reports.	Weekly
R3	PTLs received & escalated to weekly update meeting with Chief Operating officer.	Weekly
R4		
R5		
R6		
R7		
R8		
R9		
R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	Monthly progress reports to Performance Finance and Investment Committee		✓		April 2017 report.
A2	Monthly progress reports to Board		✓		May 2017 Board report
A3	Clinical Harm Group review outcomes reported to Medical Director & Elective Access Performance Group.	✓			Minutes of Clinical Harm Group
A4	Intensive Support Team review of data quality report to PFIC			✓	PFIC report & minutes November 2016
A5					
A6					
A7					
A8					
A9					
A10					
A11					
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	RTT recovery plans for all specialties for 2017/2018 but capacity not covered due to sickness.	Developing outpatient and theatre utilisation workstreams to better utilise capacity.	Mar-18
G2	Key specialities struggling to balance capacity & delivery.	Respiratory Risk Summit outcomes to be actioned .	Feb-17
G3	RTT demand with Cancer demand and eg ENT, Respiratory	ENT Risk Summit to be called with MD	Feb-17
G4			
G5			
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Provide safe, high quality care across all our services
2 Year Objective: Embed the quality performance and patient experience improvements that we began in 2016//2017
5 Year Strategic Objective: Value Our Colleagues so They Recommend Us as a Place to Work:
2 Year Objective: Ensure all colleagues feel valued and are integrated to the wider teams
5 Year Strategic Objective: Use Resources Well to Ensure we are Sustainable:
2 Year Objective: Explore all options for cost effectiveness.
2 Year Objective: Deploy our staff where patients benefit most.

STRATEGIC RISKS	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16	CURRENT ASSURED LEVEL
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12	
	TARGET RISK SCORE (Impact x Likelihood = Total)	3 x 3 = 9	

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
REF	STRATEGIC RISK		
BAF No. 7	That we cannot deliver safe, sustainable staffing levels reducing our reliance upon expensive agency staff.	Director of Organisational Development & Human Resources	People & Organisational Development Committee

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
Failure to deliver safe, high quality care and experience to patients	REF	*What are the key potential consequences (up to 4) of the risk?*
Failure to engage staff resulting in poor morale and adversely affecting care.	PC1	Higher agency levels potentially increase the risk of poor safe and quality service provision.
	PC2	Gaps in medical and nurse staffing resulting in high agency expenditure
	PC3	Adverse impact upon on staff morale and difficulties in retention and recruitment.
IMPACT ON CQC CORE OUTCOMES	PC4	Adverse impact upon finances e.g. continued high agency and locum costs
What are the Outcome Reference Numbers?		

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Inability to recruit and retain nursing staff in key specialty areas e.g. Midwifery
O2	Inability to recruit and retain Medical staff in key specialty areas e.g. Emergency Care in line with national shortages
O3	Over dependence upon temporary staffing and bank provision
O4	Variable quality of leadership in some control areas
O5	
O6	
O7	
O8	
O9	
O10	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	
C2	Annual workforce and recruitment plans.
C3	Recruiting Medical staff from overseas: Memorandum of Understanding with Pakistan College of Surgeons
C4	Frequent monitoring of nurse staffing levels against establishment.
C5	Transformation Lead overseas construction of workforce plan.
C6	Multi-layered and timely approval process through the Director and Nursing hierarchy established.
C7	Increase in Nurse Bank pay rate from 01/09/2017
C8	
C9	
C10	

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R1		
R2	Trust Workforce Executive & POD	Monthly
R3	Trust Workforce Executive & POD	Bi-monthly
R4	PFIC	Monthly
R6	Trust Workforce Executive & POD	Monthly & Bi-Monthly
R7	Trust Executive Team Meeting & PFIC	Weekly and Monthly
R10	Executive Team Meeting	Ad-hoc
R8		
R9		
R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	Spike ini Q4 on agency usage resulted in significantly enhanced control mechanisms which are demonstrating immediate reductions. Reported to PFIC monthly and NHSI weekly.		✓	✓	PFIC Reports Monthly.
A2	Review of progress and anticipated recruitment recruitment for international nurses updated.	✓			Ad-hoc & Executive Team Meeting.
A3	CCG Unannounced visits			✓	TQE reports
A4	NHSI Agency Review			✓	Quarterly Meetings
A5	Increased staffing resource on internal bank following rate uplift		✓		Board and Committee Minutes Nov 2017
A6	Achieving movement of agency medical locums onto bank	✓			
A7	Workforce Strategy approved		✓		Trust Board Report Oct 2017
A8	Nursing establishment review will ensure appropriate staffing levels	✓			Weekly reporting to executive team and included in PFIC reports.
A9					
A10					
A11					
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	Trust workforce plan reflecting new models of working.	Plan progress monitored through Trust Workforce Executive and POD.	Aug-18
G2			
G3			
G4			
G5			
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Value Our Colleagues so They Recommend Us as a Place to Work:
Ensure all colleagues are valued and feel integrated to the wider teams

STRATEGIC RISKS				
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16		CURRENT ASSURED LEVEL
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12		
	TARGET RISK SCORE (Impact x Likelihood = Total)	4 x 2 = 8		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 8	That we are not successful in our work to establish a clinically-led, engaged and empowered culture.	Director of OD & HR	People & Organisational Development Committee	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
Negative impact on patient care	REF	*What are the key potential consequences (up to 4) of the risk?*
Negative impact on recruitment and retention of staff	PC1	Lower quality of clinical care
	PC2	More adverse incidents
IMPACT ON CQC CORE OUTCOMES	PC3	Low morale of staff
What are the Outcome Reference Numbers?	PC4	

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	
O2	Lack of leadership development
O3	Lack of exposure to best practice
O4	Lack of strategy to engage clinicians
O5	Top down centralised approach in response to operational pressures.
O6	New computer system led to disengaged staff
O7	Poor outpatient processes
O8	CIP of back office staff without consideration of impact on Clinicians and patients.
O9	
O10	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Implementation & evaluation of Kings Fund Development Programme.
C2	Continuing staff survey, Pulse surveys and engagement and LIA initiatives.
C3	Continuing development for clinical leaders.
C4	Staff survey Action plan
C5	Refreshed Values linked to behaviours.
C6	Established group of Engagents
C7	Call to action working group
C8	360 Degree Appraisals Commenced at Trust Board and Executive Team Level, followed by cascade through organisation.
C9	
C10	

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R2	Trust Workforce Executive & POD	Monthly
R3	Trust Workforce Executive & POD	Monthly
R4	PoD	Monthly
R5	PoD	Bi-monthly
R6	Trust Workforce Executive & POD & Trust Board	Monthly
	Trust Workforce Executive & POD	Monthly
R8	Trust Workforce Executive	Monthly
R9	POD & Trust Board	Annually
R9		
R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	Bi-monthly reports to POD.		✓		Bi-monthly committee reports & minutes.
A2	Regular Pulse checks	✓			Trust Workforce Executive & POD
A3	Programme of Confidential Feedback Arising from completed listening events by 31 March 2018		✓		Confidential verbal feedback to POD & Board
A4	Outcomes in Q4 from SJ Focus Group information and actioned accordingly demonstrating active listening.		✓		
A5	Interventions in target areas based on Pulse survey outcomes and exit interviews, triangulated with SJ Focus Group outcomes	✓			
A6	Workforce Strategy approved.		✓		Trust Board Report & Minutes Oct 17
A7	360 Degree Appraisal for Divisional Directors		✓		Acknowledgement of Completion at POD & Trust board
A8	Confidential draft staff survey outcome report received and communicated to celebrate improvements.		✓		POD
A9					
A10					
A11					
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	Temporary uncertainty about change in CEO.	New CEO commences 26th February 2018.	Feb-18
G2	Workforce plans	Work in progress	Aug-18
G3	Interim Executive Directors	Recruitment of substantive executive directors.	Aug-18
G4			
G5			
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Use Our Resources Well to Ensure we are Sustainable:

2 Year Objective: Use our resources at their optimum.

2 Year Objective: Explore all options for cost effectiveness

STRATEGIC RISKS			CURRENT ASSURED LEVEL
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 5 = 20	
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16	
	TARGET RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12	

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 9	That the Trust overspends compared to its agreed plan & is unable to deliver future sustainability.	Director of Finance	Performance, Finance & Investment Committee	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	REF	*What are the key potential consequences (up to 4) of the risk?*
Objective 10 - Deliver the Trust's financial plan	PC1	Depletion of cash resources
Objective 5 - Substantive workforce to reduce agency staff	PC2	Inability to pay creditors
Objective 11 - Delivery of efficiency programme (£9.3m savings)	PC3	Failure in the statutory responsibility of the Board to deliver a break-even three year financial outturn.
IMPACT ON CQC CORE OUTCOMES		
What are the Outcome Reference Numbers?	PC4	

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Inability to attainment Cost Improvement Programs
O2	Requirement to deliver the NHS offer (A&E 4 hours, Deferral to Treatment 18 weeks and Cancer 62 days) leadis to the opening of additional capacity and costs associated with waiting list initiatives.
O3	Temporary workforce expenditure leading to overspends.
O4	Underperformance of clinical activity leading to reductoins in income.
O5	Investments into quality do not generate additional income to offset the investment.
O6	
O7	
O8	
O9	
O10	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Annual Financial Plan signed off at Trust Board and budgeted allocations signed off by team of three for each Division
C2	Actual expenditure compared to budgets monthly, split by Trust, Divisions and areas within the Trust
C3	Monthly forecast outturn produced based on run rates and known future events to model finances
C4	Temporary workforce controls established & maintained by Director of Organisational Development & Human Resources
C5	Trust has entered the Financial Improvement Programme (2) with KPMG. The programme produces key workstream and KPI data to assure delivery of productivity and financial cost benefits.
C6	Robust CIP model developed and reports produced monthly detailing performance against plan by scheme, Division and at Trust level (see separate BAF risk)
C7	Quarterly divisional reviews with monthly escalation to Director of Finance & Performance & Chief Operating Officer
C8	Creation of a vacancy control panel to authorise advertisements to vacant roles.
C9	Non-pay exependiture controls include weekly review of all orders placed for discretionary expenditure items.
C10	

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R1	Finance report produced for Executive, Performance, Investment & Finance Committee (PFIC) and Trust Board	Monthly
R2	Summary financial report presented to PFIC to include forecast monthly / quarterly deep dive.	Monthly & Quarterly in depth
R3	Finance report produced for Executive, Performance, Investment & Finance Committee (PFIC) and Trust Board	Monthly
R4	Expenditure on temporary workforce reported separately at PFIC.	Monthly
R5	Performance & Finance Executive and Performance, Finance & Investment Committee.	Bi-weekly; Monthly.
R6	CIP delivery reported monthly through Executive to PFIC & onwards to the Trust Board	Monthly
R7	Recovery plans explored at excutive meeting.	Quarterly/monthly
R8	Performance & Finance Executive and Performance, Finance & Investment Committee.	Bi-weekly; Monthly.
R9	Performance & Finance Executive and Performance, Finance & Investment Committee.	Bi-weekly; Monthly.
R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	Financial Plan endorsed through the Trust Board		✓		Trust Board reports.
A2	Monthly finance report recevied by Executive, PFIC and Trust Board		✓		Executive, PFIC & Trust Board minutes & Papers
A3	CIP reported performance to Executive, PFIC & Trust Board		✓		Executive, PFIC & Trust Board minutes & Papers
A4	Forecast financial modelling completed and reported the Executive and PFIC		✓		Executive, PFIC & Trust Board minutes & Papers
A5	Forecast presentation with key actions adopted through PFIC & Trust Board		✓		Executive, PFIC & Trust Board minutes & Papers
A6	Agreed agency expenditure profile for the year		✓		Executive, PFIC & Trust Board minutes & Papers
A7	KPMG engaged within FIP (2) NHSI programme			✓	Findings to Executive, PFIC & Trust Board in August & September 2017.
A8	Financial Recovery Plan adopted by Trust Board (FRP)	✓	✓		Findings to Executive, PFIC & Trust Board in September and October 2017
A9	FRP supported by KPMG (conclusions and actions)			✓	September to October 2017
A10	Performance & Finance Executive meeting bi-monthly to review improvement workstreams and delivery of financial recovery plan actions / trajectories (Divisions in attendance).	✓	✓		Board minute
A11					
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	Capacity modelling for delivery of A&E 4 hour wait	Plans being developed & tested with local health economy partners. Further wortk ongoing within Elective Access Recovery Group (EAPG).	Mar-18
G2	Temporary worker expenditure (in particular agency) plan for reduction by calendar month required	Detailed action plan and impact assessment to be undertaken and expenditure monitored against this plan during the financial year. Plan presented and owned by Executive lead and Divisional profiles completed by Divisional teams, further work planned to accomodate the closure of an additional medical ward.	Mar-18
G3	Identification & delivery of CIP with particular focus on recurrent savings.	Divisions to detail CIP modelling and implementation with reporting through PMO Director.	Apr-18
G4	Clinical income, delivery of contractual income	Capacity modelling to be undertaken within the Director of Strategy team to assure sufficient capacity exists to deliver the levels of activity by speciality included within the contract. Ongoing performance against contractual activity targets to be agreed. Links to improvement programme workstreams to deliver enhanced theatres and outpatients utilisation.	Apr-18
G5	Financial Recovery Plan improvements	Indicated gains required through enhanced productivity for outpatients and theatres (in house utilisation) show potential for enhanced utilisation and income gain with reductions in Waiting List Initiatives. The benefits require delivery in the remainder of the financial year and updates will be required to assure delivery.	Apr-18
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Use Our Resources Well to Ensure we are Sustainable:
Use our resources at their optimum.
Explore all options for cost effectiveness
5 Year Strategic Objective: Provide safe, high quality care across all our services
Ensure Services are Safe

STRATEGIC RISKS			CURRENT ASSURED LEVEL
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16	
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12	
	TARGET RISK SCORE (Impact x Likelihood = Total)	4 x 2 = 8	

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 10.	That we can't deliver our planned programme of hospital estate improvement including ITU, neonatal unit, second maternity theatre and a plan for ED	Director of Finance	Trust Board	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
	REF	*What are the key potential consequences (up to 4) of the risk?*
Failure to improve CQC ratings	PC1	Estates not fit for purpose for patients and staff.
Unable to meet financial plans	PC2	Not compliant with national standards
Lack of fit for purpose estate.	PC3	Failure to provide sustainable services
IMPACT ON CQC CORE OUTCOMES		
What are the Outcome Reference Numbers?	PC4	Lose staff to other organisations

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Constraints of physical estate to enable build
O2	Failure to achieve value for money
O3	Timeframe limitations due to complexity and size of projects
O4	Gaining approval from our regulator to include external finance to support material capital project development
O5	Support from the Black Country STP for the development need to support future service provision / configuration
O6	
O7	
O8	
O9	
O10	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Capital Project Managers in post.
C2	Legal support for contract review & variations.
C3	Funding & Business cases for ICCU in place
C4	Bi-weekly meeting with the regulator to agree business case development, timetable and debate contents / issues
C5	Regular updates to Executive Team, PFIC & Trust Board
C6	
C7	
C8	
C9	
C10	

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R1	Project Board	Fortnightly
R2	Reports to Board	At least quaterly
R3	Reports to Board	February and March 2017
R4	Reports to NHSI	Monthly
R5	Reports & Minutes to Committees and Board	Monthly
R6		
R7		
R8		
R9		
R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.
Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.
Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.
Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	ICCU approval by NHSI			✓	Board Minute Extraordinary Board March 21st 2017 for contract signing.
A2	Submission of ICCU Business Case to Board and approval		✓		2013, 2016 Board Minute re approval
A3	Approval of maternity business case at Board and approval		✓		Aug-16
A4	Approval of ED Strategic Outline Case to Board - complete		✓		Feb-17
A5	NHSI approval to finance Maternity case received - complete			✓	Jul-17
A6	Maternity & Neo-Natal case gained agreement to proceed and award contract by trust Board (previously supported through PFIC)	✓	✓		Sep-17
A7	ED business case produced and adopted by Trust Board, with the case presented to NHSI for approval (previously supported through PFIC)	✓	✓		Oct-17
A8	NHSI involved within the production of the ED business case and supportive of the STP need.			✓	Ongoing
A9	The Black Country STP prioritising the development of ED within the capital bids for providers as a key requirement to deliver future performance in accordance with the NHS contitutional standards.			✓	Support received through a prioritisation submission made by the lead commissioner on behalf of the STP for September 2017.
A10	NHSI confirmed support for the capital development of Maternity & Neo-Natal development, with the contracts signed by the Trust		✓	✓	Feb-18
A11					
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	NHSI approval for OBC for the ED business case	Review under way, awaiting feedback.	May-18
G2	Board and NHSI Approval of full ED business case.	Work under way to finalise & provisional timetable to be agreed.	Apr-18
G3	Identification of financing for the capital development of the Emergency Department	Black Country STP support for the development (put forward as a required and necessary capital development for the STP footprint, letter sought confirming their ongoing support for presentation to the regulator	Aug-18
G4			
G5			
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Provide safe, high quality care across all our services

Relevant to all 2 year objectives

STRATEGIC RISKS				
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16		CURRENT ASSURED LEVEL
	CURRENT RISK SCORE (Impact x Likelihood = Total)	3 x 2 = 6		
	TARGET RISK SCORE (Impact x Likelihood = Total)	2 x 1 = 2		
What is the strategic risk to be controlled		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 11	That our governance remains "inadequate" as assessed under the CQC Well Led standard.	Chief Executive	Trust Board	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
Failure to deliver governance improvement and therefore exit special measures.	REF	*What are the key potential consequences (up to 4) of the risk?*
Poor governance will make quality, safety and culture improvement harder to deliver.	PC1	Trust remains inadequate when reinspected.
Poor governance will make delivery of performance improvement harder to deliver.	PC2	We do not deliver an improved organisational culture for our colleagues.
IMPACT ON CQC CORE OUTCOMES	PC3	We continue to run unmitigated risks to quality and safety that have the potential to cause harm to patients.
What are the Outcome Reference Numbers?	PC4	That we lose the trust and confidence of our inspectors, regulators and stakeholders.

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Lack of board development over the last two years leading to difficulties in the Trust Board (Foresight Report conclusions)
O2	Significant turnover in the executive and senior operational teams in the last two years.
O3	Poorly developed and embedded systems for risk identification and mitigation.
O4	Lack of patient voice in the work of the Trust.
O5	Limited engagement by the Board with our major external stakeholders.
O6	Poor development and understanding of our five year strategic plan.
O7	
O8	
O9	
O10	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Risk Management Strategy & implementation
C2	New Governance structure in place from April 2016.
C3	Five Year Trust Strategic Plan & plans to deliver
C4	Approved Quality Commitment
C5	Rescheduled Board Development Sessions to provide greater space for Sessions - separate day to Board.
C6	Development of Clinically Led Model
C7	Service Improvement Strategy for delivery of improvements
C8	Rescheduled Board Day providing improved time for Board Meeting
C9	Board Time Out
C10	Updated approach to integrated performance reporting & accountability framework.

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R1	Board Reports	Quarterly
R2	Reports from Trust Quality Executive to Q&S Cttee	Monthly
R3	Trust Board	Quarterly
R4	Reports to Quality & Safety Committee & Board	Quarterly
R5	Trust Board Development sessoin documentation	Monthly
R6	Updates to P&OD Cttee on Clinically-Led model.	Quarterly
R7	PCIP reports	Quarterly
R8	Trust Board	Monthly
R9	Trust Board	At least twice per year, July 2016, Oct 2016, April 2017
R10	PFIC & Trust Board	Monthly

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	Approval of new Governance Structure		✓		TB Dec 2015 Ref: 305/15
A2	New Risk Management Strategy and updated Corporate Risk Register		✓		TB Mar 2016 Ref 363/15 & Jul 2016
A3	2016/17 Board Assurance Framework Internal Audit Report - substantial			✓	Audit Committee April 2017
A4	Reports to P&OD Cttee on the Clinically Led Model for Divisions	✓			P&OD May 2016 05/16 & 06/16
A5	Reports from Trust Quality Exec to Q&S Cttee		✓		Q&S Minutes from Feb 2016
A6	Trust 2020 Service Vision report to Board		✓		TB Feb 2016 332/15
A7	Board Capacity and Capability Review and Response (External)			✓	TB Sep 2016
A8	Self Assessment of Well Led Review		✓		TB Oct 2016 & Update May 2017
A9	Strategies to Trust Board: Quality Commitment & Patient Experience Strategies.		✓		Trust Board reports & minutes
A10	Well Led report to Oversight Committee		✓		Report & minutes January 2017
A11	Quarterly risk management reports to Board - corporate risk register and BAF		✓		Trust Board reports and minutes
A12	Report to Oversight Committee on inputs to date for Well Led Standard		✓		Oversight report and minutes
A13	Review of historic governance reviews and recommendations to ensure all delivered /in progress.		✓		Spreadsheet documentation to support Oversight Report.
A14	Assessment Against CQC Well Led Standard	✓			Board Notes from Assesssment
A15	Board approval of Accountability Framework		✓		TB Report & Minutes June 2017
A16	Organisational engagement plan re strategy development	✓			Engagement Plans
A17	Draft CQC Inspection report - rates "Well Led" as requires improvement			✓	CQC draft report
A18	Continued updates for BAF and CRR		✓		Latest BAF and CRR
A19	Further round of actions agreed with CDs to support delivery of clinically led model	✓			Clinically led model action plan
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	More structured stakeholder engagement plan required.	Updated Stakeholder Engagement strategy developed and used to engage our stakeholders (DF)	Jun-18
G2	5 year sustainability review of services.	Phase 1 completed and discussed at Clinical Executive Q1 2017/2018. Phase 2 using the full diagnostic tool to be completed at end of Q1 2018/2019.	Jun-18
G3	Changes in the Executive Team	Substantive recruitment to Director of Nursing, Medical Director, Director of People & Culture through Gatenby Sanderson.	Aug-18
G4	Board Development Programme	New Board Development Programme following recruitment of substantive Directors.	Aug-18
G5	Self Assessment of Well-Led	Self assessment of current position of Well Led in advance of annual CQC review.	Jun-18
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Use Resources Well to Ensure we are Sustainable:
Use resources at their optimum.
Deploy our staff where patients benefit most.
Explore all options for cost effectiveness.

STRATEGIC RISKS			CURRENT ASSURED LEVEL (RAG)
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12	
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 2 = 8	
	TARGET RISK SCORE (Impact x Likelihood -= Total)	4 x 1 = 4	

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 12	**That the overall strategy does not deliver required changes resulting in services that are not affordable to the Local Health Economy.**	Director of Strategy & Transformation	Trust Board	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
Failiure to meet key trust objectives.	REF	*What are the key potential consequences (up to 4) of the risk?*
Financial targets not met.	PC1	Future sustainability of the Trust would be in question
Reputation of the Trust as Partner of Choice would be impaired..	PC2	Multiple providers may lead to fragmented pathways and poor patient experience.
IMPACT ON CQC CORE OUTCOMES	PC3	Major negative effect on staff morale and reputational damage for the organisation as an employer.
What are the Outcome Reference Numbers?	PC4	
Failure to improve CQC rating for Well Led		

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Strategic planning historically has not been fully embedded across the organisation leading to a a narrow focus on in year priorities.
O2	Weak simulation and modelling capability for demand capacity and activity planning.
O3	Poor data quality leading to decisions being made on incomplete or partial baselines.
O4	Organisation is slow to embrace innovation
O5	Financial challenges have prevented investment in technologies and fit for purpose estate
O6	Trust Board is relative new and has had a number of personnel changes in recent years
O7	System-wide partnership developments are in their infancy in Walsall and Black Country
O8	
O9	
O10	

The risks are CONTROLLED by…

What are the key controls and actions (up to 10) that are in place to mitigate these risks?

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	CONTROL	REF	REPORTING MECHANISM	FREQUENCY
C1	A programme of five year clinical plans developed and reviewed.	R1	Progress reports to Trust Board	Quarterly
C2	Service Imporvement Managers in post to support sutainable change.	R2	Annual Objective Updates to Trust Board	Quarterly
C3	Five Year Strategic plan approved at February 2017 Trust Board and being embedded across the organisation.	R3	Market Share Group	Quarterly
C4	Walsall Together Partnership meets regularly.	R4	Trust Board Away Days	Throughout 2017/18
C5	2 year annual plans in place for 2017-2019 with progress updates reviewed at Trust Board.	R5	Provider Board	Monthly
C6	Supporting Strategies are being developed to underpin the main strategy.	R6		
C7	Programme of education and training for senior staff	R7		
C8	Clinically-led model in place.	R8		
C9	PM3 PMO software introduced to support monitoring.	R9		
C10	Provider Board working on future alliance arrangements	R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	Care Group Plans on a Page aligned to Strategy and reviewed at Divisonal Boards	✓			Care Group Plans
A2	Members of BCPP, part of STP development and working with Walsall Together.			✓	Monthly Trust Board Updates
A3	Secured funding for ICCU			✓	Business Case approved
A4	7 community locality teams deployed			✓	Monthly Trust Board Updates
A5	Strategy Engagement Events delivered	✓			Communications Plans
A6	Mobile Technology, 100% devices rolled out, 45% of teams now live as of March 2018			✓	Devices being rolled out
A7	Clinical-leads in place across all divisons	✓			Divisional Structure Charts
A8	Birth rate capped in Maternity. New models of care introduced.		✓		Maternity Task Force reports & Quality & Safety Reports
A9	Partnerships progressing around EOL in community		✓		Monthly Trust Board updates
A10	Black Country Proposals for Stroke and Pathology underway.			✓	Clinical Senate reviews Oct/Nov for Stroke services
A11	Case for change now prepared by provider board and being approved by governing boadies March 2018	✓	✓		Trust Board Report & Minutes March 2018
A12	Intermediate care programme approved by Trust Board		✓		Trust Board Report & Minutes
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	Trust wide demand and capacity	D&C review of all services undway for 18/19 annual planning round	Q1 2018/19
G2	Sustainability review	Sustainability reviews underway. Phase 1 now complete and phase 2 commencing. SBWG oversigh planned	end Q1 2018/19
G3	Partnership Approach	Stakeholder engagement strategy being drafted	Q1 2018/19
G4			
G5			
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Use Resources Well to Ensure we are Sustainable:
2 Year Objective: Use our resources at their optimum.
2 Year Objective: Explore all options for cost effectiveness.
2 year Objective: Deploy our staff where patients benefit most.
5 Year Strategic Objective: Working Closely with Partners in Walsall and Surrounding Areas
Collaborating with the Black Country Alliance and beyond

STRATEGIC RISKS				
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16		CURRENT ASSURED LEVEL (RAG)
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16		
	TARGET RISK SCORE (Impact x Likelihood -= Total)	4 x 1 =4		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 13	That the Service Improvement and Cost Efficiency Programme does not deliver the financial impact planned resulting in non-delivery of financial plan.	Director of Finance & Performance	Performance Finance & Investment Committee	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
Failure to deliver the Trust's financial plan	REF	*What are the key potential consequences (up to 4) of the risk?*
Failure to use resources well to ensure the Trust is sustainable	PC1	The Trust will no longer be financially sustainable
Failure to Provide safe, high quality care	PC2	Due to financial constraints the trust will not be able to provide safe, quality care and sustainable services to patients.
IMPACT ON CQC CORE OUTCOMES	PC3	NHSI consider and input to the CQC under new inspection regime financial performance. Final rating rests with CQC.
What are the Outcome Reference Numbers?	PC4	
Failure to improve CQC rating for Well Led		

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Non-delivery of the cost improvement programme
O2	The correct level of ownership and accountability of the Improvement programmes is not established
O3	Due to operational pressures divisions focus on dealing with day to day activities
O4	Improvement programmes are complex with interdependences across divisions, departments and partner organisations
O5	Staff do not have the capacity / capability to implement significant service change at the required level.
O6	Overreliance on non-recurrent savintgs delivery.
O7	Income savings require Trust to deliver activity above that contracted.
O8	
O9	
O10	

The risks are CONTROLLED by…

What are the key controls and actions (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Service Improvement Programme Managers have been aligned to Divisions to support in delivery of their Improvement Programme.
C2	Monthly Efficiency Team Meetings to monitor the delivery/ progress of the programme.
C3	Commissioned KPMG to provide capability and capactity to enable improvement programmes to deliver.
C4	Project documentation has been revised to ensure all programmes have detailed plans which clearly identify the benefits, risks & issues. This enables more robust monitoring.
C5	Sponsor Groups have been established for all the improvement programmes to ensure the robust and deliverable plans have been developed.
C6	Service Improvement Strategy has been developed, outlining the delivery of improvements
C7	A Service Improvement Training Programme has been established, giving staff the tools and techniques to be able to deliver service improvement within their area.
C8	PMO Director role established and appointed to. This will assure delivery of plans.
C9	
C10	

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R1	Programme Updates are provided at the Divisional Efficiency Teams	Monthly
R2	Overview of the Improvement Programme reported to Performance & Finance Executive (PFE) & Performance, Finance & Investment committee (PFIC) & Trust board	Monthly
R3	Monthly reports to PFE, PFIC and Trust Board.	Monthly
R4	Documentation reviewed at Divisional Efficiency Teams	Monthly
R5	Documentation reviewed at Divisional Efficiency Teams	Monthly
R6	Trust Board	Approved 01/04/2017
R7	Training updates will be provided in the reports to Performance & Finance Executive (PFE) & Performance, Finance & Investment committee (PFIC) & Trust board	Monthly
R8	PFE and PFIC.	Monthly
R9		
R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	Overview of the CIP Programme reported performance to Executive, PFIC & Trust Board		✓		DASHBOARD & programme pack for PFE, PFIC and Trust Board.
A2	Divisional Efficiency Team Meetings		✓		Monthly Meetings
A3	Improvement Programme Sponsor group meetings	✓			Monthly Meetings
A4	FIP 2 programme commencement KPMG assurance			✓	Weekly review
A5	Performance, Finance Executive monthly meetings presentation	✓	✓		
A6	Appointment of KPMG to support assurance on robustness of savings plans and enhance reporting of performance			✓	DASHBOARD & programme pack for PFE, PFIC and Trust Board.
A7					
A8					
A9					
A10					
A11					
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	Limited contingency identified	Targeted £1m contingency to deliver £13m programme. Plans to be developed in line with submissino of the 2018/19 overall plan.	May-18
G2	Capacity and ability to deliver transformation and CIP at pace	Handover plan is to be ratified at PFIC - to include capability and capacity assessment.	Apr-18
G3	2018/19 savings plans under development	Presentation to Performance Finance Executive on method for allocation of CIP target by Division and agreement for targeted benefits from workstreams.	Mar-18
G4			
G5			
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objective: Use Resources Well to Ensure we are Sustainable:
2 Year Objective: Delivering a first class service working seamlessly with partners.
2 Year Objective: Explore all options for cost effectiveness.

STRATEGIC RISKS				CURRENT ASSURED LEVEL (RAG)
	INITIAL RISK SCORE (Impact x Likelihood = Total)		4 x 3 = 12	
	CURRENT RISK SCORE (Impact x Likelihood = Total)		4 x 2 = 8	
	TARGET RISK SCORE (Impact x Likelihood -= Total)		4 x 1 = 4	
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 14	**New entrants into the market will succeed in attracting services resulting in income loss to the Trust.**	Director of Strategy & Transformation	Performance Finance & Investment Committee	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
Pathways become fragmented and unsustainable	REF	*What are the key potential consequences (up to 4) of the risk?*
Future costed assumptions for estate redevelopment could be affected.	PC1	Negative impact on staffing.
Trust is unable to meet its overhead commitments.	PC2	Patient care is negatively affected due to fragmentation
IMPACT ON CQC CORE OUTCOMES	PC3	Trust needs to merge/be taken over
What are the Outcome Reference Numbers?	PC4	
Failure to improve CQC rating for Well Led		

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Market Share Analysis being developed.
O2	Service Line Reporting has not been available
O3	Poor data quality impedes decision making.
O4	CCG in Special Financial Measures
O5	LA needs to reduce spend
O6	Health and Social Care Act encourages competition from private sector
O7	Emphasis on including third and voluntary sector organisations in provision of care.
O8	
O9	
O10	

The risks are CONTROLLED by…

What are the key controls and actions (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Regualr market share trends analysis implemented.
C2	Participation in NHS Benchmarking
C3	CCG contract review meetings
C4	Case for change with Provider Board sponsorship
C5	Provider colloboration through Provider Board
C6	
C7	
C8	
C9	
C10	

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUENCY
R1	Board	Quarterly
R2	Ad Hoc	Per national programme
R3	Provider Board	Monthly
R4		
R5		
R6		
R7		
R8		
R9		
R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

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Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?				*What is the minute reference?*
A1	Market Share Report	✓			Board reports
A2	Invested in web based opportunities alert system	✓			Trade Union update
A3	Participate in NHS Benchmarking		✓	✓	Bespoke reports to service leads and DOS
A4	Regular meetings with Partners and Commissioners				Various
A5	Partnership updates from the Walsall Together programme and provider board	✓			Various board reports / updates
A6	Sustainability of services underway	✓	✓		TCE presentations. Board and other committee reports
A7	Commericial Strategy approved		✓		Performance, Finance & Investment Committee 2017
A8	Case for Change highlights to provider landscape	✓	✓		
A9					
A10					
A11					
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	Partnership Approach	Stackholder Strategy	Apr-18
G2	Market Share Reports not accessible to Care Groups	Training to be provided on HED system to care groups	Q1 18/19
G3			
G4			
G5			
G6			
G7			
G8			
G9			
G10			

5 Year Strategic Objecitve: Provide Safe, High Quality Care across all our Services:

2 year Objective: Work with partners to ensure services are safe.

5 Year Strategic Objective: Working Closely with Partners in Walsall and Surrounding Areas

2 year Objective: Collaborating with the Black Country Alliance & beyond.

2 yyear Objective: Delivering first class services working seamlessly with partners

STRATEGIC RISKS				CURRENT ASSURED LEVEL (RAG)
	INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12		
	CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 2 = 8		
	TARGET RISK SCORE (Impact x Likelihood -= Total)	4 x 1 = 4		
What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER	
REF	STRATEGIC RISK			
BAF No. 15	**If the Trust does not agree a suitable alliance approach with Local Health Economy partners it will be unable to deliver a sustainable integrated care model.**	Director of Strategy & Transformation	Trust Board	

IMPACT ON CORPORATE OBJECTIVES *(up to top 3)*	POTENTIAL CONSEQUENCES OF THE RISK	
Some pathways may be unsustainable and fragmented	REF	*What are the key potential consequences (up to 4) of the risk?*
Non delivery of Trust vision	PC1	Trust may become unsustainable if the right approach is not achieved.
If Trust does not agree - may be forced to comply with an unsuitable model	PC2	Damage to Trust's reputation as a partner of choice
IMPACT ON CQC CORE OUTCOMES	PC3	Some services may be lost to competitors impacting on patient experience.
What are the Outcome Reference Numbers?	PC4	Negative impact on finances as economies of scale not achieved.

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

REF	ORIGIN
O1	Stakeholder Engagement and partnership working not fully developed/optimised.
O2	Culture and behaviours of organisation not matching examples of leading exemplar organisations.
O3	Demographic changes with an aging population and boundary changes which has led to cross border referral South Staffordshire and Sandwell.
O4	FYFV potentially underestimates complexities and financial resources required.
O5	
O6	
O7	
O8	
O9	
O10	

The risks are CONTROLLED by…

What are the key controls and actions (up to 10) that are in place to mitigate these risks?

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	CONTROL	REF	REPORTING MECHANISM	FREQUENCY
C1	Black Country Alliance and STP	R1	BCA Board	Monthly
C2	Walsall Together Partnership	R2	Trust Board	Monthly
C3	Listening into Action	R3	Provider Board	Monthly
C4	Service Improvement Programmes	R4		
C5		R5		
C6		R6		
C7		R7		
C8		R8		
C9		R9		
C10		R10		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

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Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

REF	POSITIVE ASSURANCE	L1	L2	L3	EVIDENCE
	What is the report received that provided that assurance?	√			*What is the minute reference?*
A1	Service Improvement Strategy	√			
A2	Trust Strategy			√	Board Reprot
A3	BCA Strategy			√	Board Report
A4	STP			√	Board Report
A5	Walsall Together Strategy			√	Board Report
A6	Joint working with BCA			√	
A7	Sustainabilty Reviews Underway - acute stroke services potentially moving to Wolverhampton. BC Pathology agreement being developed		√		Board Report
A8	External organisation recruited to write alliance business case.	√			
A9	Intermdiate care provision approved		√		Trust Board
A10	Commercial strategy approved outlining Trust approach	√			Approved by Performance, Finance & Investment Committee
A11	case for change - March 2018	√	√		Trust Board 2018
A12					
A13					
A14					
A15					
A16					
A17					
A18					
A19					
A20					

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

REF	GAP	ACTION PLAN	DEADLINE
G1	Immature system to develop partnerships	Regular system-wide meetings to establish imrpovement change approach with STP Partners. Program of work to be Planned	Q1 2018
G2			
G3			
G4			
G5			
G6			
G7			
G8			
G9			
G10			

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board			**Date: 8th March 2018**
Report Title	Patient Experience and Complaints Report			**Enclosure No.: 6**
Lead Director to Present Report	Barbara Beal - Director of Nursing (Interim)			
Report Author(s)	Louise Mabley - Patient Experience Lead Garry Perry – Head of Patient Relations Kuldeep Singh – Patient Experience Manager			
Executive Summary	To advise the Trust Board on: • The current position of Friend and Family Test results and other Patient Experience feedback back activities. • Complaints and concerns			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Trust Board is recommended to DISCUSS the report and NOTE the update provided.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Not Relevant</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Not Relevant</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Not Relevant</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Not Relevant</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☐</td></tr>
<tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☒</td></tr>
<tr><td><u>Well-Led</u></td><td>☐</td><td colspan="2"></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Corporate Risk Register 15 – National Surveys- Score Rating of 12

• Business Risks
• Finance & Performance Risks
• Reputation Risks
• External standards</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">None</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">CQC – includes a standard for management of complaints
NHSLA Standard 2.3
Local Authority Social Services and NHS Complaints (England) regulations 2009
Standard NHS Contractual requirements</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The report has been received by the Trust Quality Executive and Quality & Safety Committee.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2"></td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

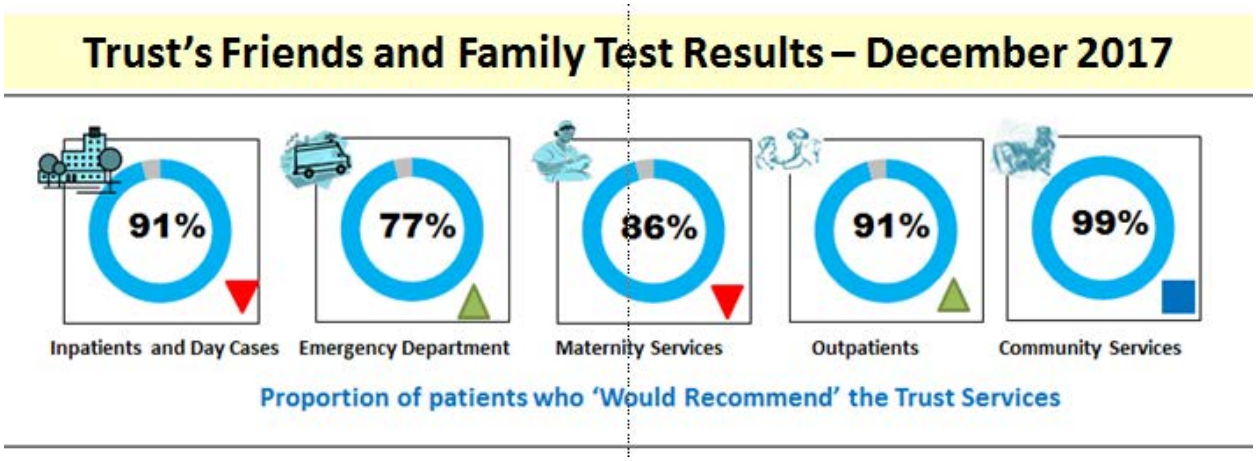
SECTION A: PATIENT EXPERIENCE UPDATE

1. MAKING A DIFFERENCE

This report provides an update on the progress being made across the Trust with regard to patient experience and focuses on:

- Patient Experience Updates: Friends & Family Test (FFT)
- National Surveys
- Staff and Patient FFT (triangulated data)
- Voluntary Service update
- Self Care Management Programmes update

2. FRIENDS & FAMILY TEST



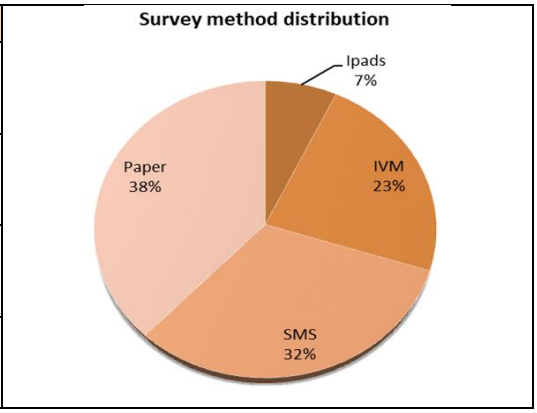
2.1 Friends & Family Test (FFT) Performance

Feedback Response

During quarter 3 (Oct – Dec 2017), the Trust received in access of 12,000 FFT responses from patients about their experience of care and treatment across the different acute and community services.

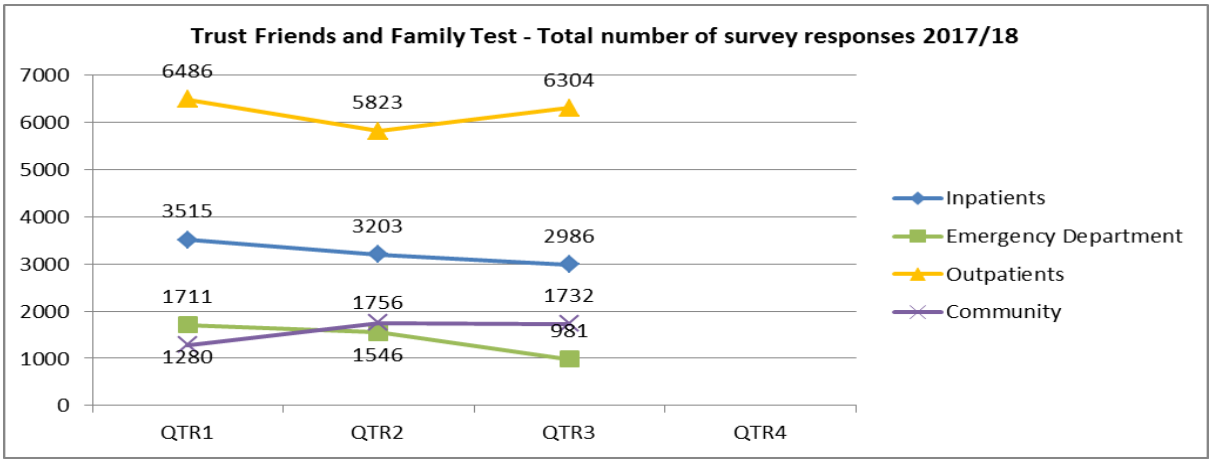
Breakdown of response methods:

Methods	Responses
Electronic tablets	854 ↑
IVM (interactive voice message)	2831 ↓
SMS(mobile texts)	4019 ↓
Paper	4687 ↓

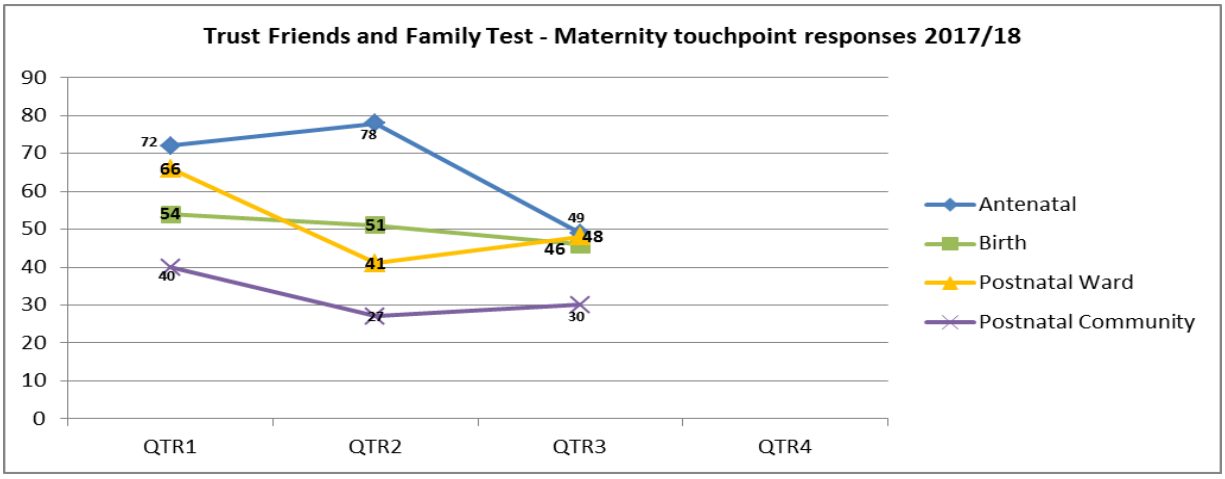


Outpatients (OP) improved their number of FFT responses the most in quarter 3 (+481 compared to Q2)) while the Emergency Department (ED) saw the biggest drop in response numbers (- 565 compared to Q2) followed by Inpatients (- 217 compared to Q2).

The ED drop in responses was largely due to the Lorenzo update disruption and the contingency paper method not having the desired uptake. The inpatient response rates are still about 10% more than the national average.



FFT feedback numbers remained low across all the Maternity Service touchpoints. The birth touchpoint, which is monitored nationally, is amonst the lowest in the region and nationally scoring between 6% - 8%.



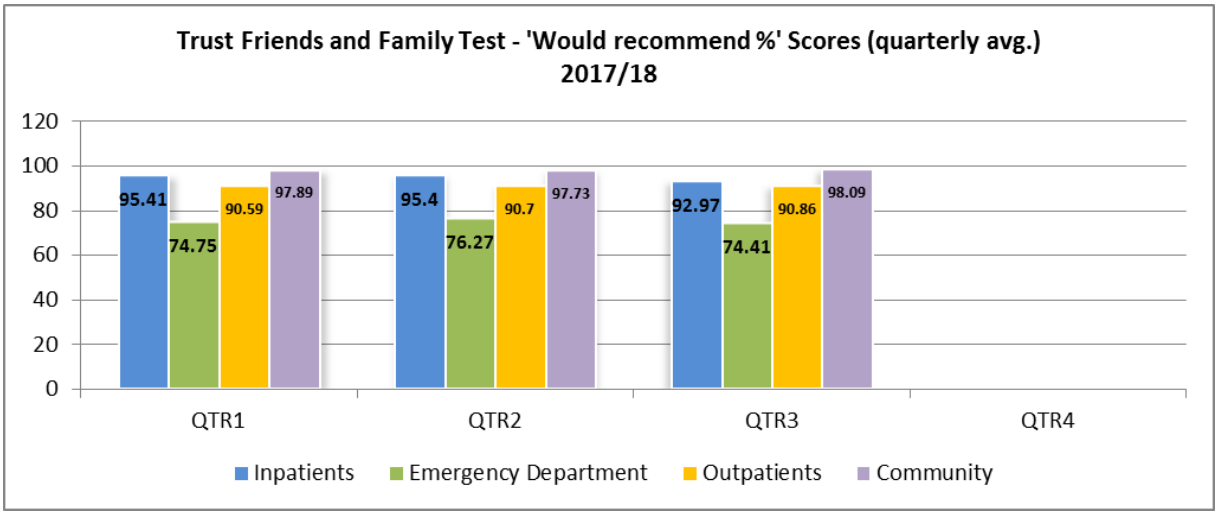
2.2 Friends and Family Test Scores

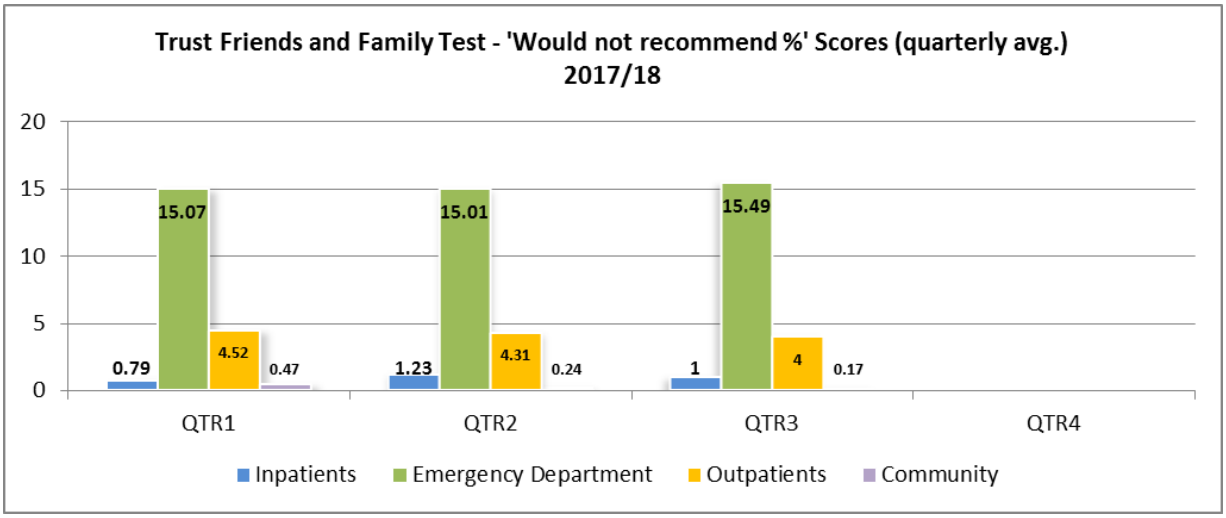
Inpatients, Outpatients, ED and Community Services:

Compared with scores from the last quarter, **IP** and **ED** 'Would Recommend' scores dropped by 2.43% and 1.89% respectively. There was no significant changes in the 'Would not Recommend' scores across all other services.

The **ED** recommendation scores continue to trail the national average by about 10% and the 'not recommend' scores remain doube the national average (7%).

The **Community Service** recommendation score of 98% (quarter avg.) was ranked high nationally. Currently, most of the Trust's Community services conduct FFT only once a month using paper surveys. Use of 'Badgernet' devices for online FFT surveys has been agreed in principle with phased roll out proposed from April 2018. This would facilitate wider coverage and real time feedback collection/reporting.

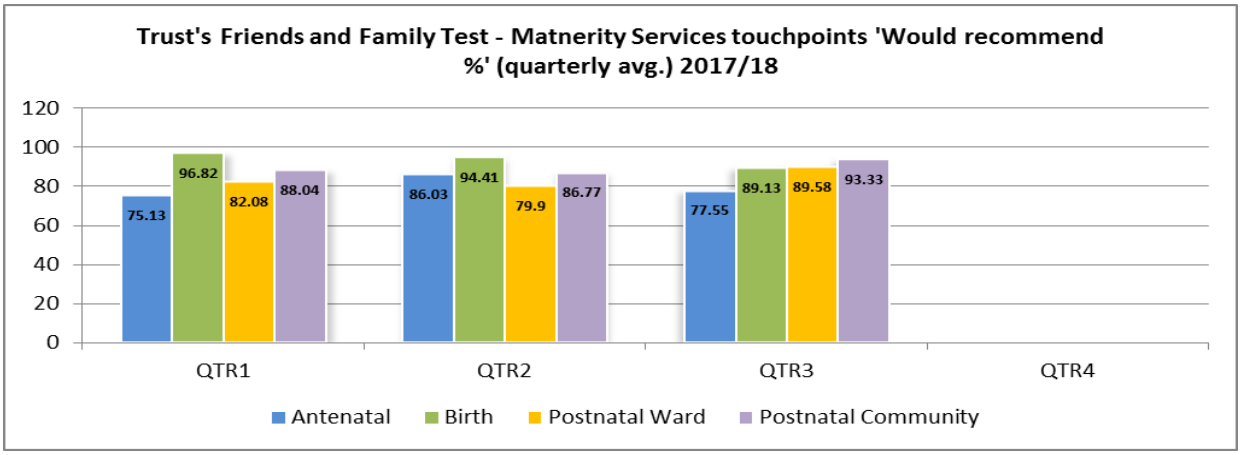


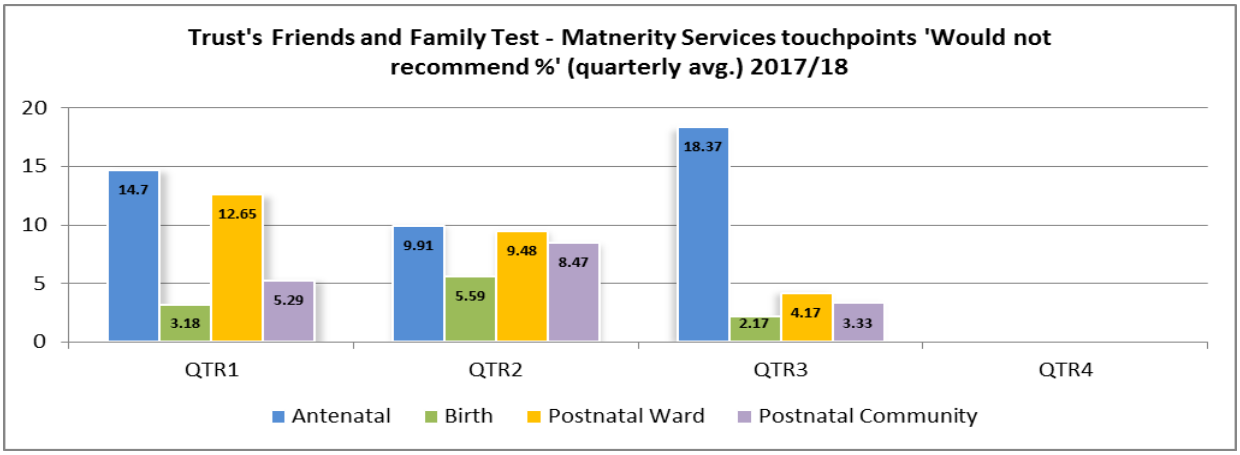


Maternity Services:

The **postnatal ward** and **postnatal community** touchpoints improved their recommendation scores by 9.68% and 6.56% respectively when compared with the previous quarter. There was a drop in the scores for **antental** (-8.48%) and **birth** (-5.28%). Antenatal trails the national average by more than 15% while birth by about 6%.

Birth, postnatal ward and postnatal community touchpoints reduced their 'not recommend' scores, however, antenatal's score increased by about 4% when compared to quarter 2 scores. When compared with the national average, antenatal score is significantly higher and birth is almost double.





2.3 Free text comments

Staff attitude, implementation of care and Environment feature as the top positive themes from patient comments while staff attitude and environment also featuring in the top 3 negative comments.

Communication, implementation of care and clinical treatment are also mentioned frequently in negative patient comments.

Top 10 Words

Positive		Negative	
1. Staff	3184	1. Time	167
2. Friendly	1355	2. Waiting	156
3. Helpful	1022	3. Staff	96
4. Good	944	4. Appointment	88
5. Attitude	939	5. Wait	63
6. Treatment	902	6. Hours	55
7. Time	763	7. Communication	43
8. Care	705	8. Hour	41
9. Clinical	624	9. Treatment	39
10. Service	599	10. Seen	38

Top 10 Themes

Positive		Negative	
1. Staff attitude	6600	1. Staff attitude	278
2. Implementation of care	2721	2. Waiting time	239
3. Environment	1678	3. Environment	213
4. Clinical Treatment	1619	4. Communication	176
5. Patient Mood/Feeling	1134	5. Implementation of care	146
6. Communication	1102	6. Clinical Treatment	124
7. Waiting time	1024	7. Patient Mood/Feeling	112
8. Admission	823	8. Admission	90
9. Staffing levels	215	9. Staffing levels	51
10. Catering	109	10. Catering	24

2.4 Triangulation of Patient and Staff FFT results

During quarter 2, the patient FFT recommendation rates were higher than both staff FFT domains of recommendation of Care and Place of work. (Q3 Staff results not available for comparions).

Patient and Staff Feedback Quarter 2 (Jul - Sept 17)					
	Patient FFT		Staff FFT		
	WR%	Total Respones	WR - Care%	WR - Work%	RR (Headcount)
MLTC	93%	2547	65%	65%	182
SURG	94%	4504	66%	63%	123
WCCSS	94%	2135	69%	67%	252
ED	76%	1546			
Community Services	98%	1756			

Top 3 themes from Staff and Patient comments			
Staff	Patient	Staff	Patient
Positive		Negative	
Implementation of Care	Staff attitude	Implementation of Care	Staff attitude
Staff attitude	Implementation of Care	Staff attitude	Waiting times
Clinial treatment	Environment	Clinial treatment	Environment

3. NATIONAL CQC SURVEYS

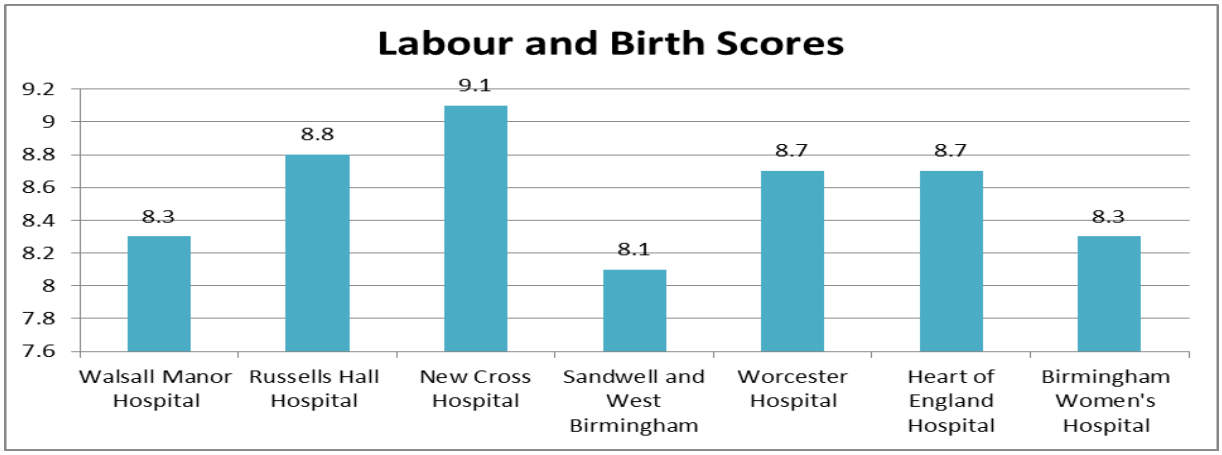
3.1 2017 National Maternity Survey Results

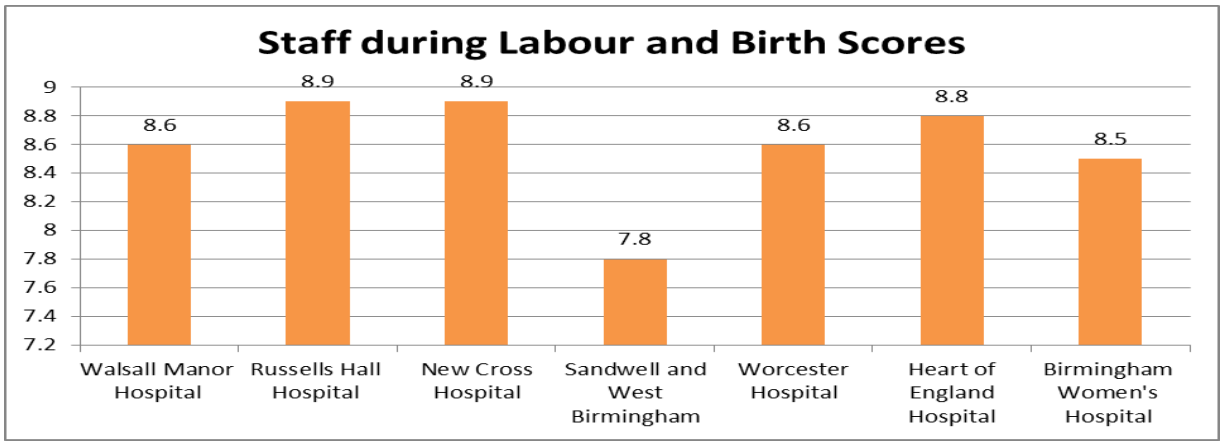
Mothers who gave birth at Walsall Healthcare NHS Trust during January and February 2017 took part in the 2017 CQC Maternity Survey. A total of 300 surveys were posted and there was a 31% response rate (92 responses).

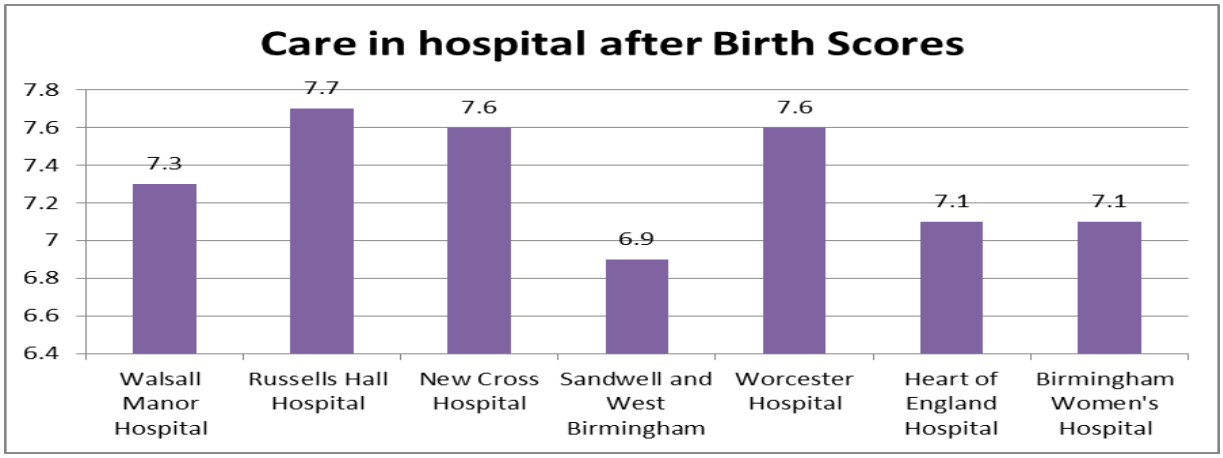
Generally, the results showed that the Trust performed 'about the same' on most of the questions when benchmarked against other Trusts nationally. The only two questions that put us as 'worse' in the comparisons were related to skin to skin contact with the baby shortly after the birth and the midwife not always informing about arranging a postnatal check-up of the mother's own health with her GP.

On comparison with our 2015 Maternity Survey results, the 2017 Survey showed that we improved in 73% of the questions and there was a slight decline in performance in 27% of the questions. Provision of information to mothers on their own physical recovery after the birth was significantly improved when compared to our 2015 survey results. Our score for the question about any concerns raised during labour and birth being taken seriously remained unchanged from the last survey.

Below are some comparison graphs with neighbouring Trusts which display the specific section scores published by CQC:

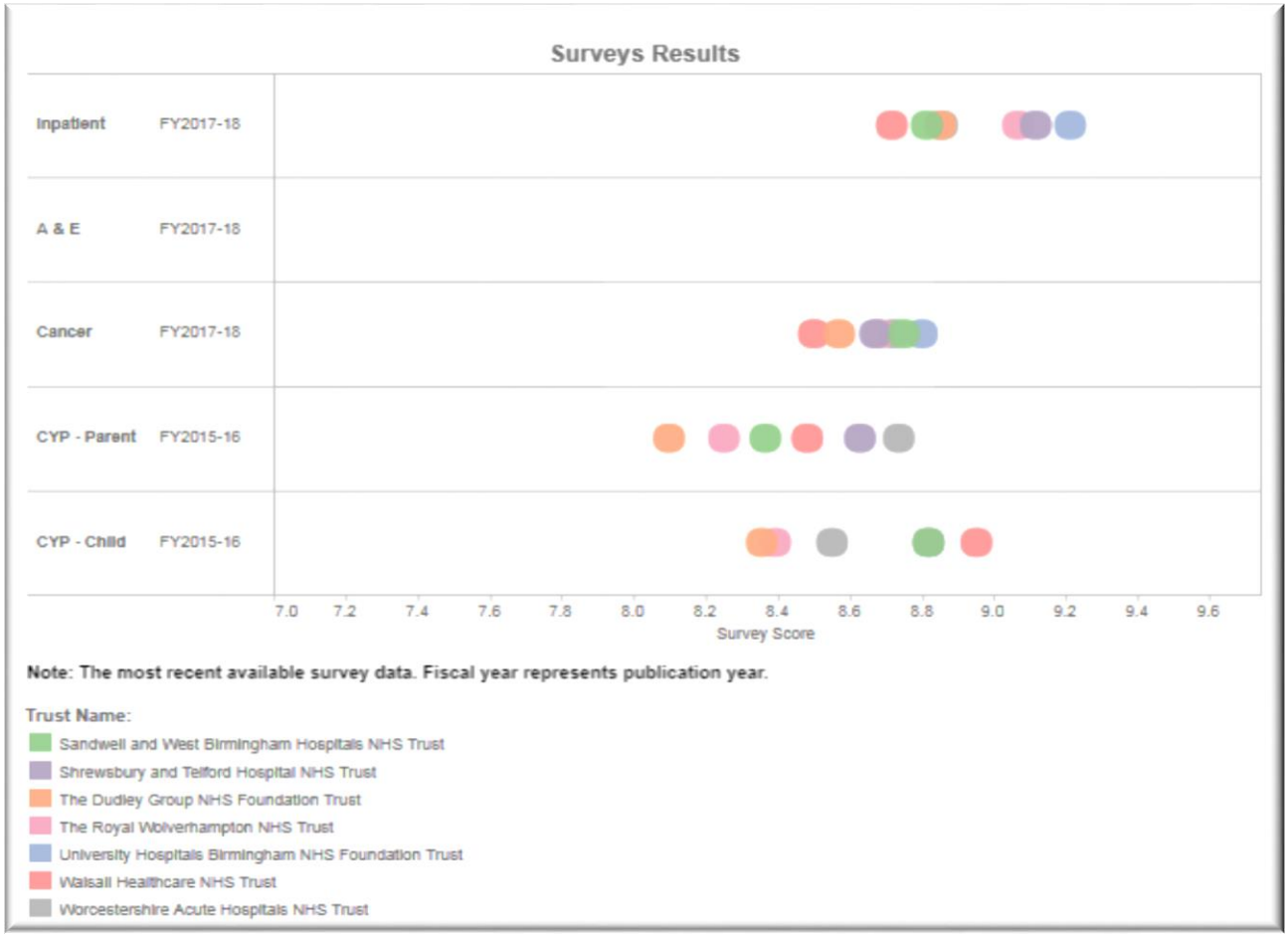






3.2 National Survey results comparison with neighbouring Trusts

The graph below shows comparison of national survey results which have been published upto September 2017. The overall scores are displayed on a scale of 1 – 10, with 1 being the least and 10 the best performance. The coloured dots respresent the different neighbouring NHS Trusts.



4. OTHER PATIENT EXPERIENCE PERFORMANCE INDICATORS

4.1 NHS Waiting Times Tracker

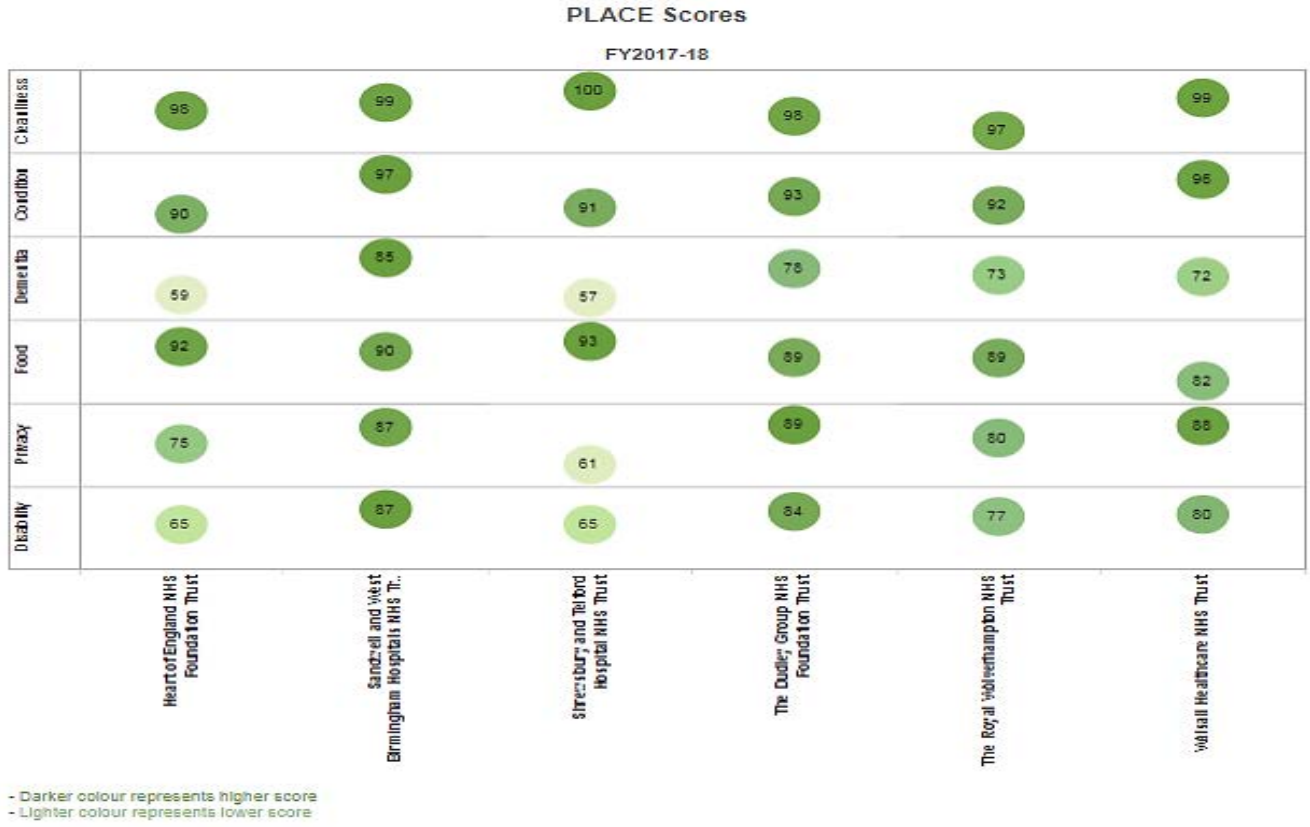
Latest Published (January 2018) data on Trust performance against three key NHS waiting-time measures:

Walsall Healthcare NHS Trust Inspection rating: **Requires improvement**		
1. A&E	**2. Cancer care**	**3. Planned ops & care**
✗	✓	✗
77.4% within 4 hours (Target 95%)	**85.5% within 62 days** (Target 85%)	**83.6% within 18 weeks** (Target 92%)

Data: BBC NHS Tracker

4.2 Patient-Led Assessments of the Care Environment (PLACE): Neighbouring Trusts scores

The Trust scores high on conditions and cleanliness while Dementia, food and Disability need improvement.

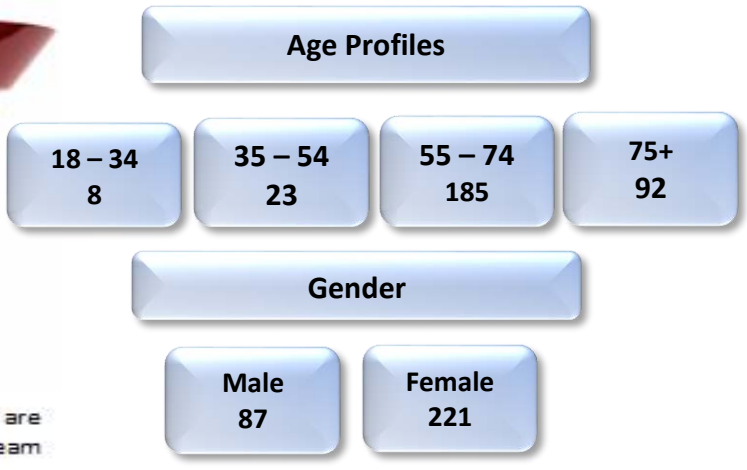


5. VOLUNTEERING

There are currently 308 volunteers across the Trust (Manor, Palliative Care Centre, Chaplaincy and Self Care Management).

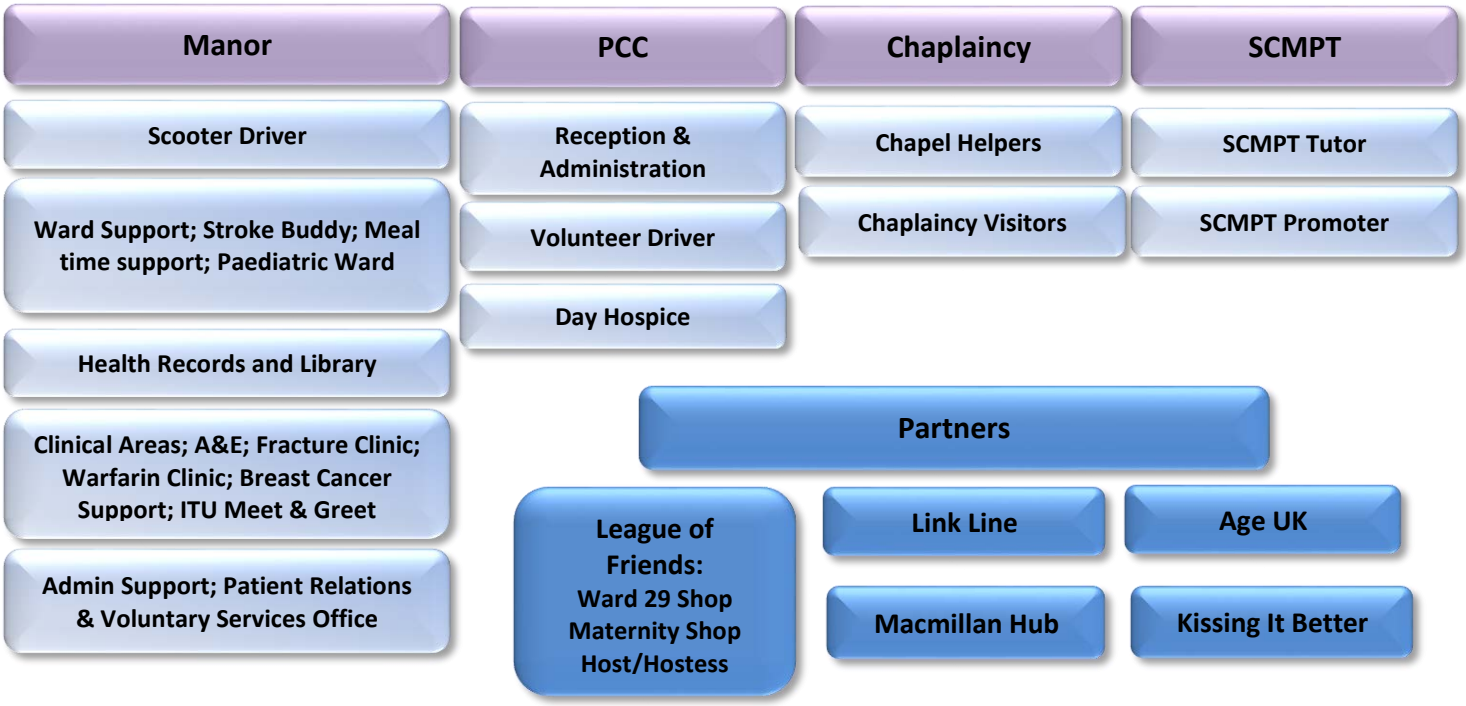
During the course of Quarters 1 - 3 the Voluntary Service received 162 enquiries of which 29 have commenced a volunteering role in the Trust.

NB: Some people will not return their application or they are signposted to other areas i.e. Widening & Participation Team



5.1 Volunteer Roles

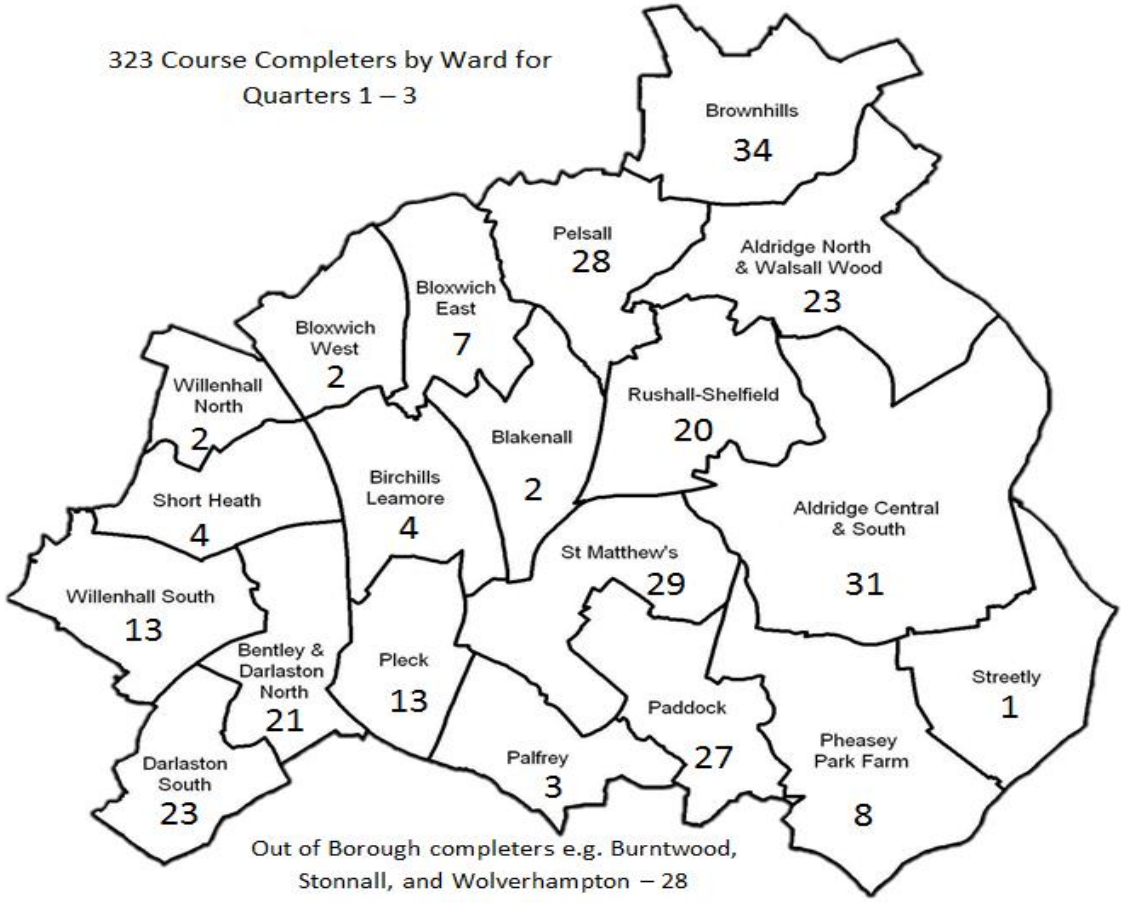
There are a number of volunteer roles across the Trust which are shown below. We also work in collaboration with partner organisations which are also shown below.



6. SELF CARE MANAGEMENT PROGRAMMES

The Self Care Management Team (SCMT) provides group based peer support and learning for skill development for individuals living with or caring for someone who has a long term health condition. Training is led by people who have personal experience of living with a long-term condition but have no professional expertise in the area. It teaches problem solving, decision making, utilising resources, developing partnerships with health providers and taking action. None of the skills gained have anything to do with the condition(s), they are to do with managing lives, using information and power. Self-management is not intended to replace medical treatment, but to be complementary by helping people with a long term condition to use their skills and expertise alongside the skills and expertise of the medical professionals.

6.1 Course Completers by Ward



6.2 Top 7 examples of Prevalence Conditions through Quarters 1 - 3

Arthritis Inc – Osteo & Rheumatoid
81

Diabetes
70

Breathing Conditions Inc – COPD , Bronchiectasis
68

Heart Problems Inc – AF & Angina
53

High/Low Blood Pressure
50

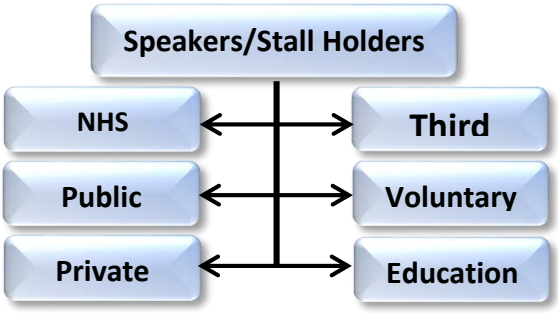
Depression & Anxiety (Inc PTSD)
47

Carer
25

6.3 Friends of Expert Patients Programme (Friends of EPP)

The Friends of EPP has been meeting since December 2010 where patients routinely share their views and experiences about the life-changing effect of attending the self- care management course, as well as gaining a plethora of information from a range of professionals. Thirty-six events have been held since 2010 with 1960 patients attending. The events are held every 2 months and are supported by the self care management team and volunteers together with a range of partners.

The provision of information at the events has created a well-informed group of people who have gained valuable insight into other services resulting in some people self referring into specific services e.g. Weight Management, Smoking Cessation, Podiatry, Diabetes, Cancer Information Support Services as well as the Police Neighbourhood Team, West Midlands Fire Service, Citizens Advice Bureau, Welfare Rights and Poppy Calls Centre.



SECTION B: COMPLAINTS & CONCERNS

7. INTRODUCTION

The purpose of this report is to provide details of the complaints and concerns received by Walsall Healthcare NHS Trust and those recently closed in the previous month. The report identifies numbers and themes of formal complaints by Division and actions taken in response to those that have been closed following investigation. Updates on complaints reported to the Parliamentary Health Service Ombudsman (PHSO) are included.

8. COMPLAINTS

8.1 Division and Theme

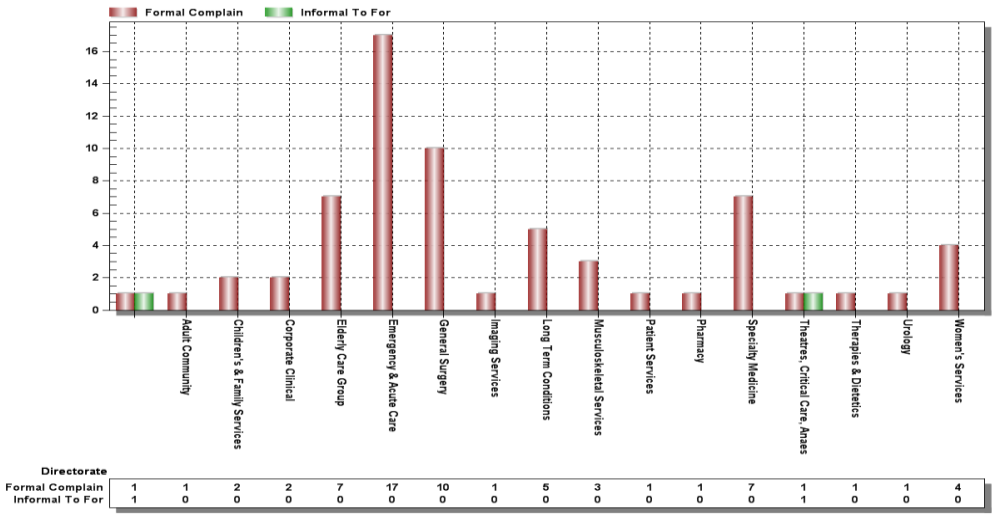
This section provides details of Formal Complaints (KO14a) and concerns received during quarter 3, October-December 2017.

Type	Oct	Nov	Dec
Formal Written Complaints (KO14a)	27	18	22
Concerns	264	286	172
NHS Choices/Patient Opinion/CQC	4	4	10
Overall total	**224**	**258**	**204**

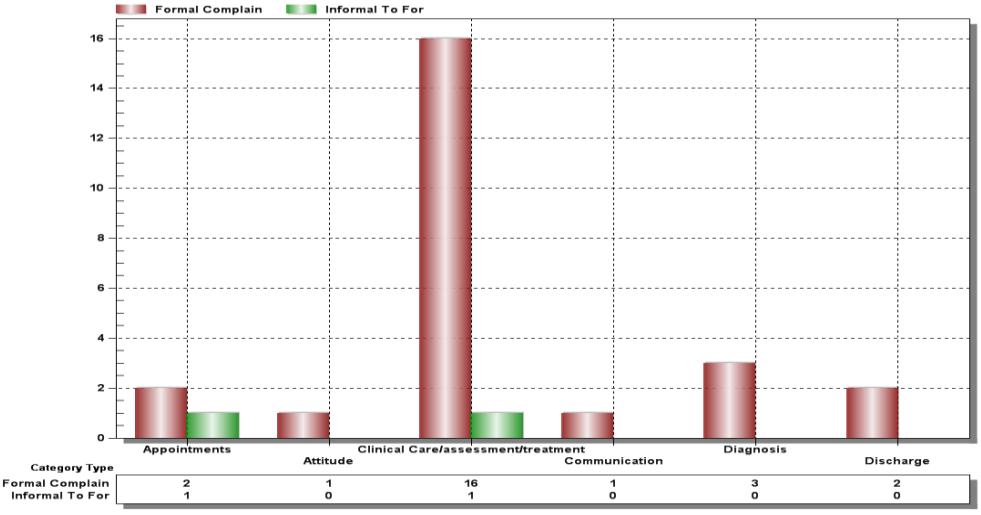
'K041a' written complaints are referred to as 'complaints' and these are managed through the Trust's complaints process and information on these is reported quarterly to the HSCIC (Health and Social Care Information Centre). The term 'concerns' is used in relation to informal concerns which are managed and resolved either on the spot, at a local level or issues which do not meet the criteria of the NHS complaint regulations or are 'out of time'.

Please note the figures for NHS Choices/Patient Opinion/CQC include 6 Compliments.

8.2 Formal Complaints by Care Group



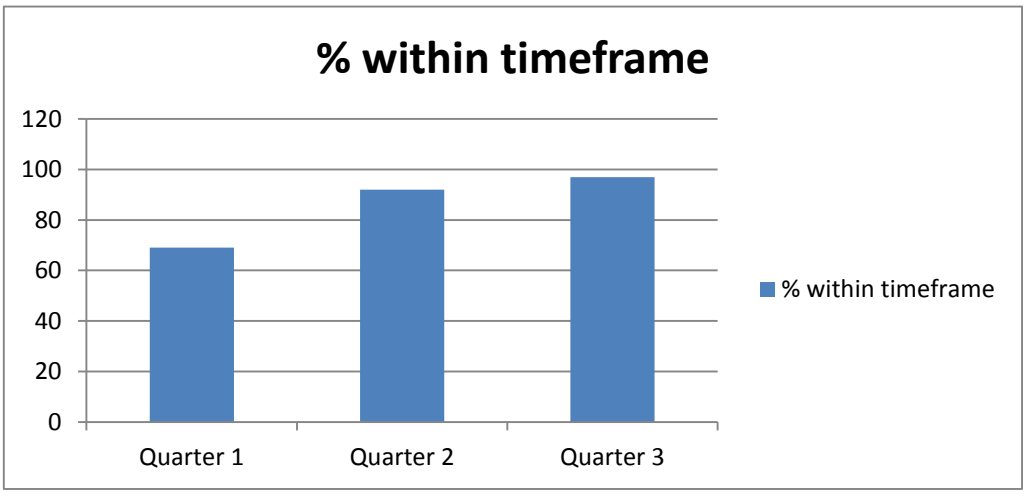
8.3 Formal Complaints – Themes



8.4 Formal Complaints per 10,000 spells

Activity	Oct	Nov	Dec
Total Formal Complaints	27	18	22
Elective activity	290	275	218
Non-elective activity	34	53	138
Emergency activity	2845	2747	2689
Complaints per in-patient activity (10,000 spells)	**8.5**	**5.8**	**7.2**

8.5 Complaint response times



During quarter 2, the Trust had a mean average of 97% of all written complaints responded to within a 30 – 45 working day timeframe. This is a further improvement from 92% in quarter 1. Early contact and agreement of timeframes with complainants is helping to drive these improvements.

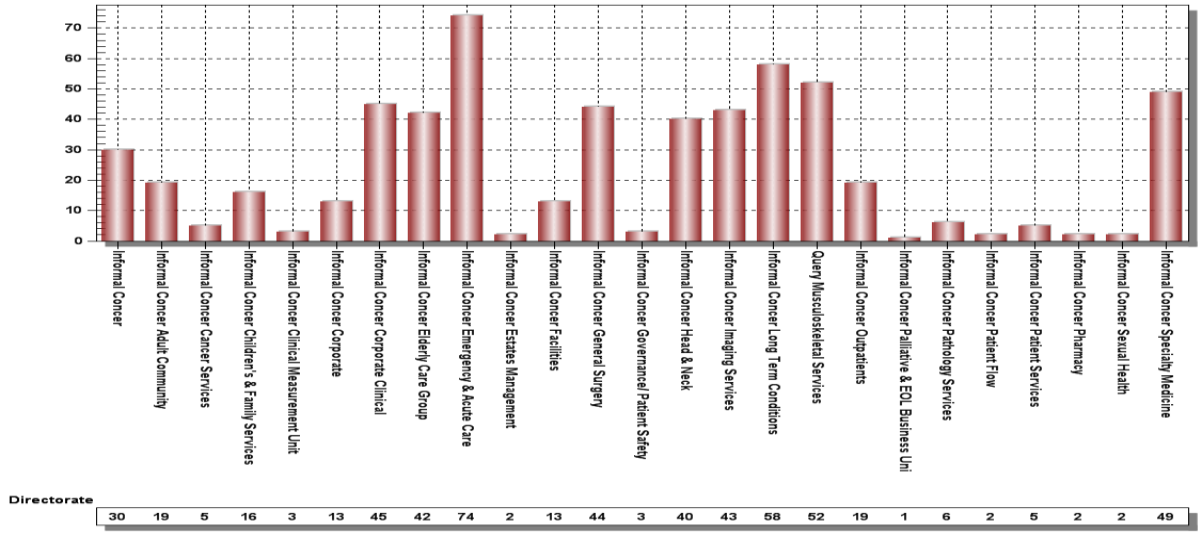
9. CONCERNS

During quarter 3, 722 concerns were received via the Patient Relations Team which is an increase of 132 concerns from quarter 2 (590).

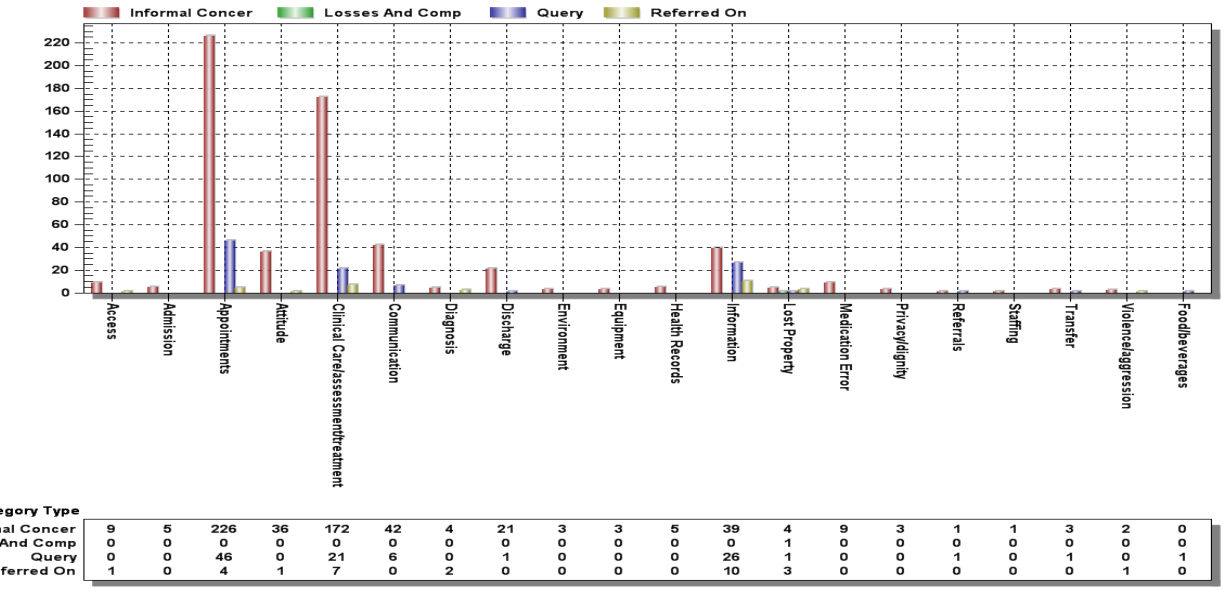
In Surgery, the Care Group for Musculoskeletal services received the highest number of concerns 52 a decrease of 2 on the previous quarter. General Surgery (44) received the next highest number of concerns raised with appointment queries, communication difficulties in trying to get through via the telephone and cancelled appointments again the key themes.

In medicine the Care Groups for Emergency and Acute Care (75) received the highest number of concerns for the Division of Medicine, concerns with clinical care and communication the top themes arising.

Concerns regarding appointment delays particularly children and family services are again the top theme for the Division of Women's and Children's.



(Concerns by care group)



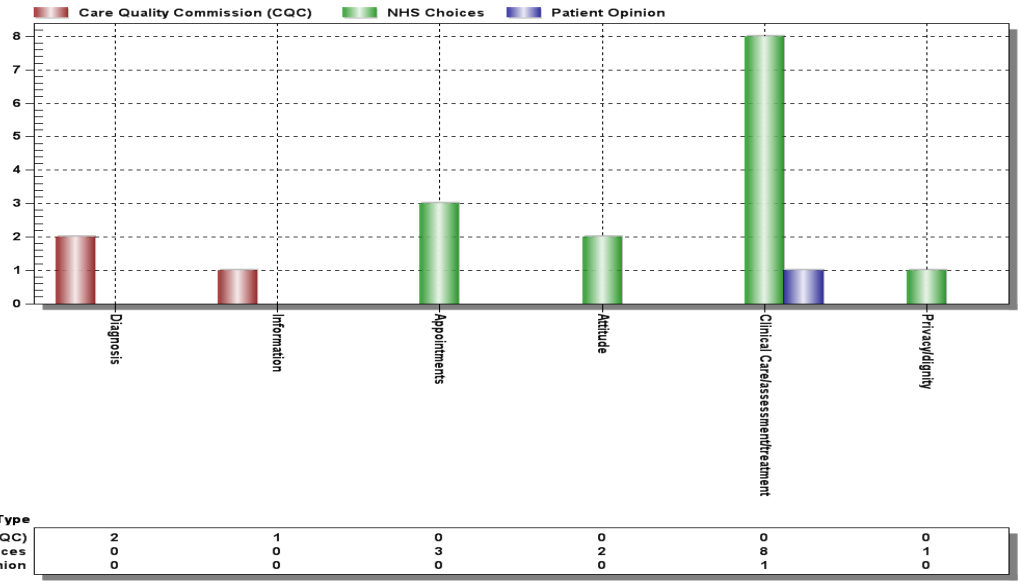
(Concerns by category)

The top three categories for all concerns raised are appointments, clinical care assessment and treatment and communication. These categorise just over 74% of the total number of concerns raised.

9.1 CQC/NHS Choices/Care Opinion

Between October and December 2017 there have been 15 comments made about the Trust via the NHS Choices/Care Opinion website. This figure includes 6 Compliments. The key category type is Clinical Care, Assessment and Treatment and communication. Feedback posted on the NHS Choice/Patient Opinion website is acknowledged and personalised with a request to contact the Trust to discuss the situation further offered. It is difficult to cross reference some of the contact unless they specifically mention that they are calling following a website posting. Additionally we are now submitting the comments directly to the areas involved so that where possible we can respond with the contact details for that area so that the issue can be owned and addressed.

In terms of CQC we have 3 new patient concerns logged for the period October-December 2017. CQC concerns are investigated and responded to directly via the CQC liaison Manager. Monthly updates are provided with details of actions taken as are also shared.



Category Type	Diagnosis	Information	Appointments	Attitude	Clinical Care/assessment/treatment	Privacy/dignity
Care Quality Commission (CQC)	2	1	0	0	0	0
NHS Choices	0	0	3	2	8	1
Patient Opinion	0	0	0	0	1	0

(CQC/Pt Opinion/NHS Choices by category)

10. PARLIAMENTARY HEALTH SERVICE OMBUDSMAN CASES

10.1 PHSO Cases Open

There are currently 5 PHSO ombudsman cases open. All cases are currently being investigated where notification has been received.

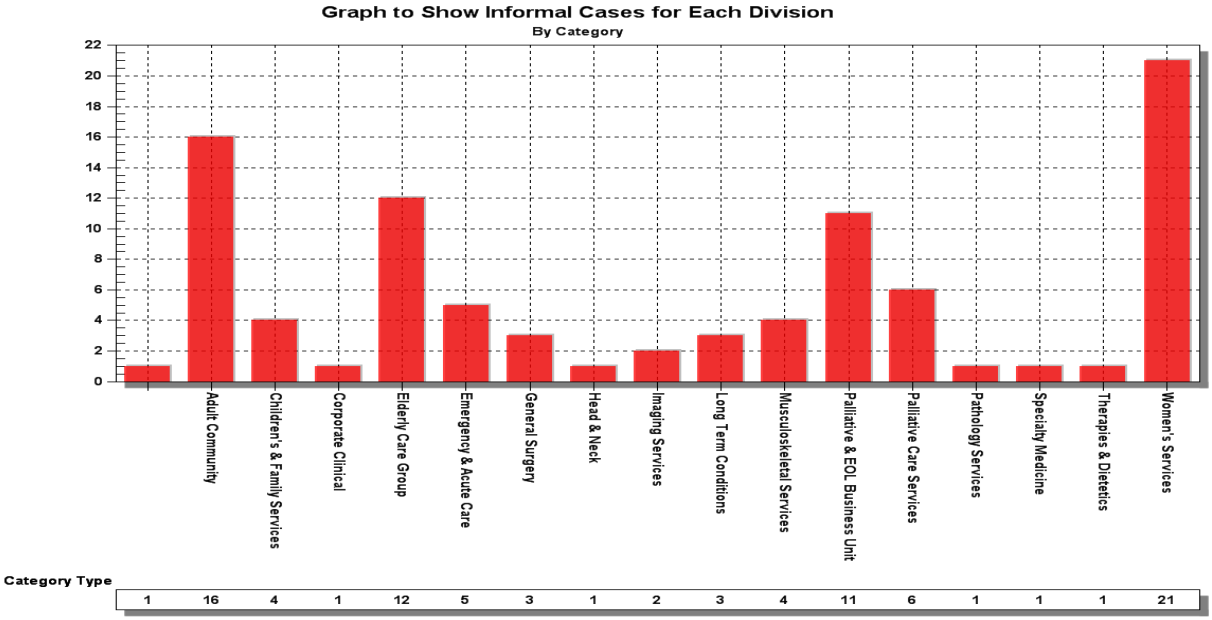
Case and Area involved	Reason and period of care	Status and Outcome
KT Surgery – Urology and Cancer Services	Complaint regarding care and treatment of late KT. Complaint that the Trust failed to intervene proactively when KT condition deteriorated and neither she nor KT were informed how serious his condition was sooner.	Awaiting PHSO outcome
DB General Surgery	**Received: 20 July 2017** Complaint relates to care and treatment for a stomach hernia. Seeking independent review of care to see if more could have been done to treat DB and avoid his suffering.	Relevant paperwork sent 31.7.2017
BJ Emergency and Acute Care MSK	**Received 8 September 2017** Complaint relates to care and treatment between June 2015 and Jan 2016. Poor management of care, delays in A&E missing a hip fracture and inadequate nursing care and medication.	Paperwork sent, confirmation of investigation received 8 September 2017
BMC Elderly Care	**Received 7 November 2017** **Joint with Walsall Council** Complaint refers to lack of rehabilitation, poor communication	Paperwork sent. Investigation commenced
MS General Surgery	**Received 26 January 2017** Complaint that the Trust kept pt unnecessarily in hospital and he was unable to work. Complaint handling caused him anxiety as Trust omitted details from its response.	Complaint file and records sent. Investigation commenced.

10.2 PHSO Cases closed

Case and Area involved	Reason and period of care	Status and Outcome
WC District Nursing	Complaint regarding care and treatment. Pt received a cut to leg and was losing lot of blood and fluids due to her oedema. District Nurse visit but did not undertake a risk assessment or complete paperwork. Bandage not changed for four days and was sodden and full of bacteria. WC was admitted and diagnosed with sepsis	Final response received – partially upheld – some failings in communication identified whilst WC was an inpatient. Action plan completed 3 months. 25 October 2017
BC WCCS	Received: 20 July 2017 Complainant feels the Trust has failed to provide a clear explanation as to what caused his son's death or what happened to his son's red book. Last four hours of his son's life were crucial and that nursing acre during these hours has not been investigated.	Outcome Partially Upheld Closed by PHSO as complied with action plan – 17 November 2017
AM MLTC	Complainant says that his father did not receive regular blood and urine tests before the Trust discharged him on 16 February 2017.	Final outcome received 18.12.2017 Not upheld
LOJO AMU	Complaint regarding care and treatment. States Doctors made promises they did not keep, failed to diagnose his condition and misdiagnosed his condition with hypertension instead of hypotension	Outcome Partially Upheld Received 23 October 2017 Action plan completed and sent 30.01.2018
AF MLTC – Ward 2	Complaint regarding decision to move late AF to ward 2 and the support given from that point. Number of concerns including lack of monitoring, delays in carrying out X-Rays and decision to put AF back on steroids. Seeks recognition of errors.	Outcome Partially Upheld Received 12 October 2017 Action plan completed 17.1.2018
DS Surgery	Complaint highlights a delay by the Trust in informing family that their loved one was suffering from terminal bladder cancer with metastases. Also complains that pain relief as it required authorisation but this was delayed as it was a Sunday.	PHSO outcome – partially upheld Received 17 November 2016 Letter to be formalised with action plan 12.12.2017

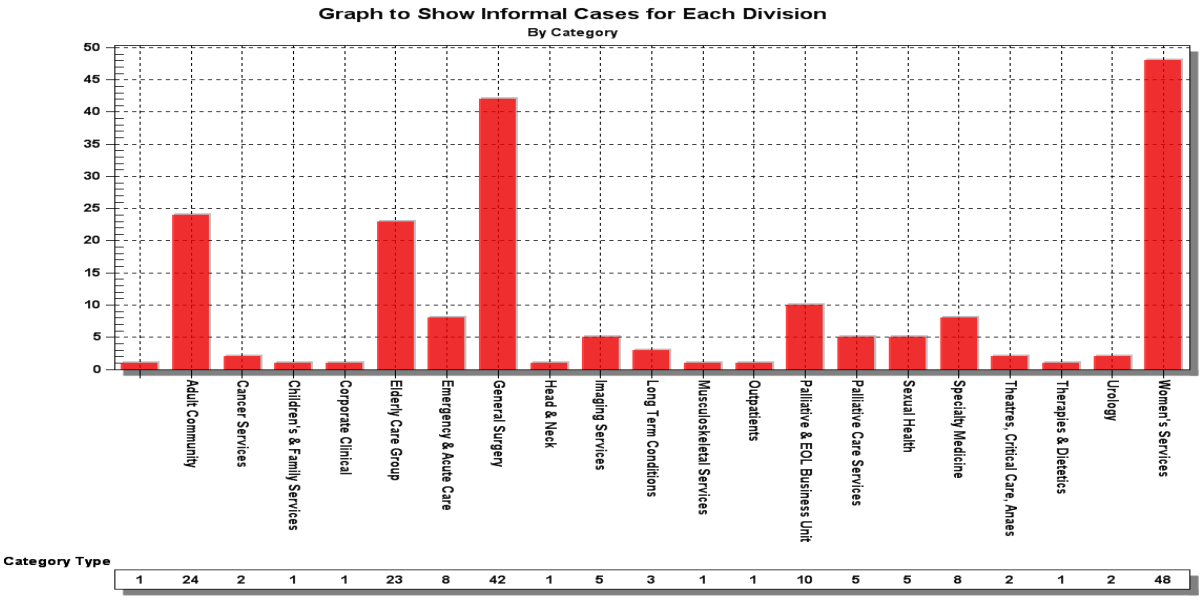
11. COMPLIMENTS

The number of compliments received for quarter 3 was 93. Women's Services, Elderly Care, Adult Community Care and Palliative Care received the highest number of compliments. Compliments recorded account for 14% of all PRT contacts received.



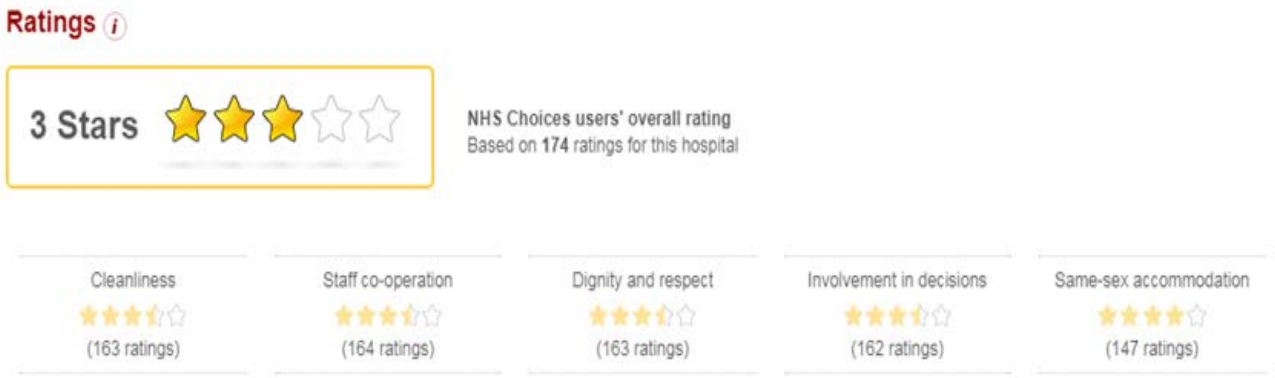
Compliments via care group

The number of compliments received for quarter 2 was 194 which is an increase of 70. Women's Services, General Surgery, Elderly Care and Adult Community Care received the highest number of compliments.



Compliments via care group

12. NHS CHOICES/CARE OPINION



NHS Choices website gives the Trust a rating of 3 out of 5 stars, which is based on 185 ratings received (11 additional comments since quarter 2). Overall rating score is based only on ratings for the question "How likely are you to recommend this service to friends and family if they needed similar care or treatment?". There are optional ratings for the areas of cleanliness, staff cooperation, dignity and respect, involvement in decisions and same sex accommodation. The above figures include data from the **Care Opinion** (formerly Patient Opinion) website which is linked to NHS Choices.

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board (Public)			**Date: 01/03/2018**
Report Title	Serious Incident Report			**Agenda Item:** **Enclosure No.:**
Lead Director to Present Report	Barbara Beal – Director of Nursing (Interim)			
Report Author(s)	Chris Rawlings – Head of Clinical Governance			
Executive Summary	1. There were 17 new Serious Incidents reported in January 2018 ○ 11 Pressure Ulcers (8 Community acquired and 3 Hospital Acquired) ○ 2 Sub-optimal care of the deteriorating patient incidents ○ 2 Patient Falls ○ 1 Diagnostic Issue ○ 1 Surgical/invasive procedure incident 2. Pressure ulcer reporting has increased predominantly in relation to unstageable grade across both hospital and community sites. (11 incidents reported in January 2018 compared to 7 incidents in December 2017). *3.* Two patients sustained severe harm following a fall and there were two cases of sub-optimal care of the deteriorating patient all attributed to different ward locations. *4.* There were no Infection Control incidents reported in January 2018.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒

<table>
<tr><td><u>Recommendation</u></td><td colspan="2">The Board is recommended to
NOTE THE REPORT FOR INFORMATION.</td></tr>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
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<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Linked to Corporate Risk 423:
Failure to recognise and respond to the deteriorating patient and those with early signs of sepsis</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Not applicable</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Health & Social Care Act
CQC Regulations</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Trust Quality Executive</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Monthly report provided on an ongoing basis</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
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Serious Incident Report – January 2018

Executive Summary

1. Introduction

Walsall Healthcare NHS Trust recognises that the prompt identification, initial management, reporting and review of Serious Incidents is important for improving patient care and staff welfare through lessons learned.

Walsall Healthcare NHS Trust also recognises the need to ensure that our staff are open and honest with patients and their families when something goes wrong and is committed to ensuring that this happens.

Serious Incidents in the NHS are defined as:

- Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare[1]

Never Events are defined as:

- Wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

The purpose of this report is to inform Public Board of the:

- Total number of incidents reported in January 2018, to include severity of actual impact
- Total Serious Incidents reported in January 2018 and during the previous 12 months
- Key themes in Serious Incidents reported in January 2018
- Category of Serious Incidents reported in January 2018
- Lessons learned from Serious Incidents closed in January 2018

2. Total Incidents

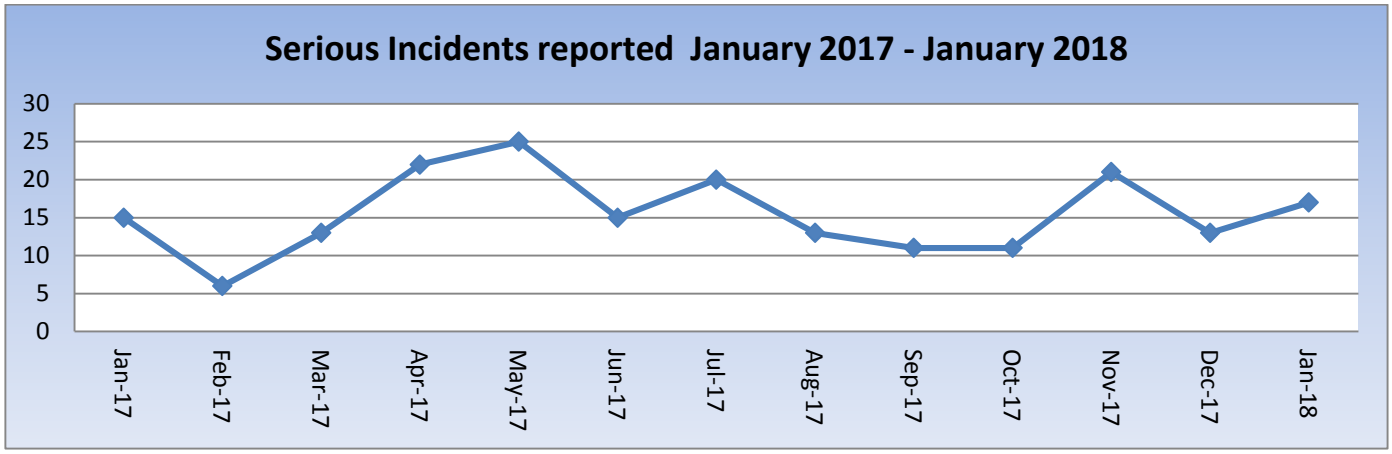
There were a total of 1301 incidents reported in January 2018
The breakdown of harm is shown below:-

Actual Impact	**Incidents reported**
Near Miss	27 (2.1%)
No Harm/Low Harm	1233 (94.7%)
Moderate Harm	35 (2.7%)
Severe Harm	5 (0.4%)
Catastrophic Harm (Death)	1 (0.1%)
TOTAL	**1301**

Note: Near Miss incidents are reported in Safeguard on a separate form to the incident reporting form. This may account for the very low numbers of near miss events being reported as there is good reporting of no harm incidents. Further review of this is being undertaken to determine whether there is a need to change the reporting form.

[1] NHSE Serious Incident Framework 2015

3. **Serious Incidents reported in January 2018 and the previous 12 months**



4. **Key Trends/Themes in new Serious Incidents**
   - 2 patient falls resulted in serious harm. Failure to accurately complete the falls assessment document has been identified as a theme.
   - 2 patients' received sub-optimal care resulting in a deterioration of their condition. No commonalities were identified and the cases were attributed to different ward locations.
   - The development of unstageable pressure ulcers acquired across the Hospital and Community sites continue to be reported at increased levels.

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5. **New Incidents**

There were 17 new Serious Incidents reported in January 2018
   - 11 Pressure Ulcers (8 Community acquired and 3 Hospital Acquired)
   - 2 Sub-optimal care of the deteriorating patient incidents
   - 2 Patient Falls
   - 1 Diagnostic Issue
   - 1 Surgical/invasive procedure incident

6. **Closed Incidents – Lessons Learned**

	2017/13449		**Treatment Delay**
	Patient attended A&E and a provisional diagnosis was made pending medical review. Consultant review was undertaken and plan to reassure and discharge home if walking assessment was satisfactory. The patient was admitted for further observation and CT head scan the following day. The patient's CT identified nothing adverse but his condition had deteriorated and medication was prescribed. Lumbar puncture confirmed a viral neurological condition requiring immediate transfer to ITU and subsequent transfer to another specialist hospital provider.		
Lessons Learned	• Lack of neurological assessment undertaken • No escalation to Medical Registrar for a provisional complex diagnosis • Clinical plan was inappropriate in light full history and change in acute neurological symptoms • No evidence of escalation of continued acute neurology • No documented evidence of escalation of patient's change in condition • Delay in patient being reviewed by Critical Care Team		
Key Changes to Practice	• Share learning at A&E care quality team meeting to ensure doctors are aware of the importance of undertaking neurology assessments for patients presenting with acute neurology and appropriate escalation • Presentation at Grand rounds to reinforce changes in symptoms and appropriate treatment plans and differential diagnosis • Review of serious incident at the Emergency acute care quality team meeting		

	• Acute neurology pathway for AMU to be developed • One to one reflection by doctors involved in the patient's care • Nursing audit of fluid balance, catheterisation and appropriate escalation of poor urine output • Reinforcement to AMU nursing staff on handover regarding appropriate escalation • Review of MCA at the Emergency acute care quality team meeting

	2017/20140		**Patient Fall**
	A patient suffered an unwitnessed fall and sustained a fractured left hip. The patient underwent hip surgery but did not survive.		
Lessons Learned	**Unrelated practice issues -** • Around patient being helped out of bed with a ?#NOF • Staff name stamps not being used consistently • Patient attended QEH for surgery on 15/06/2017 but surgery was cancelled as Enoxaparin & Aspirin had not been stopped. • No documented evidence of a re-assessment of falls following patient's return from QEH		
Key Changes to Practice	• To share RCA with staff as learning • To ensure bed rest of patients awaiting X Ray is documented and followed (although it should be pointed out that we cannot restrain a patient who has capacity) • Ward Manager to address this with team members at ward meeting • Clinical Team Lead to raise at team meeting to be mindful of requirements pre surgery and to ask if unsure as we are not a surgery ward • Review of falls assessment document and Falls Prevention Policy as currently no re-assessment element embedded.		

	2017/22239		**Sub-optimal care of the deteriorating patient**
	A patient attended A&E following previous history of blood in his stools and low haemoglobin. The patient was initially reviewed but there was no escalation or treatment commenced. The patient was transferred to an inpatient ward although no medic to medic handover took place as per policy. The patient's condition deteriorated significantly and they died before surgical intervention could take place.		
Lessons Learned	• No evidence of Junior Doctor referral or discussion with Medical Registrar • Nothing documented by A&E Junior Doctor on A&E CAS Card regarding discussion with Senior A&E Doctor • No evidence of who nurse escalated NEWS score to from A&E CAS Card • Previous DNACPR in place but not given to patient or identified as still active • Registrar to Registrar referral for resus patient did not occur • Inappropriate diagnosis made with no documented evidence of previous Hb results and Black tarry stool		
Key Changes to Practice	• One to one reflective practice to be undertaken with the Junior Doctor regarding the documentation and need to review clinical history when patients are presenting to A&E • Matron to reinforce the NMC guidelines regarding the principles of good record keeping and the Deteriorating Patient Policy which identifies the need to state who you have escalated to • Audit of A&E transfer forms to review handover process • DNACPR process review at task and finish group as part of Mortality Surveillance Group • Reinforcement to ED Doctors regarding the A&E Referral Policy and		

	Registrar/ Consultant referral for patient's in Resus, along with the need for Doctors to review patient history including previous bloods and imaging where appropriate when exploring diagnosis • Themes and trends from sepsis audits to be shred via the Lessons Learnt Bulletin and shared via Care Group Quality Teams

	2017/15067		**Treatment Delay**
	A patient attended A&E generally unwell whilst medical review did not confirm a working diagnosis. There was a delay in the patient observations and initial clerking being undertaken. There were continuous attempts to refer the patient between the medical and surgical teams who were undecided about accepting the patient. CT scan was undertaken which indicated that surgical review was necessary. Eventual surgical review identified that the patient had breached 12 hours from original referral time. Patient was transferred to an inpatient ward and decision made not for surgical intervention.		
Lessons Learned	• No decision made by any speciality regarding responsibility for the patient's treatment • Inappropriate clinical decision making regarding roles and responsibility when the patient deteriorated and became unstable • Delayed patient review by Medical Team • All Bed Managers do not have access to the whiteboard • No identification or escalation of patient's reduced urine output and deteriorating BP		
Key Changes to Practice	• Reinforce the 'Management of unstable patients by the A&E, Acute Medicine and Critical Care' SOP at Care Quality Teams • Reinforce to on-call managers their duty in line with full capacity protocol and 'Management of unstable patients by the A&E, Acute Medicine and Critical Care' SOP • Ensure all Bed Managers have access to the ED whiteboard for consistency • Weekend plan to be communicated across the trust • Reinforce comfort rounds and fluid balance monitoring at the ED Quality Team Meeting • Audit of comfort rounds and fluid balance monitoring in ED • One to one with staff nurse involved to discuss failure to escalate appropriately • Practice development session regarding the recognition of deteriorating NEWS		

	2017/17184		**Treatment Delay**
	A patient had an historical previous cancer diagnosis and completion of treatment. Patient was readmitted with a lung related condition and CT scan identified possible secondary cancer. There was a delay in the arrangement of Outpatient imaging investigations and subsequent CT scans confirmed a recurrence and increased growth of the lesion.		
Lessons Learned	• No access plan created prior to discharge to note follow up required post Bronchoscopy due to unclear process • No evidence of discussion at Lung MDT following inpatient episode following CT findings • No evidence the Bronchoscopy report was reviewed by Consultant and discussed at the Lung MDT • No clinic follow up appointment was booked as there is no clear process following the Bronchoscopy		
Key Changes to Practice	• Training session to be undertaken with MLTC Ward Clerks regarding booking of access plans following discharge from inpatient wards		

	• Review of process for booking appointments where there is no Ward Clerk or for out of hours and weekends • Risk to be added to the Long Term Conditions risk register regarding gaps in process for patients to be discussed at the Lung MDT • Review of Lung MDT processes for tracking patient discussions to ensure no patient is lost to the MDT • Article added to the lessons learnt bulletin regarding the need for the requesting Doctor to review pending investigations • Review undertaken of the RADAR process in Endoscopy • SOP to be developed regarding RADAR process in Endoscopy • Feasibility study of the ability to upload Bronchoscopy to Endosoft

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board			**Date: 8th March 2018**
Report Title	Quality & Safety Committee Highlight Report			**Agenda Item: 11** **Enclosure No: 9**
Lead Director to Present Report	Chair of Quality & Safety Committee, Non-Executive Director, Russell Beale			
Report Author(s)	Kara Blackwell, Deputy Director of Nursing			
Executive Summary	The report provides a highlight of the key issues discussed at the most recent Quality & Safety Committee meeting held on 22nd February 2018 together with the confirmed minutes of the meeting held on 25th January 2018 (appendix 1). Key items discussed at the meeting were: • Plans to undertake a review of a cohort of deaths that have shown a trend for the past 2 years relating to being admitted out of hours and with a 0-1 day length of stay. • VTE and plans to achieve this • Maternity Journey and reflections on the learning form this. • Changes in our reporting of pressure ulcers for 2018/2019, actions being taken to reduce avoidable pressure ulcers • Implementation of the GDPR • Ongoing work with ECIP to improve emergency care The meetings held on 25th January and 22nd February were quorate and chaired by Professor Beale.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Board is recommended to DISCUSS the content of the report and raise any questions in relation to the assurance provided.			

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<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Link to Board Assurance Framework Risk Statement No.1 ‘That the quality and safety of care we provide across the Trust does not improve in line with our commitment in the Patient Care Improvement Plan’</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">There are no resource implications raised within the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Compliance with Trust Standing Orders</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The Quality & Safety Committee reports to the Trust Board on a monthly basis following its meetings. The Board receives the approved minutes from the previous Quality & Safety Committee meeting and a highlight report on the key issues raised at the most recent meeting.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The minutes from the Quality & Safety Committee meeting held on 22nd February 2018 will be submitted to the Board at its meeting on 5th April 2018 at which the Board will also receive a highlight report from the Quality & Safety Committee meeting held on 29th March 2018.</td></tr>
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QUALITY & SAFETY COMMITTEE HIGHLIGHT REPORT
TRUST BOARD – 22ND FEBRUARY 2018

1. Introduction

The Quality & Safety Committee reports to the Trust Board on a monthly basis following its meetings. The Board receives the approved minutes from the previous Quality & Safety Committee meeting and a highlight report on the key issues raised at the most recent meeting.

2. Key Issues from Meeting held on 22nd February 2018

The Committee was quorate and discussed numerous items including a presentation from the Division of Estates & Facilities. Minutes will come to the Trust Board in April. The highlights for the Trust Board to be aware of are as follows:

3. Performance and Quality Report

The key points noted form the presentation of the Performance and Quality Report were:

- **Mortality** There has been an increased number of deaths which is expected in the winter months; however this will impact on the HSMR and SHMI. A multidisciplinary review of all patients who had a 0-1 day length of stay and were admitted out of hours during December and January was being undertaken by a consultant, senior nurse and community lead.
- **VTE** Performance in February saw an improvement. A robust action plan has been developed to address issues raised by the CQC and CCG to assure delivery of the national indicator of 95% over the coming months. This adopts a collaborativenursing and medical approach and will include improved medical education and escalation processes. The *FEVERED* campaign was also launched in medicine in February which includes VTE. The main area of focus are on the Medical Assessment units and Cardiology.

4. Maternity Improvement Journey

The maternity improvement journey was discussed. Whilst there were some specific differences in relation to how the CQC inspection was undertaken in maternity compared to the rest of the organisation there remains the issue around how the Trust assured itself and the rigour associated with the self-assessment process undertaken prior to the visit and also the acknowledgement of the scale of the improvements required. The importance of the cultural changes required going forward and the Edgcumbe work currently in progress, the structures required and setting out the behaviours and expectations required in relation to this were discussed.

5. Trust Quality Executive Report

Key points raised in relation to the report included:

- IP&C Environmental Audits highlight issues with cleaning and the impact the current recruitment issues in housekeeping are having on this. This was also discussed as part of the Estates and Facilities Divisional Discussion in the Q&S meeting.
- Hospital acquired grade 2 pressure ulcers have increased this year. Actions being taken included a review of the documentation booklet and inclusion of a SKIN care bundle for all patients. It was noted that unstageable pressure ulcers were not included last year so this year's data will provide a benchmark for improvement going forward. The Trust currently reports all pressure ulcers per 1,000 bed days; going forward community acquired pressure ulcers will be reported per 10,000 CCG population in line with NHSE guidance.
- Cancer targets were currently being met however the changes to these targets will make these more difficult to achieve for the more complex tertiary referral cases and the Divisions are looking into this and what actions need to be taken.

6. General Data Protection Regulation

The report was presented on the implementation of the General Data Protection Regulation. The key points included:

- Personal information held needs to be accurate, up to date, and held for the correct retention period; this is the responsibility of all staff across the Trust
- A robust action plan is in place to manage the implementation to pick up data quality issues
- Needs to be a robust programme for training staff
- Team are launching a GDPR intranet page which will go live in the next few weeks
- Currently there is a charge for providing hard copies of patient records to patients, will the Trust clarification on this required going forward

7. Emergency Care Improvement Programme Visit

The report from the recent visit undertaken by the NHS Improvement Emergency Care Improvement Programme was received by the committee.

NHS Improvement will be working with the Trust over the coming months focusing on specific workstreams to improve flow for the organisation. Although some previous work has been undertaken and there are some processes in place there needs to be further work to strengthen these and support and improve staffs understanding and engagement with these. The committee agreed to the proposal to invite the NHSI project lead, Lucy Roberts to the next Quality and Safety Committee.

8. Monthly Nurse Staffing Report

The reported was presented and key points were noted and discussed:

- Vacancies fell slightly in January 2018
- Registered nurse fill rate was >90% in January with the exception of 2 wards
- Registered nurse agency hours increased in January, this was linked to additional capacity areas including endoscopy, cardiology and 20C being used for medical outliers.

The current work being undertaken to improve e-rostering and achieve compliance with the KPIs was discussed which included the e-roster pilot, roster clinics and further work on temporary staffing. An update on overseas and student nurse recruitment and the work starting on retention was also discussed alongside an update on the TNA posts and how these will be integrated into the nursing workforce when they qualify in Jan 2018.

9. Quarterly Patient Experience Report

The report was presented and the key points noted:

- Emergency Department FFT performance for Q3 had deteriorated; this had been effected by the Lorenzo upgrade which meant that the department had had to revert back to using a paper version of the survey until this was resolved.
- There had been good Divisional representation at the Patient Experience Committee in February and presentations of the patient experience action plan updates in relation to ED and Cancer Services. Children and Young People and Maternity Services were in the process of developing their action plans in response to the recent national survey results
- In the recent results for the National Maternity Patient Experience Survey the Trust had achieved similar results to national peers and improved in 73% of questions. There were 2 questions where the Trust performed worse than peers; one related to skin to skin contact and the advice around postnatal follow up with the GP, and maternity services had actions in place to address these.
- Complaints response time improved in Q3 and was 100% in January 2018

Vicky Harris also confirmed that's she had been asked to be the non-executive lead for patient experience.

10. Efficiency in Theatres

The Surgical Division presented an update on theatre efficiency as a follow up to the discussions held at the previous meeting. The challenges associated with winter and medical outliers on Ward 20C was outlined. However, it was noted that by increasing the day case activity during this time the Division had managed to still managed to continue elective work.

The Division updated on the work being undertaken in relation to challenging late starts in theatres so that this is more robust. Knife to skin time rates had increased by 10% in the previous week. There is also work being undertaken on the Surgical Bed modelling supported by NHS Elect. The importance of consistency and competencies in relation to theatre teams and efficiency was also highlighted.

11. Division of Estates and Facilities

The presentation from Estates and Facilities was received and the following key points noted:

- The capital programme for lifecycle for the retained estate prioritises the work across the whole estate. Priority has been given to the mortuary fridges this year and the work to be done in relation to the expansion of the NNU and maternity theatres
- An LiA event had taken place with staff to encourage the reporting of minor works before they become worse and are therefore more difficult and expensive to rectify.
- The Division is working on their Quality Commitment and have drafted their QC
- The issue of recruiting domestic staff was highlighted. The Division is working with the Workforce team to look at developing dual roles to aid recruitment

There was a discussion about recruitment and managing the demand and staffing gaps in different ways and whether there were non-clinical areas where staff could be re-deployed from to clinical areas that are not getting the focus to maximise the use if the staff we have. The Division conformed they are working on this.

APPENDIX 1

MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON THURSDAY 25TH JANUARY 2018 AT 9.00 A.M ROOM 10, MLCC, WALSALL MANOR HOSPITAL

Present:	Professor R Beale	Non-Executive Director (Chair)
	Mrs K Blackwell	Deputy Director of Nursing
	Mr R Caldicott	Director of Finance & Performance
	Mr P Gayle	Non-Executive Director
	Mrs V Harris	Non-Executive Director
	Mr A Khan	Medical Director
	Mr R Kirby	Chief Executive
	Mrs L Storey	Trust Secretary
	Mr P Thomas-Hands	Chief Operating Officer (Item 191/17 onwards)
In Attendance:	Mrs C Gilbert	Divisional Director of Nursing, Surgery (Item 205/17 only)
	Mr N Turner	Divisional Director, Surgery (Item 205/17 only)
	Mrs A Winyard	Divisional Director of Operations, Surgery (Item 205/17 only)
	Miss S Garner	Executive Assistant (minutes)
Apologies:	Mrs B Beal	Interim Director of Nursing

186/17 Welcome and Introductions

Professor Beale welcomed everyone to the meeting.

187/17 Declarations of Interest

There were no declarations of interest.

188/17 Minutes of the Meeting Held on Thursday 21st December 2017

Resolution
The minutes of the meeting held on 21st December 2017 were agreed as a true and accurate record.

189/17 Action Sheet and Matters Arising

Resolution
The Committee received and noted progress on actions

included on the live action sheet.

190/17 Performance & Quality Report

Mr Khan presented the Performance & Quality report and the following updates were noted:

- Although there had been an improvement in VTE performance to 93% in December, the trajectory of 95% had not been achieved. VTE assessment had also been highlighted as a regulatory breach in the recent CQC report and the Trust had provided an action plan to the CQC to achieve the performance target by March 2018.
- An increase had been recognised in the number of deaths reported in December; this would be picked up in more detail as part of the mortality report.
- The number of C. Diff cases had increased in December which brought the Trust close to the threshold target for 2017-2018.
- There had also been an increase in the number of Flu cases admitted the Trust with a total of 15 reported to date. This was being managed appropriately and bays were being closed as required.

Mr Gayle asked how the Flu virus and current winter pressures were impacting the Trust. Mr Khan explained that the winter period had been difficult for the organisation as expected, however, although patients were waiting a long time in the Emergency Department to be transferred to a ward there had been no 12 hour breaches or major incidents reported as a result of inability to cope with pressure. Additional clinical staff had been put in place to support with this situation and a 30 minute turnaround had been agreed for flu testing to enable patients to be moved quickly and bays to be closed. This was impacting on bed availability and flow for the rest of the organisation.

There was a detailed discussion about current waits in the Emergency Department and how this was impacting ambulance handover times. Mr Khan confirmed that this was a regional issue and the Trust had not been identified as an outlier. The ambulance staff were keen to support the Trust at this difficult time and escalated concerns to the on call manager as required. Mr Gayle asked whether this contributed to an increase in mixed sex accommodation breaches. Mrs Blackwell advised that there had been no breaches reported on the inpatient wards and a discussion had taken place with the CCG and the timeframe for confirming breaches in HDU/ITU had been extended to 12 hours. She talked about work ongoing to support the Emergency Department throughout the day time to improve flow and move patients through the department quickly. Mr Khan added that all emergency elective cases had been prioritised including cancer

patients and 52 week waits. All other elective cases were being cancelled.

Resolution

The Committee received and noted the content of the Performance & Quality Report.

191/17 Maternity & Neonatal Task Force Update

The committee received the highlight report from the Maternity & Neonatal Taskforce meeting held in January and assurance had been received on progress with the four elements of the Section 29A Warning Notice. It was recognised that there had been a slight increase in the C-section rates reported in December, however, this was being addressed by the team. Further discussions had taken place about the re-opening of the Midwifery Led Unit (MLU) and it had been agreed that this would remain closed and would be reviewed again in 3 months' time.

Mr Kirby commended the team in maternity for their work to improve over the last few months and assured the committee that there was now a clear plan regarding staffing arrangements moving forward.

Mr Caldicott raised concerns regarding the cost pressures associated with the current midwife to birth ratio (1:25) which was well ahead of the target of 1:28 and the continued closure of the Midwifery Led Unit. It was noted that discussions had taken place regarding the reduction of intervention offered to patients within the hospital and it was also agreed a review of the current catchment areas agreed as part of the cap would support to close the income gap. The re-opening of the MLU had been considered in detail at the taskforce meeting and it was recognised that this would impact the current staffing plans.

Mr Gayle recognised the achievement of positive acuity levels and queried what engagement had taken place with the team to ensure the acuity tool was utilised and understood. The taskforce had discussed staff engagement in detail and it was noted that the senior team within the division were undertaking regular walk abouts to ensure the staff had a good understanding of the acuity tool. The Non-Executive Directors responsible for maternity had also agreed to take part in some walkabouts.

Mr Thomas-Hands joined the meeting.

Professor Beale asked what had caused the increase in C-section rates during December. Mrs Blackwell advised that that the team had previously undertaken a daily review of C-sections which had reduced during December. This had now been re-

implemented. It was noted that there was more work to be done regarding sustainability of the service and further support had been offered to the Divisional Director of Midwifery to enable this.

Resolution
The Committee received and noted the Maternity & Neonatal Task Force Update Report and acknowledged the positive work and progress made by the team in maternity.

192/17 Progress Update on VTE Processes

Mr Khan presented the report on VTE performance and reported that although there had been an improvement in VTE performance to 93% in December, the trajectory of 95% had not been achieved. As previously discussed, an action plan had been submitted to the CQC regarding the regulatory breach identified which included the multi-disciplinary team working together to ensure the assessment was undertaken for every patient.

Non-Executive members raised concerns in relation to non-compliance with the agreed trajectory and asked what further actions could be taken to address this. It was noted that a number of actions had been put in place and work had been done with the ward managers to hold them accountable for picking this up as part of the ward round with consultants.

Mr Kirby commended the team for the improvement to 93% in December, however, expressed that further action would need to be taken to ensure the trajectory was achieved in February in order to provide assurance that the commitment to the CQC would be achieved in March. He requested that Mr Khan and Mrs Beal work with the divisional leads to understand what further action would need to be taken. **AK/BB**

Resolution
The Progress Update on VTE Processes was received and noted by the Committee.

193/17 Patient Care Improvement Programme

The Patient Care Improvement Programme which had been developed following receipt of the CQC Inspection report received in December was received by the committee. The regulatory breaches and actions to address these had been reported back to the CQC on Monday 22nd January 2018.

Mrs Blackwell outlined the next steps in relation to the PCIP which followed on from the first stage of the plan in relation to the “must” and “should” do actions. This would include aligning

individual actions into themes, and linking these to the Trust Objectives and Quality Commitment. This work was currently being undertaken supported by the Improvement Director. It was noted that workshops were being arranged in March to support the Divisions and Care Groups to embed these required changes and enable services rated as requires improvement to progress to good, those good services to progress to outstanding, and those services rated as outstanding to continue to achieve this status. This work was due to be presented to the Trust Quality Executive in March.

Mr Gayle highlighted that issues had been raised regarding the timely completion of assessments in line with the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DOLS) and was concerned that this was linked to a growing cohort of patients with learning disabilities. Mrs Blackwell advised that this had been raised as a regulatory breach, therefore, a number of actions had been agreed to address this including a review of current training data and audits regarding compliance with MCA when completing Do Not Attempt Resuscitation (DNAR) decisions. It was noted that Specialist Nurses for Learning Disabilities had been engaged in this work to ensure patients are appropriately supported on the wards. Mr Kirby advised that the Susan Hearsey Patient Care Review was due to be presented at the Public Trust Board the following week and included a clear action plan in relation to improving the care provided to patients with learning disabilities.

Professor Beale queried whether the PCIP was being progressed at the required pace. Mrs Blackwell assured that the Trust had responded to the CQC inspection report in the required timeframe, however, would continue to progress actions quickly to enable the Trust to link the improvement work to the current Quality Commitment.

Resolution

The Committee received and noted the Patient Care Improvement Programme.

194/17 Safer Nurse Staffing Report

Mrs Blackwell presented the Safer Nurse Staffing report which set out the staffing, quality, patient safety, and operational accountability and assurance in relation to the nurse staffing skill mix/ratios on the medical and surgical inpatient wards. It was noted that benchmarking against peer organisations and NICE Guidance showed that the RN to Patient ratio exceeded the recommended 1:8 ratio on days. The report also outlined actions in relation to safe staffing and nursing workforce being undertaken over the coming months. The tool would be run again

in February and the committee would be updated accordingly.

Professor Beale confirmed that as part of recent board walks staff had highlighted that they were not able to book temporary staffing in advance and this caused an issue. Mrs Blackwell advised that work was being undertaken regarding proactive rostering to maximise the chance of filling gaps appropriately. There was a need to manage the requirement for staffing highlighted by the ward staff against a safe level of staffing and the senior nursing team were supporting these decisions.

Mr Kirby highlighted that there needed to be a focus on reducing the current number of vacancies and functioning within the funded bed-base, as the additional capacity further stretched the existing workforce. Mrs Blackwell provided an update on the current recruitment status and identified that there had been some success with Skype interviews for overseas nurses who had already passed their IELTS test. Members recognised the work that had commenced on recruitment and retention and asked for a further update on plans at the next meeting. **BB Feb 18**

Mr Caldicott highlighted that Trusts who were red rated against the model hospital data were required to produce a formal action plan. The action plan within the report suggested that the review and sign off of budgets would be undertaken before April; however, this had been completed with the ward managers already with the exception of a review of some areas in April 2018. Mr Caldicott suggested that the report be amended to reflect this. It was also noted that the cost of direct care hours was being reviewed with NHS Improvement to understand whether supernumerary nurses should be included. **KB**

Resolution
The Safer Nurse Staffing Report was received and noted by the Committee and an update on recruitment and retention was requested for the next meeting.

195/17 Report on Seven Day Services

The report on seven day services was received by the committee and it was noted that gaps remained in the four priority standards for the Trust. The report had been discussed in detail at the Trust Quality Executive. Mr Khan highlighted that the Trust were committed to ensuring that the standards with a direct impact on patient care would be achieved and solutions were being discussed for those that were clinically essential.

It was agreed that leads and timescales would need to be defined for the next steps outlined in the report. Professor Beale suggested that the relevant standards for the Trust would need to

be confirmed and approved by the Trust Board and the process should be set out in a policy so that patients and relatives knew what to expect from services provided by the Trust.

Mr Caldicott highlighted that a review of services would need to be undertaken to identify any gaps and a business case would need to be developed to address these. This would need to include the potential cost savings associated with providing seven day services e.g. reduced length of stay and effective care being provided.

Resolution
The Committee received and noted the report on Seven Day Services.

196/17 Trust Quality Executive Report

Mrs Blackwell presented the report from the Trust Quality Executive meeting held on 19th January 2018 and confirmed that the main points for escalation had been covered as part of the agenda with the exception of compliance with NatSSIP's and LocSSIP's guidance. Members were advised that the Trust had appointed a lead for this guidance and it was agreed that an update on this would be provided at the next meeting. **AK Feb 18**

Resolution
The Committee received and noted the Trust Quality Executive report and requested an update on the LocSSIP's and NatSSIP's guidance at the next meeting.

197/17 Capital Equipment Replacement Programme

Mr Khan presented the report which outlined equipment for replacement. This had been shared with the divisional teams for prioritisation due to the current financial position of the Trust. It was agreed that the final list of equipment for replacement would need to be submitted to the Trust Quality Executive and Quality & Safety Committee next month to enable discussions to take place prior to agreement of budgets taking place at the end of March. The EBME Manager would also be involved in this process to ensure equipment had been risk assessed as required. **AK Feb 18**

Resolution
The report on the Capital Equipment Replacement Programme was received and noted by the Committee and it was agreed that the final list of equipment for replacement would be submitted to the committee in February.

198/17 Data Quality – Right Patient Right Consultant Internal Audit Report

Resolution

The Internal Audit Report for Data Quality – Right Patient Right Consultant which had been commissioned by the Medical Director was received and noted by the committee prior to submission to the Audit Committee.

199/17 Safer Bundles Internal Audit Report

Mr Thomas-Hands presented the report in relation to the Safer Bundles Internal Audit which had been undertaken during summer 2016 and highlighted that the report pre-dated actions and systems subsequently put in place. The committee were advised of the work being undertaken with the Emergency Care Improvement Programme team at NHS Improvement and it was suggested that the report from their recent visit be shared with members at the next meeting along with an update on actions being taken to address the recommendations. **PTH Feb 18**

Resolution

The Committee received the Safer Bundles Internal Audit Report and requested that the report from the recent Emergency Care Improvement Programme visit be received at the next meeting along with an update on actions being taken to address the recommendations.

200/17 Risk Management Committee Information & Escalation Report

Mr Khan presented the Risk Management Committee Information and Escalation Report and the following points were noted:

- There had been 4 infection control related serious incidents reported in December in relation to Norovirus and C. Difficile cases.
- There was a benchmarking exercise being undertaken regarding the number of pressure ulcers being reported.
- Discussions were ongoing regarding compliance with duty of candour and some improvement work was being done with the divisional teams.

Mrs Harris queried whether the CQC had requested a review of all ligature points across the Trust following issues identified as part of their inspection. It was noted that this was not the case, there was a concern raised in one area in the community, however, work had been agreed to risk assess areas with potential risk across the trust.

Mr Gayle referred to the work ongoing in the community to prevent unavoidable pressure ulcers and requested further assurance that this was taking place. Mrs Blackwell identified that

a piece of work had commenced to review themes within the acute hospital and to identify key areas in the community where pressure ulcers were being reported. It was also noted that the Chair had raised this subject at the Trust Board meeting and queried whether guidance provided to patients in the community was clearly articulated. Mrs Blackwell confirmed that this was being reviewed as part of the wider work and confirmed that more detail and actions would be agreed following the review. The report was due to be received at the Trust Quality Executive in February.

Mr Gayle identified that the report referred to a risk in relation to replacement of 184 fridges in the mortuary and asked whether this had been completed. Mrs Storey clarified that this was an error in the report and it was in fact 'risk number 184' regarding replacement of mortuary fridges. It was confirmed that fridges in the mortuary had been replaced during January.

Resolution
The Committee received and noted the Risk Management Committee Information & Escalation Report.

201/17 Never Event Report and Action Plan

Mrs Blackwell presented the report on the recent Never Event in Maternity in relation to a retained swab and identified that the RCA had been undertaken and immediate actions had been taken as a result of the incident.

Members were advised that the swab and needle checks were now being audited daily to ensure that these were consistently being undertaken. A paper version for recording these checks was currently being used whilst a mandatory field was being developed on the Badger net system. Discussions had also taken place with staff to reiterate the importance of documenting swabs and needle checks.

Resolution
The Committee received and noted the Never Event Report and Action Plan.

202/17 Monthly Nursing & Midwifery Quality & Staffing Report

Mrs Blackwell presented the Monthly Nursing & Midwifery Quality & Staffing Report and confirmed that discussions regarding staffing had taken place as part of the Safer Staffing report earlier on the agenda. Members were advised that the current number of vacancies had not changed significantly, however, plans to recruit continued as previously discussed. There had been an increase in the number of Thornbury shifts used in December 2017 due to the additional capacity opened during this period.

Mr Gayle queried whether the increase in bank pay rates had impacted the number of shifts being filled with bank workers. It was noted that an increase had been seen, however, due to the current demand on the bank it had been difficult to continue to monitor this. A deep dive exercise into agency usage was due to be undertaken and would include the reasons for use. Further work was also being done to look at alternative agencies.

Committee members were advised that an anomaly had been identified between data from Rosterpro and funded rosters in relation to the unify data submission. It was noted that CSW shifts were being over-filled to backfill for RN gaps, however, the unify data suggested that shifts weren't being covered accordingly. Further work was being done to resolve this and to improve the use of Rosterpro.

Resolution
The Committee received and noted the Monthly Nursing & Midwifery Quality & Staffing Report.

203/17 Mortality Report

Mr Khan presented the Mortality report and confirmed that the HSMR and SHMI rates remained below 100 for the Trust. It was noted that actions had been identified following a number of mortality reviews and the lead for mortality had been discussing current delays in reviews being undertaken with care group teams. Mr Kirby requested that leads and timescales be defined for the recommendations outlined in the report. **AK**

Resolution
The Mortality Report was received and noted by the Committee.

204/17 Report from the Clinical Audit & Effectiveness Committee

Mr Khan presented the report from the Clinical Audit & Effectiveness Committee and highlighted that there were some CAS alerts that remained open. As previously discussed, further work was being done regarding compliance with NICE guidance for the Trust.

Resolution
The Committee received and noted the report from the Clinical Audit & Effectiveness Committee.

205/17 Presentation from the Division of Surgery

Professor Beale welcomed members of the Surgery division to

the meeting. A presentation was provided and the following points were noted:

- The division had presented at their quarterly review with the executive team this week and discussed a number of quality aspects.
- An overview of the CQC outcome for the division was received and discussions were ongoing regarding how core services within the division could progress to a good rating.
- Advice was being sought from neighbouring critical care units that had achieved outstanding in their CQC inspection.
- The division had recognised that there was more to be done to improve the response and care of deteriorating patients.
- The main divisional risks were presented to the committee
- An update on nurse staffing and current vacancies was received and it was noted that 11 RN posts had been offered as a result of some overseas recruitment.
- The Theatre Workstream was progressing at pace including development of increased utilisation schemes.
- Future discussions would be taking place regarding sustainability of services.
- Engagement had been positive in relation to the clinically led model and would continue to be embedded.

There was a discussion about average theatre utilisation and the Chair raised concerns regarding current rates for the Trust against neighbouring organisations. Mr Turner highlighted that the current number of gaps within the service was impacting on theatre utilisation rates along with high levels of emergency flow which caused increased pressure in the emergency theatre and recovery areas. Mr Thomas-Hands supported this, however, recognised that there was more work to be done by the division to confirm the current position with theatre utilisation and agree a trajectory moving forward. Mr Khan explained that there were a number of processes outside of theatres that were impacting on current activity and these were being reviewed as part of the whole pathway. It was noted that there was a need to prevent surgical bed closures due to capacity issues.

Members were advised that discussions regarding a trajectory for theatre utilisation had taken place at the Division of Surgery's Quarterly Review; improvements to bookings which supported utilisation had also been implemented. Support was requested in relation to the current booking tool and information governance restrictions regarding patient details.

Mr Caldicott recognised the level of improvement made and the work being done in theatres. He suggested that the division

undertake a benchmarking exercise against neighbouring trusts including a gap analysis in order to identify a realistic trajectory. Further support would then be provided to the division to understand how gaps could be addressed with available funds.

Mr Khan highlighted that issues with the capnography equipment had not been highlighted by the Critical Care team and asked what measures had been put in place to ensure issues were picked up in future. It was noted that the division had undertaken a piece of work to identify any concerns and continued to gain assurance from the risk register confirm and challenge meetings now held with the care group teams. The division were also asked whether feedback was received as part of the audit process and what mechanisms were in place to monitor actions. Mr Turner advised that feedback on external reports and internal audits were received at the divisional quality team meetings, however, work to strengthen this was ongoing and would be discussed at the next meeting along with discussions about performance monitoring within specific teams.

Professor Beale thanked the division for their presentation and offered support on behalf of the committee regarding current capacity and demand within theatres.

Resolution

The Committee received and noted the content of the presentation from the Division.

206/17 Items for Referral to the Trust Board

Resolution

The Committee resolved that the following items would be referred to the Trust Board at its meeting on the 1st February 2018:

- Progress in maternity services
- VTE compliance
- Never Event Final Action Plan received
- Discussion about theatre utilisation

207/17 Any Other Business

Mr Gayle highlighted that there were links regarding the People & Organisation Development Committee within the Performance and Quality report and queried how workforce elements were impacting on quality elements for the Trust. This was discussed further and it was suggested that further consideration about how this could be reflected in the report would be taken outside of the meeting.

There was also a discussion about the lack of focus on the community services by the committee and it was agreed that further assurance from the team would be beneficial. Mr Kirby confirmed that assurance from the adult and children community services would be included in the relevant divisional presentation and suggested that the community areas report separately to the committee. It was agreed that this would be considered by the executive team outside of the meeting and the agreed process would be confirmed with the Chair. Members were advised that the main areas of concern were likely to be raised by the children's community teams.

Exec Team

208/17 Reflections on Meeting: Post Meeting Questions from Trust Meeting Etiquette and Proposals for Trust Board Walks

Utilising the Post Meeting Questionnaire agreed as part of the Trust's meeting etiquette Professor Beale sought feedback from the members and attendees. The responses were noted and would be taken into consideration for future meetings.

209/17 Date & Time of Next Meeting

Thursday 22nd February 2018, 9:00am
Room 10, MLCC

Walsall Together Provider Board

Case for Change and Next Steps

January 2018

NHS Walsall Clinical Commissioning Group

Walsall Council

Walsall Healthcare NHS Trust

GP Groups

One Walsall
Inspiring and supporting social action

NHS Dudley and Walsall Mental Health Partnership NHS Trust

Version 3.0 – 12th February 2018
Release Copy

Disclaimer

This report has been prepared on the basis set out in the scope agreed with KPMG and addressed to Walsall Together Provider Board (WTPB) in accordance with the agreed written terms of engagement dated 21 November 2017 (the 'Engagement Letter'), and should be read in conjunction the Engagement Letter.

This document is for the benefit of the Walsall Together Provider Board only and only to enable the WTPB to give preliminary considerations to the findings available based on fieldwork carried out up to the date set out in the document and for no other purpose. This document has not been designed to be of benefit to anyone except the WTPB.

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Foreword

So why integrate different organisations to improve people's health and wellbeing? There are now significant reports and publications that help us answer this question, and we have referred to those. However, our starting point has been very straight forward: as leaders in the health and care system we know we cannot continue as we are currently working. Our system is disparate and offers care on an episodic basis, rather than in a coordinated efficient way.

The public tell us regularly that they cannot access the support and services they need quickly enough or locally enough. We know that as the population grows, lives longer and with more complex and inter-related illnesses that the need for coordinated care is increasing.

Professionals want to provide good quality and responsive services, but often they end up handing patients off to other colleagues and organisations without having influence or an ability to coordinate a full oversight of care.

We know that if we don't stem the increase in lifestyle related illness (obesity, diabetes, and substance misuse) then the current resources we have will not meet the needs of our population. We also know that in many areas where we spend significant amounts of money, that the outcomes for people are not always satisfactory.

Our aims in this work are multiple but in summary we aspire to:

- Offer a population, place based health and care system, that is person focused and based on the known needs of the population;
- Lose the different approaches of primary, secondary, community health and separate care; to one that is demand led, joint and centred on how best to respond to demand within the resources available;
- Operate within the resources we have to improve the quality of care and support we offer across the whole health and care system;
- Be clear about the expectations and entitlements of access to care and support for our population;
- Empower our practitioners, patients and clinicians to be the key decision makers in the design of new arrangements;
- Develop a system where prevention , early help and self-care are key, because people are well advised, confident and knowledgeable about their own health and wellbeing;
- Ensure that professionals in the health and care system are connected, share responsibility and accountability for the health of the population;
- Provide care and support that is high quality, cost effective and the best value for money;
- Ensure decisions about health and wellbeing are evidence based and underpinned by good practice and knowledgeable staff;
- Organise ourselves to achieve the above and much more.

This paper moves the Provider Board forward in its thinking and clearly outlines the next steps to transforming the Health and Care System in Walsall. We are looking at new, emerging care models

and innovative contractual arrangements which facilitate providers to work together in new ways to achieve a shared aim of improving patient outcomes.

In early 2018/19, we will have agreed a preferred model for delivering integrated care in Walsall and to drive the transformation we want to see. We have collectively identified and agreed population cohorts that will be incorporated into the model in a phased approach, starting with enabling effective support for the frail elderly and adult population. However the end-state vision is for the chosen model to serve the health and care needs of the whole Walsall population.

Each member of the Walsall Together Provider Board is committed to this vision and understands the considerable organisational and operational changes that will be required. However we as a group believe this will help to improve the delivery of services, address the health inequalities and provide long-term sustainability for the system; ensuring the people of Walsall receive high quality care as close to home as possible both now and in the future.

Mark Axcell

Chair of Walsall Together Provider Board

1 Executive Summary

Introduction and Context

The Walsall Together Provider Board was established to provide a forum for colleagues across the health and care system to design and deliver innovative, integrated care. The Board has a shared vision of improving the health and care of the people of Walsall, through providing more cohesive and person centred support that maximises independence and well-being.

The goal of the programme is to ensure, through effective collaboration, that health and care services in Walsall achieve the triple aim of:

- Improving health and wellbeing outcomes for the Walsall population;
- Improving care and quality standards in the provision of care;
- Meeting the statutory financial duties of all partner organisations.

In addition to developing new partnerships, the Board has co-designed the Walsall Model of Care, which describes how providers plan to work together; wrapping services around a patient to ensure they are seen by the right service, at the right time in the right place. We are now exploring how best to deliver this; including new governance arrangements as an initial step to strengthen joint decision making and accountability. This paper reviews the current system readiness and provides a clear roadmap to deliver system wide integration. A key element to delivering this will be strong clinical leadership and the support of individual providers; this paper aims to provide a starting point for these discussions.

Walsall's population of ~272,000, is currently served by a number of providers, including an integrated Acute and Community Provider, Mental Health Trust, 59 GP Practices, Local Authority and a third sector umbrella organisation 'One Walsall'. By following the recommendations set out below, the Walsall health and care system can address the challenges associated with delivering care across multiple providers and deliver improved health outcomes for local people alongside securing long-term financial sustainability for the system.

The providers within Walsall have already jointly developed a model of care for the local population and now need to develop a roadmap to fully deliver this in agreement with the local health and care economy. This paper recommends three immediate actions to move the current partnerships into contractual agreements; leveraging innovative payment reform and risk sharing options.

Strategic Case

When comparing Walsall's current health economy to national and local examples of successful integrated care, such as the Dudley Multispecialty Community Provider, Walsall shares many of the integral features of these systems. For example in Walsall there has been progress in the establishment of seven Place Based Teams across four localities and these will provide community, primary and social care services to populations of between 30-50,000 patients in the long-term.

Providers also already recognise the levels of duplication across the system that arises from silo working and the barriers to coordinated delivery when working across organisational boundaries. This is seen particularly in intermediate care pathways, both before and after a hospital admission. A shared vision has been borne out of these frustrations; to deliver more integrated care that saves time, resource and costs while providing a better service and outcome for patients. Thus a new integrated care model is being implemented.

The Walsall Together Provider Board has identified four priority work streams for delivery through the new model;

- Adult and Older Adult Community Services;
- Children's Services;
- Community Services and Prevention;
- Acute Service.

These have been selected as each area extends across multiple organisations and can build on the relationships and integrated working that is already in place. Adult and Older Adult Community Services in particular also addresses some of the most significant health challenges for Walsall; such as 1 in 5 older adults living with a mental health problem. Falls are also a significant clinical risk and area for improvement; in addition to the £11.3m cost incurred as a result of treating fall injuries, falls destroy confidence and reduce individuals' independence (The Annual Report of the Director of Public Health for Walsall, 2014).

Following consultation with the CCG, a phased roll out approach has been agreed and a timetable for delivery has been developed, with an intention to have the 'Adult and Older Adult Community Services' work stream live by April 2019.

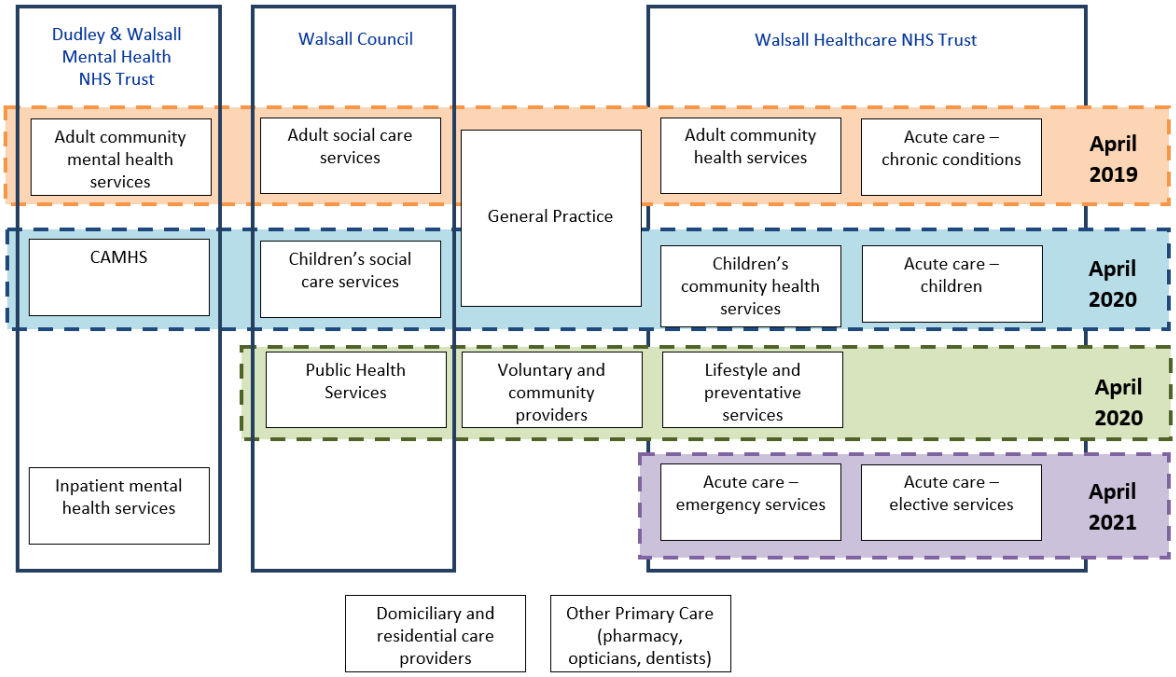


Figure 1 Proposed phased roll out of transformation work streams

While there is alignment amongst providers on the transformation required and a history of cooperative partnership working, the programme requires dedicated programme resource to ensure these work streams are delivered. A particular focus is being kept on Primary Care, as their ability to be involved and actively steering this is more challenged, due to capacity issues and a shortage of funding being made available for Primary Care engagement. This is in part due to endeavours of the Board sitting alongside Business As Usual (BAU) activities; pulling resource away from individuals' primary roles.

Additionally while partnership working is well intentioned, current contractual arrangements don't always reflect or incentivise this and in some cases providers are in fact penalised for acting as partners in the same system. For example disincentives to invest in social care to reduce unnecessary hospitalisation, disincentives for hospitals to avoid admissions through A&E and disincentives for hospitals to provide advice and guidance as alternatives to outpatient appointments. The aim of reforming contract and payment models is to better align incentives so that individual providers don't lose out from playing their part in transformation and are rewarded when the system as a whole is better off.

It should be noted that a number of these work streams are already underway and demonstrating progress towards a future state model. However the current arrangements lack the clear governance, accountability and contractual models to underpin and incentivise the pace required for the future sustainability.

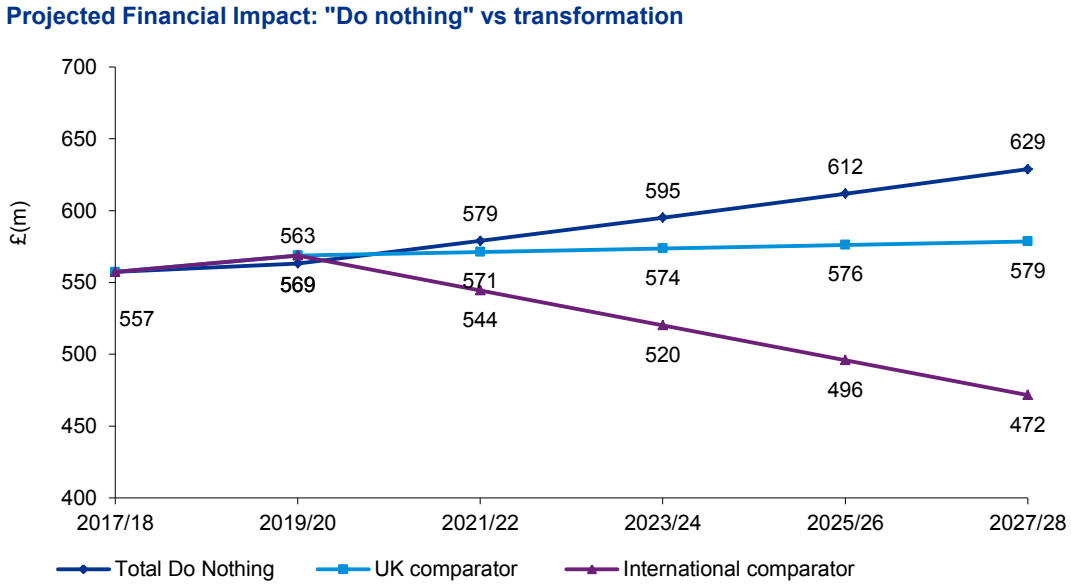
Projected Financial Impact

Whilst data on the forecast commissioner spend is available this does not provide the granular detail required to understand spend by individual providers or the activity and cost impact of different initiatives. As such, financial impact data provided below is for illustrative purposes only and whole system modelling is strongly recommended.

Using the data available, the predicted health and care commissioner spend for Walsall in 2017/18 is £557.33m. This is a cumulative total of the health spend and social care commissioner spend; £428.48m and £128.85m respectively.

Using data trends from previous years, the total system commissioner spend 2027/28 is forecast to rise to almost £629m by 2027/28; however this may be a conservative estimate, falsely lowered due to the forecast decrease in spend on Adult Social Care between 2017/18 and 2019/20. In order to provide a view on how the cost curve can be impacted, two alternative scenarios were mapped using UK and International examples of integrated system transformation. These alternative scenarios illustrate the potential for significant financial savings against the Walsall 'do nothing' scenario.

Figure 2 Walsall Health and Care Economy financial projections



Contractual and Governance Arrangements

In addition to a Care Models and Benefits workshop, two half-day workshops focussed purely on exploring payment reform, contractual arrangements and system governance has enabled providers and commissioners to develop a shared understanding of the commercial and governance arrangements available.

The WTPB considered both the options available and most importantly the impact of each of these on individual organisations. A supplementary report, *Walsall Alliance Organisational Model Appraisal*, was supplied to the WTPB on January 8 2018, providing a breakdown of four potential options, which will support discussions with the wider members of the WTPB and commissioners in agreeing a preferred route. The four options included were as follows:

- Host Provider Model (as a variant of the traditional Lead Provider model, with decision making authority delegated to a Board with equal representation from provider organisations);
- Accountable Joint Venture;
- Fully Incorporated Model;
- Alliance.

At this stage, the Host Provider model has been identified as the preferred commercial model to move forward with; although the host provider is yet to be identified. This touches on the significant amount of work required prior to both the transitional phase beginning April 2018/19, delivery of a business case and beyond into delivery of the first work stream under the new arrangement by 2019/20. Further details of transitional governance arrangements and beyond can be found in section 4.

Leadership & Programme Management

The delivery of system wide change of this scale is a significant undertaking and it is expected that the design phase will run from February 2018 to April 2019. In order for the programme to be jointly owned, Leadership & Programme Management resource should be provided/supported by the WTPB and local commissioners. This paper recommends a full time Leadership & PMO function is provided to drive the programme management, while work stream teams, led by subject matter experts ensure the delivery of the following work streams;

- Governance;
- Organisations and Contracts;
- Clinical Operating Model;
- Capital and Investment Planning;
- Implementation and Transformation;
- Data and Analytics;
- Stakeholder Engagement and Communications.

A lead from each work stream and the PMO function will report directly to the Provider Board, with the Provider Board retaining ultimate decision making authority. It is expected that external support and specialist advisors will support delivery of the work streams where appropriate and necessary.

Recommended Next Steps

This process has advanced the level of alignment amongst the Walsall Together Provider Board and commissioners and developed a shared understanding of appropriate and available options for a new model. In order to drive the project forward from this position, we recommend the following three actions for immediate approval:

1. Establishing a Leadership & Programme Team with access to dedicated resource to run the development process;
2. Developing a business case for stakeholder sign-off (Including NHSI & NHSE) within the next six months to include the following priorities:
    a. Defining appropriate governance to facilitate collective leadership in transition and end state;
    b. The development of a comprehensive, Walsall wide financial model for the system;
    c. Developing a Clinical Operating Model;
    d. Developing an appropriate contractual model.
3. The creation of a budget and resource commitments to support both internal and external inputs to the process over the next 6 months. These are broken down as follows;

Internal requirements:

a. Dedicated director time (1FTE);
b. Support for the board meetings/governance;
c. Leadership & PMO provision, including a Chief Officer;
d. Nominated Work Stream Leads (likely part time);
e. Communication and messaging support (0.5 FTE);
f. Clinical time for backfill for those tasked with delivery;
g. Circa £115k to facilitate Primary Care participation and clinical time release (figures based on a previous proposal to the CCG by the GP Leadership Group);
h. Commitment from organisations to free up resources to participate in the process during the next stage.

Whilst this represents a significant internal investment for the partners, it is fair to say that it builds on the significant commitments that have already been undertaken and the goodwill shown by all to participate in the process.

External requirements:

a. Light touch external support around further definition to the governance structure, but to include legal advice that will ensure satisfaction of the regulatory environment;

b. Significant support to the development of a comprehensive, Walsall wide financial model for the system;

c. Significant support to the development of a comprehensive, Walsall specific target operating model (TOM) for the future state system of health and care in Walsall. This to be developed through the initial priority care areas that have been identified and likely working with a “model community”.

d. Significant support to agreeing the commercial model for Walsall and the roadmap for transition.

While a detailed budget is yet to be created, at this stage it is recommended that a ceiling budget for external support be set at £400k to support the requirements outlined above.

In terms of cost versus benefit analysis, it is clear that there is a significant opportunity to move towards a more integrated delivery model in Walsall. The analysis within this document (section 3.3.1) illustrates a potential for more integrated working to release annualised savings of between £49m and £153m at a system level.

This is a compelling rationale for continued development of the partnership approach as well as the necessary internal and external investment and commitment to shared progress.

As part of the Walsall Together Programme, a branch of the Black Country and Birmingham STP, the Walsall Together Provider Board have developed a model of care to address some of the health inequalities unique to Walsall. These include an average health life expectancy 3.4 years lower than the national average and an increasingly dependent and ethnically diverse population all while sitting in one of the most deprived areas in the country (33rd out of 326). Following insights from across the UK and internationally, the WTPB have identified initiatives such as Population Management Hubs, as key to delivering the transformation and long-term sustainability required for the future.

2 Strategic case

2.1 Introduction

The Walsall Together Provider Board (WTPB) is seeking to facilitate improved wellbeing and enhanced delivery of health and social care to the people of Walsall. This deepens its integration across health and care and forms part of the wider Walsall Together agenda to deliver integrated care to the local population that supports individuals to develop proactive self-care behaviours and maximises the potential of existing teams and the broader Walsall health and care system.

The Walsall Together programme set out to deliver three key objectives:

- Improved outcomes;
- Better quality / safety / experiences;
- Financial sustainability of health and care sector.

The existence of the Walsall Together Programme and its progress to date in unifying providers, including ~151 GPs across 59 practices and the implementation of place-based care teams, signifies the appetite for more integrated working in the area. However the traditional barriers to collaboration, including ambiguous accountability and varying payment models, continue to impede realisation of significant system change. As such, WTPB is seeking to agree a new contractual model to deliver its agreed Model of Care, focusing initially on key priority areas but with the capacity for expansion over time to meet ongoing transformation programmes and provider flexibility.

2.2 Member organisations and ambitions

Walsall Healthcare NHS Trust (WHNT) - Walsall Healthcare NHS Trust is an integrated provider across Acute and Community services. They deliver a full range of acute hospital services including A&E, outpatients, and diagnostics, elective and non-elective admissions, in addition to Community services.

Motivations – As current provider of the Community Services contract in Walsall, WHT strategic direction is set to continue to build on the integration already embedded in their service offering. This would form the foundations of a jointly managed contract. Following on from the identified target patient cohort of frail elderly, WHT has identified Adult Community Services as the initial first phase to transition. This would be followed by Children' Community Services and finally LTC management in the Community. This final element would provide opportunity to involve secondary

and intermediate care, once new ways of working and pathways have been established and strengthened.

Walsall Metropolitan Borough Council – Walsall Metropolitan Borough Council provide Adult Social Care and Children's Services, and Public Health. This includes but is not limited to; safeguarding, supporting those with mental health needs, those with physical or learning disabilities and those acting as a carer. There are statutory responsibilities to safeguard those at risk of abuse, to look after children who cannot live within their own immediate family and to offer early help and support to children in the most need.

Motivations –There are distinct segments of services provided by the Council that would be eligible for management under a new integrated model; for example some Adult Social Care and some Children's Services and some elements of Public Health, however some statutory requirements are likely to remain within control of the Local Authority. The Council is also a commissioner and those responsibilities will be separated between strategic commissioning and the potential operational functions which can be transferred to this new arrangement.

Dudley and Walsall Mental Health Partnership Trust - Dudley and Walsall Mental Health Partnership Trust (DWMHPT) provide a full range of mental health services under contract with the CCG to the people of Dudley and Walsall. This includes community mental health services for children, adults and older people, in addition to inpatient facilities for adult and older people. Some mental health Social Care services are also provided via partnerships with Walsall Council. It is a one of only four national hubs for Specialist Deaf CAMHS and was given a CQC rating of "Good" in November 2016.

Motivations – The Trust has been a key partner in the Dudley Multispecialty Care Provider (MCP) Vanguard and are keen to further develop the locality based model in Walsall. Furthermore the opportunity to integrate physical and mental health is paramount to addressing issues such as; the high rates of mental health conditions among people with long-term physical health problems, the reduced life expectancy of those with the most severe forms of mental illness(largely attributable to poor physical health), poor management of 'medically unexplained symptoms' lacking an identifiable organic cause and the limited support for the wider psychological aspects of physical health.

GP Groups – Walsall CCG commissions 59 GP practices, covering approximately 281,000 patients. The GP landscape in Walsall is typically broad, consisting of two federations, two partnerships, one private provider and a small number of individual practices. The largest of these is the 'Alliance' federation, covering over half the patient population with 27 practices. The distribution of GP groups is shown below:

Table 1 The distribution of Primary Care Providers groups across Walsall

Name	Organisation	Number of Practices	List Size
Alliance	Federation	27	106,107
Palmaris	Federation	7	65,567
Modality	Partnership	7	32,455
The Practice Group	Private Company	7	29,137
Umbrella	Partnership	5	27,978
No Group	N/A	6	19,906

Motivations – GPs in Walsall have formed a 'GP Leadership Group' to facilitate co-operative working within Primary Care, although they recognises that it is unable to represent every GP in Walsall. Furthermore while the GPs are supportive of new ways of working, they require sufficient resource and financial support to enable their ongoing participation in discussion and delivery moving forward.

2.3 Case for Change

2.3.1 Challenges/ issues in the local system

There are five specific population challenges that we face in our service delivery alongside the financial pressures: growth in activity (spells for emergency care, inpatients and outpatients); the deprivation levels of the population; the diversity of the population; the increasing healthcare needs of our population and the inequality of life expectancy across the area. The specific challenges and metrics are set out below.

2.3.1.1 Growth in Activity

Overall resident population is set to have increased by 4.5% over 10 years by 2021, growing from 269,500 in 2011 to 281,700. Furthermore, as is found across the country, Walsall has an increasingly aging population, with the number of residents over 65 set to rise by 13.8% over the same period. (Walsall CCG Strategic Plan 2014-2019, 2014).

2.3.1.2 Deprivation

Walsall is one of the most deprived boroughs in England; ranked 33rd out of 326 local authorities, with 27% of children living in poverty. We know deprivation is linked to high rates of infant mortality and at 8 per 1000 births this is significantly higher in Walsall than statistical neighbours. Likewise the incidence of preventable diseases is significantly higher than the national average, including; diabetes (8.7% against a national average of 6.4%), coronary heart disease (4.0% against a national average of 3.2%) and chronic kidney disease (5.2% against a national average of 4.1%).

Also correlated is the impact on substance misuse and smoking; Walsall has a significantly higher rate of problematic drug users and the estimated prevalence for smoking 22.7% (c.45,000 adults) and smoking related deaths are significantly higher than national averages.

2.3.1.3 Diversity

Almost 1 in 4 residents are from a minority ethnic group, compared to the England average of 1 in 5. The largest increase has been from people with an Asian background. This is likely to impact the birth rate, as residents from minority ethnic groups tend to have higher birth rates. This also impacts on community cohesion as the areas ethnic composition has changed quite rapidly. This can actually contribute to areas becoming less diverse and some ethnic minority groups can be highly concentrated in a particular area (up to 90%).

English language proficiency is very good in Walsall and in line with the English and Welsh averages. However 3.3% of households have no occupants that speak English as their main language, 6,200 residents cannot speak English well and 1,200 who cannot speak the language at all. This can make delivering healthcare and health information challenging and can be a barrier to accessing services.

2.3.1.4 Increasing healthcare needs

Walsall has an increasingly dependent population, with an above average proportion of the resident population made up of children and older people, with a correspondingly low proportion of working

age adults. Furthermore, 1 in 5 residents have a health condition that limits their day to day activities, increasing the number of people who are unable to work (DWMH Clinical and Social Care Strategic Vision 2015-20, 2015). An ageing population also increases the occurrence of age-linked diseases and incidents; the number of residents with Dementia is, likely to increase by 22.5% over the next eight years, putting extra pressure on all health services (Five year Strategic Plan for Walsall, 2014), while falls cost Walsall £11.3million per year (The Annual Report of the Director of Public Health for Walsall, 2014). These aspects put additional strain on the health and care system, but also on Walsall residents as the number of individuals caring for someone with a long-term condition is increasing, from 10.6% in 2001 to 11.6% in 2011 (Walsall Strategic Needs Assessment May, 2014).

2.3.1.5 Health Inequality

The average healthy life expectancy in Walsall is just 60.3 years; 2.3 years less than the West Midlands average and 3.4 years lower than the England average. Male life expectancy is particularly poor at just over 77 years, compared to 79 years nationally. Walsall also performs poorly on the number of unplanned admissions for ambulatory care sensitive admissions and unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s.

A range of measures demonstrate that older people in Walsall are high users of institutional care, an approach that neither promotes efficient use of limited resources, nor meets the individually identified needs of older people and their carers. We also know that while 1 in 5 community dwelling older people have a mental health problem, 2 in 5 of those living in care homes are suffering from depression (The Annual Report of the Director of Public Health for Walsall, 2014).

2.3.2 Regional and national strategic alignment

The Walsall Model of Care sits alongside both regional and national strategies and has been designed to contribute to the broader health and care objectives, as shown below.

Black Country and West Birmingham STP

The Black Country and West Birmingham Sustainability and Transformation Plan (STP) was published on November 21 2016. The STP is a blueprint for the future development of healthcare and wellbeing services across 18 organisations in the Black Country and the West of Birmingham including primary care, community services, social care, mental health and acute and specialised services. STPs offer a new way of working for health and social care services locally, focusing on delivering health and care services defined by local area boundaries, not by local organisational boundaries. The aims are to:

- Improve the health and wellbeing of local people;
- Improve the quality of local health and care services;
- Deliver financial stability and efficiencies throughout the local health care system.

Walsall is identified in the STP as one of the four established place based care models and will continue to deliver services to its population as part of this broader programme. The Walsall model's continuing alignment with the STP will be monitored throughout and facilitated through regular communication from the STP programme group and CCG. Likewise local developments will be shared between the WTPB, CCG and STP programme group to ensure learning is shared and built upon.

Five Year Forward View and adherence to contracting guidance

The NHS 'Five Year Forward View' (FYFV) published in 2014, and the follow up report 'FYFV Next Steps' in 2016 describe the high level of fragmentation that has arisen in the NHS and explains how the divisions between primary and secondary care are increasingly barriers to personalised and coordinated health services. They also assert that out of hospital care needs to become a much larger part of what the NHS does, and that services need to be integrated around the patient.

The recommendations set out in the FYFV include:

- Developing new models of care – based around partnership, integration and joining up organisations and funding streams. These may require the development of Accountable Care Partnerships/Organisations.
- A radical upgrade in prevention and public health;
- Increasing the control patients have over their care when they require access to services.

Out-of-hospital services are a vital part of the urgent and emergency care system. Yet for patients and staff they rarely feel as coherent and streamlined as they should be. Integrated Care models are intended to make it much easier to simplify the interactions between GP in-hours, GP extended access services, minor injury units, walk-in centres, community pharmacies, 111, GP out-of-hours, and A&E.

Accountable Care Partnerships/Organisations (ACPs or ACOs)

ACPs have emerged as a key strand of NHS policy as part of essential actions to manage quality and financial sustainability in health and social care, bringing health and social care organisations together creating a single health and care system in a specific geographical area organised around patient needs. They are accountable for the delivery and quality of that care. This requires a range of providers working together to develop new ways of integrated working.

These new forms do not replace the accountabilities of individual organisations, rather they supplement them. Nevertheless, to be successful these partnerships need a basic governance and implementation support – this is in line with the Black Country and West Birmingham STP, and the Walsall Together Programme.

ACPs involve:

- Shared decision making and population health management;
- Collective management of funding for the ACPs' defined population through a system control total;
- A system partnership that has clear plans – and the capacity and capability to execute those plans;
- ' Integration' of providers whether virtually or through actual merger or joint management;
- Simultaneous ' integration' with GP practices formed into primary care networks;
- A system that acts and behaves as though one single system, even though in law there are a number of distinct entities.

Walsall's proposals build on many of these key themes and provide a stable model fit for the future.

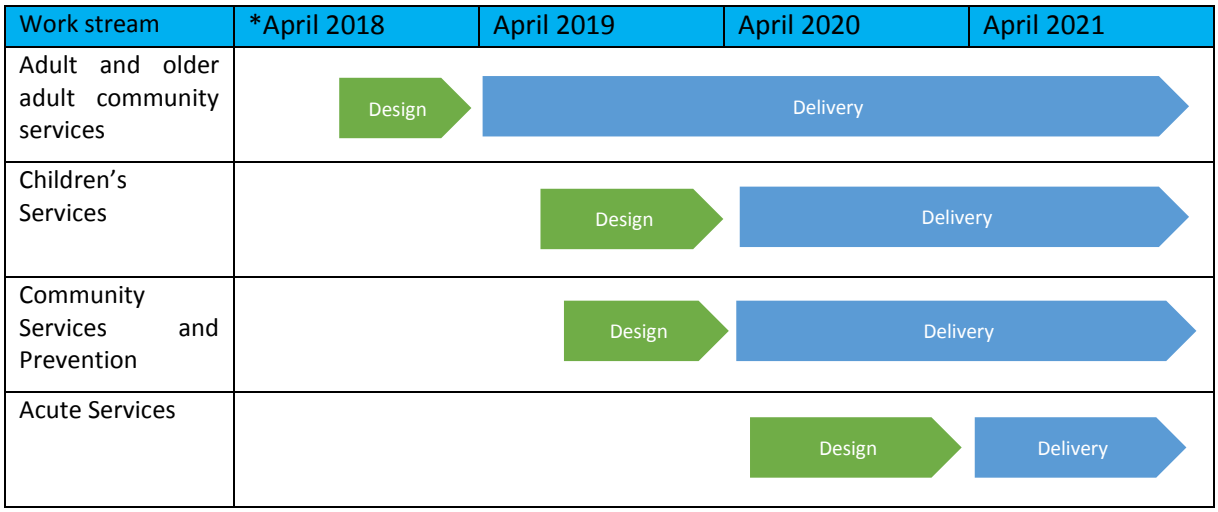
2.4 Scope

The proposed transformation and future model of care will help manage demand out of hospital and manage costs across health and social care. On 29 June 2017, WTPB held a workshop to discuss the high need, high cost users of their services and identified priority patient cohorts that would benefit from improved integrated services. This session highlighted the considerable overlap between organisations highest users and the specific patient cohorts these users belong to. These were

broadly identified as the frail elderly with co-morbidities, including mental health and additional social care needs.

The group recognised that in order to provide a manageable scope for an initial programme, elements of this pathway would be addressed alongside other priorities for the area in a phased approach.

Figure 3 Proposed phased delivery of transformation



**Each work stream builds on work already completed as part of the Walsall Model of Care (Section 2.5.1)*

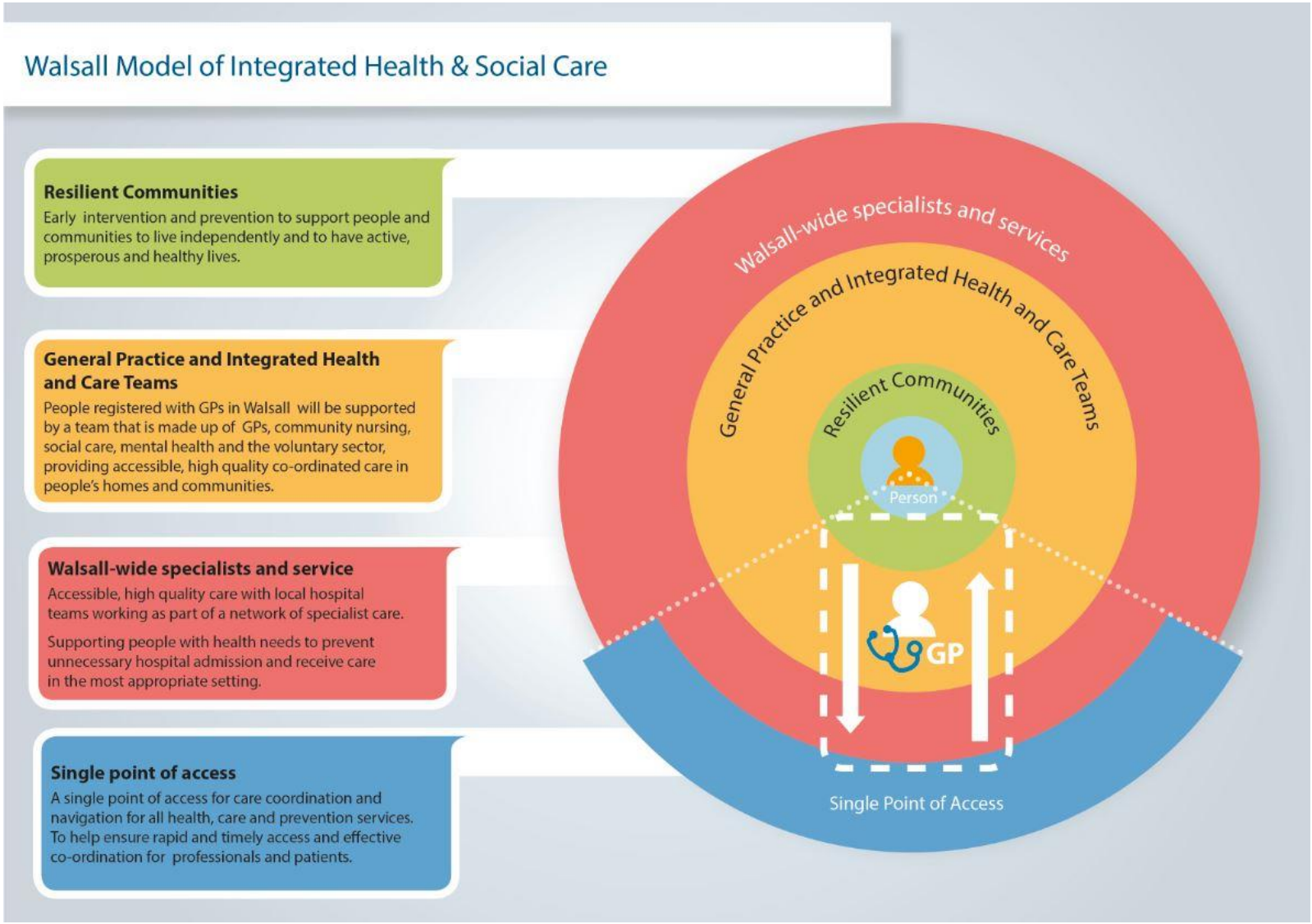
2.5 Service model and benefits summary

2.5.1 Current service model

The WTPB was established in 2016 to provide a forum for local providers to work collaboratively in designing and improving the health and social care received by the population of Walsall. All party members recognise the benefits of closer working; including reduced duplication, more streamlined pathways and high quality care being delivered more efficiently to the population.

The primary output of the WTPB to date had been the collaborative design of the Integrated Health and Social Care Model for Walsall, as shown in figure 3. This integrated model, which wraps services around a patient, based in a community setting, inclusive of Primary Care, includes the establishment of three key service areas with a Single Point of Access. These areas are outlined in greater detail below:

Figure 4 Walsall Model of Integrated Health & Social Care



Resilient Communities: Patients are first and foremost citizens of their immediate communities and as such this aspect of the model should be the first port of call for patients wishing to address their health and social care needs. This may include accessing preventative medicine or early intervention services; such as community activities and groups to prevent isolation and mental health issues or healthy lifestyle tools and services such as diet advice, exercise classes or support groups. Local and national public health Interventions have shown to be highly cost saving, with £14.30 saved for every £1 invested[2].

There has been significant progress made on this work stream, including the deployment of referral Hubs by Public Health. These Hubs support patients through the system and model the "Making Every Contact Count" scheme. This joins health care providers with voluntary sector agencies and other providers, such as the fire service, to deliver projects in the community; reducing isolation and supporting people to live independently in their own homes

General Practice and Integrated Health and Care Teams: General Practice remains the cornerstone of the NHS and patients registered with a GP in Walsall will continue to be supported by their practice. However the primary care team is becoming increasingly diverse to include community nursing, social care, mental health and voluntary workers. It is recognised that as the population ages, more people than ever are living longer with one or more long-term conditions; often accompanied by other mental health or social care needs. By continuing to grow and develop Integrated Health and Care Teams (IHCT), patients in Walsall will receive care from a variety of organisations to ensure care is being delivered by the most appropriate individual in the most appropriate setting. IHCT, or Multidisciplinary Care Teams, are recognised as an essential aspect of integrated care. By working in a more joined-up way, evidence suggests it is possible to reduce hospital admission rates by as much as 19% when compared traditional care[3], in addition to reducing duplication and referral waiting times. This will only be achievable if we transfer resource into the new model of are and build on the good work already started with these teams

Significant progress has been made here, with seven Place Based Teams working across the four localities in Walsall. Each provider is working to align their caseloads to identify the highest services users and high risk patients. Rolled out since June 2017, this is already reducing duplication and the number of unnecessary GP appointments.

Walsall-wide Specialists and Service: When patients require specialist care, this will be facilitated by an appropriate network, including neighbouring hospitals, to ensure patients receive the highest quality care available and unnecessary hospital admissions are avoided where possible. Walsall has begun to develop this service, beginning initially with the Integrated Diabetes Service, which allows clinicians working in Primary Care to seek clinical advice from Specialist Endocrinologists. There is a similar service in place for respiratory conditions, linking Specialist Respiratory nurses with a locality, providing support in the management of COPD and bronchiectasis.

Single Point of Access: Navigating the health and care system can be complicated and frustrating for patients. A lack of cross-organisation communication can mean patients are passed from one provider to another, while the demand pressures can mean referrals take weeks or months to be successful. A single point of access for patients means that they are directed to the right service at the right time and unnecessary steps can be avoided. However a single point of access can have even greater benefit for patients when used to facilitate care coordination and deliver preventative medicine. The potential for this tool will be covered in more detail under future service model opportunities. Due to the cross organisation and technological requirements to unlock the potential of this element, this is the least developed area of the model at present. It is expected that these barriers will be removed or lessened through the proposed model and that some of these expected benefits can be realised.

2.5.2 Future service model opportunities

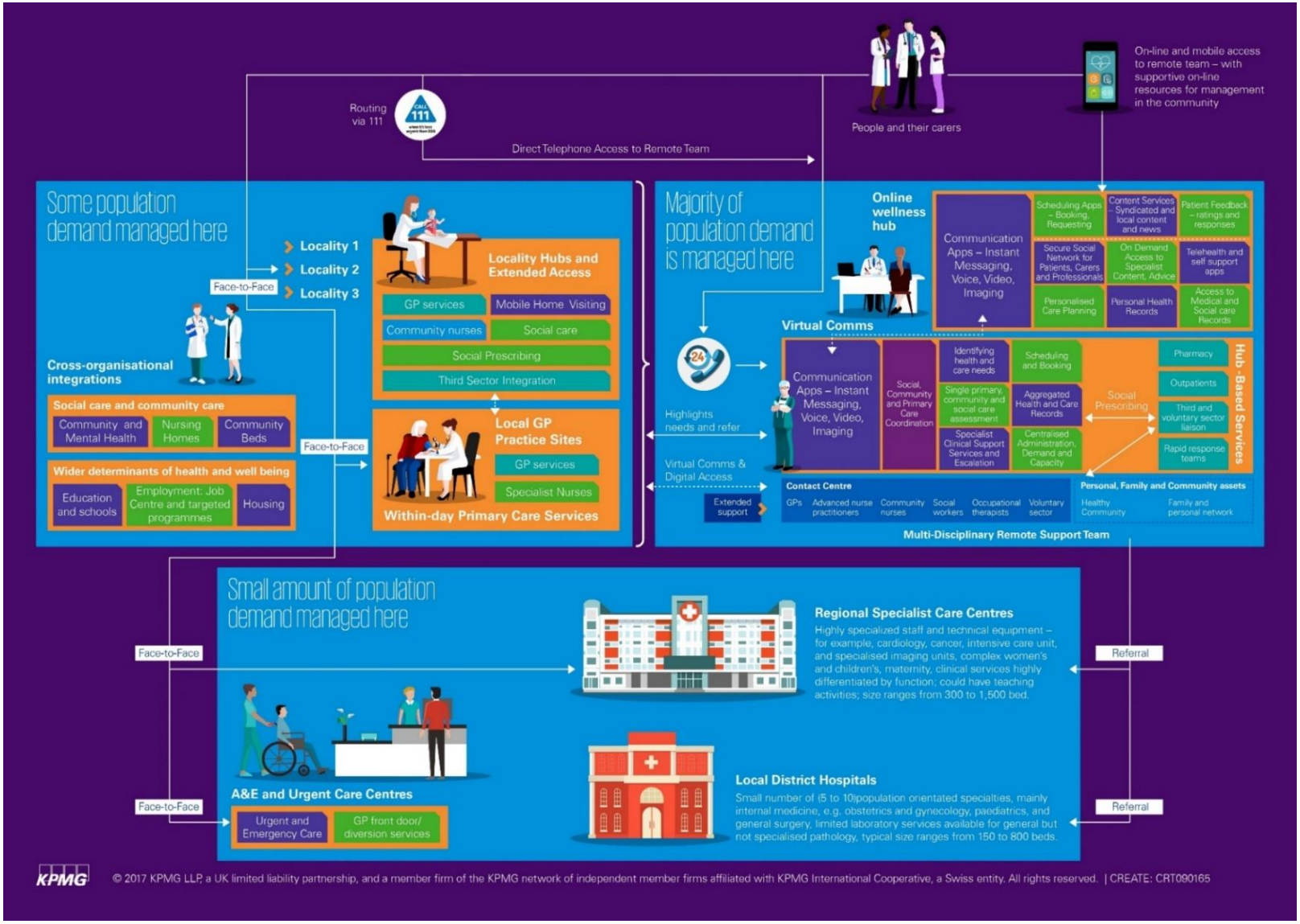
The WTPB decided to advance this work through a series of workshops; beginning with comparing the Walsall Model of Care with other UK and international examples and the associated benefits of these, to both patients and organisations. There are similarities found across all integrated systems; such as the "shift-left" of services, (from expensive secondary care settings to lower cost community settings), multidisciplinary teams wrapped around a patient and streamlined referral pathways to highlight a few. Other such initiatives that may run in parallel include;

- Population Management Hub;
- Established locality teams at the heart of population health
- Consultants in Community;
- Care Home in Reach Service;
- Outpatients in the Community;
- Specialist Skills in Community;
- Ambulatory Care Model;
- Condition Specific Rehabilitations (i.e. in Heart Failure and COPD);
- Implement GP Case Management;
- Social Prescribing;
- Implementation Mental Health & Substance Abuse Liaison Services;
- Implementation of Hospice at Home service;
- Implementation of care co-ordination centre;
- Fast Response Service / Integrated Rapid response service;
- Community bed provision;
- New approaches to urgent and emergency care centres;
- Extending access to Primary Care;
- Hospice at Home in the Care Home setting;
- Clinical referrals management;
- Reduce number of outpatient follow ups;
- Clinical Thresholds;

The Population Management Hub was highlighted as a particularly key initiative, building on the Single Point of Access work stream currently in development but evolving this in to a tool to manage and direct demand to the most appropriate setting. Initially this Hub would fulfil administrative functions across organisations, such as; scheduling and booking appointments, however by bringing clinical teams together "in-house" these Hubs would also provide clinical services, such as; outpatient appointments, pharmacy and social prescribing services through voluntary and third sector teams that are based here.

As data-sharing capabilities are improved across providers and also between patient and provider, it is envisioned that this facility will be able to prevent illness exacerbation and admissions by tracking patient activity in addition to real-time care-coordination. This is visualised at a generic level in the service model below:

Figure 5 A generic future state service model



Achieving this type of service model by implementing individual transformation projects, in separate provider organisations doesn't work - delivering this level of change in parallel requires a holistic approach to transformation, where all partners are signed up to a new Clinical Operating Model (COM) for the system.

This future Clinical Operating Model, must be supported by robust data and analytics in order to plan the transformation, monitor performance and move towards population management in real time.

2.6 Risks and Interdependencies

There are substantial risks associated with large scale projects involving multiple organisations, however identifying these early and developing solutions can reduce their likelihood and impact. A number of the risks and interdependencies identified so far are listed below and it is recommended that a similar process is maintained as appropriate throughout the development and implementation of the new commercial arrangements.

Table 2 Identified Risks and Interdependencies

Risk / Interdependencies	Description
New model financially destabilises one or more providers and therefore can't be agreed.	Without a clear system wide view of costs, it is possible that new ways of working reduce activity in certain areas, leading to destabilisation of these organisations. Working collaboratively with appropriate risk share arrangements will be key.
New model does not deliver a sustainable health economy for Walsall.	A new proposal must deliver an improved financial position when compared to the current financial forecast when taking a "Do-nothing" position.
The new clinical model does not align with wider work on sustainable clinical models for Walsall Healthcare NHS Trust service review and Dudley and Walsall Mental Health Trust Black Country wide Mental Health model development	Over the next 12 months two of the partners will be taking part in reviews of services and clinical models. Any development of clinical proposals during 18/19 should ensure alignment with these pieces of work and have full clinical engagement.
Lack of alignment between commissioners and providers in delivering the new model/integration programme.	As KPMG have seen in their work in Guernsey and STPs across the country, successful system transformation plans are those which harbour close working relationships between the provider and commissioners to develop a shared vision.
Sufficient focus on the new model and integration programme with other challenges.	Without building in dedicated time and resource, the project can become side-lined amongst BAU and other pressing challenges. Stakeholder engagement should be scheduled and maintained throughout as a priority.
Willingness of primary care to support proposals.	Walsall's diverse GP landscape, including 5 different groups alongside independent practices poses a challenge for a gaining a coherent and unified Primary Care Voice. As the cornerstone of the NHS, we how important support from Primary Care is for system change.
Understanding the voluntary sector	The unique but vital input from the third sector can

opportunity and perspective.	be complicated to facilitate due to financial restrictions. Our experience with charities will support identifying what are feasible “offers” for the voluntary sector and NHS.
Not fulfilling your statutory duties either financially or in terms of oversight.	Developing and designing new contracts takes place alongside an evolving and complex regulatory environment for providers. Statutory duties must be considered and fulfilled
Tax impacts.	The headline tax and VAT consequences associated with creating any new entities or quasi-entities should be considered prior to agreement, where the governance of such entities is not led by an NHS Trust prime provider.

The Walsall health and care system deficit is forecast to rise to £165.1m by 2020/21 if no action is taken to address this. While there is a lack of system wide financial data at sufficient granularity to enable modelling of initiatives against cost and activity impacts, it is possible to draw upon the impacts of comparators. Using this data, an indicative saving of between £49m and £153m per annum could be realised depending on the level and success of integration initiatives. In order to understand these figures more clearly, the system modelling capabilities must be strengthened and a full benefits analysis completed.

3 Projected Financial Impact

3.1 Introduction

A solid understanding of the baseline financial position and forecast future spending will provide a clear starting point for risk sharing arrangements and target savings. This will require an understanding of not just commissioner spending with individual providers but also a common understanding of the drivers of provider costs within each organisation (linked where possible to activity so that it is possible to see the impact of shifting care between settings). Using predicted spend data from the CCG, medium term financial plans from Walsall Council and applying external benchmarks, a high level, indicative interpretation has been prepared below for the purposes of considering what the impact could be on the financial sustainability of the health and care system, thereby enabling the best possible services across Walsall.

In order to move further in this process, it is recommended that full system modelling is completed to provide a clear view on expenditure across the system and allow for intelligent forecasting against "Do nothing" and new transformation scenarios. This will in turn inform proposed shared budgets and risk sharing options. Please note, due to scarcity of available and comparative data, all figures and forecasts shown below are indicative.

3.2 Financial context-by organisation

3.2.1 Walsall Healthcare NHS Trust

Following a series of recent challenges, The Trust has now commenced a credible recovery program which has started with the newly announced CQC ratings which highlight the Trust as Requires Improvement over all and importantly community services as Outstanding. Walsall Healthcare Trust's deficit stands at (£21m) but is currently producing a 3 year financial recovery plan to sustainability. The Trust is currently forecasting a reduction of £707,000 in their deficit position for 2018/19 and a further reduction of almost £7m by 2019/20 to bring their end year deficit to (£12.7m).

3.2.2 Primary Care

Primary Care is commissioned by Walsall CCG via both capitated GMS and Locally Enhanced Services (LES) contracts. Due to an ever increasing demand on Primary Care, practices are increasingly stretched to deliver patient care within budget. Although a breakdown of costs is unavailable, Walsall CCG spend on delegated Primary Care rose to £38.28m in 2017/18. A further £10.3m of Primary Care was delivered by the CCG, however this is a decrease of £0.2m from 2016/17.

3.2.3 Dudley and Walsall Mental Health Partnership NHS Trust

A piece of modelling work has been completed by the Trust that shows the split of costs and income between the Walsall and Dudley boroughs. Data from Walsall CCG suggests a decrease in spending for 2017/18 compared to the previous period, however spend is forecast to continue to be in line with budgets. For 2016/17 with was £45.42m while the 2017/18 budget is £44.19m with the forecast outturn in line with budget.

3.2.4 Walsall Council (Social Care only)

National Social Care budgets have been reduced by 26% in real terms over the last 4 years. Locally, Walsall Council savings requirement for Social Care stands at £15m over the period 2018-20; comprised of £9.3m for Adult Social Care and £5.7m for Children's Services. Consequently the provision for Adult Social Care in particular faces major reductions over this period, with the greatest cuts to be made during 2018/19. This reflects the cut backs on almost all but statutory care services. However as the graph below demonstrates, there is a difference in spending trends across these two services, with Children's Services spend increasing from £56.27m in 2015/16 to £64.7m in 2018/19, before forecast spend dipping to £63.53m in 2019/20.

The inclusion of Public Health commissioning and services has been discussed by the wider group and

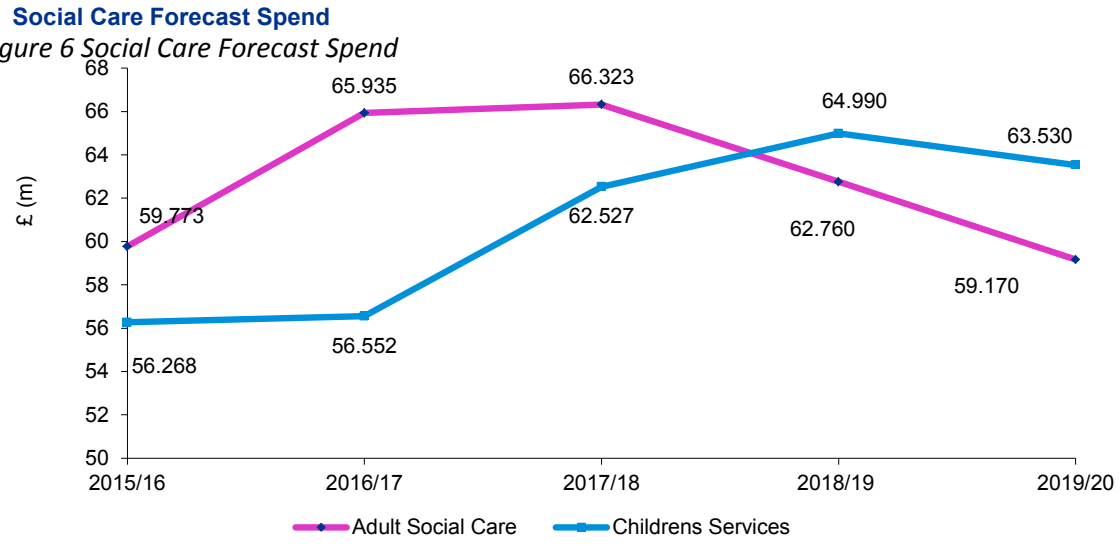


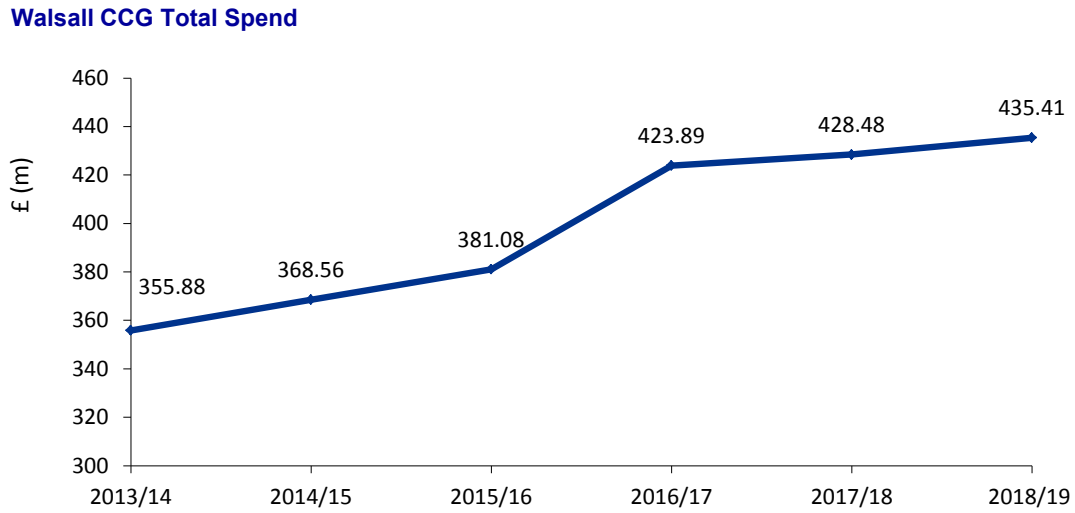
Figure 6 Social Care Forecast Spend

there is the intention that this may be delegated to a Host Provider as appropriate and when possible.

3.2.5 Walsall CCG

Walsall CCG is exiting a challenging period, having been placed in 'Special Measures' in July 2016 due to poor performance against NHS Constitutional standards but also a deteriorating financial position. The CCG has worked extensively to rectify the issues raised in the report and achieved a surplus of £3.8m in 2016/17. The 2017/18 budget currently stands at £426.1m for the commissioning of community, hospital, primary care and mental health services, with a forecast spend of costs of £428.48m, with this set to rise to £441.06m by 2021.

Figure 7 Walsall CCG Total Spend



3.3 Walsall Health and Care System

Using available data, Walsall's predicted total health and care system spend for 2017/18 is £557.33m. This is comprised of £428.48m and £128.85m spend between Walsall CCG and Social Care (including Adult Social Care and Children's Services) respectively. For the purpose of this document, elements of Public Health spend have been excluded, however there may be opportunities to broaden the scope in the future.

This is forecast to rise by 2.8% by 2019/20 to £563.15m. On this trajectory, the whole health and care system spend for Walsall by 2027/28 is forecast at over £628m. This may be a conservative estimate of the total cost, as Social Care and health budgets been reduced substantively over the last few years and this has reduced the trend of growth used to forecast future spend. These reductions are unlikely to be replicated as the existing savings were, in part, delivered by reducing the level of services available. Consequently the remaining services are broadly minimum statutory duties and any further reductions will not be possible.

Table 3 Breakdown of total spend by service for Walsall Health and Care System

SERVICE	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£ (000)	£ (000)	£ (000)	£ (000)	£ (000)	£ (000)	£ (000)
Acute Services	182,330	187,387	195,672	205,051	206,388	212,780	217,246
Mental Health Services	43,907	44,454	46,393	47,925	40,796	41,852	42,915
Primary Care	9,964	9,848	11,908	10,538	10,301	11,446	11,230
Prescribing	45,714	48,118	49,978	50,499	50,969	52,740	54,955

Intermediate and Continuing Healthcare	20,369	20,726	21,150	21,991	24,302	26,483	28,386
Community Services	28,415	28,809	29,044	30,310	30,551	30,910	31,408
Other (including Estates, BCF)	15,229	17,135	15,378	11,629	17,282	9,619	4,051
Delegated Primary Care				36,312	38,280	40,068	41,233
Running Costs	6,317	6,575	6,507	5,787	5,754	5,620	5,679
Surplus	3,635	5,504	5,054	3,843	3,857	3,890	3,959
TOTAL	**355,880**	**368,556**	**381,084**	**423,885**	**428,480**	**435,408**	**441,062**
Adult Social Care			59,773	65,935	66,323	62,760	59,170
Children's Services			56,268	56,552	62,527	64,990	63,530
TOTAL			**497,125**	**546,372**	**557,330**	**563,158**	**563,762**

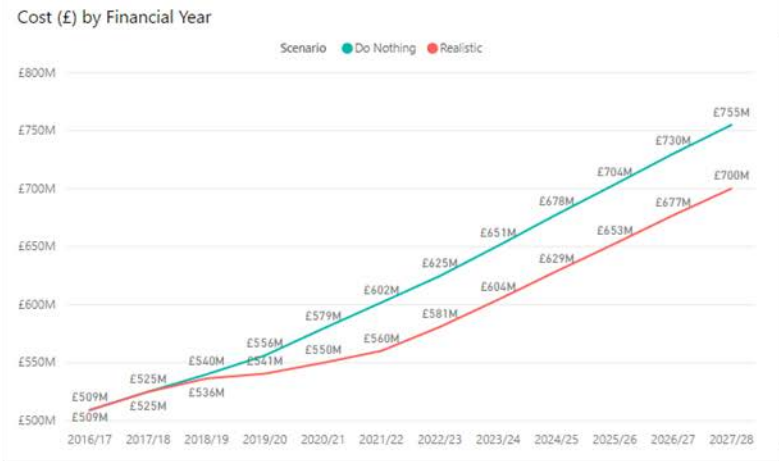
Sources: CCG Comparative Data (Nov 2017), Social Care data provided by Senior Finance Manager, Walsall Council (Jan 2019).

3.4 Comparable systems and benefits

To provide context to the proposed changes in Walsall and also to broaden understanding of the innovation taking place elsewhere, the WTPB held a 'Care Models and Benefits' workshop on 30 November 2017, inviting colleagues from across the health and care system (Appendix 2). This workshop drew on both UK and international comparators to illustrate the potential financial impact of transformation schemes where there has been a high level of collaboration between acute, community and primary care, alongside social care services. These two illustrative examples have been used to demonstrate the potential impact on Walsall. This is a very high-level approach but indicates the size of the opportunity in monetary terms.

The graphic below illustrates the impact of a new integrated service model within a comparable UK health and care economy:

Figure 8 UK Health and Care System Comparator



Implementation of the New Models of Care Schemes 2027/28

- **8%** decrease in cost to deliver services.
- **£56m** cost reduction from implementing schemes.
- The development of a population management hub supports the delivery of **£43m** of the savings above.

Impact on primary care:

Shifting activity out of A&E and into primary care correlates to an 18% increase in GP attendance activity. However, this equates to a saving of £3.1m by delivering care in a cheaper setting.

Potential cost reduction by locality:

North	£11 million – 8%
Central	£21 million – 7%
South	£16 million – 7%
Other	£8 million – 10%

Cumulative impact on 2027/28 demand:

Cumulative Impact of Schemes	
Segment	**% Change**
AE	
76-85	-35
All	-34
IP - General Medicine	
65-75	-10
76-85	-23
All	-20
OP	
All	-29

This modelling is a realistic UK proxy for Walsall and illustrates the potential for annual savings of £560m over 10 years for a similar sized population. (Note a comprehensive financial modelling exercise has not yet been conducted in Walsall specifically and this would need to be done prior to implementing a future service model).

Outside of the UK a comparable international benchmark for delivering joined up care within a National Insurance funded health and care economy would be the Israeli system. The data below illustrates the achievements of Clalit (the largest integrated care provider in Israel) over a 30 year period.

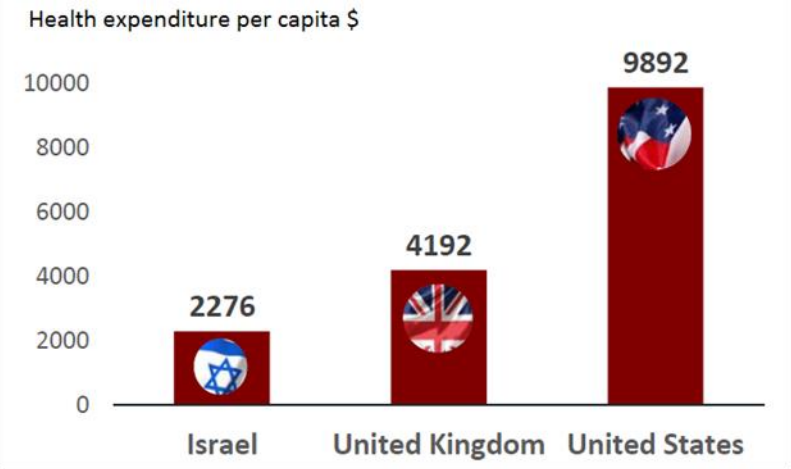
Figure 9 International Health and Care System Comparator

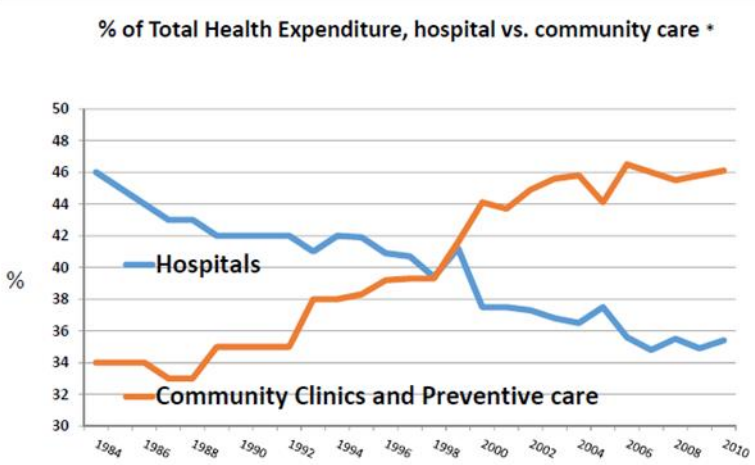
Background

The health care system in Israel was established by Clalit, a non-governmental, non-profit organisation. It has defined the health standards for the entire country for some 90 years. In January, 1995, in an effort to set health care on a more economically sound path, a national health insurance law went into effect. Every member pays in proportion to his or her income, and each is entitled to the same quality and range of medical services.

One of Clalit's unique features is its total involvement in the health services it offers. It employs as salaried personnel the nurses and doctors, teachers, researchers and administrators who staff its hospitals and GP clinics, including 7,500 physicians, 11,500 nurses, 1,300 pharmacists, 4,400 paramedics and laboratory/imaging technicians and 9,400 administrative personnel

Clalit has adopted a decentralized form of organisation, in which the country is divided into 8 districts. Each district has wide scope of independence in decision-making. The districts vary in size from some 340,000 patients to over 600,000 patients, and are responsible for a varying number of GP clinics, ranging from 60 to more than 180. Budgeting is based on a capitation system.





* By Ran Balicer, based on Israel Central Bureau of Statistics data

Clalit is probably the best international benchmark for the potential of delivering truly integrated services to a local population, within a publically funded system. They have radically reduced the costs of acute care per capita, whilst also increasing the expenditure on community and preventative care and are now an outlier internationally in terms of their health expenditure per capita.

In the UK example above, the financial impact of each proposed or currently operational initiative was modelled to generate a cumulative impact for the transformation delivered under the new commercial model. This level of modelling provides a system wide view on the individual impact of schemes across organisations; giving decision makers insight on the financial implications of "industrialising "or decommissioning schemes.

As a detailed transformation plan, including details of proposed initiatives, is not currently developed in Walsall, we have drawn upon these two comparators to provide an outline of the potential savings that could be achieved following implementation of the new model and associated transformation.

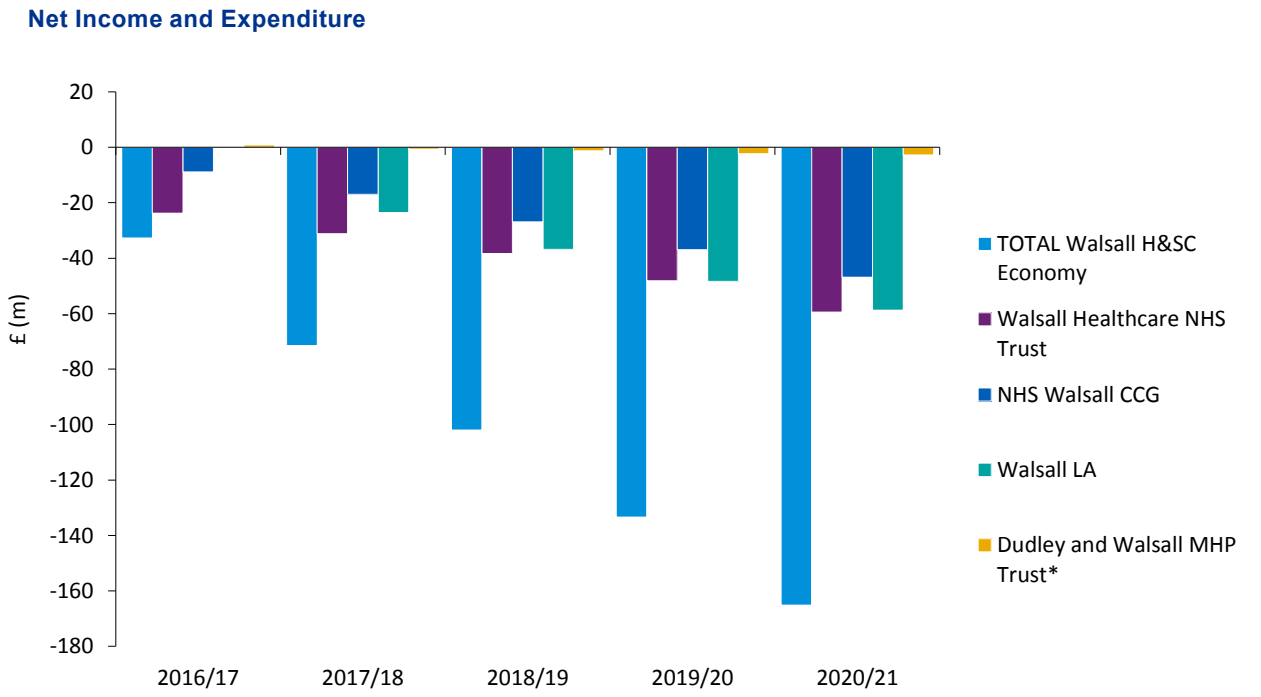
Table 4 Summary of UK and International comparators

System	Population	Acute	Community Services	Payment model	Outcomes
Walsall	272,000	Single acute provider; 2 alternative providers nearby.	Provided by the Acute and Mental Health Trust.	To be decided- Alliance model proposed	Potential outcomes yet to be mapped.
UK example	260,100	Single acute provider.	Provided by the Acute Trust.	Accountable Care Pilot.	Projected 8% decrease in cost to deliver services by 2027/28.
International example	8.6 million; split into 8 districts [Rob to confirm]	Facilities in each district; serving populations of between 340,000 and over 600,000.	Facilities in each district; serving populations of between 340,000 and over 600,000.	Beverage Model with capitated budgets.	Increased spend on Community Clinics and Preventative Care by 12%. Delivered a reduced Hospital spend by 20%. Almost 50% less expenditure per capita $ than the UK.

3.4.1 Projected financial impact

An initial "Do-Nothing" forecast made during 2016/17 predicted a Walsall health and care system deficit of £165.1m by 2020/21. This would increase Walsall's contribution to the Black Country STP deficit position from 17% to 20% and is illustrated below.

Figure 10 'Do-nothing' financial forecasts from 2016/17 for local providers and whole system. In each case organisations have implemented programmes to mitigate these projections



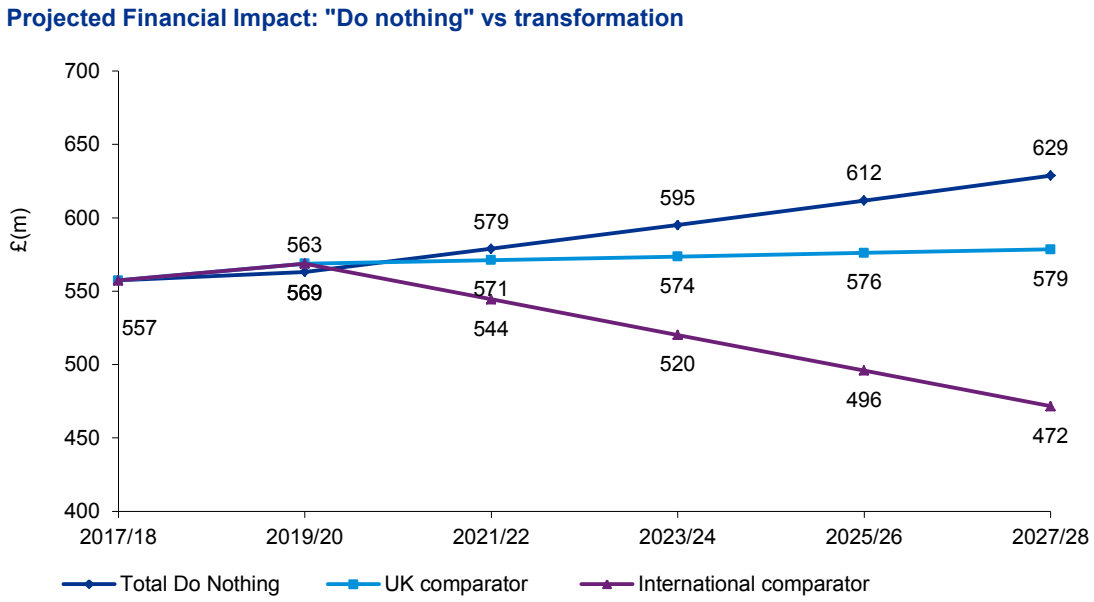
*Being 50% share of Trust's I&E plan

Using the high level data available for the periods 2017-2019 for the Walsall Health and Care system, an assumption can be made that spending increases by 2.8% over a 2 year period. This figure was used to forecast a whole system spend of £628.82m for the period 2027/28. This illustrative increase of 12.83% equates to an additional funding requirement of £71.49m over the next 10 years.

This high level example of increased spending is based solely on current forecasted spend and is likely to be a reserved estimation based on the extreme financial pressures and associated cutbacks being made by the Walsall health and care system.

In the absence of identified transformation initiatives to be implemented, modelling undertaken elsewhere was mapped on to the financial forecasts for Walsall. In the figure below, we use the two comparators given above to illustrate how system wide transformation can bend the cost curve. In the UK example a realistic reduction in overall spend of 8% was forecast based on the proposed transformation scheme, while the international system was able to successfully reduce their health and care spend by 25%. For Walsall, this would translate to an overall system saving of £50m and £157m respectively.

Figure 11 Walsall Health and Social Care Forecast spend against comparative systems



3.5 Assumptions applied

The data presented here has been provided by Walsall CCG and Walsall Council, however the calculations generated are purely illustrative and are not a substitute for Whole System Modelling. The projected forecast includes an indicative increase spend of 1% spend to cover additional investment requirements. This is to reflect the initial pump priming and ongoing costs associated with implementing and maintaining new schemes. Through full system modelling, it is expected cost of new transformation schemes would be fully costed to allow accurate analysis of overall system cost impact and return on investment.

A realistic reduction of 8% was forecast using the data from a comparable UK Health and Care System. In this scenario, data was gathered across the spectrum of care including activity and financial. This health economy, taking the baseline figures an increase of 40% total cost was forecast by 2027/28. This included activity increases of; 10% in acute, 8% in Primary Care, 30% in Adult Social Care activity and 5% in mental health.

By identifying initiatives to be deployed, such as social prescribing, community bed provision and population management hubs, it was possible to map the impacts of these over a period of 10 years; taking into account the cost of implementation. Taken as a whole, this programme of transformation was shown to decrease the overall system cost by 8% by the year 2027/28. Due to the similarities with Walsall, including population and distribution of providers, this is a good benchmark for the impact that could be seen locally.

In the international example, which has seen a reduction in total spend of 25%, data has also formed a large part of the success. Alongside the provision of health and social care they have established a research institute, which uses the population data for research and the development of new drugs, techniques and tools. This has enabled them to not only track the effectiveness of interventions and

policies and act accordingly, but also refine diagnostics and preventative medicine based on the evidence of their efficacy.

Following an appraisal of four contractual models, the WTPB have selected "Host Provider" as their preferred model. In this model the Host Provider is contracted by the commissioner to deliver a range of health and care services. The Host Provider then subcontracts with other providers in order to deliver the services beyond their sphere of activity. The Host Provider is accountable to the commissioner and bears all risk; allowing gains/losses to be distributed to other providers via the contractual arrangements.

4 contractual and Governance Arrangements

4.1 Introduction

Two further workshops were held focusing specifically on the contractual issues, risk sharing arrangements and governance. Following the later of these two workshops, there remained some uncertainty on which model would best serve the needs of the population and also how these would impact local organisations. As such, a supplementary review was prepared called *Walsall Alliance Model Options Analysis* (Appendix 3), which was provided to the WTPB on the 8 January 2018. This report detailed four commercial models and the impact of these on each individual organisation in Walsall. The four options appraised are summarised below:

1) Alliance

An Alliance provides a flexible but contractual agreement between providers and commissioners. The Alliance contract sets out the budget, terms and risk sharing agreements, while master service agreements govern the delivery of different transformation schemes. This flexible model allows for incremental growth, but can be at risk of unilateral decisions.

2) Host Provider Model

In the Walsall health and social care economy, the role of Host Provider could be fulfilled either by the Council or one of the two NHS Trusts. These are the organisations with the inbuilt capacity to absorb some of the functions necessary to act as a Host Provider (such as strategy functions and contracting teams) as well as the fact that they are most able to bear risk due to their scale. In this model the commissioner holds a single contract with the Host Provider. The proposed arrangement for Walsall requires the Host Provider to establish a separate Partnership Board, with its own distinct executive management team and governance arrangements. Further work will be required to set out this arrangements.

3) Accountable Joint Venture (Corporate)

This model involves the creation of a new legal entity between providers, which singularly contracts with the commissioners. Creation of a new entity does carry a longer timeframe and greater resource investment to implementation, however all providers are equitable; increasing alignment, contribution and collaboration. Alternatively. Joint Ventures can be purely contractual, which does not require

formation of a legal entity. Financial and contractual arrangements can then be retained, flexed or delegated to the joint venture as required.

4) Fully Incorporated Model

An example of an Accountable Care Organisation (ACO) whereby all providers would merge into a single organisation (which could either be a new organisation or existing organisations could be absorbed into a single entity). There would be a single contract between providers and commissioners, however the new organisation may still subcontract services when necessary. This model streamlines decision making and management and simplifies risk sharing. Often an end state target, as difficult to implement initially and gain buy-in.

4.2 Impact on Commissioners

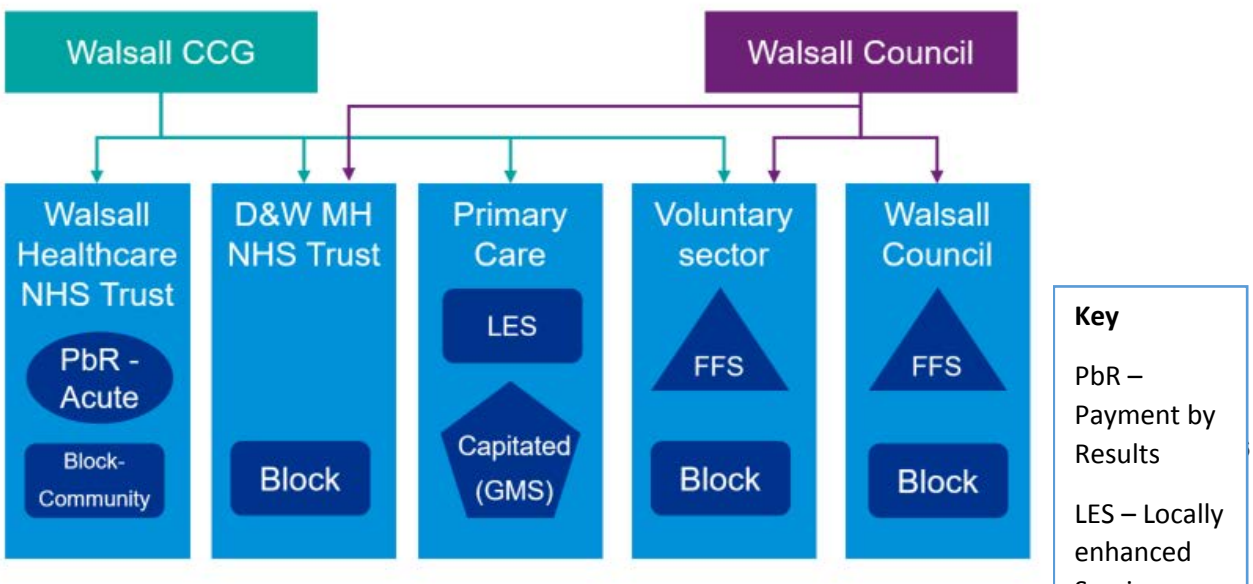
The development of a new commercial model will facilitate innovative new ways of provider working however it also provides a unique opportunity to simplify and streamline commissioning processes. As seen in Figure 13 below, currently both Walsall CCG and Walsall Council hold a range of contracts with multiple providers. The devolution of some commissioning functions from the CCG and Council (Social Care) into a new provider model is supported by local commissioners and will allow those providing patient care to have much greater control over how it is delivered. It also reduces duplication in the system and can increase the pace at which new initiatives are implemented. There are two key next steps in relation to commissioners:

- Commissioning functions that would be appropriate for transferring into a provider model will be identified and agreed as part of the ongoing programme development.
- Agreeing the form of commissioning between the commissioner and the providers (with their increased functions).

This leaves an important and residual set of strategic commissioning functions which could operate across Walsall, but are unified from currently disparate organisational arrangements. This means there are opportunities for the Council and CCG to join up their commissioning intentions, to aggregate regional CCG commissioning and to ally with specialist commissioning. The incorporation of the existing governance arrangements to facilitate this joining up is an action form this paper; for example the oversight of the Health and Wellbeing Board.

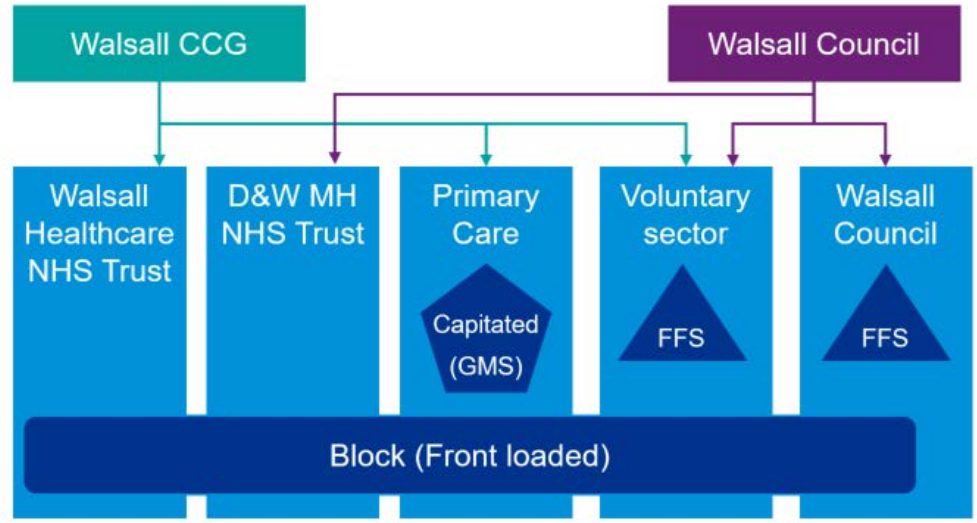
4.3 High level options for commercial arrangements

Based on similar work elsewhere, we expect that Walsall will have a period of transition between current state and the desired end state. This is likely to involve unique contracting arrangements to provide



assurance to the commissioners and allow providers to adapt to new ways of working before adopting more radical long-term, risk sharing contracts.

Figure 13 Payment models and contracting with partial integration



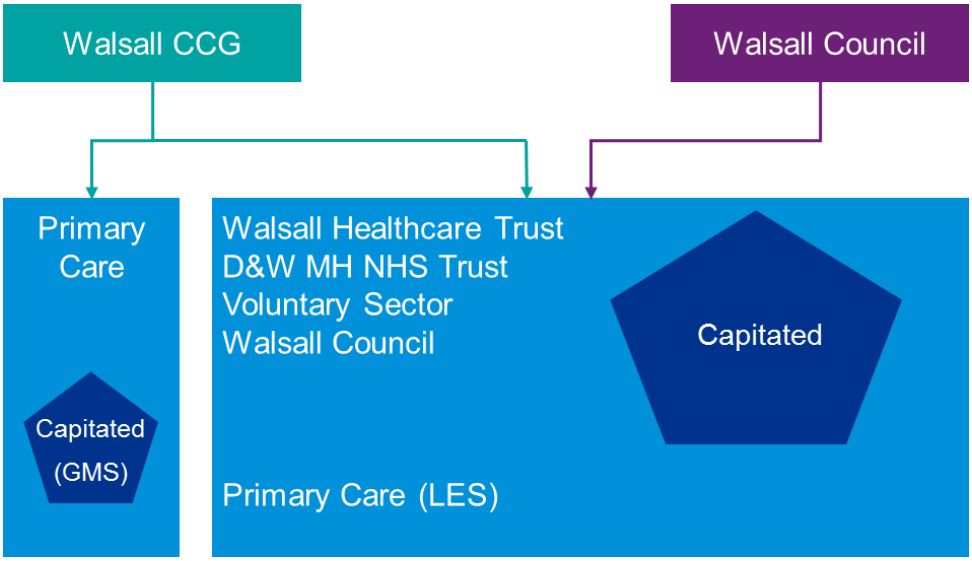


Figure 14 Payment models and contracting with full integration (excluding the GMS contract)

- Opportunity to increase the resource and allocation on LES as part of the new model

These system outlines are described in more detail below:

Option	Description	Benefits	Disadvantages	Alignment with ACO

				roadmap
No integration	Current state. Each organisation has multiple service contracts with differing payment mechanisms.	No amendments to existing arrangements required.	Does not incentivise collaborative or integrated working.	The current model is financially unsustainable and will have guidance imposed if a local solution is not proposed.
Partial integration	a) The WHT contracts (Including Community services) held by the CCG will be integrated in to a single block contract. b) The WHT and DWMHPT contracts will be integrated in to a single front loaded block contract. c) All contracts from the CCG (excluding GMS, but including LES) will be integrated into a single block contract. d) All contracts with the CCG (excluding GMS, but including LES) and those from Walsall Council (Adult Social Care, Children's Services, aspects of Public Health) will be integrated into a single block contract. In all above options, one year contracts will be signed with a binding risk share agreement and the block payments are payable in instalments.	a) WHT is incentivised to invest in Community Services. WHT is empowered to make decisions regarding their budgets and spending. b) Primary, Community and Acute incentivised to collaborate. Enables the journey towards full integration with capitated budgets.	There is less scope for all organisations to transform as some of the existing barriers to closer collaboration will remain in place (such as separate budgets and performance targets).	This contracting structure is an extension of the ACS structure where the commissioners integrate their service contracts under a single payment mechanism. The commissioners may operate a pooled budget.
Full integration	A single contract is implemented for all Walsall contracts, underpinned by a capitated budget. This contract structure supports the implementation of an ACO lead provider model.	Providers are incentivised to collaborate. Implementation of a capitated budget enables providers to make decisions on where they invest. Providers will be	Requires a long transition period to achieve full integration.	Full integration of contracts enables the implementation of an ACO. Some of the commissioning functions may be transferred to the ACO.

		incentivised to invest in low cost settings.		

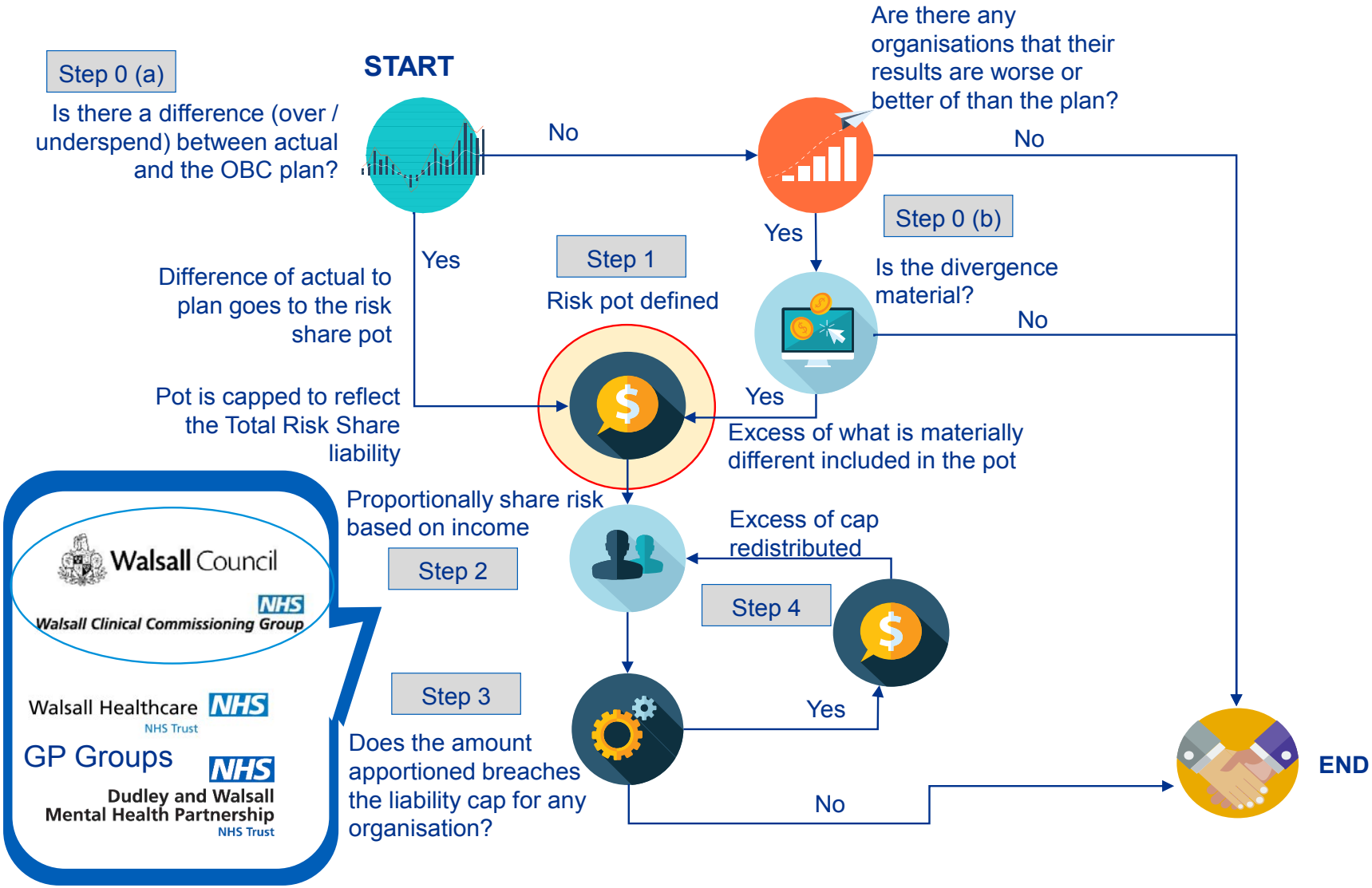
4.4 Agreed contractual principles

A workshop was held on 08 December 2017 to discuss the principles of a range of contractual arrangements that could be put in place between the providers; including the associated risk sharing arrangements. This workshop included a high level overview of the variety of payment models, many of which are used currently in Walsall, but demonstrated some of the innovative new ways these payment models are being deployed elsewhere. While contractual requirements are relatively inflexible, by utilising a range of payment models to deliver agreed outcomes, Walsall can dramatically alter how care is delivered.

In addition to this workshop and following the later circulation of the *Walsall Alliance Model Options Analysis* (Appendix 3) document, the WTPB have identified the 'Host Provider' model as the preferred route forward at this stage. There remains significant work to be completed prior to a new model being adopted, not least the identification of the Host Provider, and as such the details such as contractual arrangements, payment and risk sharing options remain to be discussed at a later date. However the WTPB reviewed and established design principles for risk sharing in Walsall and an example risk process has been circulated.

Figure 15 Design Principles for Risk Share

Figure 16 Example Risk Share Decision Making Process



The process flow detailed above demonstrates how gains and losses in the model can be shared proportionately amongst its members. Fundamentally, a risk share agreement should ensure that no individual member "loses out" and that the system benefits as a whole. This can be applied to a range of contractual arrangements, including a Host Provider model, with terms laid out in each contract.

4.5 Key contractual matters

Each of the health and care providers that participate in Walsall Together have a series of bi-lateral contracts between themselves and the commissioners of those services (including Walsall CCG, Walsall Council and NHSE). There is a long-term ambition to move to a simplified contractual structure and potentially to a contract based on capitation for the local population of Walsall. However, it was agreed that in the next 12-18 months it was unlikely that these contracts could feasibly be replaced and so the short to medium term aim is to reach a commercial agreement that will sit on top of the existing bi-lateral contracts as a separate contract (a 'wrapper' contract).

Figure 17 A new model will require a cultural shift from transactional to cooperative

Differences of worked risk sharing mechanisms		
Australian Alliance	**Walsall Together Alliance**	**PFI Style Contracting**
No cost/risk share, only gain share		Only risk allocation, gain remains with each organisation
No blame culture		Each organisation separately responsible for specific risks
Risk shared 50:50 between Commissioners and Providers		Risk is undertaken by the party best able to manage the risk
Overall system view		Organisational view
Open book accounting		Closed book accounting
Parties work together to solve issues		Organisations working separately and in some cases in competition (lead provider)
Principles based approach		Rules based approach

4.6 Proposed governance structure

A further workshop on the 4 January 2018 was held to provide opportunity for organisations to challenge a proposed governance structure, based on similar models elsewhere but with Walsall specific judgements remaining to be made. These included the role of the CCG as commissioner, Walsall Council as a provider/commissioner and also the involvement of One Walsall, the third sector body.

Until this point and as requested by Walsall CCG, Walsall CCG had been indirectly involved in discussions, with these instead being led by the members of the Provider Board. Walsall Council and Public Health parties were therefore involved in their provider capacity, rather than as commissioners. However, over the course of the consultation period, there was a reflection from the group that commissioner

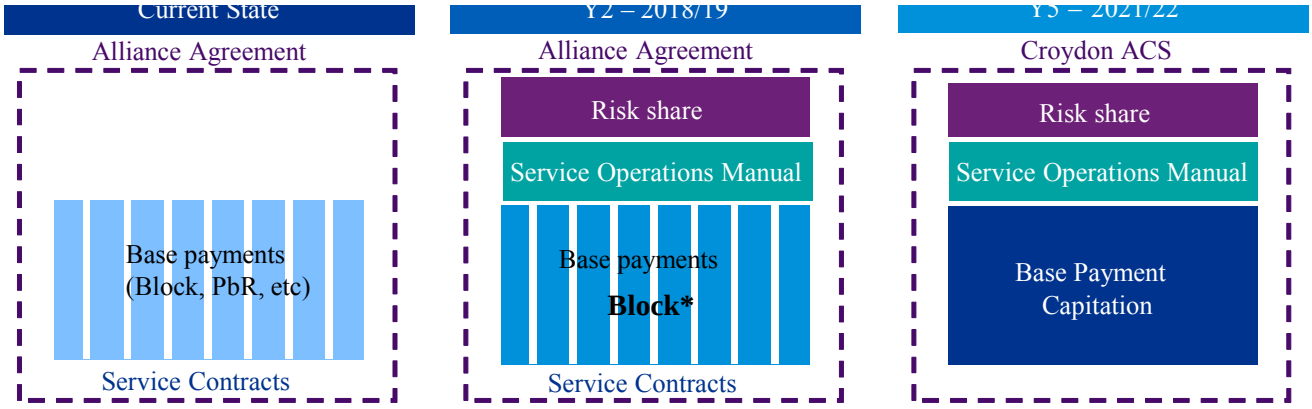
involvement would increase momentum and also ensure greater alignment between providers and commissioners when a proposal was to be made to regulatory bodies. Consequently this workshop had greater commissioner representation than previous workshops, which provided the opportunity to challenge the viability of options directly.

Some of the options explored included:

- Developing the commercial model(s) for Walsall including the organisational form for provision and the contractual framework, payment model and approach to risk sharing. The broad expectation is that transition this will involve integration of current contracts under a new commercial structure with consolidation of funding streams under a capitated budget. However, there are key questions still to be resolved are about scope and phasing of integration and the implications for individual commissioners and providers.
- Strengthening system governance in Walsall to formalise partnership working between commissioners and providers and to facilitate collective system leadership. This was seen as particularly important during transition to the new commercial model(s) although it may continue to play an important role in facilitating partnership working in the end state.

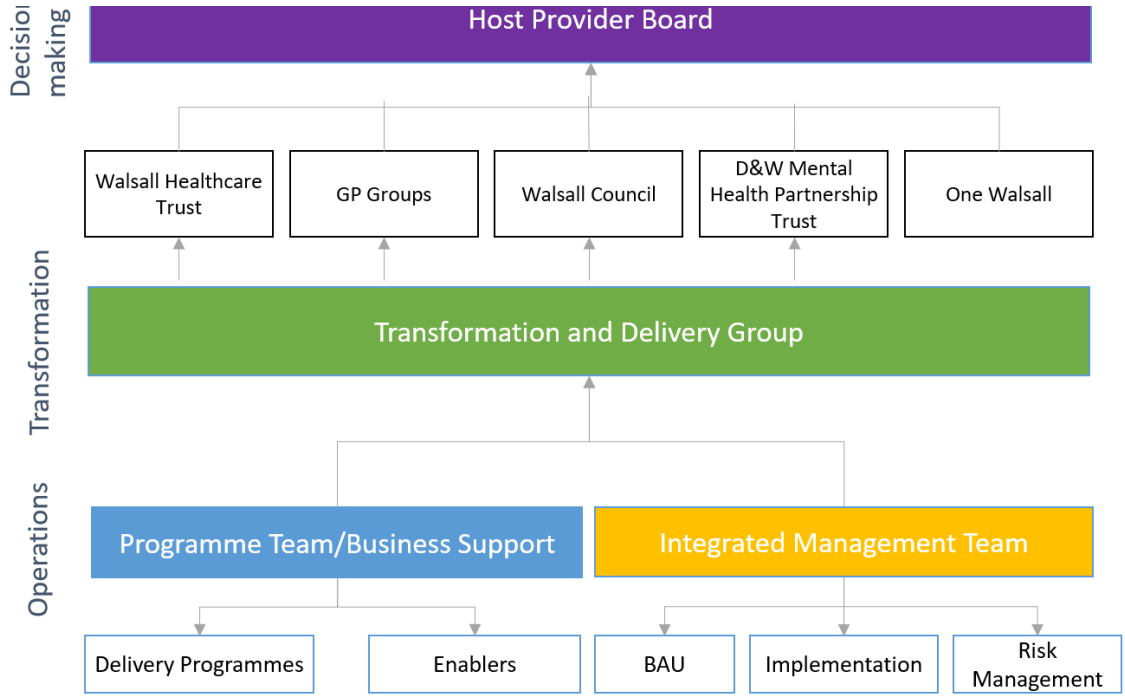
A key conclusion from the workshop was that further work is needed to agree a shared vision for the end state commercial model and the roadmap for transition. This will require appraisal of options for the end state and transition for the system as a whole and from the perspective of individual partners. The diagram below sets out an overview of the transition path for establishing an Accountable Care System in Croydon where the transition is being facilitated through a Commissioner/Provider Alliance.

Figure 18 Transition path for developing the commercial model for the Croydon Accountable Care System (ACS)



In the interim there is support for taking immediate action to strengthen the existing programme governance for Walsall Together, drawing learning from the Croydon model of a Commissioner/Provider Alliance. This approach is illustrated in the diagram below. The role and functions of a Commissioner/Provider Alliance would be expected to evolve over the transition period and some functions may transfer to the provider organisation(s) over time as the new commercial model is implemented. The case for continuing with any form of Commissioner/Provider Alliance would need to be reviewed for the end state.

Figure 19 Option of establishing a Walsall Commissioner/Provider Alliance to strengthen system governance and facilitate collective leadership of the transition programme



4.6.1 Host Provider Governance

The following principles have been agreed for the governance of a proposed Host Provider:

- The Host Provider should provide a safe place for governance – providing confidence for commissioners and providers;
- The Host Provider will support a Board which is representative of all of the provider organisations*;
- The Host Provider will agree an approach to delegated authority for services within scope as part of the development of the Host Provider model.

*As the cornerstone and front door of the NHS, the WTPB has always recognised the importance of Primary Care involvement and GPs will continue to play a crucial role as the programme develops, for example providing clinical leadership during design of the Clinical Operating Model. It is also essential that a Primary Care representative continues to sit on the Board. However due to the unique nature in which Primary Care is delivered, there is a challenge for the Board in achieving a single 'Primary Care voice', as individuals GP practices will each continue to deliver their own GMS contract as commissioned by the CCG. The GP Leadership Group has started to bring together the different GP partnerships and Federations, however there are a number of GPs that remain outside of the GP Leadership Group.

The GP Leadership Group will need to consider what amendments to structure and process are necessary to strengthen the 'Primary Care voice' and to ensure the Primary Care community is represented at the Board. An enabler to this will be adequate resourcing as referenced in section 5, however the expected

outcomes and deliverables from this arrangement must be identified in order to keep pace. It should also be acknowledged that the task of ‘unifying’ 59 practices into a single perspective is not a small ask and that while significant resources will be invested in achieving this, there may still remain some outliers.

A dedicated PMO and accompanying budget to support its functions is to be identified and effected by April 2018 to build on the momentum generated throughout this process. The PMO Lead will report in to a Board with equal representation from all organisations; likely to be the WTPB in the interim, prior to the Host Provider being identified. Once established, the Host Provider will continue to defer decision making responsibility to the Board, who will oversee 7 identified work streams. Each work stream will have a dedicated team and include where necessary specialist/external support; managed by a Works Stream Lead, who report will report directly in to the Board.

5 Leadership & Programme Management

5.1 Introduction

This paper provides a clear starting point and direction for future progress, with identified next steps to deliver system level transformation. In order capitalise on the momentum, strong alignment and shared ownership developed thus far, it is essential that dedicated resource is made available to the programme. This has support from both the WTPB and local commissioners; demonstrating the commitment to this vision from a system perspective.

Nevertheless, the support of individual organisations and individual providers of health and care is integral to the success of the programme, and as such, there remains considerable internal discussions to be had by the partner organisations and with our Primary Care colleagues. The benefits case must be clear why the proposal presented here is the right one for Walsall and the input from colleagues will be invaluable in shaping the programme design and delivery.

In reflection of this, the proposals for programme management presented here are approximate based on the current understanding of requirements and may change in response to changing needs.

5.2 Programme Management Arrangements

5.2.1 Board

The proposed Host Provider Model reflects the partnership mind-set held by the WTPB and the commitment to continuing to build on the strong relationships developed between providers of health and care in Walsall as part of the WTPB. This will be leveraged immediately with the current WTPB members assuming the Executive Board role from February 2018 in the interim. One of the first tasks of the Board will be to identify the Host Provider; which will provide a “safe-home” for governance. The Board will then move across to sit within the Host Provider; however the membership will continue to reflect the partner organisations, with equal representation and most importantly retain its decision making authority over the programme.

It is expected that continued Primary Care representation at Board level will be supported and facilitated by the CCG in relation to agreed outcomes and deliverables, however the terms of these arrangements are yet to be discussed.

5.2.2 Project Management

A dedicated, full-time Leadership & Project Management Office (PMO) will provide the necessary project management support over the next 12 months to ensure the programme moves into delivery by April 2019. It is expected that this would be resourced by at least 3 Full Time Equivalents; with one FTE assuming the Chief Office role for the PMO and the delivery of this programme.

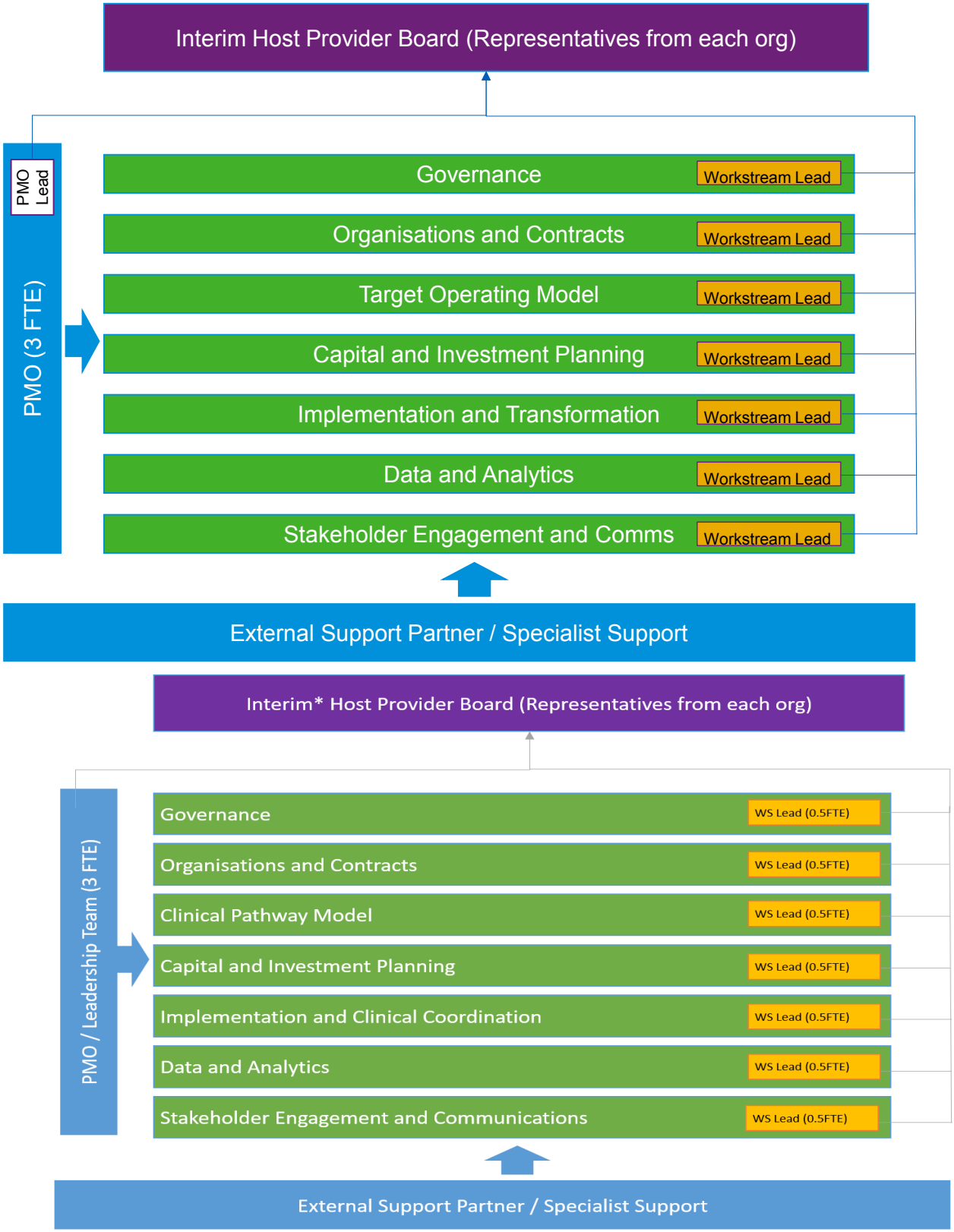
5.2.3 Work Streams

The next steps laid out in this document reflect the level of ambition of the proposal and also go some way to outlining the amount of work required to deliver the programmes' aims. As such the next phase is crucial and requires strong leadership. We have identified seven work streams which will be driven by team, with an identified lead who will have experience in that particular field, to move into delivery by April 2019. These teams will require support and steer from the PMO throughout and will draw upon specialist advice and/or external services as necessary. The work streams are as follows;

- Governance;
- Organisations and Contracts;
- Clinical Operating Model;
- Capital and Investment Planning;
- Implementation and Transformation;
- Data and Analytics;
- Stakeholder Engagement and Communications.

The diagram below provides a high level outline of how these work streams will be managed and the reporting structure for the interim arrangements.

Figure 20 Programme Management Arrangements for 2018-2019


Interim Host Provider Board (Representatives from each org)
PMO Lead
PMO (3 FTE)
Governance
Workstream Lead
Organisations and Contracts
Workstream Lead
Target Operating Model
Workstream Lead
Capital and Investment Planning
Workstream Lead
Implementation and Transformation
Workstream Lead
Data and Analytics
Workstream Lead
Stakeholder Engagement and Comms
Workstream Lead
External Support Partner / Specialist Support
Interim* Host Provider Board (Representatives from each org)
PMO / Leadership Team (3 FTE)
Governance
WS Lead (0.5FTE)
Organisations and Contracts
WS Lead (0.5FTE)
Clinical Pathway Model
WS Lead (0.5FTE)
Capital and Investment Planning
WS Lead (0.5FTE)
Implementation and Clinical Coordination
WS Lead (0.5FTE)
Data and Analytics
WS Lead (0.5FTE)
Stakeholder Engagement and Communications
WS Lead (0.5FTE)
External Support Partner / Specialist Support

5.2.4 Roles and Functions

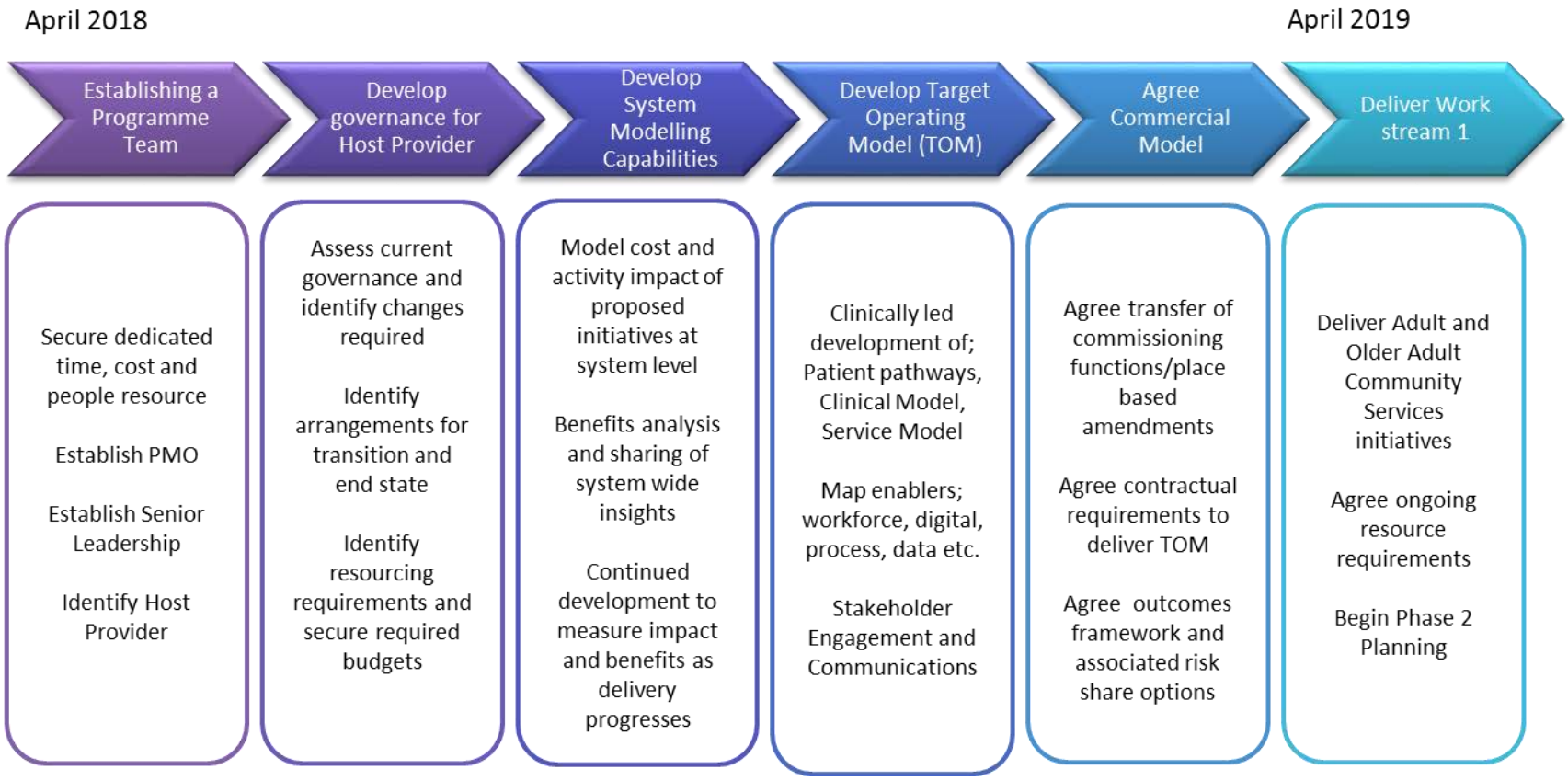
The table below describes in further detail the roles and functions of the groups outlined above. The continuation of some of these roles, such as the Work Stream Teams, beyond April 2019 will be decided as part of the ongoing programme management.

Role	Description
Host Provider Board	In the interim, the WTPB will fulfil this role. As part of the Governance and Organisations work stream, a Host Provider is to be identified and the Board will then sit within the Host Provider, while retaining the equal representation membership from each provider organisation. The Board will provide strategic direction and have ultimate decision making responsibility. The Board will receive regular updates from the Chief Officer and Work Stream Leads.
PMO (3 FTE)	3 Full Time Equivalent. The PMO team will oversee all 7 work streams and work alongside the Work Stream Leads and any External/Specialist advisors.
Chief Officer (1 FTE from PMO)	As part of the PMO function, the Chief Officer will have responsibility for managing overall delivery of the work streams. They will report directly into the Board.
Work Stream Teams	Work Stream Teams are subject to flex and adapt as necessary to reflect the non-concurrent delivery. Each Work stream is managed by a Work Stream Lead with support from the PMO and External/Specialist advisors where necessary.
Work Stream Lead (0.5 FTE)	Each of the 7 Work Stream Leads will have overall responsibility for delivery of their work stream. Each WS Lead will report directly into the Board.
External Support Partner/Specialist Advisors	External and/or specialist advisors will work alongside the PMO and Work Stream Leads as necessary, providing support where internal resource cannot be allocated.

5.3 Project Implementation Proposal

A high level timeline for project implementation and associated tasks is shown below. Development of a detailed timeline will be completed by the PMO function.

Figure 21 Project Implementation Plan



5.4 Stakeholder Communications Plan

A communications plan for the Walsall Together Partnership has been created alongside plans for each organisation to ensure the propositions in this paper are circulated amongst all stakeholders for discussion. Sufficient time should also be allocated to provide stakeholders with a consideration period within which to respond to the Walsall Together Provider Board.

* Denotes formal decision making bodies

5.4.1 Walsall Together Partnership

Group	Date	Lead	Status
Walsall Together Board	31/1/18	Mark Axcell	Listed as an agenda item for verbal update.
Walsall Together Provider Board	7/2/18	Mark Axcell	Main agenda item which will commence approval process of partner organisations. Requires agreement of parties Not formal decision maker
Health and Wellbeing Board *	TBA – could be April Board or a Development session	Paula Furnival/Barbara Watts	Statutory duty to oversee integration at system level and receives /endorses commissioning intentions of CCG and Council
Strategic Partnership Group	TBA	Simon Brake/Paula Furnival	Coordinating group across system No formal decision making powers
Health and Care Overview and Scrutiny Committee	TBA – following Cabinet	Paula Furnival/Barbara Watts	Formal scrutiny of service change

5.4.2 GP Leadership Group

Group	Date	Lead	Status
Walsall Alliance Federation	TBC	Waheed Saleem/Dr Sohaib Siddiq	Briefing and engagement
Palmaris	TBC	Chris Blunt/Dr Bhupinder Sarai	Briefing and engagement
Modality	TBC	Dr Narinder Sohata	Briefing and Engagement
Umbrella	TBC	Greg Bloom/ Dr Ryan Hobson	Briefing and Engagement
TPG	TBC	Ian Rose	Briefing and Engagement

5.4.3 Walsall Healthcare Trust

Group	Date	Lead	Status
Board *	8/3/2018	Daren Fradgley	Decision maker To be phased in the same time period at Cabinet, DWMHT Board and CCG Governing Body
Executives	Underway	Daren Fradgley	For alignment and support
Performance, Finance and Investment Committee	23/2/2018	Daren Fradgley	Conversations underway to bring committee members up to speed
NED's - Board Development Session	29/01/2018	Daren Fradgley	Open briefing for all board members

5.4.4 Walsall CCG

Group	Date	Lead	Status
Governing Body (Private Session)	TBA with Simon	Simon Brake/Paul	Preparation and endorsement for the Governing Body
Governing Body (Public Session) *	TBA with Simon	Simon Brake/Paul Tulley	Decision maker To be phased in the same time period as other Boards
GP Leadership Forum	30/1/2018	Paula Furnival/Daren Fradgley	Is this too early?
LMC	TBA with Simon Brake		TBC
Locality Boards?	TBA with Simon Brake		TBC

5.4.5 Dudley and Walsall MH Trust

Group	Date	Lead	Status
Board *	1/3/2018	Mark Axcell	Decision maker To be phased in the same time period as other Boards
Board Familiarisation	19/2/2018	Mark Axcell	TBC
Executives	Underway and continuing throughout February 2018.	Mark Axcell	TBC
MEXT	February MEXT	Mark Axcell	TBC

5.4.6 Walsall Council

Group	Date	Lead	Status
Portfolio holder	Underway	Paula Furnival	TBC
CEO and ED's	30/1/2018	Paula Furnival	Booked
CMT	February 2018	Paula Furnival	TBC
Cabinet /CMT	March 2018	Paula Furnival	TBC
Cabinet *	TBA	Paula Furnival	Decision maker To be phased in the same time period as other Boards

This document consolidates the progress that has been made to date in both delivering the Walsall Model of Care and the development of an appropriate commercial model to incentivise and animate providers to deliver the phased transformation. There are now three recommended steps for immediate action following approval, to allow the development of a business case over the next six months and to prepare to deliver the first work stream by April 2018/19.

6 Recommended Next Steps

This case for change has moved the system to a point where it understands at an outline level the direction of travel for delivering more integrated health and care services in Walsall. However the work has also shown that there are critical gaps of knowledge within the Walsall system that will enable the Host Provider governance structure to become more accountable, deliver transformation at a system level and truly join up care – with the full buy-in of all stakeholders.

We are therefore recommending that the WTPB, must now undertake a more detailed business planning process (to include a business case for consideration with NHS Improvement that all stakeholders can sign-off on). Within this process we are recommending that the leadership structure agree three immediate actions:

1) Establishment of a programme team, with an interim programme structure akin to that shown below, with access to dedicated resources to run the detailed development process;

    a. Agreeing resource allocation and budget;

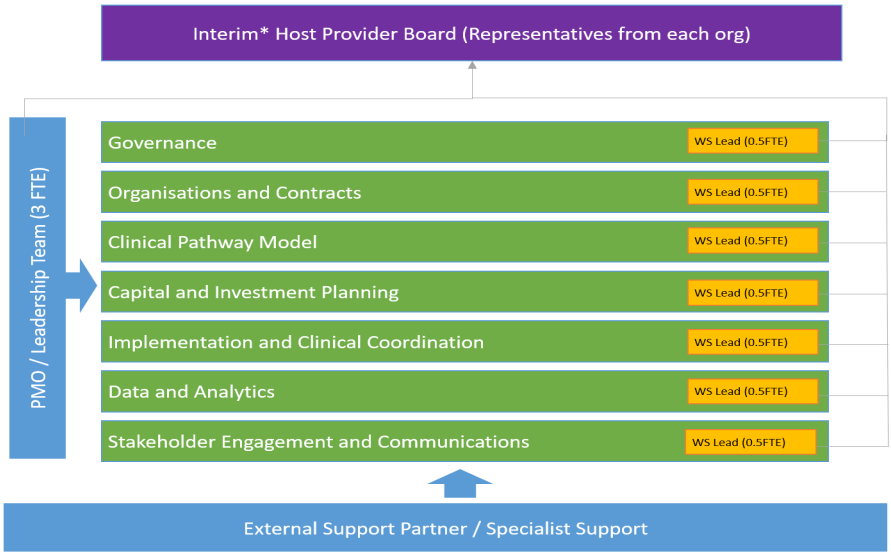
    b. Establishing a new senior tier of leadership;

    c. Establishing a dedicated PMO;

    d. Developing a stakeholder engagement and communications plan; including the public and

Figure 22 Proposed Interim Programme Team Structure

regulators.



**The Walsall Together Provider Board to fulfil this role until Host Provider Arrangements agreed.*

2) Within this structure the development of a business case for consideration with NHS Improvement within the next six months, to include the following priorities:

   a. Clearly defining the governance structure of the host provider model, with roles and responsibilities well defined and clear lines of accountability between the host provider, commissioners and the provider supply chain;

      i. Understanding existing governance implications in consequence of adopting a new integration model;

      ii. Identifying and securing resource requirements to support proposals;

      iii. Agreeing how the different priorities of governance can enhance the improvements in wellbeing (such as political accountability);

   b. The development of a comprehensive, Walsall wide financial model for the system. This should include:

      i. Developing a clear understanding of the baseline financial and activity position of the health and care system, as well as the "do nothing scenario" for the future;

      ii. Strengthening relationships amongst stakeholders and building confidence in the system that change is both necessary but also possible;

      iii. Developing, modelling and applying a number of business and organisational change scenarios that could be delivered in Walsall. Through this developing a more specific "do something" scenario for Walsall, by applying these initiatives within a theoretical future state scenario;

      iv. Establishing the ground work required for the Host Provider to set system direction through a new funding, population management and performance management model for all providers.

c. The development of a comprehensive, Walsall specific Clinical Operating Model (COM) for the future state system of health and care in Walsall. For us, it is critical that a system wide Target Operating Model in Walsall is clinically-led and developed in collaboration with existing service providers and users, with new experiences and knowledge embedded within the wider team. Furthermore the existing model and current service design projects should be challenged as part of this process in order to improve quality and achieve sustainability. To achieve this, we believe that a number of layers need to be collaboratively worked through, to achieve clarity in developing the TOM:

    i. What are your desired end user experiences across end to end health and care delivery?

Figure 23 Developing a Clinical Operating Model

    ii. How will these be delivered through an optimised clinical model/professional workflow?

    iii. How will service models support that workflow end-to-end?

    iv. Do you have the enablers, including workforce, in place to deliver on the future state service models?

    v. How will the Host Provider Board/contractual arrangements ensure the commissioned services are delivered? What incentives and risk sharing options will facilitate the integrated working?

    vi. How will these pathways grow? Can successful initiatives be “industrialised”? Can they be expanded to deliver to the whole population?

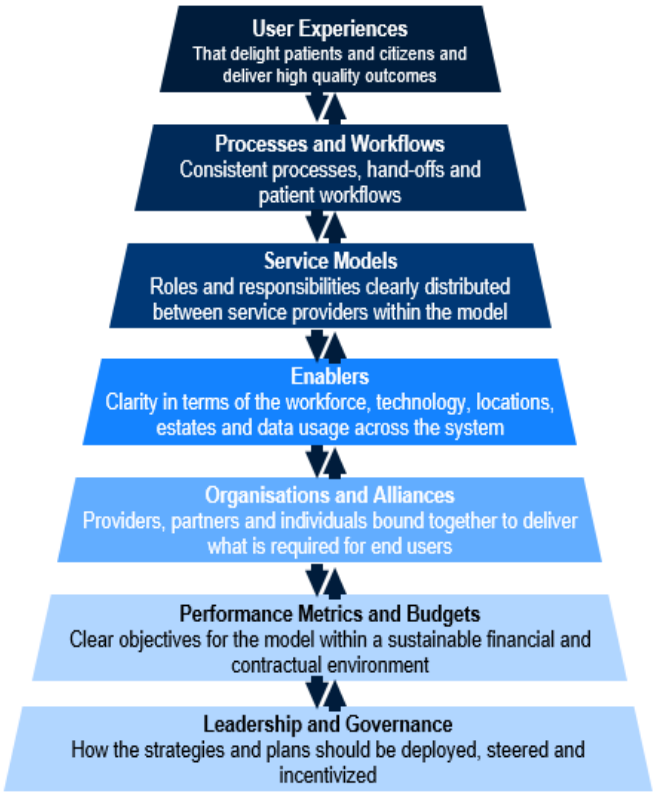
    vii. How will you manage performance and ensure that the money works in the system – and can you transition to this future state?

d. Agreement on the commercial model for Walsall and the roadmap for transition. This will include:

i. How the provider organisations operate alongside the Host provider to deliver the TOM;

ii. Agreeing which commissioner hosted functions can be transferred to the Host Provider, such as IT and support functions;

iii. Agreeing an integrated place based commissioning arrangement across the CCG , Council, and Public Health;



iv. Creating an agreed outcomes framework and associated risk share arrangements;

v. Agreeing the allocation of financial resources to facilitate delivery of transformation phases.

And finally;

3) The creation of a budget and resource commitments to support both internal and external inputs to the process over the next six months. These are broken down as follows;

Internal requirements:

a. Dedicated director time (1FTE);

b. Support for the board meetings/governance;
c. PMO provision, including a Chief Officer;
d. Nominated Work Stream Leads (likely part time);
e. Communication and messaging support (0.5 FTE);
f. Clinical time for backfill for those tasked with delivery;
g. Circa £115k to facilitate Primary Care participation and clinical time release (figures based on a previous proposal to the CCG by the GP Leadership Group);
h. Commitment from organisations to free up resources to participate in the process during the next stage.

Whilst this represents a significant internal investment for the partners, it is fair to say that it builds on the significant commitments that have already been undertaken and the goodwill shown by all to participate in the process.

External requirements:

a. Light touch external support around further definition to the governance structure, but to include legal advice that will ensure satisfaction of the regulatory environment;

b. Significant support to the development of a comprehensive, Walsall wide financial model for the system. This should include:

    i. Developing a clear understanding of the baseline financial and activity position of the health and care system, as well as the "do nothing scenario" for the future;

    ii. Developing, modelling and applying a number of business and organisational change scenarios that could be delivered in Walsall. Through this developing a more specific "do something" scenario for Walsall, by applying these initiatives within a theoretical future state scenario;

    iii. Establishing the ground work required for the Host Provider to set system direction through a new funding, population management and performance management model for all providers.

c. Significant support to the development of a comprehensive, Walsall specific clinical operating model (COM) for the future state system of health and care in Walsall. This to be developed through the initial priority care areas that have been identified and likely working with a "model community" that could then become the early/first adopter of the model for their population. This process would need significant clinical/professional input, which is critical to agreeing a shift in care from higher cost to lower cost settings, as well as in designing the future workflows for example.

d. Significant support to agreeing the commercial model for Walsall and the roadmap for transition. This will include:

    i. Scope of organisational or contractual integration;
    ii. Organisational form for integrated provision;
    iii. Contractual model(s);
    iv. Payment model(s);

v. Approach to risk/reward sharing.

While a detailed budget is yet to be created, at this stage it is recommended that a ceiling budget for external support be set at £400k to support the requirements outlined above.

In terms of cost versus benefit analysis, it is clear that there is a significant opportunity to move towards a more integrated delivery model in Walsall. The analysis within this document (section 3.3.1) illustrates a potential for more integrated working to release annualised savings of between £49m and £153m at a system level.

This is a compelling rationale for continued development of the partnership approach as well as the necessary internal and external investment and commitment to shared progress.

7 Appendices

7.1 References

1 Health Evaluation Data 2015/16 against 2014/15 and Q1 2016/17 year on year

2 Masters R, Anwar E, Collins B et al. (2017) Return on investment of public health interventions: a systematic review. *Journal of Epidemiology & Community Health,* 0, 1-8.

3 Dorling G, Fountaine T, McKenna S and Suresh B. (2015) *The Evidence for Integrated Care*. McKinsey&Company.

7.2 Workshop Attendees

Benefits and Risk Share Workshop attendees 30 November 2017

Name	Organisation	Role
Daren Fradgley	Walsall Healthcare NHS Trust	Director of Strategy & Transformation
Andrew Griggs	Walsall Healthcare NHS Trust	Programme Manager / Integrated Care
Paula Furnival	Walsall Council	Executive Director of Adult Social Care
Waheed Saleem	Walsall Alliance (GPs)	Managing Director for Walsall Alliance/ GP Leadership Group Representative
Sally Roberts	Walsall CCG	Director of Governance, Quality and Safety
Alex Boys	One Walsall (voluntary sector)	Chief Executive
Barbara Watts	Public Health	Director of Public Health
Dr Anand Richie	Walsall CCG Alliance (GP Fed)	Clinical Chair and GP
Dr Narinder Sohata	Modality Partnership (GP Partnership)	GP
Ian Rose	The Practice Group (Private)	Engagement Lead
Greg Bloom	Umbrella (GP Fed)	Group Practice Manager
Dr Nasir Asghar	Alliance (GP Fed)	GP
Robin Vickers	KPMG	Director
David Bevan	KPMG	Associate Director
Hannah Lewis	KPMG	Associate

Risk Share and Commercials Workshop attendees 8 December 2017

Name	Organisation	Role

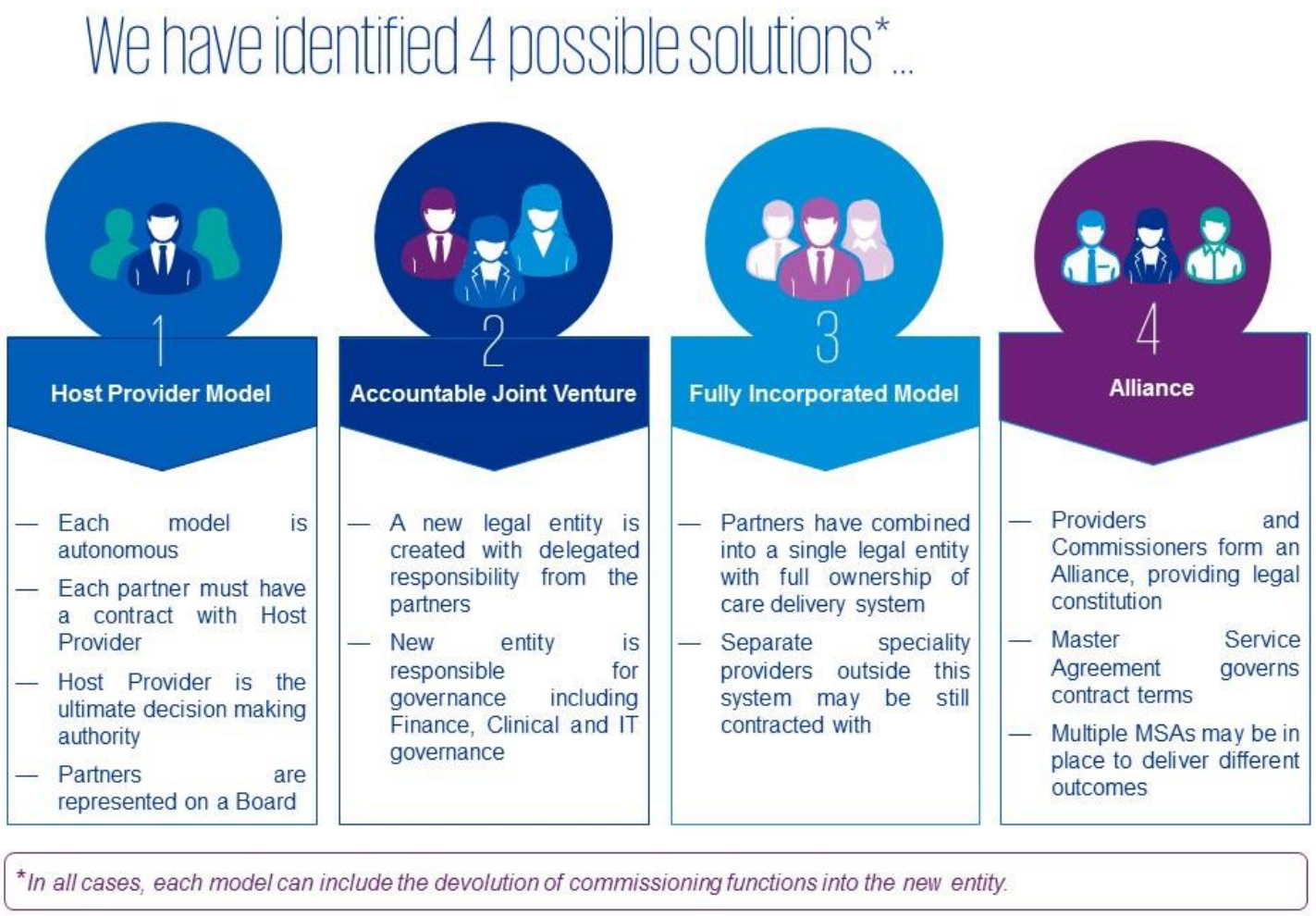
Daren Fradgley	Walsall Healthcare NHS Trust	Director of Strategy & Transformation
Tony Gallagher	Walsall CCG	Chief Financial Officer
Andy Griggs	Walsall Healthcare NHS Trust	Project Manager
Waheed Saleem	Walsall Alliance Ltd	Managing Director for Walsall Alliance/ GP Leadership Group Representative
Paula Furnival	Walsall Council	Executive Director Adult Social Care Lead
Rupert Davies	Dudley & Walsall MH NHS Trust	Interim Director of Finance
Paul Tully	Walsall CCG	Director of Commissioning
Sally Roberts	Walsall CCG	Director of Governance, Quality and Safety
Robin Vickers	KPMG	Director
Sebastian Habibi	KPMG	Director
David Bevan	KPMG	Associate Director
Tony Kettle	Walsall Healthcare NHS Trust	Deputy Director of Finance
Paul Stevenson	Walsall Healthcare NHS Trust	Head Accountant

Governance Workshop attendees 4 January 2017

Name	Organisation	Role
Daren Fradgley	Walsall Healthcare NHS Trust	Director of Strategy & Transformation
Mark Axcell	Dudley & Walsall MH Trust	Chief Executive and Chair of Walsall Together Provider Board (WTPB)
Andrew Griggs	Walsall Healthcare NHS Trust	Programme Manager / Integrated Care
Paula Furnival	Walsall Council	Executive Director of Adult Social Care
Waheed Saleem	Walsall Alliance (GPs)	Managing Director for Walsall Alliance/ GP Leadership Group Representative
Chris Blunt	Portland Medical Group (Palmaris)	Lead for engagement
Paul Tully	Walsall CCG	Director of Commissioning
Simon Brake	Walsall CCG	Chief Officer
Alex Boys	One Walsall (voluntary sector representative)	Chief Executive
Barbara Watts	Public Health	Director of Public Health
Richard Kirby	Walsall Healthcare NHS Trust	Chief Executive
Sebastian Habibi	KPMG	Director
David Bevan	KPMG	Associate Director

Hannah Lewis	KPMG	Associate

7.3 Extract of Walsall Alliance Model Options Analysis



Alliance Contract Model

Example: Lambeth and Croydon accountable care programmes

Lambeth and Croydon have established commissioner/provider Alliances to improve outcomes and value for defined populations. The Alliance structure provides a framework for joint accountability, alignment of contracts and risk/reward sharing

Commissioners and providers form an Alliance. An overarching Alliance Agreement provides the legal constitution of the Alliance (i.e. contractual joint venture).

- Master Service Agreement sets overarching contract terms e.g. overall budget, outcomes, KPIs, and the framework for risk/reward sharing;
- Commissioners contract with providers within the framework of the overarching Alliance Agreement and Master Service Agreement.

Pros

- The Alliance provides for relationships of 'equal partners';
- The Alliance agreement providers a legal basis for joint accountability;
- The structure provides flexibility on key issues such as scope of transformation and the extent and phasing of provider integration. For example there could be multiple Master Service Agreements governing different service areas or subpopulations under the overarching Alliance Agreement;
- The structure provides a framework within which the governance and contractual form of provider collaboration could evolve (e.g. incremental integration of contracts and/or the emergence of Host Provider arrangements).

Cons

- The governance and contractual structure can be potentially complex;
- Commissioner members of the Alliance may have to continue sharing financial risk with providers;
- Relies absolutely on building and maintaining trust and collaborative behaviours;
- Potentially vulnerable to unilateral decisions to exit the Alliance and/or the failure of individual partners.

Alliance Contract Model: Local Impacts

This option could be implemented within existing organisational structures and would provide a contractual framework for joint accountability, collective decision making, alignment of contracts and risk/reward sharing. The key merits of this option may be as a transitional stage in the development of integrated provider organisations and contractual structures. This option is also potentially viable as an end state solution within which there may be partial integration of provider organisations and contracts whilst other provider members of the Alliance continue to contract bilaterally with the commissioners.

Organisation	Accountability	Impact
Commissioner	All Alliance members are accountable to the other Alliance members under the terms of the Alliance Agreement	Commissioners will contract with providers and share risk/reward within the framework of the Alliance Agreement and Master Service Agreement
Dudley and Walsall Mental Health Trust	Providers are accountable to commissioners through bilateral contracts (albeit that these may be integrated over the life cycle of the Alliance)	Providers will be accountable as Alliance members and through their contracts with commissioners (or as part of a Host Provider or other integrated organisation as/when it emerges)
Primary Care		
One Walsall	Bilateral contracts are subordinate to the Master Service Agreement (i.e. 'contractual wrapper') that is signed by all Alliance members.	Some providers may be Alliance members and remain outside of any integrated provider organisation or contractual joint venture that emerges
Walsall Council		
Walsall Healthcare Trust	The commissioners are obliged to use reasonable endeavours to align third party contracts with the Alliance Agreement and Master Service Agreement where possible	The council may be both a commissioner and provider within the Alliance

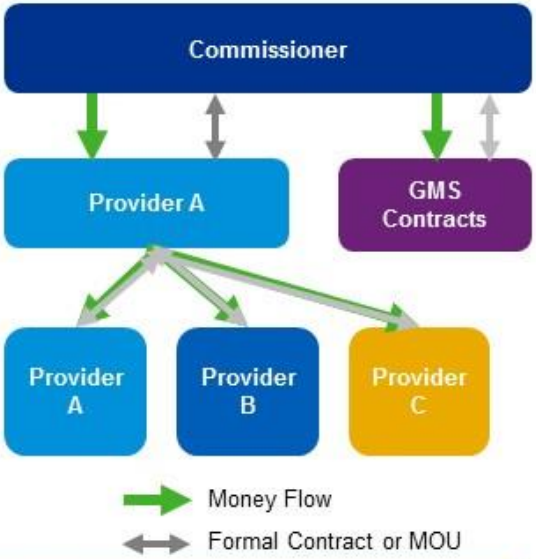
Alliance Contract Model: Local Impacts

As this option may be implemented within existing organisational structures it is likely that statutory duties and employment will remain as now and only change over time if/when integrated provider organisations emerge within the Alliance. For example, this may have implications for provider or commissioner staff (e.g. as commissioning activities transfer to providers and/.or where service provision is governed by a new organisation).

Other key components of the model will be determined by agreement between Alliance members.

Model	Finance	Contracts	Statutory duties	System Board Membership	Board role/function	Existing Provider Board's roles/ functions	Staff
Alliance Contract	Organisations continue to receive their own finance under existing contractual arrangements but have financial commitments to co-invest in share delivery teams, shared and they will share in financial upside / downside under terms set out in the Alliance Agreement and Master Service Agreement	Commissioner contracts can remain the same but would be governed by the Master Service Agreement and Alliance Agreement	Organisations likely to formally retain statutory duties in a legal sense but could nominate responsibility for delivering these to the Alliance Board	An Alliance Board would be established and all Alliance members would be equal partners. n.b. The Alliance agreement may also provide for Associate Members, albeit that they may or may not be Board members	Board will set strategic direction and facilitate collective decision making under the Alliance Agreement. This would include collective agreement on priorities, transformation plans, risk/reward sharing and the terms of the Master Service Agreement The Board may be supported by an Integrated Management Team and potentially also by a dedicated programme office and/or Strategy and Delivery executive	May reduce number of existing Boards / Sub-Committees (either in number or in frequency of meetings - i.e. retained to discharge formal statutory duties but with substantive functions and decision-making at the Alliance Board	Likely to remain as now, at least initially, pending the emergence of an integrated provider organisation and/or the transfer of commissioning activities from commissioner to provider organisations

Host Provider Model



Example: MSK, Bedfordshire UK

The collaboration involved an NHS Trust, an NHS Foundation Trust, a third sector organisation and a newly formed corporate joint venture. Each of the participants held a different role in contributing to the delivery of integrated MSK services. The model was used to reduce 'micro-commissioning' of complex care pathways and remove perverse incentives (PbR). Patients are clinically triaged to ensure arrival on the right part of the pathway. Secondary care referrals have decreased and supply chain financial reward has increased.

Commissioner holds one contract with a host provider who subcontracts the rest of services with other providers

- Each provider has a contract or MOU with the host provider;
- host provider cannot 'decommission' services from providers without approval from the Commissioner).
- host provider is responsible for administration of the contract, providing case management and oversight of patient records, monitoring service and quality measures and liaising with the Commissioner.

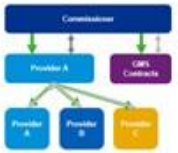
Pros

- Requires less time and investment for providers to come together, as they can work directly together supported by contracts or MOUs between themselves;
- Using a pre-existing provider with defined governance and decision making processes reduces 'start-up time';
- Enables money to move within the pathway;
- There is a single point of oversight of a contract and entity responsible for delivering agreed outcomes and performance across continuum of care.

Cons

- Success is largely based on collaboration and trust between host provider and other providers. A large risk is if the host provider makes decisions the other providers do not agree upon. May be politically difficult to select a host provider amongst a group;
- All providers must agree to shared savings and risk distribution amongst themselves;
- Possible provider monopoly;
- While the host provider maintains more power, it also incurs more investment (time, money, resources) and risk for that provider.

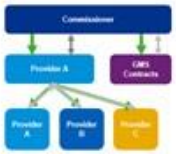
Host Provider Model: Local Impacts



A Host Provider model can be a quicker and simpler way to implement a new contracting model, as existing governance between the Host Provider and the commissioner is maintained and Primary Care GMS can remain outside of the agreement. Although the provider/commissioner relationship is maintained, elements of commissioning can be delegated to the host Provider.

Organisation	Accountability	Impact
Commissioner	-	Simple to manage as a single contract is required with the LP. Confidence in new model as currently contracting with Provider. Administrative and monitoring costs likely reduced as pass to Host Provider.
Host Provider	**Directly accountable to commissioner**	Greatest time and resource investment both initially and ongoing; would need to consider employment/skill mix to ensure they are able to fulfil contracting, supply chain management and commissioning requirements. To include administrative and monitoring costs inherited from Commissioner. Required to develop MOUs/Contracts with other providers. Has ultimate responsibility for delivery of contracts and will be held accountable by the commissioner. Can maintain existing governance structures and decision making capabilities and enables pathway management.
Dudley and Walsall Mental Health Trust	Accountable to host Provider as dictated by MOU/contract	Requires agreement of an MOU/contract with Lead Provider.
Primary Care	Accountable to commissioner as holder of GMS contracts and as dictated by MOU/contract with Host Provider for non-GMS functions.	Contract with Host Provider would sit alongside existing GMS contracts. The services as part of the contract would carry reduced risk for GPs, as accountability sits with Host Provider.
One Walsall	Accountable to Host Provider as dictated by MOU/contract	Requires agreement of an MOU/contract with Host Provider.
Walsall Council	Accountable to Host Provider as dictated by MOU/contract	Potential conflicts with delivering social care if contracted by a healthcare provider. May wish to consider keeping control of commissioning functions. Dependent on initial pathway scope, it may not be appropriate to be included or contribute to the budget, however a board position and collaboration can be maintained until such a point that greater involvement is appropriate.
Walsall Healthcare Trust	Accountable to Host Provider as dictated by MOU/contract	Requires agreement of an MOU/contract with Host Provider.

Host Provider Model: Local Impacts



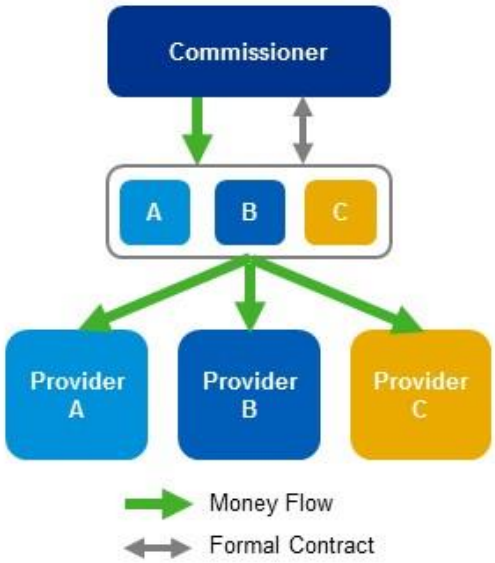
One of the impacts raised highlights the requirements on the Host Provider to manage system risk. If a current provider is selected, this may involve significant organisational change, including the possibility of integration with other providers, which may result in change substantial enough to view the provider as a new organisation.

Consequently it is worthwhile making a distinction between:

- Existing Provider as Host Provider;
- Transformed Existing Provider; capable of managing risk.

Model	Finance	Contracts	Statutory duties	Board Membership	Board role/function	Existing Provider Board's roles/ functions	Staff
Existing Provider as Host Provider	One organisation receives all the money and then passes funding on to sub-contractors	Commissioners contract with Host Provider that then subcontracts to other parties to deliver services it cannot deliver itself	Host Provider only likely to retain statutory duties for functions it can discharge itself	Existing Board of whoever selected as Host Provider	Host Provider existing roles / functions with added responsibility for services now being subcontracted	Unlikely to reduce number and frequency of sub-contractor boards	Staff can be transferred into Host Provider subject to the level of services it proposes to deliver. This could include back office / support staff
Transformed Existing Provider capable of managing risk	One organisation receives all the money and then passes funding on to sub-contractors	Commissioners contract with Host Provider that then subcontracts to other parties to deliver services it cannot deliver itself	Host Provider potentially allocated responsibility for statutory duties due to increased capability and competencies of Board members	Existing Host Provider board refreshed (whether wholesale or in part) so that reflects the new functions.	Host Provider existing roles / functions with added responsibility for services now being subcontracted	Likely to reduce number and frequency of sub-contractor boards as more substantive decisions can be taken safely by Host Provider board	Staff can be transferred into Host Provider subject to the level of services it proposes to deliver. This could include back office / support staff

Accountable Joint Venture



Example: Liverpool Clinical Laboratories (Liverpool, UK)

Liverpool Clinical Laboratories is a contractual joint venture owned by both Aintree University Hospital NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust.

Providers form a new entity (can be a formal or informal arrangement) which becomes the single responsible entity for the management and coordination of services.

- Only requires one contract between commissioners and providers;
- New entity has oversight over objectives, resource allocation, governance, etc. and is representative of participating providers. It is advised that separate work groups be set up to manage Finance, Clinical and IT aspects of new contract.

Pros

- Equitable representation of providers in a new entity, avoiding the need to constantly get provider 'buy in';
- Sharing ownership in new entity can lead to greater buy in to collectively contribute;
- Greater consistency of services provided and integration of care with a new entity providing collective oversight;
- Single provider entity means less contract management and administration from commissioning side;
- Each provider retains its financial and operating autonomy;
- Other providers, such as third sector or community providers, may also be included in the new entity in an informal 'affiliate' way.

Cons

- Providers will need to provide a lot of upfront investment and also time to decide upon representation, decision-making and delegation processes, distribution of any earned shared savings or losses;
- Providers need to endow new entity with enough power to enforce difficult decisions;
- Culturally may be extremely difficult for providers to come together as a new entity.

Accountable Joint Venture: Local Impacts

This model can be framed around specific patient pathways or alternatively focus on whole population; although this is difficult to implement as a first step. The focus may impact which parties are involved, or in the case of Local Authority and third sector parties, which service elements would be appropriate for inclusion. This is the most inclusive and collaborative of the three approaches; recognising the contribution of a range of providers and building on solid partnership working.

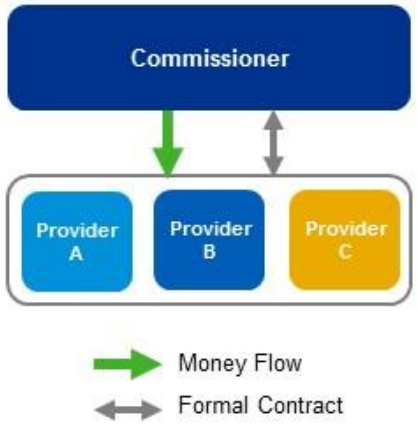
Organisation	Accountability	Impact
Commissioner	-	Most, if not all contracts, subsumed by a single contract with new venture. Risk associated with contracting with new entity and this being stable long term.
Dudley and Walsall Mental Health Trust	Jointly accountable to commissioner	New governance structures and decision making bodies to be created; may involve the reallocation of WTPB representative and current executives. Ongoing relationship development between provider partners required.
Primary Care		Not all GP practices may choose to be involved in an alliance and continued/increased GP buy in may be difficult. Ongoing relationship development between provider partners required.
One Walsall		New governance structures and decision making bodies to be created; may involve the reallocation of WTPB representative and current executives. Ongoing relationship development between provider partners required.
Walsall Council		Decision to be made on which elements would be moved into a joint venture/alliance. e.g Adult Social Care and Children's Services. May be dependent on commissioning functions of the joint venture and the level of control retained over expenditure. New governance structures and decision making bodies to be created; may involve the reallocation of WTPB representative and current executives. Ongoing relationship development between provider partners required.
Walsall Healthcare Trust		New governance structures and decision making bodies to be created; may involve the reallocation of WTPB representative and current executives. Ongoing relationship development between provider partners required.

Accountable Joint Venture: Local Impacts

As with the Host Provider model, there are two alternative approaches to a establishing a joint venture/alliance contract; either a contractual or corporate joint venture and the values of each of these should be considered. For example, the corporate joint venture route would result in the creation of a new organisation which can be held to account directly contracted with. There are however implications around tax and legislation if this was the preferred route.

Model	Finance	Contracts	Statutory duties	System Board Membership	Board role/function	Existing Provider Board's roles/ functions	Staff
Contractual Joint Venture	Organisations continue to receive their own finance under existing contractual arrangements but have financial commitments to co-invest in share delivery teams, shared and they will share in financial upside / downside.	Commissioner contracts can remain the same but there would be a inter-provider contract that would share financial risk and reward of the system performing better / worse than expected	Organisations likely to formally retain statutory duties in a legal sense but could nominate responsibility for delivering these to the Alliance Board	Should move to a single system CEO, single system DoF (even if initially there is some doubling up of roles in an interim period). There would need to be operational coverage of the different areas of service delivery.	Board responsible for allocating funds to projects. Significantly greater potential to take on accountability for performance of business as usual *if* that is the agreement of the providers. The roles however are subject to agreement. The more powers it is given and the money it is given, the more it matters	May reduce number of existing Boards / Sub-Committees (either in number or in frequency of meetings - i.e. retained to discharge formal statutory duties but with substantive functions and decision-making at the Alliance Board	Remain hired and funded by a host organisation but can join joint teams. The relevance of the host organisation can become increasingly 'nominal' insofar as greater alignment of a System Board with teeth means it is easier to shift to a common culture and get staff to buy in to the vision of integrated working.
Corporate Joint Venture	Corporate joint venture can receive funding	Commissioners can contract with the JV	As above	As above	As above	As above	Staff can be hired by JV but may remain hired by host organisations. There can be tax and TUPE issues related to this model.

Fully Incorporated Model



Example: Geisinger Health System in Northeast Pennsylvania, US

The Gesinger Health System has a more unified and centralised governance structure. Also in the Northeast US, New York Presbyterian Healthcare System in NYC, the University of Pennsylvania Health System and the Johns Hopkins Health System, which are academic health system variants, are a confederation of institutions, clinical centres, and faculty practice plans.

Providers fully integrate/merge into a single new organisational form (e.g., Accountable Care Organisation (ACO))

- New provider group and commissioner hold one contract;
- Integrated provider delivers vast majority of all services with subcontractors as needed.

Pros

- Reduction in management between providers—assuming the integrated entity is functioning efficiently;
- Most efficient model for decision making;
- Greater consistency of care to patients.
- Less politics/no balancing of power between collaborating providers;
- Easier administration/oversight of contract;
- Single provider entity responsible for outcomes and cost;
- No need to distribute risk nor shared savings amongst providers;

Cons

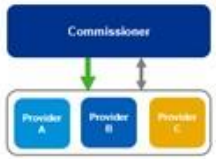
- Most difficult model to set up at the outset. Providers may not want to join. Will require significant investment cost to merge workforce, resources, pathways, estates, etc;
- Commissioners have limited ability to engage in the detail of implementation. Also would be a major liability if the integrated provider failed;
- Patient choice may suffer from a single provider.

Fully Incorporated Model: Local Impacts

For many this model represents a future state rather than an immediate option for change. Although labelled as fully incorporated, it does not necessarily have to involve all organisations in Walsall; some GPs, local authority and third sector services may still sit outside of this. For all parties involved, there will be significant organisational impacts, including staffing implications as the need for individual departments/groups is diminished.

Organisation	Accountability	Impact
Commissioner	-	A single contract with the new entity reduces complexity, however input in to delivery can be limited.
Dudley and Walsall Mental Health Trust	Jointly accountable to commissioner	Obligations as the mental heath provider for the Dudley MCP may exclude the Mental Health Trust from being a fulling integrated partner. The level of involvement/nature of their role and delivery of services would need to be reviewed.
Primary Care		May not be amenable to all GP groups, may increase fracturing and variation in patient care.
One Walsall		May be a joint partner or be subcontracted by new entity.
Walsall Council		May be a separation of care services into the new entity, whist maintaining statutory responsibilities.
Walsall Healthcare Trust		Implications for the Community Services contract currently held by the Trust. Ownership transition to the new organisation/entity.

Fully Incorporated Model: Local Impacts



It should be noted that a fully incorporated model could also refer to the MCP/PACS/ICO models, that many providers are familiar with, alongside the broader ACO/ACS model. The insights below are generic across this range of integrated organisations.

Model	Finance	Contracts	Statutory duties	System Board Membership	Board role/function	Existing Provider Board's roles/ functions	Staff
Fully Incorporated Model/Integrated Care Organisation	One organisation receives all funding for in scope services. However, there will always be some services subcontracted or contracted with third parties not "in" the integrated organisation (whether that is the Council or GP GMS funding	One contract (subject to above caveats on funding)	ICO could take on statutory duties	Should move to a single system CEO, single system DoF (even if initially there is some doubling up of roles in an interim period). There would need to be operational coverage of the different areas of service delivery.	ICO takes on all functions	Do not exist for organisations that join ACO	All staff are hired by ICO

7.4 Analysis of commercial models

Model	Finance	Contracts	Statutory duties	System Board Membership	Board role/function	Existing Provider Board's roles/ functions	Staff
Existing Provider as Lead Provider	One organisation receives all the money and then passes funding on to sub-contractors	Commissioners contract with lead provider that then subcontracts to other parties to deliver services it cannot deliver itself	Lead provider only likely to retain statutory duties for functions it can discharge itself	Existing Board of whoever selected as lead provider	Lead provider existing roles / functions with added responsibility for services now being subcontracted	Unlikely to reduce number and frequency of sub-contractor boards	Staff can be transferred into lead provider subject to the level of services it proposes to deliver. This could include back office / support staff
Transformed Existing Provider capable of managing risk	One organisation receives all the money and then passes funding on to sub-contractors.	Commissioners' contract with lead provider that then subcontracts to other parties to deliver services it cannot deliver itself.	Lead provider potentially allocated responsibility for statutory duties due to increased capability and competencies of Board members.	Existing lead provider board refreshed (whether wholesale or in part) so that reflects the new functions.	Lead provider existing roles / functions with added responsibility for services now being subcontracted.	Likely to reduce number and frequency of sub-contractor boards as more substantive decisions can be taken safely by lead provider board.	Staff can be transferred into lead provider subject to the level of services it proposes to deliver. This could include back office / support staff.
Contractual Joint Venture	Organisations continue to receive their own finance under existing contractual arrangements but have financial commitments to	Commissioner contracts can remain the same but there would be an inter-provider contract that would share financial risk and reward of the	Organisations likely to formally retain statutory duties in a legal sense but could nominate responsibility for delivering these to the Alliance Board.	Should move to a single system CEO, single system DoF (even if initially there is some doubling up of roles in an interim period). There would need to be	Board responsible for allocating funds to projects. Significantly greater potential to take on accountability for performance of business as usual *if*	May reduce number of existing Boards / Sub-Committees (either in number or in frequency of meetings - i.e. retained to discharge formal	Remain hired and funded by a host organisation but can join joint teams. The relevance of the host organisation can become increasingly

	co-invest in share delivery teams, shared and they will share in financial upside / downside.	system performing better / worse than expected.		operational coverage of the different areas of service delivery.	that is the agreement of the providers. The roles however are subject to agreement. The more powers it is given and the money it is given, the more it matters.	statutory duties but with substantive functions and decision-making at the Alliance Board.	'nominal' insofar as greater alignment of a System Board with teeth means it is easier to shift to a common culture and get staff to buy in to the vision of integrated working.
Corporate Joint Venture	Corporate joint venture can receive funding.	Commissioners can contract with the JV.	As above.	As above.	As above.	As above.	Staff can be hired by JV but may remain hired by host organisations. There can be tax and TUPE issues related to this model.
Fully Incorporated Model/Integrated Care Organisation	One organisation receives all funding for in scope services. However, there will always be some services subcontracted or contracted with third parties not "in" the integrated organisation (whether that is the Council or GP GMS funding.	One contract (subject to above caveats on funding).	Organisation could take on statutory duties.	Should move to a single system CEO, single system DoF (even if initially there is some doubling up of roles in an interim period). There would need to be operational coverage of the different areas of service delivery.	Organisation takes on all functions.	Do not exist for organisations that join the integrated organisation.	All staff are hired by one organisation.

Alliance Contract	Organisations continue to receive their own finance under existing contractual arrangements but have financial commitments to co-invest in share delivery teams, shared and they will share in financial upside / downside under terms set out in the Alliance Agreement and Master Service Agreement.	Commissioner contracts can remain the same but would be governed by the Master Service Agreement and Alliance Agreement.	Organisations likely to formally retain statutory duties in a legal sense but could nominate responsibility for delivering these to the Alliance Board.	An Alliance Board would be established and all Alliance members would be equal partners. N.B. The Alliance agreement may also provide for Associate Members, albeit that they may or may not be Board members.	Board will set strategic direction and facilitate collective decision making under the Alliance Agreement. This would include collective agreement on priorities, transformation plans, risk/reward sharing and the terms of the Master Service Agreement The Board may be supported by an Integrated Management Team and potentially also by a dedicated programme office and/or Strategy and Delivery executive.	May reduce number of existing Boards / Sub-Committees (either in number or in frequency of meetings - i.e. retained to discharge formal statutory duties but with substantive functions and decision-making at the Alliance Board.	Likely to remain as now, at least initially, pending the emergence of an integrated provider organisation and/or the transfer of commissioning activities from commissioner to provider organisations.

7.5 Abbreviations

ACO	Accountable Care Organisations
ACP	Accountable Care Partnership
ACS	Accountable Care System
CAMHS	Children and Adolescents Mental Health Services
CQC	Care Quality Commission
FYFV	Five Year Forward View
IHCT	Integrated Health and Care Teams
MCP	Multispecialty Care Provider
PbR	Payment by Results
TOM	Target Operating Model
DWMHPT	Dudley and Walsall Mental Health
WMBC	Walsall Metropolitan Borough Council
WHT	Walsall Healthcare NHS Trust
WTPB	Walsall Together Provider Board

7.6 Document version control

Document information	
Document Title:	Walsall Together Provider Board : Case For Change and Next Steps
Date:	31/01/2018
Owner:	Mark Axcell, Daren Fradgley, Paula Furnival and Waheed Saleem

Document history			
Version	**Change made by**	**Date**	**Description of change**
0.001	Hannah Lewis	15/12/2017	Document name, merging of economic and financial case to include recommendations.
0.002	David Bevan	22/12/2017	Identification of section owners
0.01	Robin Vickers	04/01/2018	Recommended next steps moved to end of document and populated.
0.02	Sebastian Habibi	5/1/2018	Governance overview
0.03	Hannah Lewis	9/1/29018	Benefits and transformation opportunity moved to Financial Impact
0.8	Hannah Lewis	10/1/2018	Financial Impact added, commercial section amended, org models added.
0.6	Hannah Lewis	26/1/2018	Programme Management Section added, Model of Care initiatives added, Recommended Next Steps amended
2.0	Daren Fradgley	08/02/18	Amendments to case to reflect comments of Walsall Provider Board meeting of 7th February 2018
3.0	Mark Axcell	12/02/18	Remove of track change comments

Document review			
Version	**Reviewer**	**Date**	**Description of review and summary of required actions**
0.8	Waheed Saleem	18/1/2018	Comments provided directly on the document. Minor amendments to GP group summaries and wording.
0.8	Paula Furnival	18/1/2018	Consolidate financial section. Detail population management hub. Add section on commissioning to be delegated to providers.
0.8	Daren Fradgley	19/1/2018	Further description of progress to date and population need.
0.8	Mark Axcell	19/1/2018	Reference wider work e.g. STP, Walsall Healthcare Service review, Mental Health Clinical Model. Clarity on each sections conclusion.
0.6	Mark Axcell, Waheed Saleem	28/1/2018	Staff role title changes, clinical model added.

BOARD/COMMITTEE REPORT

Meeting	**TRUST BOARD**	**Date: 8th March 2018**
Report Title	**WALSALL TOGETHER CASE FOR CHANGE**	**Agenda Item: 12** **Enclosure No.:10**
Lead Director to Present Report	Daren Fradgley – Director of Strategy & Improvement	
Report Author(s)	Walsall Together Provider Board	
Executive Summary	The Walsall Together Case for Change is a prosed integration of Health and Care Services into a new model of care as outline in the Five Year Forward View. The case is Walsall's response to the Place Based Care model that is within the Black Country Sustainability and Transformation Plan. The Case for Change has been produced by the Walsall Together Provider Board as an outline of change together with a proposal of next steps for the next 12 months to establish a Host Provider Contract with Commissioners by April 2019. The document focuses on the need for change together with a proposal to organise the provision of services based on the greatest needs of the population. The resultant work will produce a set of pathway changes across multiple providers to respond to the population needs and falls short of dealing with organisational form. The document also covers what good looks like through integration of health and care in parts of the UK and internationally and draws this best evidence into the Walsall model. A series of next steps which can be found section 6 of the report and have been consider by the Trust Board in seminar sessions. • **Establishing a Leadership team with access to dedicated resource** • **Strengthening system governance to facilitate collective leadership in transition** • **Develop Walsall specific whole system modelling capabilities** • **Develop an appropriate contractual model** • **Developing a Clinical Operating Model with clear outcomes** Board members has asked for the Walsall Together Provider Board to consider an appropriately resourced communications and engagement team that should include some patient representatives, consideration on how the Leadership team is funded across the system and how The Trust will involve the regulators in the development. Trust Board members have also recommended that a formal document of intent is approved by all providers within the next steps list above.	

Purpose	**Approval**	**Decision**	**Discussion**	**Note for Information**
	☒	☐	☐	☐

<table>
<tr><td><u>Recommendation</u></td><td colspan="2">1. APPROVE the direction of travel outlined in the case for change subject to regular reviews by the Trust Board over the next 12 months with a full business case being written within this period.
2. REQUIRE the Provider Board to scope out the resource requirements for the next phase so this can be added to the Trust Annual Plan
3. REQUIRE the Provider Board to agree an engagement plan with the regulators and key stakeholders.
4. REQUIRE the Provider Board to formalise a document of intent between all members as a next step.</td></tr>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performace and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Embed an engaged, enpowered and clinically led organisational culture</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☐</td><td><u>Effective</u></td><td>☒</td></tr><tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☒</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Links to the Strategic and Demand Reduction risks identified in the Board Assurance Framework.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Currently being qualified</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">The Trust as a member of the Walsall Together Provider Board is in discussion with NHSI & NHSE about their involvement and requirements moving forward. The full business case will need legal considerations exploring which should include but not limited to contractual changes with Commissioners and Partners, changes to governance arrangements and future service provision.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Walsall Provider Board – February 2018
Walsall Partnership Board – Highlight only – February 2018
Trust Board Seminar sessions – January & February 2018</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Define the resource required for the next 12 months and produce a comprehensive set of plans as outlined in the case for change.
Work to be coordinated initially by the Provider Board until the Host Provider Board is established. Regular updates to be presented to Trust Board.</td></tr>
</table>

Freedom of Information Status	**The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee**

Stroke Services Reconfiguration

Trust Board March 2018

1. WALSALL CONTEXT

The aim to reconfigure stroke services for the benefit of Walsall patients has been considered by Walsall CCG in a number of initiatives since the publication of the clinical senate review in 2012, in essence this is not a new concept for Walsall or indeed the Black Country.

In 2015 Walsall Healthcare Trust (WHT) completed an options appraisal of stroke services based on the assumption that additional activity would be achieved from South Staffordshire. However, changes in the local healthcare economy means that this additional activity will not materialise in Walsall and the income from the service is not sufficient to sustain the service in line with the requirements of a Hyper Acute Stroke Unit (HASU)/ Acute Stroke Unit (ASU).

Following on-going discussions with Royal Wolverhampton Hospital Trust (RWT) and commissioners it was agreed in 2017 that HASU and ASU for Walsall patients should be transferred to RWT, while community stroke rehabilitation services within WHT.

The proposal has been independently reviewed having been part of a public consultation; clinical senate review, discussion at HOSC and with other stakeholder groups, all of which are generally in favour of the proposal, which is due to take effect from 11 April 2018.

2. BLACK COUNTRY SUSTAINABILITY AND TRANSFORMATION PLAN

The proposed stroke service reconfiguration meets the Black Country Sustainability and Transformation Plan vision as described in this extract from the executive summary of the plan;

'For the future, we must transform services to adapt to rising demands. We must make the most of modern healthcare through innovation and best practice in order to change the way we spend money and use our limited resources.
We must also focus on shifting demand away from our hospitals and to a more community-centred approach. When patients need hospital care, however, it should be of the highest quality, providing specialist interventions in the right place and at the right time with less variation in the care that patients receive.
It is clear to us that our current ways of operating are unsustainable. Under our plan, individual organisations and partnerships will continue to make the improvements and efficiencies that are directly within their own control but the overall scale of opportunity will be transformed by our working together as a single system with a common interest.
At the heart of our plan is a focus on standardising service delivery and outcomes, reducing variation through place-based models of care provided closer to home and through extended collaboration between hospitals and other organisations'

3. THE CASE FOR CHANGE

Good quality stroke services, as defined by the National Stroke Strategy (2007), require 24/7 access to thrombolysis treatment and a 7 day high risk TIA clinic. These services require a reasonable scale to ensure that there is sufficient consultant coverage to provide comprehensive, sustainable services. For this reason, stroke networks across the country

have reviewed stroke provision and concentrated it on fewer, larger centres. It is likely that this trend will continue as it has a direct correlation with improved outcomes for patients.

Currently all patients in Walsall CCG area exhibiting symptoms of stroke are conveyed to and dealt with by Walsall Healthcare Trust (WHT) at the Manor Hospital, and according to the Sentinel Stroke National Audit Programme (SSNAP) report for financial year 2015/16, WHT treated 375 stroke patients. Whilst overall WHT was rated as 'good' (and 'improving' over the last two years), the mainly low scoring domains (D or E average) were related to the stroke unit and thrombolysis provision.

The NHS Right Care Commissioning for Value Focus Pack for Cardiovascular Disease (April 2016) shows that Walsall is in worse in a number of areas of the pathway compared to CCG's of similar size and demographics. In the main these outcomes pertain to lack of clinical resource and lack of capital resource, in particular with regards community beds.

At present Wolverhampton and Walsall see respectively approximately 600 and 400 confirmed stroke patients each year. To be a viable Hyper acute Stroke service it is recommended that there are a minimum of 600 confirmed stroke patients each year. For Walsall Healthcare Trust the income from activity of 400 confirmed stroke patients is insufficient to fund staffing levels to meet the HASU requirements and there is no potential to increase stroke numbers in future, despite considerations of patient flow arising from other stroke reconfigured areas eg: Burton.

NHS England previously wrote to all providers of urgent care network specialist services requesting an audit of compliance against the seven day services standards for acute stroke, STEMI heart attack, major trauma, emergency vascular and paediatric intensive care services. The aim of this audit was to identify those individual services where attention and action was needed to ensure that all patients requiring services for stroke receive the best possible care on a 24/7 basis. The results of the audit have identified that WHT is below the standard expected for time to first consultant review (60% not met) and Ongoing consultant-directed review (40% not met).

With respect to Stroke consultant workforce in Wolverhampton there are 4 WTE consultants and at Walsall there are 2 WTE consultants. The British Association of Stroke physicians (BASP) recommend that a 24/7 Hyper-acute stroke service should consist of at least 6 WTE consultants. Combining two cohorts of consultants will improve the availability of senior decision making cover and more importantly achieve the compliance requirements for seven day services.

There would also be a larger pool of stroke trained nurses to help drive forward the required standard of care. RWT already has 7- day physiotherapy and occupational therapy which would be maintained; through this process 7- day Speech and language therapy access would also be achieved. The sharing of patient time and therapy spaces can only realistically be achieved in a single unit, preferably one physically laid out to mimic a patient's journey towards recovery.

4. GOVERNANCE

The process has been overseen by a commissioner-led Board, which includes representatives of WHT and RWT, with each organisation having sub-committees and representation in various work streams, each reporting back to the Board (figure 1). WMAS and social care have also been involved in the discussions in the parts of the pathway that relates to them.

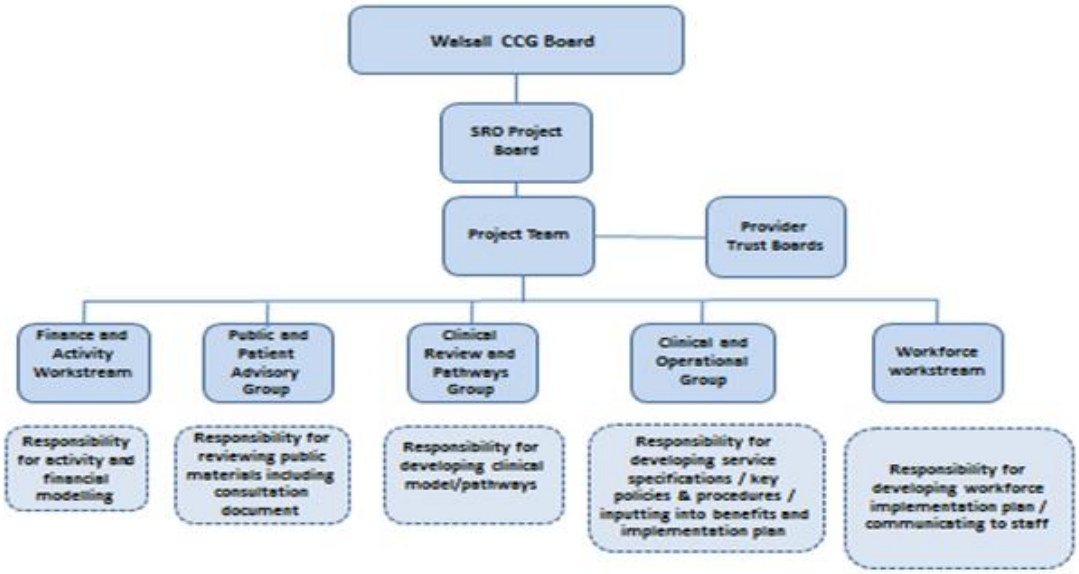


Figure 1: Governance Structure

4.1 EXTERNAL ASSURANCE

The reconfigured pathways have undergone a series of external assurance tests some of which have been shared in public and have all approved the service change. These included – Public Engagement via Healthwatch, West Midlands Clinical Senate Review of the whole end to end service, Walsall Overview and Scrutiny Committee and NHS England (including NHS Improvement)

5. PATHWAYS

The patient pathways have been agreed between the provider organisations with consultation involving WMAS and social care services.

- Appendix 1 shows the model for suspected stroke patients being transported by WMAS
- Appendix 2 shows the model for suspected stroke patients presenting at Walsall ED
- Appendix 3 shows the model for community rehabilitation including Levels 4 and 5 inpatient rehabilitation.

5.1 COMMUNITY REHABILITATION

Community rehabilitation, Early Supported Discharge (ESD) and Level 4 and Level 5 inpatient rehabilitation patients will be provided by WHT in the community in the long term. However there currently isn't the access to an 18-bedded community facility to accommodate this activity. Plans for future provision of community beds are being reviewed with partners.

5.2 CURRENT DEMAND – REHABILITATION SERVICES

Patient Group	%	Number
No Rehab Potential	**29%**	**163**
No rehab needs	**22%**	**124**
No rehab potential	**7%**	**39**
Rehab Potential	**71%**	**401**
ESD (Level 2)	**20%**	**112**
Community Rehab (Level 3)	**22%**	**124**
Bed based (Level 4)	**14%**	**80**
Bed based (Level 5)	**15%**	**85**

Initially, the L4 and L5 provision will be provided from Ward 1 in the Manor Hospital for a period of 6-12 months while a suitable alternative facility is commissioned in the community.

The community pathways for both the interim hospital rehabilitation provision and the future community facility have been fully costed.

6. FINANCES AND CONTRACTING

The tariff for current stroke activity provides minimal contribution after the costs are removed. In the current contract round this income and costs will be removed through a contract variation. The Trust is currently working with the CCG on the costs for future rehab services which will be added to the 2018/19 contract with an element of premium costs to cover all staffing costs whilst the rehab workforce stabilises.

7. CONCLUSION

The HASU and ASU services will transfer from Walsall to Wolverhampton from 11th April 2018 over a transition process lasting a few weeks.

8. OUTSTANDING RISKS

At the time of writing this paper the following two risks remain – the mitigations are also noted.

8.1 The final tariff for stroke rehab has not been agreed with the CCG which should be considered as a risk given the late stage of the program. The Trust continues to have discussions with the CCG about this and will not agree to the variation of current costs as a mitigation until this is resolved.

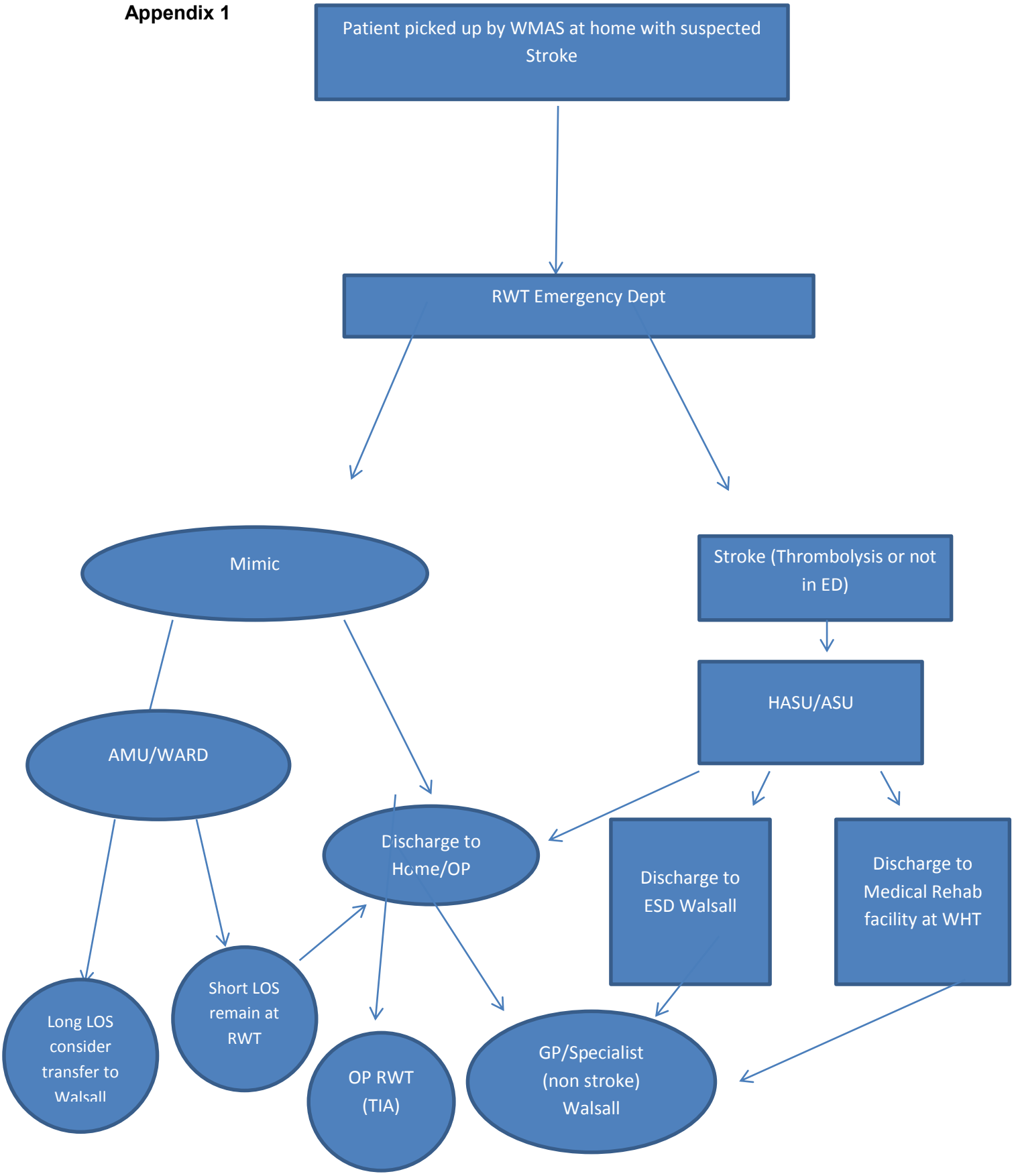
8.2 The longer-term location of the community rehab facility remains unclear. There is an option available to the Trust with partners, but this hasn't been confirmed and would challenge the original October 2018 deadline. To mitigate this, the Trust will continue to provide rehab services on ward 1 until this option can be finalised or further mitigated.

Daren Fradgley

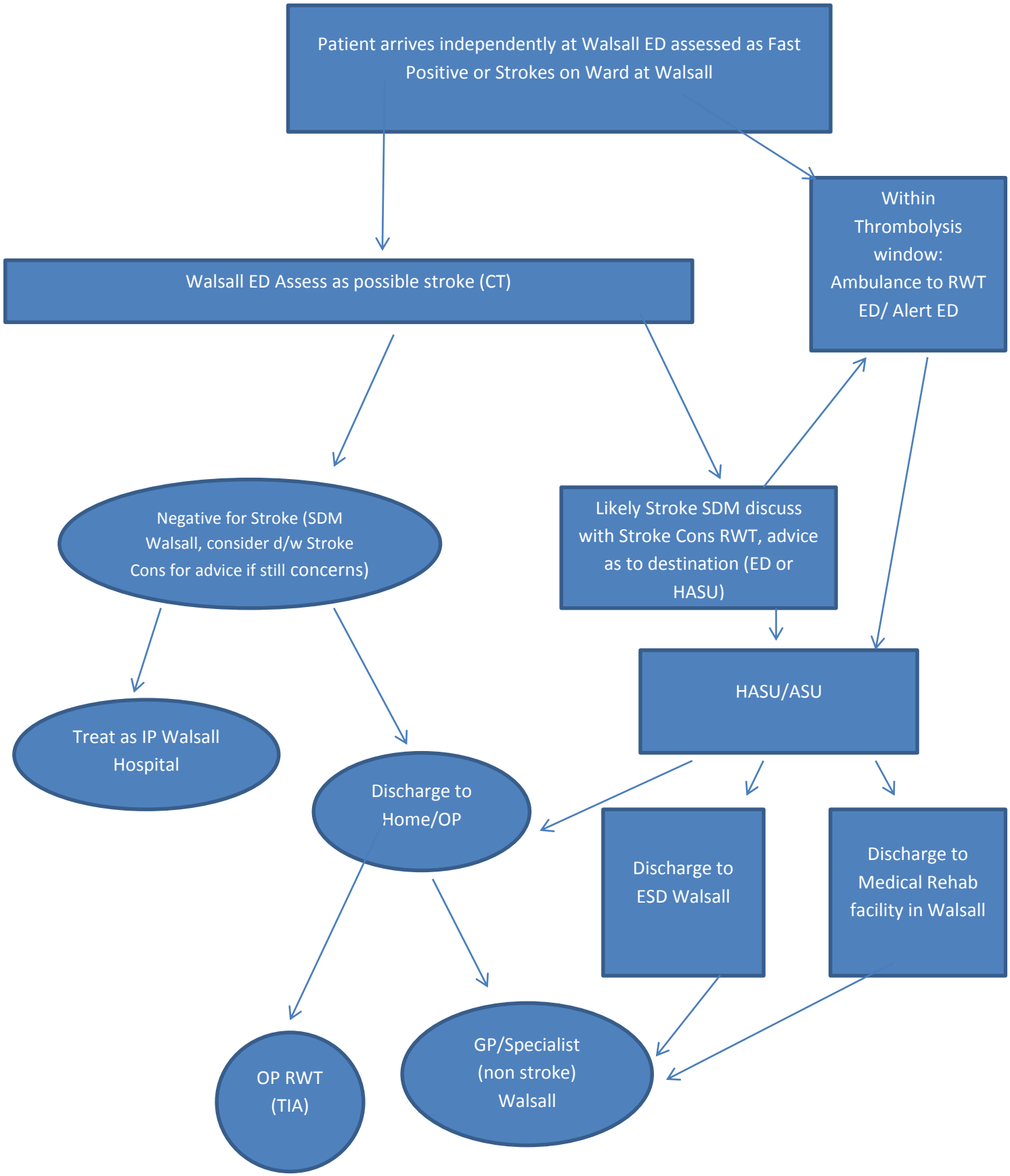
Director of Strategy & Improvement

2nd March 2018

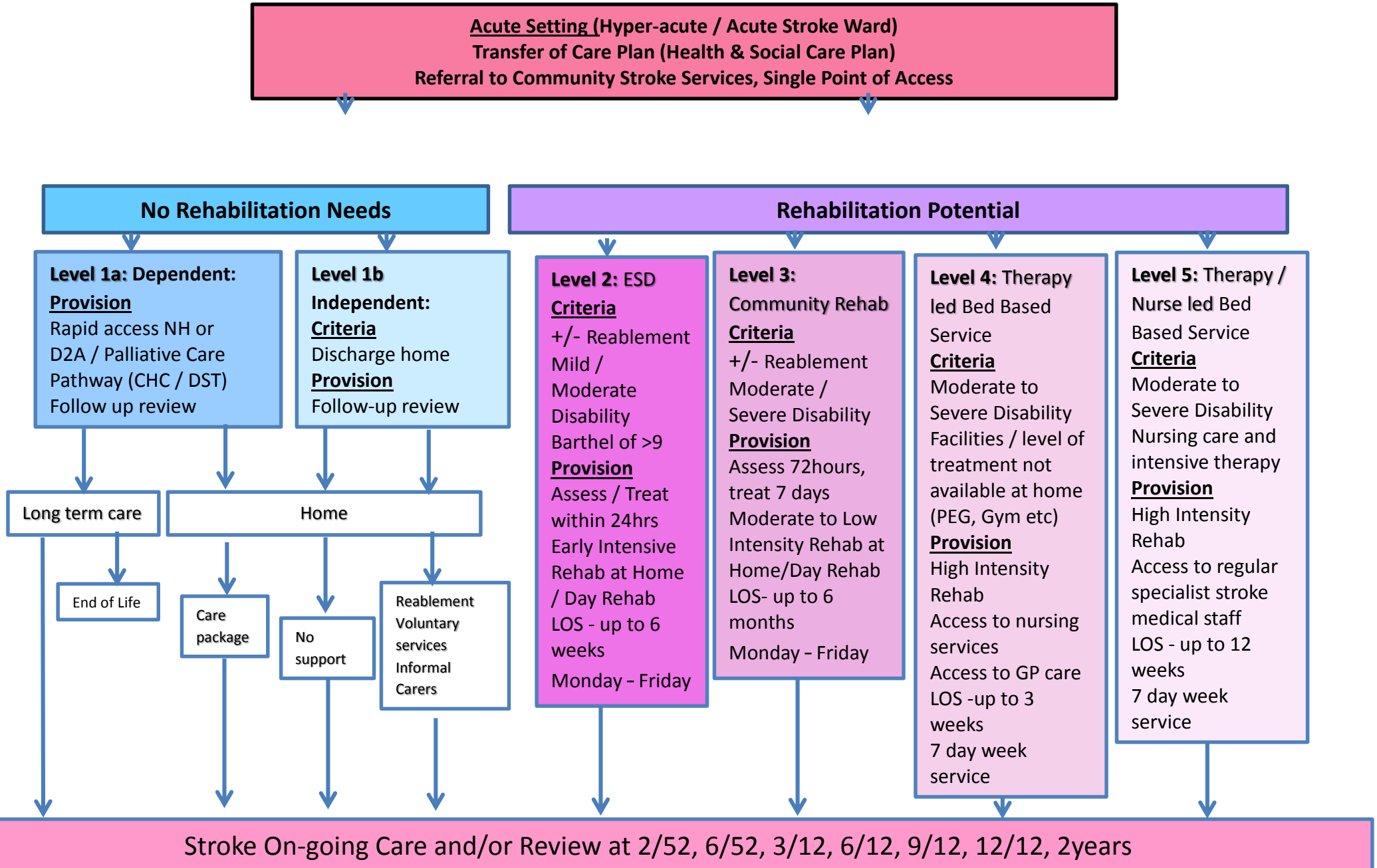
Appendix 1


Patient picked up by WMAS at home with suspected Stroke
RWT Emergency Dept
Mimic
Stroke (Thrombolysis or not in ED)
HASU/ASU
AMU/WARD
Discharge to Home/OP
Discharge to ESD Walsall
Discharge to Medical Rehab facility at WHT
Long LOS consider transfer to Walsall
Short LOS remain at RWT
OP RWT (TIA)
GP/Specialist (non stroke) Walsall

Appendix 2


Patient arrives independently at Walsall ED assessed as Fast Positive or Strokes on Ward at Walsall
Within Thrombolysis window: Ambulance to RWT ED/ Alert ED
Walsall ED Assess as possible stroke (CT)
Negative for Stroke (SDM Walsall, consider d/w Stroke Cons for advice if still concerns)
Likely Stroke SDM discuss with Stroke Cons RWT, advice as to destination (ED or HASU)
HASU/ASU
Treat as IP Walsall Hospital
Discharge to Home/OP
Discharge to ESD Walsall
Discharge to Medical Rehab facility in Walsall
OP RWT (TIA)
GP/Specialist (non stroke) Walsall

Appendix 3 Community Rehabilitation Models of Care



BOARD/COMMITTEE REPORT

Meeting	**Trust Board**		**Date: 8th March 2018**
Report Title	**Stroke Service Reconfiguration**		**Agenda Item: 13** **Enclosure No.: 11**
Lead Director to Present Report	**Daren Fradgley - Director of Strategy & Improvement**		
Report Author(s)	**Roseanne Crossey – Head of Business Development and Planning**		
Executive Summary	This report provides an update on the reconfiguration of stroke services, which involves the transfer of HASU/ASU stroke services from Walsall to Wolverhampton effective 11 April 2018. The level of activity in Walsall is insufficient to achieve the levels of income required to meet national standards in acute stroke services. The report details the rationale behind the decision, which meets the national guidelines for specialist stroke units and is aligned to the Black Country Sustainability and Transformation Plan. The proposals have been rigorously scrutinised by public representatives, commissioners and peer groups. Various work streams have been active and report directly to an oversight Board which has representatives of providers and commissioners. The clinical work streams have agreed the pathways, which include the provision of community rehabilitation services back in Walsall. The level 4 and level 5 inpatient rehabilitation services will temporarily be provided at Manor Hospital while a suitable community base site is commissioned. This is expected to take no longer than a year. The staffing models have been fully costed, and a contract variation for the community provision is part of the current contract negotiations. The paper also outlines two outstanding risks that are currently being mitigated but will need to be resolved as outlined in the paper.		
Purpose	**Approval** ☒	**Decision** ☐	**Discussion** ☐	**Note for Information** ☐
Recommendation	To **APPROVE** the information contained within this report.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outtrun</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Embed continual service improvement as the way we do things linked to our Improvement plan</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Deliver a sustainability review of all our services to set plans for next 5 years</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Embed an engaged, enpowered and clinically led organisational culture</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr>
<tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☒</td></tr>
<tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Two project risks remain that are currently mitigated but will require resolution. The financial risk will require resolution with the contract variation planned during March. The longer-term location of Rehab will require a clear plan during Q1 2018/19</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Some staff are eligible to TUPE to Wolverhampton. This list has been shared with RWT and is currently undergoing internal TUPE process.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Formal progress reporting to ensure correct approval processes are in place.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Previously considered at previous Trust Boards in July 17 and October 17.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2"></td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

NHS Walsall Clinical Commissioning Group

Walsall Council

Walsall Healthcare NHS Trust

NHS Dudley and Walsall Mental Health Partnership NHS Trust

Walsall Together: Intermediate Care Model

What Is the problem that we are trying to fix?

- The Walsall Local Health and Social Care Economy is overly reliant on a bed based model of post-acute care when national and local evidence shows that a significant proportion of this care could be provided at home (wherever that setting might be) with appropriate clinical or support services.

- Walsall Healthcare Trust (WHT) has consistently failed to meet the A&E 95% waiting target. Whilst a proportion of this is due to internal WHT issues, a significant proportion are patients deemed medically fit for discharge but waiting for something from external partners which adversely affects flow through the hospital and availability of beds for those in A&E/Medical Assessment Unit who need admission.

- Prolonged stays in hospital result in patient de-compensation and poorer outcomes.

- Intermediate Care Services in Walsall work in isolation making pathways complex to navigate, delays in hand-over, potential duplication of effort.

- Walsall CCG and Council currently invests above what the National Benchmarking suggests is reasonable for the demographic of Walsall.

Proposed Intermediate Care Service (ICS): Refreshed vision

1. A community based health and social care single service with responsibility for complex patients who require support to facilitate discharge from an in-patient hospital bed.
2. Provide a rapid response to care delivery in the right place at the right time to maximise a patient's independence, deploying the optimum skill mix to ensure that the response provided is appropriate and proportionate to the assessed needs with the default position being for the patient to return home.
3. Integration through a new shared culture, mind-set, values, objectives, working processes and practice.'

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Proposed Intermediate Care Service (ICS): Key Components

1. Streamlined processes with referral via a single point of access
2. Defined health and social care activities performed out of the hospital setting post discharge including assessments, therapy provision etc.
3. Information captured once and made available through patient journey
4. Allocation of the ICS care-coordinator to develop, monitor and navigate the patient via a patient centric intermediate care plan through the ICS 'journey'
5. An enabling culture to facilitate patients, with carers, to regain confidence and/or function so that patients enjoy supported Self Care to realise their goals
6. MDT collaboration to assess and provide holistic care to effectively resolve issues across health and social care domains
7. The service will operate seven days per week

IDT co-ordinators will continue to support discharge planning for patients with 'complex' support needs for 12 months

Clarify criteria, roles / responsibilities for IDT co-ordinators to optimise task allocation across ward discharge processes

Intermediate Care Service and Pathways will support Discharge from Hospital & Step up from Community Services

ICS Model Principles, Assumptions & Constraints

Principles

1. For medically fit patients, transfer clinical and social care activities, e.g. assessments, therapy etc, to least restrictive safe environment to reduce LOS & level of decompensation
2. Assign care co-ordinator to efficiently 'navigate' patient through the ICS pathways and care provision (across multiple roles and providers) and monitor progress against plan
3. Facilitate supported Self-Care to maximise independence and enable patients / carers to achieve their goals and reduce financial costs
4. Governance that takes a 'system' approach to resolve 'bottlenecks' that would otherwise constrain performance / outcomes across the whole 'system'

Assumption

1. Trust implements SAFER / Red to Green principles to optimise ward discharge processes
2. Sufficient Community Health Service capacity, including therapy, to meet the on-going health needs post discharge

Constraints

1. Current IT systems are not sufficiently mature to enable data to be captured once, maintained in a single data source, and made available for re-use
2. Current IT systems are not sufficiently mature to enable collaboration, streamlined communication and workflow across teams and partners

Trust Business Benefits

The benefits model is predicated on the Trust 'liberating' beds through facilitating earlier discharge or avoiding admissions for patients that require health and/or social care support. The actual beds liberation is dependent on the maturity of transformation, that is ability to induce staff to change behaviours / working practices, across ward processes and Community Services. The proposed scenarios and accompanying beds reduction benefits are:

1. Liberate **28 (21 phase 1) beds p.a**. IF the Trust has high transformation capability
2. Liberate **23 (16 phase 1) beds p.a**. IF the Trust has moderate transformation capability
3. Liberate **18 (11 phase 1) beds p.a**. IF the Trust has low transformation capability
4. Improved utilisation of therapy staff by significantly reducing 'Assess to Discharge' with staff reallocated to other therapy activities

Improving for Patients:

1. Reduce dis-benefits of unnecessary hospital in-patient stay (beyond MFFD) e.g. decompensation etc
2. Improved and more responsive post-discharge care, via a MDT approach, and assigned co-ordinator to meet the patient needs in the most appropriate setting.

Improving for Colleagues:

1. Defined requirements across partners setting out the respective roles and responsibilities
2. Enhanced multi-disciplinary collaboration and optimised use of skills of staff

Assumption:

1. The implementation of the ICS will have access to adequate transformation support

Benefits model takes a conservative approach to translate 'mathematical' bed days liberated to actual bed days (20%)

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Trust Business Benefits Summary Model

Ref	Phase 1: Intermediate Care Pathways to Reduce LOS	Mathematical	Reality (20% of Mathematical)	Reality
	In-patient Stay Day Liberation: Totals	**Number of Bed days Liberated per week**	**Number of Bed days Liberated per week**	**Number of Beds Liberated**
1	Reinstate Care Pathway	20	4	0.6
2	Reablement Pathway	198	40	5.6
3	DH2A Pathway	275	55	7.8
4	D2A Pathway	120	24	3.4
5	ICT bed base	25	5	0.7
6	Non-weight bearing total	84	17	2.4
7	Mental Health Pathway	80	16	2.3
	Total	**721**	**144**	**21**

Translation from Mathewmatical Model to Reaiity

1 Most patients will enjoy multiple 'enablers' of the new service , these can not be treated as additive but rather need to consolidate and rationalise multiple enablers
2 Recognition that muliple enablers need to be synchronised to deliver business benefits - singular enablers by themselve do not necessarily realise business benefits
3 Bed days need to be 'bunched-up' to liberate bays which enable reductions in staffing

Ref	Phase 2: Intermediate Care Discharge Pathways to Avoid Admission from Community Settings	Number of Bed days Liberated per week	Number of Bed days Liberated per week across Teams	Number of Beds Liberated
8	Number of additional patients per week PER Place Team accessing Intermediate Care Service that will avoid a hospital admission	1	50.0	7

Benefits Realisation Parameters

1 Seven Placed-based teams that will access the intermediate care service
2 Number of additional patients that through accessing the proposed Intermediate Care Service will avoid an admission = 1
3 Average LOS of admitted patient = 7.14 (same as used in Total Mobile Business Case)

Ref	Phases 1 & 2: Intermediate Care Discharge Pathways to Reduce LOS Avoid Admission from Community Settings	Number of Bed days Liberated	Number of Beds Liberated
9	Patients accessing various intermediate care pathways from hospital (to facilitate discharge) and avoid admission (community setting)	194	28

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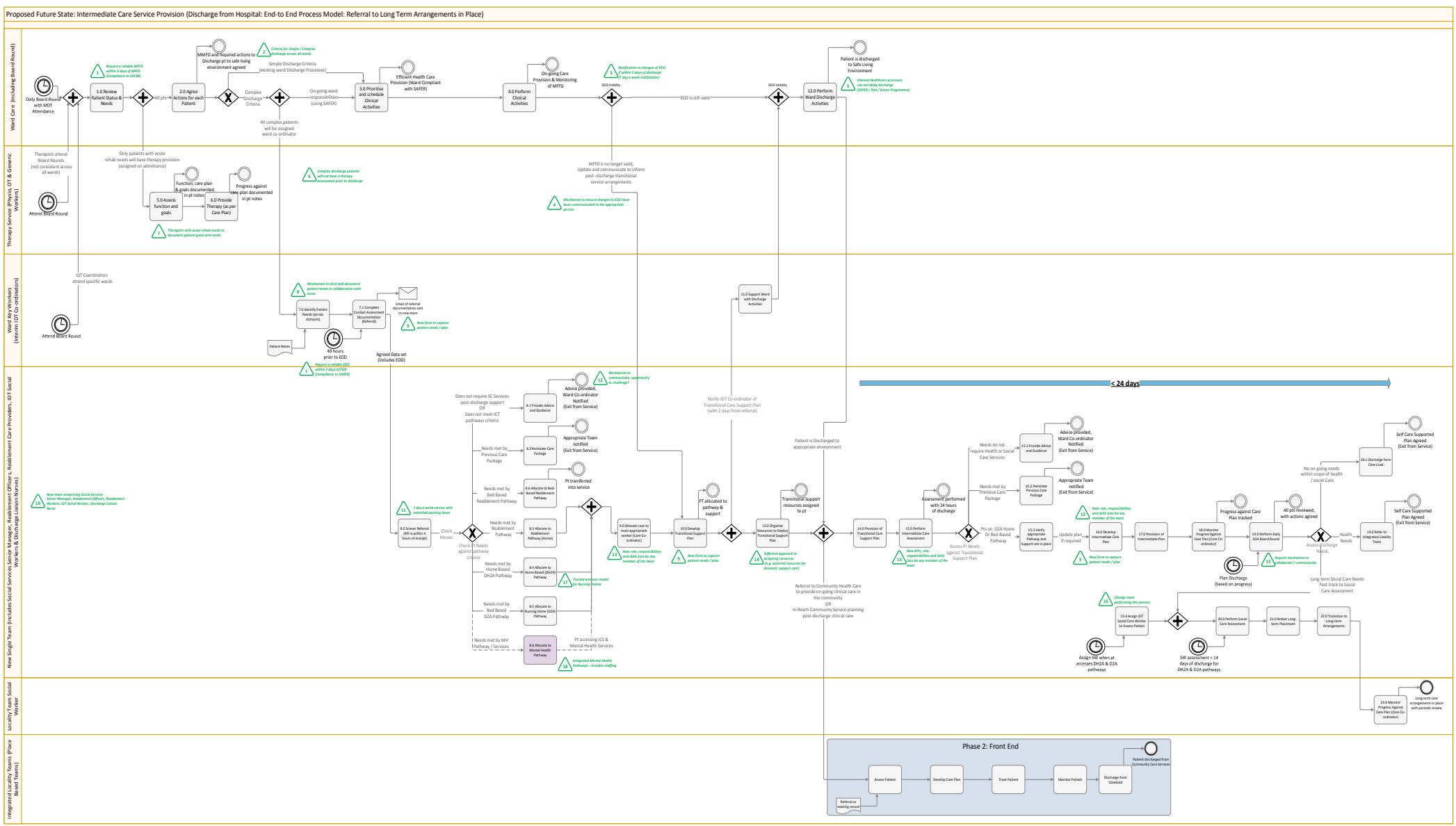
Intermediate Care Model: End-to-end Process Model



Social Services Business Benefits

The benefits model is predicated on Social Services receiving patients that are less decompensated, and therefore with less health needs, that with less resources and with MDT working realise benefits across outcomes, patient and staff experience and financials.

Patient benefits

1. Increased independence
2. Reduced impairment
3. Improved personalisation
4. Reduced delays
5. Improved continuity of care

Staff benefits

1. Improved alignment to need – providing more comprehensive care
2. Improved information sharing – better (more informed) decision making
3. Clearer accountability
4. Improved continuity of care
5. Stronger sense of team

System benefits

Enables and supports overall system changes to deliver more effective care closer to home:

1. Improved continuity of care
2. Reduced dependency
3. Reduced rate of crisis
4. Reduced acuity
5. Reduced inequality
6. Reduced total costs

Cost benefits

1. Reduced ongoing care (TBD)
2. Rebalanced bedded care
3. Improved value-for-money from bed-based services

Intermediate Care Model Objectives and the Journey

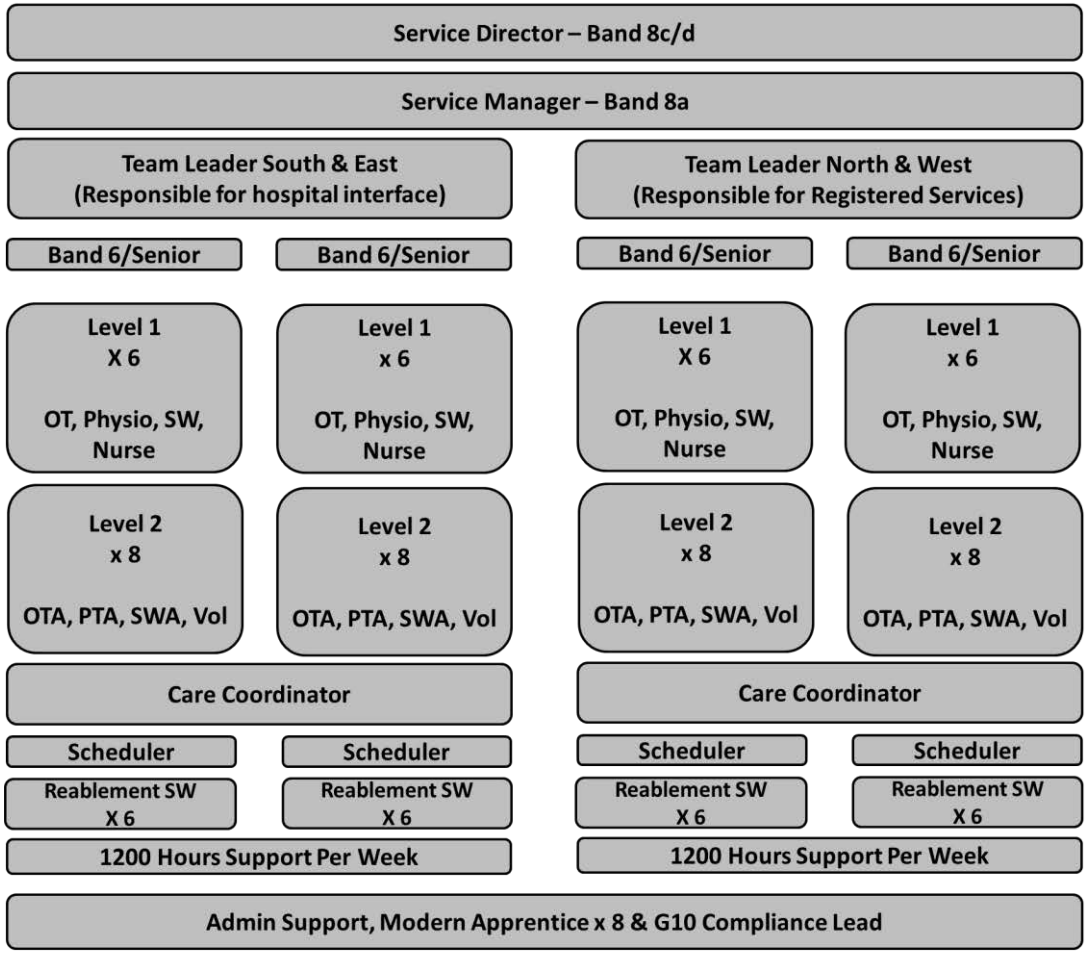
Objectives

1. Transition to more responsive and integrated ICS pathways that will reduce hospital LOS by 'transferring' clinical and social activities out of the hospital setting
2. Reduce fragmentation and complexity, via a single MDT, streamlining referrals, care assessments, co-ordination, monitoring and exit from the Intermediate Care services
3. Long-term care arrangements satisfy Care Act requirements in the least restrictive safe environment with supported Self-Care to maximise independence and reduce costs
4. Governance that effectively manages service performance and compliance to the 'mandatory' requirements across the partners / service providers

The transformation journey:

1. Obtain approval for the Intermediate Care Model, business case and specification, and high level transition plan (phase 1)
2. Phased implementation, defined scope, milestones and business change, towards the the future state ICS satisfying agreed business requirements for each partner (phases 2 - 4)
3. Implement the 'Management of Change' to 'formalise' the structures and processes underpinning the new ICS and transition to 7 day working (phase 5)
4. Deployment of IT enablement to streamline collaboration, communication and reduce manual effort across roles / teams (phase 6)

Staff Profile



Role Description:

- 1 Service Manager – responsible for overall service delivery
- 2 x Team Leaders – responsible for day-to- day management of the teams
- 4 x Senior Practitioners – responsible for coordinating team activities
- 24 x Level 1 – responsible for generic and specialist interventions/ assessments.
- 32 x Level 2 – responsible for generic interventions that do not require the skills of a registered practitioner. This could be supporting people with rehab exercises or conducting conversations about people's social needs etc
- 2 x Care Coordinators– responsible for the support work staff, CQC compliance and care purchasing
- 4 x schedulers– responsible for the co-ordination of support work staff
- 24 x Support Workers – responsible for direct care/support and reablement
- 8 x Admin assistants & Modern Apprentice admin assistants – responsible for the administrative functions to support the service.
  1 x Compliance lead is the registered manager for the reablement element of the service
- Total: 105 Staff, 2 Registered Services (inc additional 53 staff & £3m Commissioning Budget (beds & care hours)

Implementation Approach

A phased approach will be utilised to:

- Manage scope, complexity and less risk to implementation / current service performance
- Assist to gain commitment from staff and overcome resistance to change
- Skills and experience / insights are gained which help smooth subsequent phases
- Resolution of agreed bottlenecks to generate the 'headroom' to make the transition

Each phase will have it's own dependencies and risks that will need management focus to The phases are:

1. Phase 0 & 1: Engage and confirm / Design
2. Phase 2: Phase 3: Transition
3. Phase 4:Management of Change
4. Phase 5: Consolidate & Rationalise
5. Phase 6: Relocate
6. Phase 7: Closure

Refer to appendix 1 for description of phases

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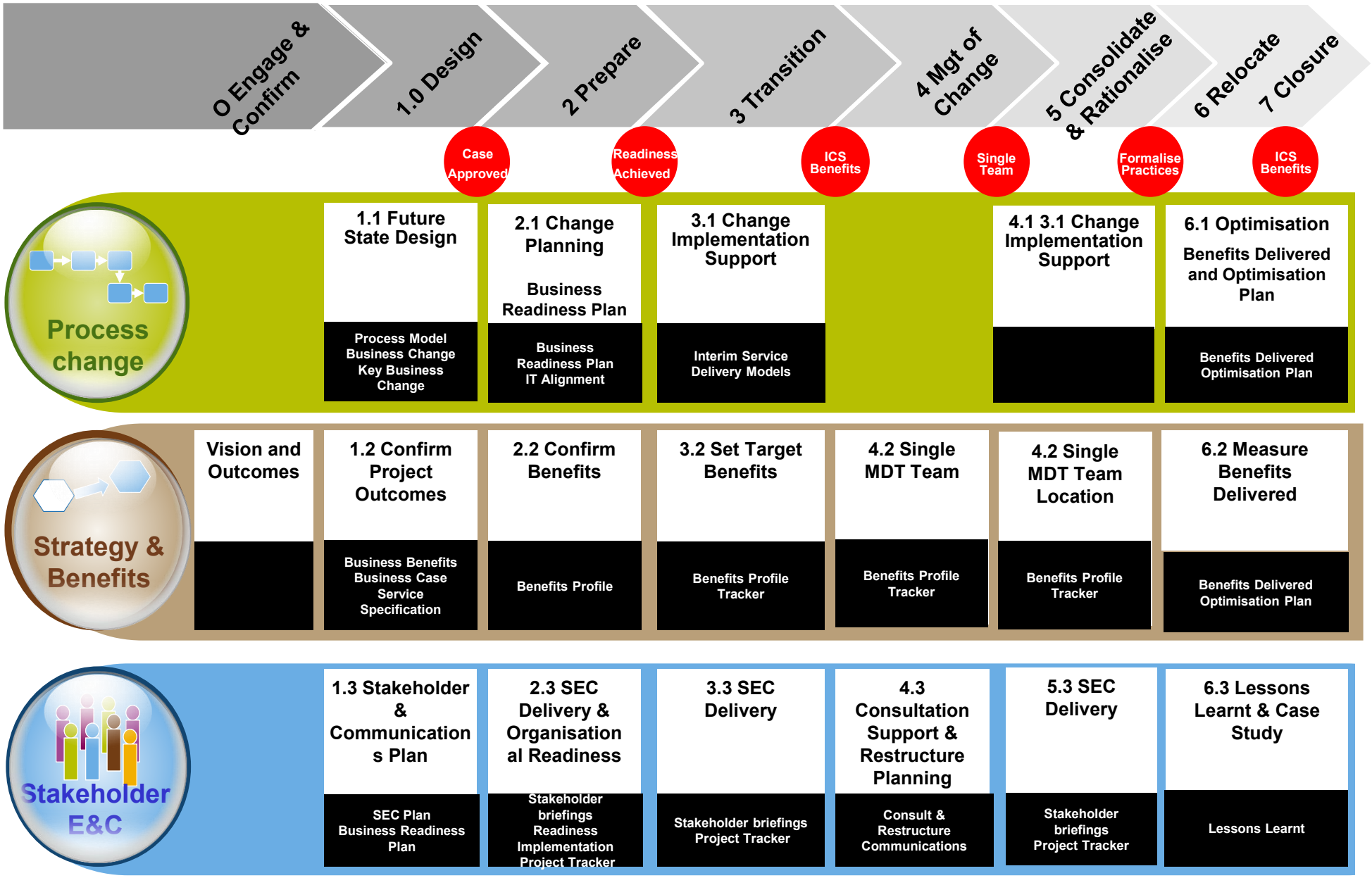
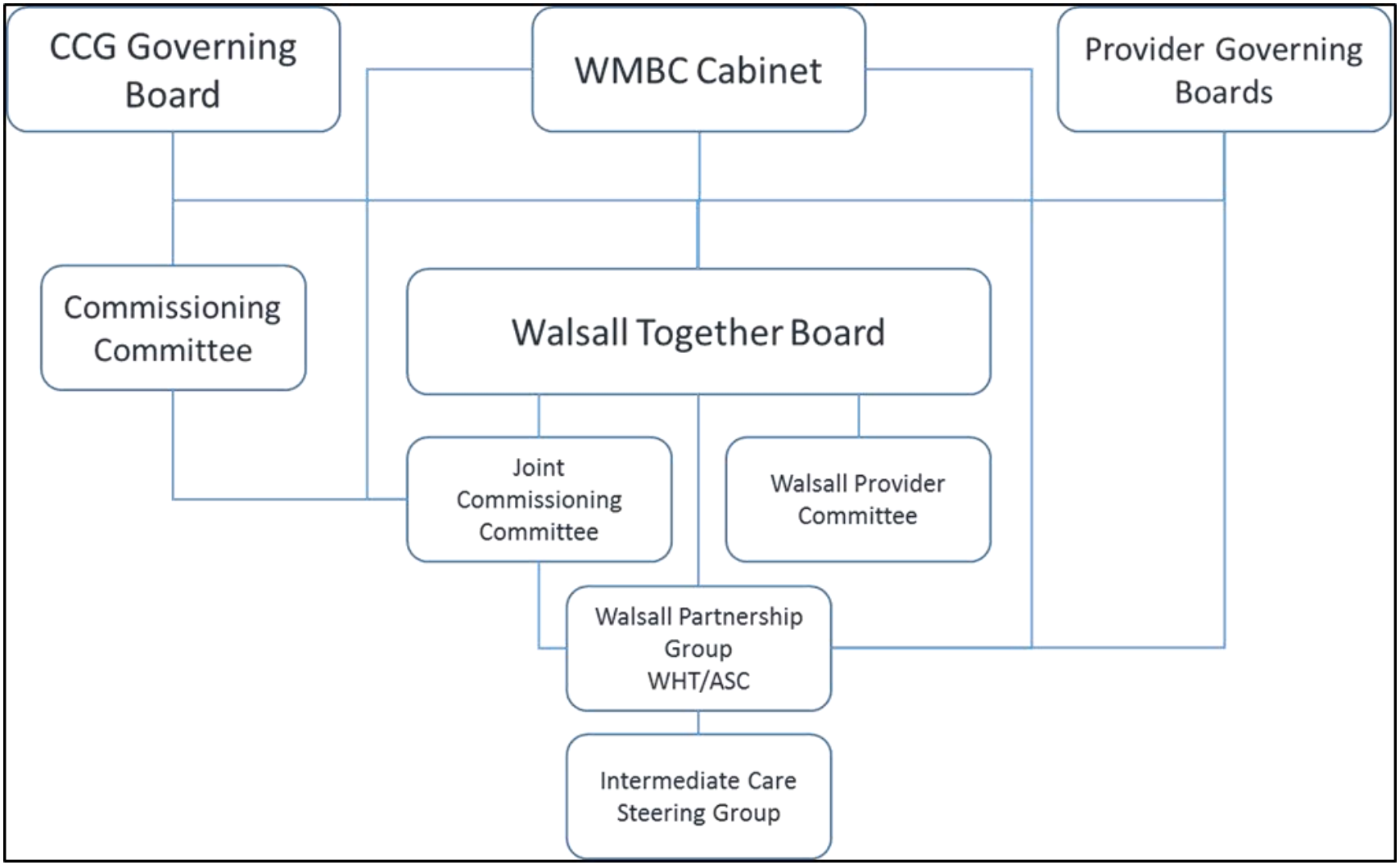
The Business Change approach



Integrated Governance and Management Framework

Refer to Integrated Governance Framework Paper.



Phases 0 & 1
Confirm & Engage and Design

- *Agreement of conceptual intermediate care service (ICS) model and underpinning principles by the Walsall Together Partners*

- *Focus on logical design of ICS, including management systems, processes model / service specification with accompanying Business Change and high level implementation plan that will resolve current issues and transition to future state ICS. Determination of business benefits and ICS financials to develop a business case for the proposed ICS service.*

Phase 0 & 1: Approve Business Case & Service Specification

Objectives

1. *Trust Business Case and Specification 'signed-off' with accompanying benefits and risks*
2. *Financials, including staff costs and potential bed day liberation for the Trust agreed*
3. *Governance model to manage implementation strategy, delivery, risks and performance agreed*

The transformation journey:

1. Obtain approval for the Trust business case, includes finances
2. Obtain approval for Intermediate Care Service specification, mandatory requirements per partner and high level transition plan
3. Recruit Intermediate Care Service Director and Service Manager
4. Agree Governance model, includes scope and roles / responsibilities
5. Check demand / capacity model
6. Assess and plan readiness to prepare partners to implement required Business Change
7. Develop stakeholder engagement & communication plan

Phase 0 & 1: Current Progress, Outcomes and Risks

Progress, Outcomes: Status – On track

1. Effective engagement with respective managers / leads and staff to articulate ICS Process Model and accompanying business requirements, roles and responsibilities
2. Develop business case, including financials and benefits model, and specification.
3. Develop transition plan and define scope of phases
4. Develop Governance Model
5. On-going negotiations re ICS financials

Risks

1. Delays to approve business case and subsequent recruitment of ICS management structure will delay implementation or add to workload of existing staff
2. Current workload, including interim tactics, of team leads reduces capacity and focus on design and readiness to implement proposed ICS which will resolve a number of operational bottlenecks
3. Current community therapy capacity is insufficient to meet the therapy needs of patients discharged when MFFD but with on-going therapy required out-of-hospital
4. Duplication of scope across interim tactics and ICS implementation plan and prioritisation given to interim tactics may undermine ICS implementation plan / approach

Phase 1: Business Readiness Themes

1. *Vision & Scope - alignment with Trust objectives and current improvement initiatives*
2. *Sponsorship – sufficient to maintain focus and provide timely effective support*
3. *Benefits – ensure Business Change improvements impact the 'bottom line'*
4. *Critical success factors – agreement and focus on what 'must' be done right consistently*
5. *Capability – ensure skill and capacity to effectively meet the demand*
6. *Training & Development - develop skill in alignment with Trust workforce strategy*
7. *Resources – Business Change and Project Management resource available to the project*
8. Data / information – collect data once and share across teams through the patient journey
9. IT enablement – alignment to the business requirements to enable collaboration, streamline workflow and communication

Readiness will simplify implementation and overcome resistance to change

Phase 2: Prepare

- *Identify and drive the actions required to ensure 'partners' are adequately prepared for the implementation of the agreed Business Change to comply with mandatory requirements and be able to successfully adopt the new ways of working required to ensure sustainable business results*

Phase 2: Prepare to Transition Objectives

1. *Governance model implemented, and ICS service strategy and risks managed*
2. *Readiness assessed and remedial plan in place across partners to:*
    1. *Transfer clinical and social care activities out-of-hospital setting*
    2. *Implement Information capture and sharing mechanisms (including referral forms)*
    3. Implement interim role of IDT staff acting as Ward Key Coordinator
    4. Implement Trusted Assessor model for ward based interventions IT
    5. *Determine optimal IT enablement to streamline collaboration, communication & workflow*
    6. *Revision of policy re Therapy 'Discharge to Assess' and mechanisms to access equipment agreed*
    7. *Trusted assessor model for Nursing Home providers*
3. *Commissioning review of Bed Based Rehab undertaken*
4. *Realignment of existing ICS resources to perform clinical and social care activities out-of-hospital setting*
5. *Best practice defined across pathways, assessments and care planning*

Phase 2: Prepare to Transition Transformation Journey

1. Define the role of Ward Key Coordinator and provide training (interim resource)
2. Define Information capture and sharing mechanisms agreed (including referral forms)
3. Define ICS pathways criteria (including MH pathways)
4. Define ward interventions, and approval mechanisms, to implement Trusted Assessors
5. Assess 'business readiness' to implement ICS model
6. Define best practice to perform assessments in community setting
7. Develop Trusted Assessor model with Nursing Homes
8. Revise policy / practices to minimise Therapy 'Discharge to Assess'
9. Undertake Commissioning Review of Bed Based Rehab
10. Realign staff to perform clinical and social care activities out-of-hospital setting
11. Implement stakeholder engagement & communication plan and readiness plan

Phase 3: Transition

- *Focus on implementing the required Business Change, including changes new working practices, roles and responsibilities, leadership behaviors, and cultural characteristics required to successfully establish and operate the improved ICS. Implementation of Communication & Stakeholder engagement plan to facilitate commitment and support to transition to the proposed ICS model.*

Phase 3: Transition Transformation Journey

1. *Transfer assessments from hospital to community setting*
2. *Implement new practices to capture patient needs post-discharge and generate referral to the Intermediate Care Service*
3. *Reduce therapy 'Assess to Discharge' with new practices to identify and provide equipment*
4. *Implement new referral process*
5. *Implement single referral for intermediate care referrals to ensure patients 'flow' to the appropriate pathway (based on agreed pathways) – includes out-of-borough referrals for Walsall patients*
6. *Implement Trust assessor model for ward interventions (agreed set of interventions)*
7. *Incorporate Self Care into ICS Care Planning*
8. *Implement Trust assessor model for nursing homes and governance to manage performance / quality*
9. *Implement governance arrangements for private sector providers of domiciliary care*
10. *Commission pathways, including capacity, to provide bed-based intermediate care*

Phases 4 & 5
Mgt of Change and Consolidate & Rationalise

- *Focus on undertaking a Management of Change with collective and individual consultation to align teams / staffing to the proposed ICS model.*

- *Focus on consolidating teams / staffing to create a single 'team' with single access function and assigning roles underpinning the ICS model, including MDT service delivery.*

Phases 4 & 5: Mgt of Change and Consolidate & Rationalise Transformation Journey

1. *Consult on proposed ICS organisational structure and roles with leadership and staff*
2. *Consolidate and rationalise disparate teams into a single ICS service*
3. *Assign roles / responsibilities to staff in the single ICS team*
4. *Extend service provision to 7 days a week*
5. *Improve IT enablement within and across partner organisations*

Phases 6 & 7
Relocate and Project Closure

- *Focus to relocate to ICS team to new premises to facilitate MDT collaboration with the required infrastructure to enable streamlined care delivery.*

- *Focus on 'hand-over' of the streamlined and 'stable' ICS service to the ICS management team and to evaluate the extent to which the project was successful and note any lessons learned for future projects.*

Phases 6 & 7: Transition Transformation Journey

1. *Relocate ICS team to new location with the required infrastructure*

Appendices

Appendix 1: Phase Descriptions

1. Phase 0: Engage and confirm - Agreement of conceptual intermediate care service (ICS) model and underpinning principles by the Walsall Together Partners
2. Phase 1: Design - Focus on logical design of ICS, including management systems, processes model / service specification with accompanying Business Change and high level implementation plan that will resolve current issues and transition to future state ICS. Determination of business benefits and ICS financials to develop a business case for the proposed ICS service.
3. Phase 2: Prepare - Identify and drive the actions required to ensure 'partners' are adequately prepared for the implementation of the agreed Business Change to comply with mandatory requirements and be able to successfully adopt the new ways of working required to ensure sustainable business results
4. Phase 3: Transition - Focus on implementing the required Business Change, including changes new working practices, roles and responsibilities, leadership behaviors, and cultural characteristics required to successfully establish and operate the improved ICS. Implementation of Communication & Stakeholder engagement plan to facilitate commitment and support to transition to the proposed ICS model.
5. Phase 4:Management of Change - Focus on undertaking a Management of Change with collective and individual consultation to align teams / staffing to the proposed ICS model.
6. Phase 5: Consolidate & Rationalise - Focus on consolidating teams / staffing to create a single 'team' with single access function and assigning roles underpinning the ICS model, including MDT service delivery.
7. Phase 6: Relocate - Focus to relocate to ICS team to new premises to facilitate MDT collaboration with the required infrastructure to enable streamlined care delivery.
8. Phase 7: Closure - Focus on 'hand-over' of the streamlined and 'stable' ICS service to the ICS management team and to evaluate the extent to which the project was successful and note any lessons learned for future projects.

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	**Trust Board**			**Date: 8th March 2018**
Report Title	**Intermediate Care Service Programme Report**			**Agenda Item: 14** **Enclosure No: 12**
Lead Director to Present Report	Daren Fradgley, Director Strategy & Improvement			
Report Author(s)	Kerrie Allward, Head of Integrated Commissioning, Walsall Council Narinder Gogna, ICS Programme Manager			
Executive Summary	• The Intermediate Care Service (ICS) Model and phase 0-3 implementation, was approved by the Trust in September 2017 • Progress of the implementation has been overseen by the Walsall Together (WT) Board and The Urgent and Emergency Care Improvement (UECI) Board • The WT and UECI Boards are supportive of the model development and progression to full implementation. • Implementation of the new model of Intermediate Care is in line with Trust Strategic direction and does not increase financial risk to the Trust • This report highlights the progress on Phases 0 - 3 as requested by Trust Board. It also confirms that the next phases will commence as planned overseen by the Walsall Together Program Board. Regular updates will continue to come to PFIC and Trust Board.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Board is asked to: 1.**Note** the content of the paper and the progress made and nest steps planned 2.**Discuss** any areas of concerns			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
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<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
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</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Areas of significant underperformance are expected to be reported within Corporate/Divisional Risk registers.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Not applicable to this report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">None</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">None</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2"></td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

Executive Summary

i. Intermediate Care Service (ICS) business case, phase 0-3, was approved by the Trust in September 2017 which enabled ICS staff to be transferred from the Trust to interim ICS line management and budget. This facilitated consolidation of the disparate ICS teams reducing fragmentation, complexity and implementation of a 'team' around the patient ethos.

ii. Furthermore, phase 0-3 has implemented a number of key changes to processes, roles / responsibilities, information flows, location of work and IT enablement to:

- Implement a model where discharge home to assess and home-based admission avoidance is the default approach which is focussed on setting patient-centred goals
- Non-acute activities are performed in a community setting facilitating earlier discharge e.g. on-going therapy for medically fit patients, social care assessments etc.
- Adopt best practices re integrated care service delivery with a MDT approach of checking progress against agreed outcomes
- Enhance use of the voluntary sector to facilitate independence through supported Self Care
- Streamline referral management to make the appropriate ICS resources to develop an intermediate plan to discharge to safe living environment
- Patient leaflets and staff training to provide consistent messages to patients re ICS post-discharge support and patient / carer responsibilities.

iii. Phase 0-3 has established the necessary foundation for alignment of working practices, governance arrangements and adoption of new behaviours to facilitate partnership to agree and implement changes where 'care delivery requires effective collaboration across partners. Phases 0-3 will be completed by the end of March 2018, with the focus of the last month to translate the changes to bottom line performance improvement.

iv. This report highlights implementation progress across a number of high impact changes, with effective partnership working between Trust and ICS operational leads. Phase 4 -7 builds and further develops ICS capabilities to:

- Further consolidate staff across ICS pathways to create a single 'team' where the appropriate staff are allocated to patients based on their needs and not pathway criteria
- Delineation between reablement and domiciliary care roles, latter provided by the private sector so that ICS enhances it reablement capabilities and financial savings can be made by less costly provision of domiciliary care
- Voluntary sector staff as integral members of ICS staffing to facilitate an enabling culture that supports patients, with carers, to regain confidence and/or function so that patients enjoy supported Self Care
- Default is for non-acute activities to be performed in a community setting facilitating earlier discharge
- Single integrated ICS 'pathway' with clarity on roles, responsibilities and information flows so that information is captured once and made available through patient journey - as per ECIP recommendations
- Consistent messages to support patients plan their post-discharge support

v. Phases 4 -7, will enable both the Trust and ICS to realise the full business benefits of the ICS design. With effective partnership working at both operational leads and senior management. The Trust Executive Team will continue to members of ICS Partnership Group – the mechanism to direct and monitor the ICS programme against agreed direction and objectives.

vi. Regular progress reports will be provided to the Trust Board and PFIC for review and oversight.

1. Report

1.1 There is a plethora of evidence that care provision in the least restrictive environment is the most optimal service delivery model for patients, Health Services, Social Care Services and the wider System. The reconfigured Intermediate Care Service (ICS) is an enabler for patients to be discharged to a safe living environment when in-patient acute care interventions are completed (patient is medically fit for discharge). The full ICS Business Case can be found at **Appendix 1**.

1.2 At the heart of the ICS reconfiguration is to 'organise' ICS staff so that non-acute activities, such as Social Care assessments, Therapy, Continuing Health Care Assessments etc. are transferred to a community setting when a patient becomes medically fit. Patients will then be supported by a 'team' dependent on the patient needs, with access to both ICS and voluntary sector services to support and monitor progress against the care plan through to discharge.

1.3 The benefits span all of the stakeholders, from patients with improved experience and outcomes through to patients being less dependent on care post-discharge from ICS. A key benefit for the Trust, 'liberating' beds, is predicated on facilitating earlier discharge or avoiding admissions for patients that require health and/or social care support (subsequent phase). The actual beds liberated is dependent on the maturity of transformation capability, that is the ability to induce staff to change behaviours / working practices, across ward processes and ICS to resolve issues that constrain patient flow from in-patient care to intermediate care services.

2. Implementation approach and plan.

2.1 Implementation of the reconfigured ICS has involved significant change across governance / management, business processes, roles / responsibilities, skills, information flows and location of work.

2.2 Phase 0-3 was approved by the Trust in September 2017 which enabled ICS staff to be transferred from the Trust to interim ICS line management and budget. This facilitated consolidation of the disparate ICS teams reducing fragmentation, complexity and implementation of a MDT 'team' around the patient ethos). Furthermore, it provided the basis for partnership working between the Trust and ICS to prepare and implement the necessary Business Changes.

2.15 Implementing the high impact changes has enabled ICS to:

- Make discharge home to assess (DH2A) and home-based admission avoidance (Reablement) the default approach with patient-centred goal setting
- Transfer non-acute activities to a community setting facilitating earlier discharge

- Adopt best practices re integrated care service delivery with a multi-disciplinary Team (MDT) approach to check progress against agreed goals / outcomes
- Enhance use of the voluntary sector to facilitate independence through supported Self Care
- Streamline referral management to make the appropriate ICS resources to develop an intermediate plan to discharge to safe living environment
- Access to patient leaflets and staff training to provide consistent messages to patients re ICS post-discharge support and patient / carer responsibilities.

2.16 Phase 0-3 has established the necessary foundation in terms of working practices, governance arrangements and partnership between ICS and Trust operational leads to agree and implement changes to enable integrated service delivery.

2.17 Phase 4 – 7 of the ICS implementation focuses on undertaking a Management of Change to align teams/staffing to the proposed ICS staffing model. It will further consolidate staff across ICS pathways to create a single 'team' where the appropriate staff are allocated to patients based on their needs and not pathway criteria. Initial modelling of the Management of Change shows that there is unlikely to be a reduction in Trust Staff within the reconfigured ICS model and the new leadership arrangements will be jointly accountable to both the Trust and the Council, meaning that phases 4-7 does not increase risk to Walsall Healthcare Trust.

Existing high impact changes will be further developed and formalised, including:

2.18 Phases 4-7 will also see the high impact changes be further developed and formalised, including:

Single ICS Service

- Consolidate teams, upskill staff and rationalise management and staffing in line with the proposed ICS design.

Transfer non-acute care activities to community setting

- ICS team has the necessary roles to perform assessments and access to equipment in a variety of community settings – this will be default pathway for medically fit patients that require non-acute interventions to facilitate discharge.

Single Referral Point

- All Walsall patients requiring support on discharge will be supported on discharge by ICS. Referrals for the service will be through a single referral. ICS staff will screen and assign to lead professional to develop an intermediate plan to facilitate discharge to safe living environment.

Consistent messages re ICS Pathways

- All ward staff will attend briefing sessions as part of their training / induction and existing staff will attend briefings on intermediate care so that patients have consistent messages re post-discharge support. This will be supported by clear patient literature and posters throughout the hospital

Better use of Therapy Services

- Changes to ward practices to enable Therapy staff to participate earlier into the appropriate patient journey and transfer appropriate activity to community-based therapy staff.

Governance Framework in place to align priorities and working practices

- Clear governance arrangements between Walsall healthcare Trust and Walsall Council to support the delivery of the joint service.

3. Next Steps

Phases 4 -7, will enable both the Trust and Council to realise the full business benefits of the ICS design. With effective partnership working at both operational leads and senior management. The Trust Executive Team will continue to be members of ICS Partnership Group – the mechanism to direct and monitor the ICS programme against agreed direction and objectives.

Regular progress reports will be provided to the Trust Board and PFIC for review and oversight.

Appendix

1	Intermediate Care Model	

BOARD/COMMITTEE REPORT

Meeting	**Trust Board**	
Report Title	**Q3 Trust Objectives**	**Agenda Item:15** **Enclosure No.: 13**
Lead Director to Present Report	**Daren Fradgley - Director of Strategy & Improvement**	
Report Author(s)	Barbara Beal, Director of Nursing; Joanne Adams, Business Manager to Medical Director; Kuldeep Singh, Patient Experience; Roseanne Crossey – Head of Business Development and Planning; Tony Kettle - Deputy Director of Finance; Russell Caldicott – Director of Finance & Performance Phillip Thomas Hands – Chief Operating Officer; Jane Longden – Director of Estates & Facilities; Michala Dytor HR Manager; Louise Ludgrove, Director of HR & OD (interim); Karen Bendall, OD Manager; Simon Johnson, Engagement Lead; Tom Johnson, LiA Lead.	

Executive Summary

The attached report details the progress achieved on the Trust objectives as at Q3 2017/18.

The table below highlights the current amber status overall which is reflected in the sub objectives with 1 green,. 5 amber ratings one of which is a deterioration on the previous quarter and 1 red.

Ref	Objective	Executive Owner(s)	Expected Completion Date	Q1	Q2	Q3
1	Embed the quality, performance and patient experience improvements that we began in 2016/17	Medical Director, Director of Nursing and Chief Operating Officer	Mar 19	A	A	A
2	Embed an engaged, empowered and clinically-led organisational culture	Director of HR and OD	Mar 19	G	A	A
3	Track our financial position so that our deficit reduces.	Director of Finance	Mar 19	R	R	R
4	With local partners change models of care to keep hospital activity at no more than 2016/17 outturn.	Director of Strategy and Transformation	Mar 19	G	G	G
5	Embed continual service improvement as the way we do things linked to our Improvement Plan	Director of Strategy and Transformation, COO, Director of Finance	Mar 19	A	G	A
6	Ensure our hospital estate is future proof and fit for purpose	Director of Finance and Director of Strategy and Transformation.	Mar 19	A	A	A
7	Deliver a sustainability review of all our services to set plans for the next five years.	Director of Strategy and Transformation	Mar 19	A	A	A

All of these objectives have been debated within the relevant board committees

Purpose	**Approval**	**Decision**	**Discussion**	**Note for Information**
	☒	☐	☒	☐

<table>
<tr><td><u>Recommendation</u></td><td colspan="2">To DISCUSS and APPROVE the content of the Report.</td></tr>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performace and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Embed continual service improvement as the way we do things linked to our Improvement plan</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
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<tr><td>Use resources well to ensure we are Sustainable</td><td>Tackle our financial position so that our deficit reduces</td></tr>
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<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">
<table>
<tr><th>Risk Reference</th><th>Risk Statement</th></tr>
<tr><td>1</td><td>That the quality & safety of care we provide across the Trust does not improve in line with our commitment in line with our Quality Commitment.</td></tr>
<tr><td>2</td><td>That we continue to provide inadequate care for patients attending our Emergency Department</td></tr>
<tr><td>3</td><td>That we continue to provide "inadequate" care for patients of our maternity & neonatal services.</td></tr>
<tr><td>4</td><td>Integration of community services fails to deliver the required reduction in acute admissions.</td></tr>
<tr><td>5</td><td>That our emergency care pathway does not improve resulting in continued delays for patients and poor flow through the hospital.</td></tr>
<tr><td>6</td><td>Insufficient capacity leads to inability to deliver the elective national constitutional standards (cancer, 18 weeks and diagnostics) resulting in potential harm to patients.</td></tr>
<tr><td>9</td><td>That the Trust overspends compared to its agreed plan and is unable to deliver future financial sustainability.</td></tr>
<tr><td>10</td><td>That we cannot deliver our planned programme of hospital estate improvement including ITU, Neonatal Unit, 2nd Maternity Theatre and plan for Emergency Department.</td></tr>
<tr><td>13</td><td>That the Service Improvement and Cost Improvement Programme does not deliver the financial impact planned, resulting in non-delivery of financial plan.</td></tr>
<tr><td>14</td><td>New entrants into the market will succeed in attracting services resulting in income loss to the Trust.</td></tr>
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</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">None</td></tr>
<tr><td><u>Other Regulatory</u></td><td colspan="2"></td></tr>
</table>

/Legal Implications	Objective progress reporting is part of the Trusts annual planning cycle
Report History	Each of the objectives has been presented to relevant Board sub- committee
Next Steps	
Freedom of Information Status	**The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee**

	Objective 1: Embed the quality, performance and patient experience improvements that we began in 2016/17		Overall RAG Rating	A	A	A				Monitoring Committee - Quality and Safety Committee	
Ref	OBJECTIVE	Executive Owner(s)	Expected Completion Date	Q1	Q2	Q3	Q4	Quarter Update	Business Assurances	Corporate Oversight	Independent Oversight
1.1	Deliver priorities set out in our Quality Commitment	Medical Director; Director of Nursing and Chief Operating Officer	Mar-19	A	A	A		The implementation of the Quality Committment continues and has been mapped onto the PCIP Following receipt of the CQC Report ensuring business as usual as part of the Trust's improvement plan. VTE - performance for VTE assessment within 24 hours improved during Q3 achieving 93.45% for December 2017. This continues to remain below the 95% performance national target. An action plan has been developed in conjunction with the DoN and her teams to support a multi-healthcare professional approach to delivering this performance indicator. It is expected that a performance of 95% will be achieved by the end of Q4.	Performance is presented monthly at TQE and Q&S Committee. The Mortality Report is also presented at these committees and at CQR. Maternity and ED taskforces meet regularly. HSMR performance of less than 100 has been maintained for May-September; and SHMI of less than 100 for 2 consecutive months - July and August. The Trust has embedded the principles of learning from death per national quality board directives. Work continues with external bodies and regional peers to devlop our procsses further. this includes undertaking joint pieces of work with the CCG to review models of care and patient pathways that trigger areas of interest to be reviewed.	Mortality Report and VTE performances are presented at Q&S & Trust Board.	It is a requirement that the newly developed Policy is accessible to the public and so is published on the Trust's website. SHMI is a national benchmarking tool. Performance is benchmarked against other organisations nationally and regionally. CQC reinspected the hospital and community services earlier this year.
1.2	Improved overall patient satisfaction as reported in 2017 and 2018 patient surveys and improved FFT feedback from our patients – especially in ED and maternity			A	R	R		Maternity Taskforce has continued to meet throughout Q3, the ED Taskforce was planned not to meet over the winter but will meet in March 2018. ED FFT remains approx 10% below the national average. The recommendation rate for ED in Q3 was 74.41%, which is a slight decrease from the 76.27% in Q2. ED saw a drop in its repsonse rates in Q3 largely due to a technology update meaning the department had to implement a paper survey as a contingency during this time period. In maternity the postnatal ward and postnatal community both improved their recommendation scores in Q3 compared with Q2. There was a drop in scores for antenatal and birth. Antenatal trails the national average by 15% and birth by 6%, however the response rates are low, so a small change either way can make a big difference in percentages. The team have returned to a paper based survey as SMS texting resulted in reduced response rates, they are also piloting the use of ipads which is starting to show an improvement in response rates. The National Maternity Survey results showed an improvement in 73% of questions and that the Trust maternity services performed about the same on most questions when benchmarked against Trusts nationally. Services are looking at different ways to improve response rates with patients.	Maternity Taskforces meet regularly. Ed Taskforce will meet during March 2018 Patient experience reports are shared with divisional leadership and there is Dvisional representation at Patient Experience Committee.	Exception Reports are made to the Board on a monthly basis.	Nothing to report externally from this period
1.3	Deliver reduced intervention rates in maternity (c sections and inductions of labour) as a result of implementing our Normality Strategy.			R	A	A		Good progress continues to be made. Against the national target for C-sections of <30%, the service achieved 25.77 in Oct, 28.62 in Nov, there was an increase in Dec to 32.86 and actions have been implemented to address this.	Maternity task force meets monthly	Performance rates are included in Trust Board papers.	Nothing to report externally from this period
1.4	Improved quality and patient experience for our elective care pathways			G	G	A		• The Trust continues to maintain delivery of national standards for cancer, and diagnostics. • The trust recognises that it has not achieved the trajectory performance that it had previously agreed with NHS England. Performance is at 80.99% for Dec 17. Previously the trust had achieved levels of 85.06% (Sep 17). The trust will continue to work with VIST and NHS Improvement. An outpatient follow-the CCG and NHSI with a view to reducing the number of unnecessary follow-ups. Following feedback from inpatients, a "quiet" protocol is being worked on to help patients sleep better. This is likely to be introduced in late Q4 2017/ early Q1 2018.	Divisional Operations Meetings/Boards receive performance updates	Reports are sent to Quality and Safety Committee and Trust Quality Executive.	Performance is monitored by the CCG and NHSI with national benchmarking.
1.5	Improved quality and patient experience in our emergency care pathways			A	A	A		The ED Care Group is making good progress with patient involvement. The service has started to introduce volunteers to help patients fill out surveys, and ensure they are hydrated, comfortable and provide support whilst in the Dept. The patient experience team attend ED meetings and provide audio sound bites back from patients, which are shared with the team. The ED Care Group have developed an action plan to improve areas identified via FFT feedback and the National Survey	ED Taskforce; Divisional Operations Group; and Divisional Board meeting receive updates on progress.	Reports are sent to Patient Experience Committee, Quality and Safety Committee and Trust Quality Executive. Performance dashboard is included in Board papers	Performance is discussed with CCG at CRM meetings
1.6	Reduce safety concerns with paediatric pathways and improve experience of teenagers transitioning to adult care			G	G	G		Pathways are in place from ED to PAU as well as primary care pathways into PAU. Transition is in place for the three main long term conditions for children and young people, epilepsy, respiratory and diabetes. There is also a community health transition team for children and young people with physical disabilities.	Safety concerns/risk are on service/divisional and corporate risk registers. Risk are reviewed at Divisional Quality Meetings. This is not on the WCCS RR and all actions are in place	Key risks are monitored at the Quality and Safety Executive, and exception reports are made to the Board.	Diabetes Steering Group meets quarterly and is made up Public Health, CCG, Diabetes UK and representatives from the Trust.

BAF Ref	BAF Risk Statement	Q1	Q2	Q3	Q4
	That the quality & safety of care we provide across the Trust does not improve in line with our commitment in line with our Quality	A	A	A	
	That we continue to provide inadequate care for patients attending our Emergency Department	A	A	A	
	That we continue to provide "inadequate" care for patients of our maternity & neonatal services.	A	A	A	

	Objective 2: Embed an engaged, empowered and clinically-led organisational culture		Overall RAG rating	G	A	A			Monitoring Committee - People and Organistional Development (POD)		
Ref	OBJECTIVE	Executive Owner(s)	Expected Completion Date	Q1	Q2	Q3	Q4	Quarter Update	Business Assurances	Corporate Oversight	Independent Oversight
2.1	Improved colleague satisfaction measured through 2017 and 2018 staff surveys			G	A	A		Pulse surveys are being taken to gauge colleagues' views. Past surveys have shown regular improvement. Actions identified from the Pulse Survey will form part of the next Listening into Action phase. Each of the divisions' teams of three has completed the Kings Fund training, which included two-way feedback between participants and trainees. Informal results have been received from Quality Health of Trust 2017 Staff Survey results. national (official) results will follow in March. Early indications suggest 42% of questions see an improvement on 2016 by 2% or more, 13% see a worsening position of 2% or more and 45% are about the same (within 2%). 19 Focus groups were completed by the Staff Engagement Lead and an Action Plan agreed by Board/Exec relating to elements that should impact positively staff satisfaction. 55 colleagues have agreed to become 'Engagents' (staff reference group) and the first meeting took place in Q4 with high turnout. This group can be a temperature check for future engagement activity.	Pulse Survey results are presented at POD and TWE, and Trust Board. National Staff Survey results are presented to trust Board.	TWE have recieved - an intenerally release analysis of first-cut analysis of staff survey result.	Results of National Staff Survey are benchmarked and reported nationally. Also a quick summary on listening events.
2.2	Listening into Action year 2 plan developed and delivered successfully ensuring that this becomes the way we do things round here – impact demonstrated in LiA Pulse Check score improvement.			G	G	G		Wave 3 Teams presented their achievements at the Pass it On Event on the 22nd November. Their achievements include : • Infection control have increased the knowledge of ANTT (Aseptic Non-touch technique) in key target areas from 40% to 96% in just 20 weeks; • The communications team have reduced the number of global emails sent out by 70% since the introduction of Daily Dose; • Learning from Excellence launch has seen over 95 nominations for outstanding clinical practice; Tissue Viability have secured replacement mattresses and have predicted savings of £120k in 2018-19; Zero exception reports within surgical junior doctors since August 2017; Introduction of specific training and development for admin and clerical colleagues. Wave 4 Teams have been launched and this year will be offered additional Quality Improvement training to help maximise the changes implemented and to help make the changes more sustainable. The active teams are:- mouth care; perinantal/mental health; IT services; continence; widening participation team; UTIs; Estates Small Works. The 9 Big Ticket Item teams continue to work on their improvement projects with an updated plan to present at Trust Clinical Executive in March. 4 Crowd Fixing Events took place during Quarter 3 with an action plan being reviewed, actioned and monitored at the LiA Sponsor Group Meetings.	Links to updates, feedback from the programmes and outcomes of the assessments.	Results are updated to the Board through the board committes in various performance reports and LiA updates	None to report at this point.
2.3	Deliver our standards for appraisal and mandatory training			G	A	A		Mandatory training is currently static at the 80% mark. Issues with the IT systems (Java) is proving challenging as this is having an effect on completions of e-learning. This is now an external issue. Internal IT issues have been resolved. In Q3 the Trust trialed auto enrolment which proved to have a positive impact in specific areas i.e. Safeguarding , However in other areas did not have as much impact. Auto enrollement will be rolled out for all modules from April 2018. The appraisal rate increased across the quarter. An LiA session that was planned for December has now been rescheudled for for March due to winter pressures., with a view to achieving colleague engagement to improve the quality of appraisals, and to streamline the paperwork involved.	HR/OD dashboard is presented to Divisional Boards and TWE.	Papers are presented at POD and Trust Board.	Dashboards are presented at JNCC.
2.4	Continued reductions in sickness absence			A	R	R		We continue to embed the new Attendance Policy, which will have a 12 month review in Q1 2018. Analysis shows that MSK and stress cases continue to be a challenge. Self-referral physio has had a good uptake and is currently carried out within existing resource. Stress issues are proving to be predominantly home related, and the Trust is providing access to resource / support via OH and the Health & Wellbeing Hub. At Divisional level 'confirm and challenge' meetings are being undertaken with Care groups and Matrons. Flu vaccination at Jan 2018 is 62%, while sickness levels have risen from October 2017, with significant increases in cough / colds and gastro. Analysis of sickness regarding increase in substantive RN's doing bank shifts and sickness absence HR team continue to support manager's at local level and with Occupational Health – working with staffside on application of policy	KPIs reports to Divisional Board, and to JNCC.	Reported to POD monthly	Sickness forms part of the oversight undertakne by NHSI
2.5	Develop and implement plans for new roles to ensure a sustainable workforce	Director of HR and OD	Mar-19	G	A	G		The work force strategy was presented and approved by Board in October. The draft Health and Care Workforce Strategy (for consultation) produced by HEE and partners, is being circulated for comment across the Trust to help inform the final strategy to be produced in July 2018 which will impact on the future workforce through to 2027. Interviews are also taking place for further apprenticeship opportunities such as Health Care Apprentices. The first cohort of 26 Trainee Nursing Associates are due to graduate in January 2019. The Apprenticeship standard for Nursing Associates has now been approved for delivery and WHT staff will begin the apprenticeship in March 2018, there are plans to run another cohort from September 2018. Work to identify where the next cohort of trainees will come from is ongoing. Other new roles include the development of Maternity Support Workers who will part of a multi skilled team required to deliver safe and effective care. Work continues and is on track for the development of a Trustwide ACP programme/ framework. A review of the role of Physician Associates and how can they can be utilised within the Trust is underway. Development of core competencies for nursing roles including mandatory training is on target. We will continue to work to develop roles that are multi skilled to help to meet the changing requirements of patient needs.	Cross-organisational workforce steering group meets bi monthly. Papers presented at TWE	Papers presented at POD. Workforce Strategy presented to Trust Board.	Input into Black Country STP. Participate in monthly Local Workforce Action Board, based on developing workforce capacity and change across the STP Region. Input in to Black Country People Strategy. Workforce plans included in Annual Plan returns to NHSI.
2.6	Plan agreed for reducing agency spend and delivered as planned (NB Unlikely to achieve NHSI £5m ceiling in at least year 1			G	A	A		The organisation will be undertaking a robust piece of work to review all elements of the medical workforce to ensure quality and safety but also to support in reducing the reliance on locum staff. The organisation has begun elements of this work during 2016/17. The medical staffing team has undergone a change of management to develop, centralise and streamline systems, processes and controls for managing the medical workforce. Vacancies within the medical staffing team have been recruited to. A multifunctional IT system for managing the medical workforce has been procured, Allocate, and is currently being implemented A process for authorising medical locums has been implemented and is monitored and reported on a weekly basis through the Divisional Director team meeting led by the MD A renewed focus on recruitment to substantive posts has been implemented The medical staffing team are working with HTE and cluster peers to implement capped locum rates and use those agencies signed up to a tiered approach and within the framework The medical staffing team are actively seeking to transfer regular agency workers to the trust bank to reduce commission and uncapped rates being applied. NHSI allocated the trust a £1.2m target reduction in spend on agency staff for 2017/18. The trust spent £4.8 million on agency staff during 2016/17, subsequently a trajectory was developed to reduce the agency spend to £3.4 million by the end of 2017/18 representing a reduction of £1.4 million to allow a tolerance for winter pressures above that seen the previous year or latency in recruitment plans. The current spend on agency as of month 10 is reported as £2.02m The spend at month 10 for 2016/17 was reported as £4.4m This represents a reduction of £2.33m YTD A significant amount of these costs has transferred to trust bank costs although overall medial spend on temporary staff has seen a reduction YTD Overall spend month 10 for 2016/17 was reported as £7.97m Overall spend month 10 for 2017/18 is reported as £7.36m representing an overall reduction of £610k Nursing agency in Q1 was lower than the agreed run rate by £1m but increased from November by	Each Division receives an HR update on agency expenditure, which is discussed in their divisional board meetings	Papers are presented at POD and Trust Board	Workforce reviews centered around agency useage and spend are conducted by NHSI on a ragualr basis
2.7	Improved staff confidence in raising concerns and receiving an appropriate response in staff survey results			G	G	G		Feedback from the focus groups has been fed back to Trust Executive, Trust Board, various committees where 1 of the agreed areas relates to Bullying, Harrassment and Behaviours. A number of actions sit within this area to encourage an open, transparent and safe culture where staff can raise concerns. One action has been that a number of staff that were regularly cited as driving behavioural that were sometimes unhelpful will all receive feedback and a coaching conversation with the expectation that they reflect and alter their approach/behaviours where it has caused problems. 'Engagents' have been implemented (there are currently 51) who will act as a reference group for changes the organisation wishes to make but also to share what staff are talking about at ground level so concerns could reach the senior teams through this avenue. All staff have been made aware of the outcome of their feedback and what is happening as a result of that through internal communication channels (Daily Dose, In the Loop). One significant early action is the agreement to refresh Trust values, which will be staff chosen and then create a behavioural framework on the back of that to express what people should expect to see and what they would not expect to see in terms of behaviour.	Engagement leads reports to committees on an adhoc basis.	The Freedom Guardians report bi-annually to Board. Survey results are presented at POD, TCE and to Trust Board.	National Staff Survey results are benchmarked and reported nationally.

BAF Ref	BAF Risk Statement	Q1	Q2	Q3	Q4
No. 7	That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff.	A	A	A	
No. 8	That we are not successful in our work to establish a clinically-led, engaged & empowered culture.	A	A	A	

	Objective - Track our financial position so that our deficit reduces.		Overall RAG Rating	R	R	R			Monitoring Committee - Performance and Financial Investment Committee		
Ref	**OBJECTIVE**	**Executive Owner(s)**	**Expected Completion Date**	**Q1**	**Q2**	**Q3**	**Q4**	**Quarter Update**	**Business Assurances**	**Corporate Oversight**	**Independent Oversight**
3.1	Annual deficit in line with plan - £21m in 2017/18 and £15.2m in 2018/19	Director of Finance	On-going	R	R	R		At Q3 the Trust is off plan by £4m as a consequence of temporary staffing costs in nursing and medical areas; under achievement of savings programmes and being below plan on clinical income. The latter is largely a consequence of outpatients, elective and non-elective care episodes. The recovery of the financial position is dependant on improved income from outpatients and theatres efficiency workstreams, reducing temporary workforce costs & other expenditure and other non recurrent measures including disposal of land and buildings. The financial recovery plan to attain the £20.5m deficit has been presented to the Trust Board.	Reporting of financial performance bi-weekly against agreed recovery trajectories for the year, reporting monthly to the Performance, Finance & Investment Committee and onwards to the Trust Board.	Financial Recovery Plan adopted by Trust Board and monitored through PFIC, Improvement Taskforce and Performance Finance Executive.	Trust is within NHSI enhanced financial measures (weekly oversight).
3.2	Savings programme delivered in 2017/18 and 2018/19 - £21.5m delivered successfully over 2 years		Mar-18	R	R	R		The Trust is behind plan at M09 by £1.5m (YTD plan £8.1m, actual delivery £6.6m). Also, there is a significant element of savings YTD driven through non-recurrent measures (£2.0m), thus placing greater pressure on financial sustainability as costs remain in future trading. A risk adjusted plan that delivers the targeted £11m savings target has been developed but relies heavily on increasing clinical income (outpatients and elective) and further non recurrent measures, therefore risks remain in attainment of the outturn.	Reporting of financial performance bi-weekly against agreed recovery trajectories for the year, reporting monthly to the Performance, Finance & Investment Committee and onwards to the Trust Board.	Financial Recovery Plan adopted by Trust Board and monitored through PFIC, Improvement Taskforce and Performance Finance Executive.	Trust is within NHSI enhanced financial measures (weekly oversight).
3.3	A clear plan that continues to reduce our deficit for the longer-term in line with an agreed LTFM		Mar-18	R	R	A		The Trust received a letter of undertakings from NHSI in which the Trust sought to produce a three year financial sustainability (recovery) plan that enables delivery of a balanced financial outturn, this will be produced in the final quarter of the financial year and clearly links to delivery of the aspects referred to in 3.1 & 3.2 above.	The Trust has produced a high level draft 3 year financial plan indicating financial recovery in 2020/21. The plan is based upon achievement of the 2017/18 forecast outturn target, sucessful negotiation of improved contract income in 2018/19, and approval of 2018/19 budget.	Trust Board adoption in final quarter of the financial year.	Trust is within NHSI enhanced financial measures (weekly oversight).

BAF Ref	BAF Risk Statement	Q1	Q2	Q3	Q4
No. 9	That the Trust overspends compared to its agreed plan & is unable to deliver future financial sustainability.	R	R	R	
No. 13	That the Service Improvement and Cost Improvement Programme does not deliver the financial impact planned resulting in non-delivery of financial plan.	R	R	R	
No. 14.	New entrants into the market will succeed in attracting services resulting in income loss to the Trust.	A	A	A	

	Objective 4: With local partners change models of care to keep hospital activity at no more than 2016/17 outturn.		Overall RAG Rating	G	G	G			Monitoring Committee - Contract Review Meeting, and Walsall Together Partnership and STP.		
Ref	**OBJECTIVE**	**Executive Owner(s)**	**Expected Completion Date**	**Q1**	**Q2**	**Q3**	**Q4**	**Quarter Update**	**Business Assurances**	**Corporate Oversight**	**Independent Oversight**
4.1	Reduce hospital occupied bed days for each of our 7 locality teams – including reducing hospital length of stay and reducing emergency readmissions	Director of Strategy and Improvement	Mar-19	G	G	G		There are seven GP Led MDT's underway with pilot practices, each of the four locality areas North, South, East and West are covered. An MDT coordinator post has been establisehed and is currently being recruited to, this will assist in ensuring effective MDT's and the monitoring of their success rate. Further practices have been identified for the next wave of GP Led MDT's. The TotalMobile solution roll out has commenced with the West teams going live with the the solution during February, to be followed by the other teams during February and March. The Contenance Service redeign is complete and recruitment has now finished, all staff will be in place and cases aligned by 1st Apr. The Respiratory services resdesign is underway with the 90 day consultation due to end in February.	Care at Home (CaH) dashboard is produced monthly. Place based care project team meetings as part of the Walsall Together program governance	Community progress reported to PFIC in the performance report, as does the avoidance admissions dashboard on Placed based Team project group.. Papers on Intermediate Care and the work on MDT have been shared with the Board	MDT work is shared with Walsall Together Partnership board. Planned to provide updates to the wider STP group when the new governance is completed.
4.2	Dissolve organisational boundaries between health and social care to operate with a single management structure; co-located teams; SPA and single IT system and mobile technology			G	G	G		Mobile Technology devices have been in staff hands for familiarisation since Q2, the TotalMobile solution has now been signed off by the program board and ready for roll out starting in February with West 1 and West 2, and the other five locality based teams to go live during Q4. KPMG won the tender to assist with the creation of a case for change for the wider Alliance working	Mobile Technology working group in place with an overarching program board. Oversight of the case for change is through a project group of key system leaders that has been meeting weekly.	Progress of community work is reported to Trust Bpard through partnership paper Walsall Together Partnership Board Monthly Provider Board	The ACO work is monitored at the Walsall Together Partnership Board
4.3	Redesign of care pathways to reduce reliance on acute care and support patients at home – commencing with respiratory pathway.			G	A	G		The Continence Service redesign is complete and recruitment has now finished, all staff will be in place and cases aligned by 1st Apr. The Respiratory services redesign is underway with the 90 day consultation due to end in February.	Services are monitored as part of the Care at Home dashboard and reviewed in the place based team project group. There is an internal stroke project group overseen by a project board.	Stroke services proposal was consulted at Board. Update papers on community and partnership have been presented to Trust Board.	For stroke - Clinical Senate Review. Business Case to NHSE - December 2017. The Stroke Project Board has representatives from WHT, RWT and WCCG.
4.4	BCA/STP programme agreed and delivered as planned			G	G	A		A new four way model agreed at Trust Board with the four providers across acute and community.The Black Country Pathology work and proposals for transfer of acute stroke services are progressing. Future planning for STP is being reviewed but is considered to be behind following a recent external review.	Pathology: Shadow management team in place plus various work streams, including communications; people; and individual service areas. Internal governance structure for stroke includes a project board; operational group with sub groups for activity and IT.	Full BC Pathology business case has been to all Trust Boards.	Black Country Pathology Oversight Group. Pathology People Committee; Stroke proposals to be reviewed by the Clinical Senate, and a business case will go from the CCG to NHSE.
4.5	Walsall Together programme of work agreed and delivered as planned.			A	A	A		Place based care is on track with staff from all three partner organisations forming into cooperative teams, the voluntary sector are expected to join in during Q4. The intermediate care services plan is progressing with some delays due to a delayed start. Resilient communities is on track.	Provider Board is working on an alliance agreement with the sponsorship of the Walsall together Partnership Board.	The Partnership Paper has been presented to Trust Board; CaH partnership papers were received at PFIC; Resilient communities proposals were presented to Trust Board.	Walsall Together Partnership Papers.

BAF Ref	BAF Risk Statement	Q1	Q2	Q3	Q4
No.4	Integration of community services fails to deliver the required reduction in acute admissions.	A	A	A	

	Objective 5: Embed continual service improvement as the way we do things linked to our Improvement Plan		Overall RAG Rating	A	G	A			Monitoring Committee - Performance Finance and Investment Committee		
Ref	**OBJECTIVE**	**Executive Owner(s)**	**Expected Completion Date**	**Q1**	**Q2**	**Q3**	**Q4**	**Quarter Update**	**Business Assurances**	**Corporate Oversight**	**Independent Oversight**
5.1	Improvement Programme agreed by start of the plan period including 9 work streams with clear plan for delivery of service change in each	Director of Strategy and Improvement		G	A	A		As part of the Improvement plan, priority has been given to the following 5 areas. Patient Flow led by Medicine. Outpatients & Theatres led by Surgery. Agency staffing being led by Executive leads (DHROD, MD) and Procurement led by DOF.	All updates are part of programme dashboards	Updates presented at PFIC and Board	KPMG have been reviewing the work through the FIP2 commision
5.2	Operational improvement in line with plan	COO		A	A	A		The reorganisaiton of the medical wards was completed in Q3.. Performance showed improvement towards trajectory in Q3.	ED Task Group	Papers and discussions at EAPG. Performance metrics are included in Trust Board pack.	Elective Access Performance Group which includes partners
5.3	Introduce a discharge to assess service in order to reduce patients on clinically stable list still in acute hospital (aim for c. 60 maximum)	COO		G	G	G		The integration with ICS began in November, which was later than planned. The clinically stable list in Q3 stablised at a lower level than 2016.	ICS Steering Group	The Phase Gate Report was presented at PFIC and Trust Board. Performance metrics are included in Trust Board pack.	
5.4	Publish an Improvement Strategy for the Trust outlining a single improvement methodology that is adopted as a common approach	Director of Strategy and Improvement		G	G	G		Completed			
5.5	Invest in IT and new technologies to enable technology supported change to include:	CEO/Director of Strategy and Transformation & Director of Finance	Mar-19								
	Mobile technology	Director of Strategy and Improvement		G	G	G		Mobile tech - All mobile devices have been deployed to the Place Based Teams and the TotalMobile solution has been approved for roll out after successful configuration and user acceptance testing. A strategic review of electronic records is unnderway with the output recommendations planned for March 18. A business case for bed management is now complete and will be considered by Exec in march 18. E pescribing has been completed for Chemo. A wider roll out for the rest of the Trust is being worked through with DXC	Each of the work streams have a working group.	Information Executive Group, with reports to PFIC	Independent review of elctronic records underway.
	Bed management system										
	Electronic records										
	Telemedicine										
	E-prescribing rollout										
5.6	Deliver agreed changes working with partners including:	Medical Director		G	G	G		The Black Country Pathology work is progressing. The business case was present to Trust Boards in February and adopted. Work tream leads are now progressing as planned			
	Black Country Alliance pathology shared service								Updates given at Pathology Project Group.	Draft business case going to Trust Board in November.	Executive representation on Oversight Committee from all four trusts. Part of a national directive.
	Black Country Alliance procurement approach	Direcor of Finance & Performance						Joint appointment made for Procurment lead. Clinical procurment group established and meeting. Behind plan but recoverbale	BCPP Procurement Group.	Reports go to PFIC, and BPP Steering Groups	

BAF Ref	BAF Risk Statement	Q1	Q2	Q2	Q4
No. 13	That the Service Improvement and Cost Improvement Programmes do not deliver the financial impact planned resulting in non-delivery of financial plan.	R	R	R	

	Objective 6: Ensure our hospital estate is future proof and fit for purpose		Overall RAG Rating	A	A	A			Monitoring Committee - Performance Finance and Investment Committee		
Ref	OBJECTIVE	Executive Owner(s)	Expected Completion Date	Q1	Q2	Q3	Q4	Quarter Update	Business Assurances	Corporate Oversight	Independent Oversight
6.1	Delivery of a future estate programme which will see delivery of fit for purpose ITU, Maternity, Neonates & ED and diagnostic capacity.	Director of Finance and Director of Strategy and Transformation.	Mar-19	A	A	A		The ICCU build is 3 weeks behind schedule but completion date of Autumn 2018 should not be affected- The OBC for ED department-has been reviewed by NHSI (9.2.18) Final confirmation iminent to proceed to FBC. Maternity FBC - Build is in delay. Final documents have been submitted to funders for consideration 14.2.18 - contract is being finalised by the legal teams. Plan to start build April 2018. MRI worked commenced 11.1.18 starting a 30 week programme. In addition to the capital build progress outlined above, an estate strategy is being worked on to include a site development plan for Q4/Q1. The Trust is working with the STP footprint on local estates forum and with the joint pathology business case. Community estate is being assessed to include looking at provision of community stroke rehabilitation beds.	Regular project team meetings take place, including design and user group/commissioning meetings. Estates Improvement Programme assesses space utilisation. Space Utilisation meetings have been re launched. Weekly Head of Services update with responsible Executive Director.	Program discussed and PFIC and Trust Board	Working across STP footprint

BAF Ref	BAF Risk Statement	Q1	Q2	Q3	Q4
No. 10	That we cannot deliver our planned programme of hospital estate improvements including ITU, Neonatal Unit, 2nd Maternity Theatre, and plans for a new Emergency Department.	A	A	A	

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	Objective 7: Deliver a sustainability review of all our services to set plans for the next five years.		Overall RAG Rating	A	A	A			Monitoring Committee - Performance Finance and Investment Committee		
Ref	**OBJECTIVE**	**Executive Owner(s)**	**Expected Completion Date**	**Q1**	**Q2**	**Q3**	**Q4**	**Quarter Update**	**Business Assurances**	**Corporate Oversight**	**Independent Oversight**
7.1	Next stage of development of our five-year plan.	Director of Strategy and Improvement.	Mar-19	A	G	G		The stroke review has progressed significantly with the CCG with the case going to trust board in March. Work continues with Diabetes Services, EOL and Walsall Together (Intermediate Care Services). The trust is involved in building a case for change with other partners in the provider board. This is excpected to be reviewed in Q4 by Trust Board	Stroke working groups meet bi weekly to discuss pathways, activity and finance, and IT requirements. A working group has been set up to progress partnership with St Giles on EOL care. The Walsall Provider Board is coordinating the case for change.	The stroke project board discuss updates regularly, and the proposals for stroke services have been reviewed at Board. Exec committee review the sustainability papers. The Five year Strategy is published online, and Strategic Board working Group will be re-established in Q3/Q4.	Proposals reviewed by Clinical Senate. Public Consultations took place between August and September, led by Health Watch Walsall and the CCG.
7.2	Full demand and capacity review of all services linked to service line reporting and market share information			R	A	A		The demand and capacity review is underway. A number of team members will be undertaking formal Demand & Capacity training to further develop the knowledge base for the trust. All specialties will be completed by end of Q4 for outpatient plans. This work is underpinned by using the IMAS tool. The Trust also has 3 staff now undertaking or completing the train the trainer course to embed the tool.	The work is linked to improvement programme for outpatients, and also to the workforce strategy group. It will also feed into the annual planning work group.	Performance dashboard is presented at Trust Board. Together with progress on productivity in these areas covered by PFIC	An overview of demand and capacity is shared with the CCG at AFQIPP meetings.
7.3	Continue our work to undertake a strategic review of each service to assess their potential for sustainability – and decide which services we can continue to operate and those that should be delivered through partnerships in future – Clear view by Q 2 2017/18			G	A	A		Strategic Sustainability review process has commenced to review all services though Q4 & Q1. This will result in a prioirty list being produced for 18/19 plan. Focused work continues for Respiratory and Urology services. Stroke has moved forward significantly. The sustainability reviews provided focus within the TOT's and have identified a number of opportunities, especially with regard to workforce, capacity and partnership opportunities.	Steering groups have been set up for the BC Pathology service with a shadow management team in place. Respiratory and Urology task groups meet regularly to go through action plans. Stroke Project Board is in place and internal governance structure being set up for this project in Q3. Trust wide sustainability reviews have commenced and will be reviewed in a Clinical exec Workshop during February 18	Stroke Project Board updates are included in Partnership Paper presented to Trust Board. Sustainability reviews will be presented to PFIC when first pahse is completed.	Clinical Senate reviewing Stroke proposals, which are part of national directive. BC Pathology is also part of national directive. Both services have project boards/oversight committees made up of representatives of the partners. Papers are presented to these Boards/committees.

BAF Ref	BAF Risk Statement	Q1	Q2	Q3	Q4
No. 5	That our emergency care pathway does not improve resulting in continue delays for patients and poor flow through the hospital.	A	A	A	
No. 14	New entrants into the market will succeed in attracting services resulting in income loss to the Trust.	A	A	A	

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date:** 8th March 2018
Report Title	People and Organisational Development Committee Highlight Report			**Agenda Item: 16** **Enclosure No.: 14**
Lead Director to Present Report	Non-executive Director and Committee Member, Mr Philip Gayle			
Report Author(s)	Trust Secretary, Linda Storey			
Executive Summary	The report provides a highlight of the key issues discussed at the most recent People and Organisational Development Committee Meeting held on the 19th February 2018 together with the confirmed minutes of the meeting held on the 18th December 2018.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Board is recommended to DISCUSS the content of the report and raise any questions in relation to the assurance provided.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed an engaged, empowered and clinically led organisational culture</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Not Relevant</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Not Relevant</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Embed an engaged, empowered and clinically led organisational culture</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr><tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☒</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">BAF Risks:
No. 7 ‘That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff’.

No. 8 ‘That we are not successful in our work to establish a clinically-led, engaged and empowered culture.

11 ‘That our governance remains “inadequate” as assessed under the CQC Well Led standard’.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">There are no resource implications raised within the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Compliance with Trust Standing Orders.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The Committee reports to the next Trust Board following its meeting at which the Board receives the approved minutes from the previous meeting and a highlight report on the key issues raised at the most recent meeting.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The minutes from the meeting held on the 19th February will be submitted to the Trust Board in May 2018.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HIGHLIGHT REPORT

The meeting was quorate and Chaired by Mr Philip Gayle, Non-executive Director and Chair of the Committee.

Key issues discussed were:

1. Meeting Format and Timetable

The Committee discussed its current meeting format and timetable and agreed that it should move to a bi-monthly formal meeting schedule with a planning meeting held in the intervening month to which members would attend. A review of the membership and terms of reference would also be undertaken.

2. Health and Safety Quarterly Report

The Quarter 3 Health and Safety Report was received.

There had been a total of 102 reported workplace accidents and near misses from 1st October – 31th December 2017.

The top three reported incident types were:

1. Sharps and Needle Sticks.
2. Slips, Trip and Falls.
3. Cuts and Abrasions.

Q3 saw an increase in sharps and needle stick incidents, with 35 incidents recorded. Sharps and needle stick incidents remain the most frequently reported incident type within the Trust. The Committee requested that further information be provided on the issue in order to gain assurance on training and the reporting of the incidents.

3. Violence and Aggression Toward Staff

The Committee received an update on the refresh of the zero tolerance campaign in relation to violence and aggression toward staff. The Communications Team would be working on the re-launch of the Respect Us Anti-Violence and Aggression campaign that ran successfully in 2015. The aim was to raise awareness amongst visitors to the hospital that violence and aggression towards our colleagues was not acceptable; to reassure colleagues that such incidents were taken seriously by the Trust; and to encourage staff that they should feel confident to report an incident as well as in the support that is available to them.

4. Flu Update

The Committee was noted that the latest percentage for flu vaccination uptake stood at 61-62%.

5. Consultant Vacancy Report

The Committee received a new report outlining the status of consultant vacancies in the Trust together with the progress to fill the gaps.

The Committee is recommended to receive the report for DISCUSSION.

Walsall Healthcare NHS
NHS Trust

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WALSALL HEALTHCARE NHS TRUST
MINUTES OF PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE
HELD ON MONDAY 18 DECEMBER 2017 AT 10.00
IN SEMINAR ROOM ROUTE 121

Present:	Mr J Silverwood	Non-Executive Director ***(Chair)***
	Mrs M Belle	Workforce Lead
	Mrs K Blackwell	Deputy Director of Nursing
	Miss M Dytor	Head of Human Resources Operations
	Mr D Fradgley	Director of Strategy and Transformation
	Mr P Gayle	Non-Executive Director
	Mrs L Ludgrove	Interim Director of Organisational Development and Human Resources
	Mrs L Storey	Trust Secretary
Apologies:	Mrs B Beal	Director of Nursing
	Mrs D Carrington	Associate Non-Executive Director
	Mrs V Harris	Non-Executive Director
	Mr R Kirby	Chief Executive Officer
	Mrs J Poole	Head of Health and Safety
In attendance:	Mrs C Gilbert	Divisional Director of Nursing, Surgery
	Mr N Turner	Divisional Director, Surgery

92/17 WELCOME AND APOLOGIES

The Committee Chair welcomed members to the meeting and apologies were noted.

93/17 MATTERS ARISING

No items were noted under matters arising from the Committee.

94/17 MINUTES OF THE LAST MEETING

Resolution

Minutes of the previous meeting held on Monday 20th November 2017 were received and approved as an accurate record.

95/17 ACTION LOG

Resolution

Members reviewed the live action log and updates were noted.

96/17 DIVISIONAL UPDATE – SURGERY

The Divisional Director of Surgery and Divisional Director of Nursing presented a summary of the presentation circulated to members ahead of the meeting.

Members were asked for any questions or comments following the presentation summary. The Committee Chair commented that sickness levels and the number of vacancies for the Division were a concern going into winter. Mr Gayle queried if Managers were allowing flexibility with current employees shifts, offering different

shifts to encourage employee retention. The Divisional Director confirmed that where possible flexibility was discussed.

Mr Gayle asked about specific issues in Theatre's., It was explained that there had been some harassment and bullying cases with a small group of employee's which were being addressed.

The Divisional Director commented that the Division was receiving external support from John Mason which was planned to continue. It was added that the Division anticipated improvements in its performance as a result of that work.

Resolution
The Committee received and noted the content of the presentation.

97/17 HEALTH AND SAFETY QUALITY AND SAFETY REPORT/LSMS REPORT

The report was taken as read and members were asked for any questions or comments.

The Director of Strategy and Transformation highlighted concerns that there appeared to be a trend of falls within the Trust, due to the weather conditions. The Director of Strategy and Transformation added that he was also concerned that there was a high level of verbal abuse on surgical wards, higher than ED where understandably patients and families were already distressed. The Division were advised to review the data and investigate the reasons for the surgical wards having a higher level of verbal abuse. The Committee Chair acknowledged that violence and aggression was a concerning factor within the report, especially employee to employee behaviour.

The Trust Secretary noted that Health and Safety Committee had not met regularly since the summer which was a concern. The next meeting was scheduled for the following week.The Trust Secretary advised that the meeting sequence would be reviewed to re-establish a regular schedule.

The Director of Strategy and Transformation advised that a formal action point had been raised at the Trust Executive meeting, with regards to another fall on the escalators in the Atrium. Members were informed that the individual attended ED with a head injury where it was confirmed there was no long term injuries from the fall and the patient was discharged home. Members were advised that the incident was being reviewed to determine if it was reportable under RIDDOR.

Members were informed that Jill Poole, Head of Health and Safety, was leaving the Trust in December and interviews for her role would be taking place in January 2018.

Resolution
The Committee received and noted the content of the report.

98/17 FLU UPDATE

The Committee was advised that the latest percentage for flu vaccination uptake stood at 55%. The meeting was advised that the divisional teams were receiving

regular communications outlining their compliance and monthly targets. The measures to encourage uptake had been increased to include prizes and additional leave days together with promotion of the Unicef Campaign. A key issue remained the number of peer vaccinators and the Deputy Director of Nursing was working with the teams to increase the numbers. The Committee was reminded that the national target was 70% compliance by the end of February 2018.

Resolution
The Committee noted the updates provided and the importance of achieving 70% by the end of February 2018.

99/17 RECRUITMENT, FINAL AUDIT REPORT

In accordance with the Trust's governance framework the Committee received the finalised internal audit report on recruitment. The audit had been commissioned as part of the Trust's internal audit plan for 2017/18. The audit comprised of an evaluation of the recruitment, selection and vetting procedures to provide assurance as to whether procedures were followed in all instances and that only individuals with the appropriate skills, qualifications and experience were appointed. The outcome of the audit was one of substantial compliance.

The Committee noted that there was one high level recommendation to review the prescribed content of Job Descriptions to ensure the core requirements could be met; to then ensure the guidance was followed for Job Descriptions issued to applicants, especially the inclusion of the appropriate wording for Health and Safety, and the Duty of Candour.

Mr Gayle raised concerns that some processes were not followed, and queried how that was being addressed. The Interim Director of Organisational Development and Human Resources assured members that the concerns had been addressed.

Resolution
The Committee received and noted the content of the report.

100/17 REFLECTIONS ON OD/HR ACTION PLAN

The Committee received the report on the reflections of the Interim Director of Organisational Development and Human Resources. Members were asked for any questions or comments.

Mr Gayle commented that there was good narrative within the action plan, and noted that the Equality Diversity and Inclusion Committee (EDIC) needed to was falling behind with its workplan. The Interim Director of OD and HR acknowledged the concern raised and recognised that the delay needed to be addressed.

The Director of Strategy and Transformation requested further clarity in relation to Point 3 of the report relating tostrategic leadershipThe Interim Director of OD and HR explained that the next steps were under discussion to evaluate work with the Kings Fund.

The Deputy Director of Nursing queried if the 360 degree assessment was for Divisional Directors only. The Interim Director of OD and HR advised that it was being initiated with the Divisional Directors and would be implemented across the Trust starting with the Executive team after Divisional Directors.

Resolution

The Committee received and noted the report and requested that its be included in the report submitted to Trust Board.

101/17 ENGAGEMENT IMPLEMENTATION FOLLOWING BOARD

The Engagement Lead informed members that following full agreement from the Trust Board implementation of the action plan was scheduled to take place in the New Year. The Committee was advised about an employee being frequently contacted regarding staff concerns who was not a Freedom to Speak up Guardian. It was explained that the employee raised a concern as they had only recently come into post. The Interim Director of OD and HR recognised the concerns raised and advised that there were a multitude of employees assigned to support colleagues to be redirected to. The Interim Director of OD and HR added that the Trust were looking to continue with the Freedom to Speak Up Guardians for a second year, although some issues had emerged and were being addressed. The Trust Secretary commented that the Trust was unique with having 3 Freedom to Speak Up Guardians, as most Trust only had 1.

Resolution

The Committee noted the verbal update and the positive work being undertaken which included the implementation of Engagement Teams and the work of the Freedom to Speak Up Guardians.

102/17 WORKFORCE KPIs

The Head of HR Operations presented the report circulated ahead of the meeting. It was explained that sickness, reported at 5.55% had been analysed to identify trends for sickness. Members were advised that key reasons for sickness were; coughs, colds, gastro and anxiety. It was added that the biggest increase in sickness was due to long term conditions such as Cancer. The Head of HR Operations advised that the Trust had lost 109 days of Care Support Worker time due to sickness.

A discussion was held about the correlation between sickness absence and working on bank following the increase in bank pay rates at the end of the summer. It was explained that analysis had been undertaken to ascertain whether there was increased sickness as a result of staff working additional hours on the bank. Further analysis was required but early indication showed some correlation. It was noted that further work would be required to identify whether policy could be implemented to address the issues. **MD**

The Head of HR Operations advised that mandatory training compliance was 79% and that e-learning issue had been resolved. Members were advised that auto enrolment for Safeguarding was successful, however Prevent was unfortunately not as successful and therefore was being reviewed. It was added that Clinical

update was also being reviewed to reduce to half a day.

Appraisals continued to be monitored and regular reports were being circulated to Divisions to ensure completion of appraisals. It was added that training would also be available in the new year. The Committee Chair commented that it was important to improve the appraisal compliance for April, as discussed in previous meetings.

The Committee Chair added that he was concerned with the sickness levels, as they were anticipated to increase during winter. The Director of Strategy and Transformation advised that he felt the Trust was improving with the monitoring of sickness, as Managers receive regular communications and support from HR and the sickness policy had been reviewed and updated. It was added however that the implementation of the policies and guidance was not as successful, although the guidance and support was available. The Head of HR Operations added that meetings were held every Monday with Divisional teams to review their report, along with weekly messages cascaded to Divisional teams. The Director of Strategy and Transformation advised that all Managers were responsible for adhering to policies, which required monitoring. Mr Gayle advised that teams also needed to be mindful of alternative support for employees, such as Occupational Health which was often seen as a Management tool.

Resolution
The Committee received and noted the content of the report.

103/17 ANY OTHER BUSINESS

Stepping up programme
Mr Gayle highlighted that the Trust Chair had raised concerns regarding the deficit model. Members were advised that Mr Gayle had provided reassurance to the Trust Chair, who was to agree how to lead the programme moving forward.

Equality Diversity Inclusion Committee
MrGayle advised that he wanted to discuss in EDIC that Managers were required to evidence why they were sending employees on courses and hold the employee to account for their attendance.

104/17 NEXT MEETING
Monday 15 January 2017, 15:00 in MLCC Room 10

BOARD/COMMITTEE REPORT

Meeting	Trust Board	**Date:** 8th March 2018
Report Title	Month 10 Finance Report	**Agenda Item: 17** **Enclosure No.: 14**
Lead Director to Present Report	Mr R Caldicott, Director of Finance	
Report Author(s)	Mr T Kettle, Deputy Director of Finance Mr P Steventon, Head of Financial Management	
Executive Summary	1. The Trust has achieved a £20.4m deficit to date with a targeted delivery of a £20.5m deficit for the year. There remains significant risk to delivery of the planned outturn. 2. The Trust £20.4m deficit compares to the plan of a deficit totalling £16.8m at month 10, giving an unfavourable variance of £3.6m for the period ended 31st January 2018. 3. The 2017/18 contract agreement for acute services with Walsall CCG is on a cost & volume basis for elective care with the Trust paid for emergency activity that exceeds 1% of contract. The contract agreed for community services remains a 'block' arrangement. 4. The Trust is below plan on clinical income, largely as a consequence of reduced obstetric activity (births) and out-patients / elective activity below also being below planned levels. 5. Fines are capped at £1.0m and the CCG is committed to reinvesting £1.5m of Emergency Threshold deductions and CQUIN underperformance, subject to agreement of areas of investment. 6. The Divisional financial performance was: - • Clinical Divisions expenditure overall is £5.5m adverse to plan mainly due to temporary staffing costs and CIP underperformance. • CIP delivery YTD is £7.2m. The annual target is £11m. • Temporary staffing expenditure in January 2017 remains in month at £1.9m 7. The Trust's full year targeted savings for 2017/18 are £11m. As at month 10 the Trust has delivered £7.2m against a phased plan of £9.1m. 8. The Trust must maintain a minimum £1.0m cash balance while in receipt of Loan funding to support the deficit position. The Trust's cash balance at the end of January 18 is £1.1m. The Trust has access to additional borrowing to support the £20.5m deficit plan.	

<table>
<tr><td><u>Purpose</u></td><td>Approval
☐</td><td>Decision
☐</td><td>Discussion
☐</td><td>Note for Information
☒</td></tr>
<tr><td><u>Recommendation</u></td><td colspan="4">Trust Board is recommended to: NOTE THE REPORT AND ASSOCIATED RISKS</td></tr>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td colspan="2">Provide Safe High Quality Care Across all of Our Services</td><td colspan="2">Not Relevant</td></tr>
<tr><td colspan="2">Care for Patients at Home Whenever we can</td><td colspan="2">Not Relevant</td></tr>
<tr><td colspan="2">Work Closely with Partners in Walsall and Surrounding Areas</td><td colspan="2">Not Relevant</td></tr>
<tr><td colspan="2">Value our Colleagues so they recommend us as a place to work</td><td colspan="2">Not Relevant</td></tr>
<tr><td colspan="2">Use resources well to ensure we are Sustainable</td><td colspan="2">Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="4">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☐</td><td><u>Effective</u></td><td>☒</td></tr><tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☐</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="4"></td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="4">The financial risks are identified in the key messages section of the report, the clinical income below plan, delivery of CIP, maintaining a reduction in temporary worker expenditure, borrowing to support operational services and the delivery of targeted financial and performance recovery plans are the key risks for the Trust to financial year end.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="4">The Trust needs to demonstrate financial viability</td></tr>
<tr><td><u>Report History</u></td><td colspan="4"></td></tr>
<tr><td><u>Next Steps</u></td><td colspan="4"></td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="4">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
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Walsall Healthcare NHS
NHS Trust

2017/18 Finance Report
January 2018 (Month 10)

Becoming your partners for first class integrated care

2017/18 Finance Report: April 2017 to January 2018 (Month 10)	Page
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Key Messages

Financial Month 10 plan.	• The financial position for the Trust at M10 is a deficit of £20,395k against the planned deficit of £16,773k, resulting in an unfavorable variance of £3,622k (£3,991k December) • The clinical income position is down against plan (obstetrics and outpatients below plan) and Clinical divisions are currently overspending on nursing and medical establishments, resulting in the increased deficit to plan • CIP delivery is behind plan (£7.2m delivered to date against a target of £9.1m) and 28.3% of the delivered CIP achieved non-recurrently. The utilisation of non-recurrent savings for CIP delivery places greater emphasis on areas to remain within budgets, as underspends are not available to off-set areas exceeding budgeted allocations • Temporary workforce remains high at £1.9m (Nursing £1.02m of this cost).
Financial Risks	• Ability to deliver financial recovery against increasing spending on temporary workforce and income risk • CIP delivery in the first half of the year has a high proportion of non recurrent savings (targeted recurrent) • Delivery of CQUIN targets and contractual activity to deliver clinical income
CIP	• The Trust's Cost Improvement Target for the year is £11m recurrent spend reduction with savings of £7.2m delivered YTD of which £2m is achieved non-recurrently.
Bank, Agency and Locum spend	• Temporary staffing costs reduced in January 2018 by £75k to £1.86m (£1.94m in December 17). • Agency costs increased by £104k to £0.79m in January 18 (£0.69m in December 17). • Bank Staffing costs reduced by £34k to £0.57m in January 18 (£0.61m in December 17). • Locum staffing costs reduced by £145k in January 18 to £0.5m (£0.64m in December 17).

Summary Financial Performance to January 2018 (Month 10)

Financial Performance - Period ended 31st January 2018

Description	Annual Budget	Budget to Date	Actual to Date		Variance
	£'000	£'000	£'000		£'000
Income					
NHS Activity Revenue	226,568	189,397	186,910		(2,487)
Non NHS Clinical Revenue (RTA Etc)	981	853	989		136
Education and Training Income	8,981	7,167	7,183		16
Other Operating Income (Incl Non Rec)	8,513	7,331	10,306		2,975
Total Income	**245,042**	**204,748**	**205,388**		**640**
Expenditure					
Employee Benefits Expense	(172,316)	(142,393)	(145,266)		(2,874)
Drug Expense	(16,895)	(16,000)	(16,285)		(285)
Clinical Supplies	(18,472)	(15,198)	(15,628)		(429)
Non Clinical Supplies	(15,749)	(13,026)	(13,332)		(305)
PFI Operating Expenses	(5,019)	(4,177)	(4,153)		24
Other Operating Expense	(21,717)	(17,774)	(17,897)		(123)
Sub - Total Operating Expenses	**(250,167)**	**(208,568)**	**(212,560)**		**(3,991)**
Earnings before Interest & Depreciation	**(5,126)**	**(3,820)**	**(7,172)**		**(3,352)**
Interest expense on Working Capital	51	43	17		(26)
Interest Expense on Loans and leases	(8,536)	(7,254)	(7,508)		(254)
Depreciation and Amortisation	(6,890)	(5,742)	(5,732)		10
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(15,374)**	**(12,954)**	**(13,223)**		**(270)**
Total Expenses	**(265,542)**	**(221,522)**	**(225,783)**		**(4,261)**
RETAINED SURPLUS/(DEFICIT)	**(20,500)**	**(16,773)**	**(20,395)**		**(3,622)**
Impairments	0	0	0		0
ADJUSTED SURPLUS/(DEFICIT)	**(20,500)**	**(16,773)**	**(20,395)**		**(3,622)**

Division	YTD Budget £000's	YTD Actual £000's	Variance £000's	*Narrative*
MLTC	48,316	51,024	(2,708)	*MLTC is £2.7m overspent year to date as a result of nursing staffing cost overruns (Wards, capacity and specialist areas – £1.7m) and Medical agency cover for ED and Gastro.(£1.2m).*
Surgery	44,885	46,781	(1,896)	*Surgery is £1.9m overspent due to overspends mainly within Nursing £0.5m (Gen Surgery) and medics £0.5m (Anaesthetics) and Critical Care/Theatres (£0.4m).*
WC & CSS	56,438	57,361	(923)	*WCCSS is overspent by £0.9m driven by medical staffing overspends (£0.4m) mainly Paediatrics and non delivery of CIP*
Estates & Facilities	12,664	13,101	(437)	*Off plan due to non delivery of CIP.*

Financial Performance

- The total financial position for the Trust at M10 is a deficit of £20,395k, which is only £105k short of the annual plan of £20.5m. The YTD deficit plan is £16,773k, which results in an unfavourable YTD variance of £3,622k (£3,991k in M09 – December)
- The contracted income position is down against plan (£2,487k), the underperformance largely a consequence of reduced Obstetric activity, outpatients and elective utilisation. Other income is over-performing largely as a consequence of FULL winter STP (£250k & NHSI (£1.6m) funding and other one off income allocations such as Diabetes (£800k).
- The main area of overspending is pay (£2,874k) and is largely as a consequence of nursing expenditure on wards, temporary workforce in month expenditure on Nursing £1.02m (the highest over the previous calendar year). There are also overspends within medical budgets.

CIP 2017/18 Delivery

- The Trust's Annual Cost Improvement Programme requirement is £11m.
- The CIP plan for M10 is £9,047k (82% of the target) and actual delivery is £7,213k, which is an under achievement of the savings target of £1,834k. In addition, of this total £2,040k was delivered non-recurrently, placing increased pressure on future financial sustainability.

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding is £1.07m.
- The Trust's agreed borrowing for 2017/18 is £20.5m, reflecting the deficit plan.
- The Trust has utilised earlier borrowing to ensure continued payment for goods and services because of overspending against plan. The interest payable on the increased loan will add to future savings requirements.

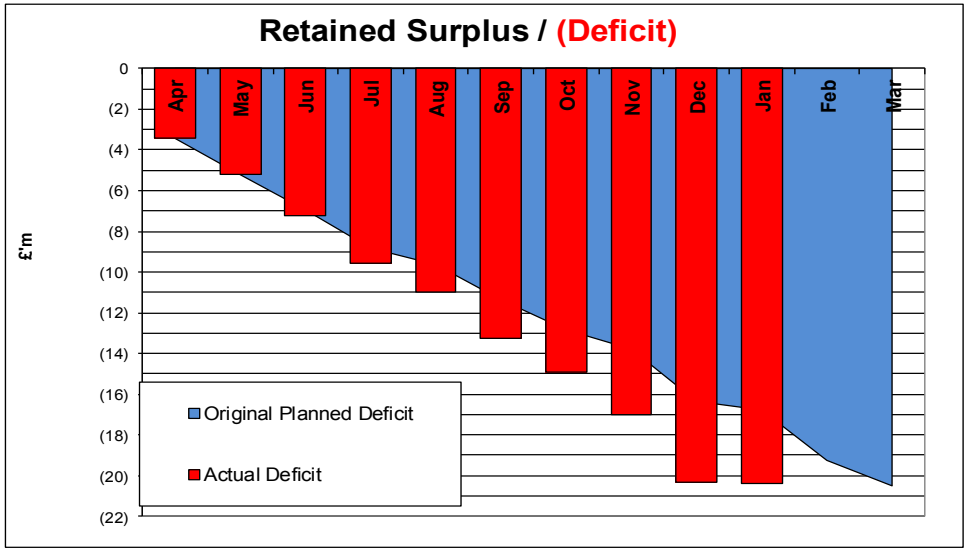
Capital

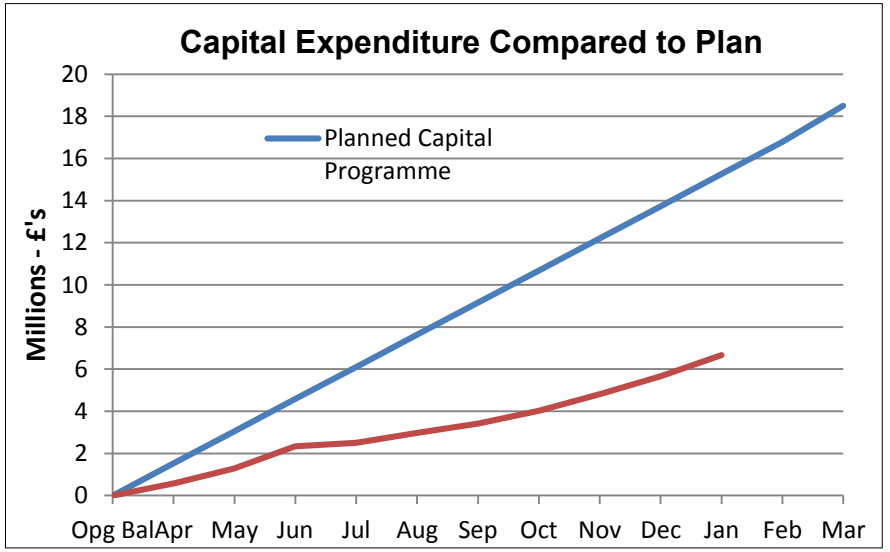
- The year to date capital expenditure is £6.3m, with the main spends relating to ICCU (£3.9m), Medical Equipment (£0.6m) and Community Mobile technology (£0.6m).

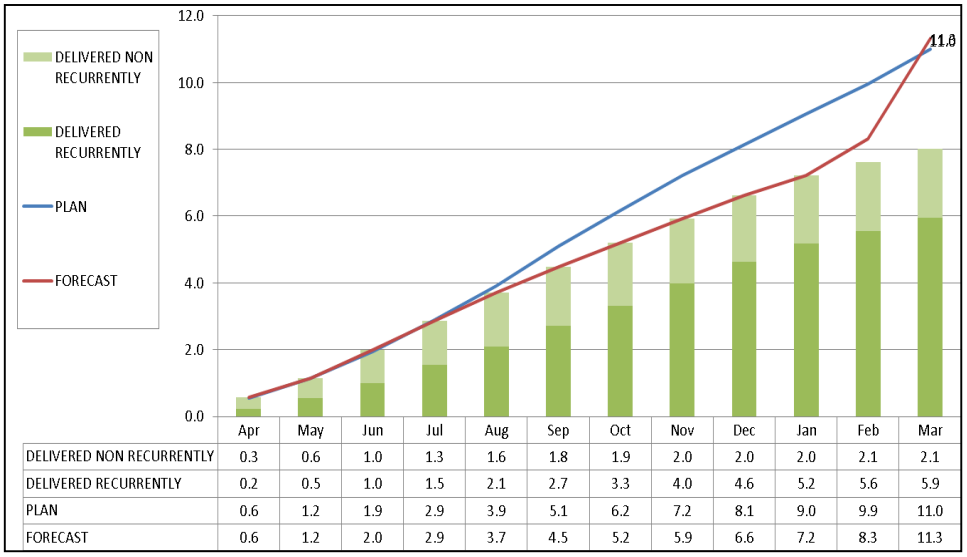
Temporary Workforce

- £1.861m January 2018 (£1.935m December 2017) a £74k reduction in month and £494k increase over Aprils expenditure (£1.367m).

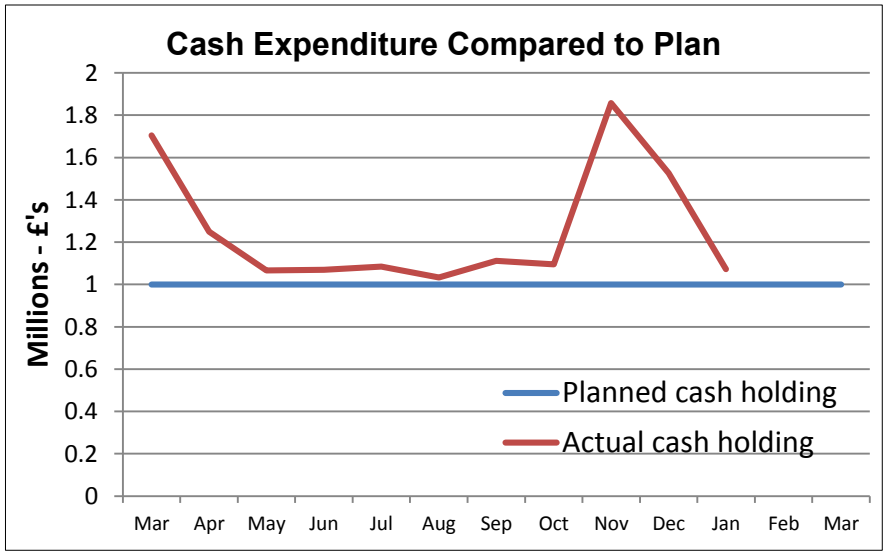
Overall Summary and RAG Assessment continued







	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.3	0.6	1.0	1.3	1.6	1.8	1.9	2.0	2.0	2.0	2.1	2.1
DELIVERED RECURRENTLY	0.2	0.5	1.0	1.5	2.1	2.7	3.3	4.0	4.6	5.2	5.6	5.9
PLAN	0.6	1.2	1.9	2.9	3.9	5.1	6.2	7.2	8.1	9.0	9.9	11.0
FORECAST	0.6	1.2	2.0	2.9	3.7	4.5	5.2	5.9	6.6	7.2	8.3	11.3



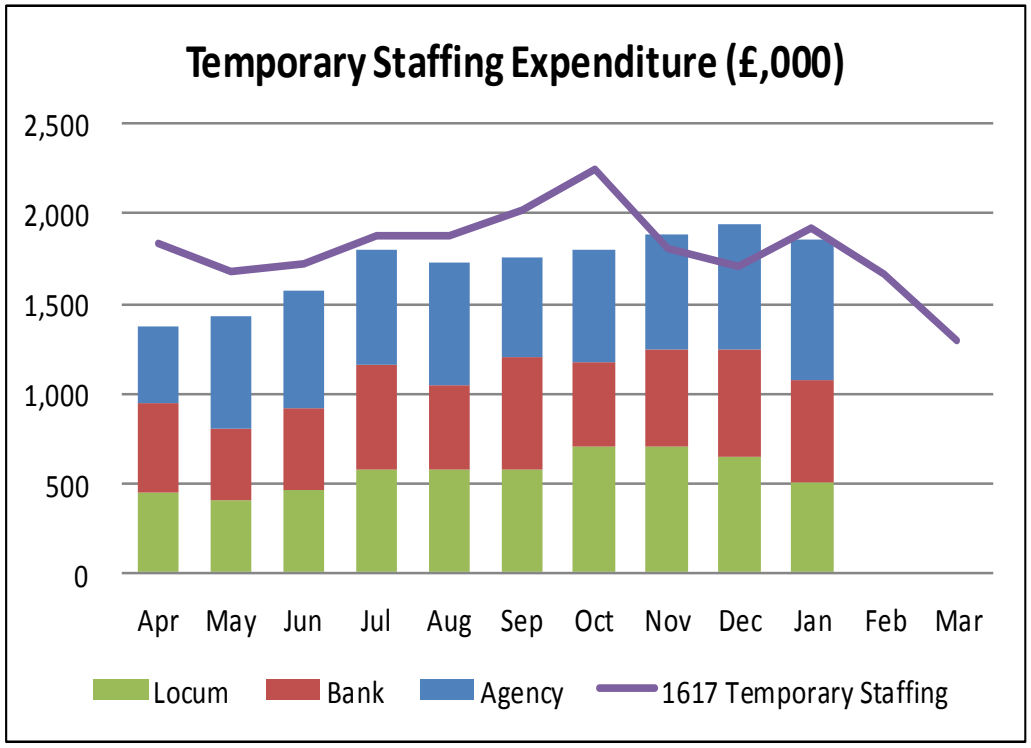
Divisional Income & Expenditure positions: April 2017 to January 2018 (Month 10)

DIVISIONAL POSITIONS	Healthcare Income				Expenditure Less Other Income				Net Divisional Position			
	Annual	Year to Date		Variance	Annual	Year to Date		Variance	Annual	Year to Date		Variance
	Budget	Budget	Actual	Over (-) / Under	Budget	Budget	Actual	Over (-) / Under	Budget	Budget	Actual	Over (-) / Under
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Divisions												
Medical & Long Term Conditions	79,961	65,696	68,184	2,488	(56,856)	(48,316)	(51,024)	(2,708)	23,105	17,380	17,160	(220)
Surgical	53,953	44,891	43,740	(1,151)	(52,718)	(44,885)	(46,781)	(1,896)	1,235	6	(3,041)	(3,047)
Women, Childrens & Diagnostics	67,426	56,127	51,651	(4,475)	(67,176)	(56,438)	(57,361)	(923)	250	(311)	(5,710)	(5,399)
Total Clinical Divisions	**201,341**	**166,713**	**163,575**	**(3,138)**	**(176,750)**	**(149,639)**	**(155,166)**	**(5,527)**	**24,590**	**17,074**	**8,409**	**(8,665)**
Estates & Facilities				0	(15,316)	(12,664)	(13,101)	(437)	(15,316)	(12,664)	(13,101)	(437)
Total Operational Services	**201,341**	**166,713**	**163,575**	**(3,138)**	**(192,067)**	**(162,303)**	**(168,267)**	**(5,964)**	**9,274**	**4,410**	**(4,691)**	**(9,102)**
Corporate Services												
Management Executive					(1,776)	(1,504)	(1,534)	(30)	(1,776)	(1,504)	(1,534)	(30)
Nurse Director					(5,661)	(4,681)	(4,499)	182	(5,661)	(4,681)	(4,499)	182
Chief Operating Officer					(263)	(233)	(229)	5	(263)	(233)	(229)	5
Medical					(1,380)	(1,220)	(1,299)	(79)	(1,380)	(1,220)	(1,299)	(79)
Finance					(1,559)	(1,286)	(771)	515	(1,559)	(1,286)	(771)	515
Informatics					(4,502)	(3,678)	(3,145)	533	(4,502)	(3,678)	(3,145)	533
Strategy & Partnership					(919)	(709)	(646)	63	(919)	(709)	(646)	63
Corporate Affairs					(520)	(454)	(502)	(48)	(520)	(454)	(502)	(48)
Human Resources					200	73	1	(72)	200	73	1	(72)
Medical Negligence / Emp Liability					(13,152)	(10,960)	(10,973)	(12)	(13,152)	(10,960)	(10,973)	(12)
PFI Charges					(4,889)	(4,074)	(4,120)	(46)	(4,889)	(4,074)	(4,120)	(46)
Total Corporate Services	**0**	**0**	**0**	**0**	**(34,422)**	**(28,726)**	**(27,716)**	**1,010**	**(34,422)**	**(28,726)**	**(27,716)**	**1,010**
TOTAL ALLOCATED BUDGETS	**201,341**	**166,713**	**163,575**	**(3,138)**	**(226,488)**	**(191,029)**	**(195,983)**	**(4,954)**	**(25,148)**	**(24,316)**	**(32,407)**	**(8,092)**
Profit/Loss on Disposal of Assets					0	0	0	0	0	0	0	0
Depreciation - Owned & Donated Assets					(6,790)	(5,658)	(5,484)	175	(6,790)	(5,658)	(5,484)	175
Depreciation - Impairments					**0**	0	0	0	**0**	0	0	0
Total Depreciation					**(6,790)**	**(5,658)**	**(5,484)**	**175**	**(6,790)**	**(5,658)**	**(5,484)**	**175**
Unitary Payment Interest					(7,687)	(6,406)	(6,479)	(74)	(7,687)	(6,406)	(6,479)	(74)
Interest Receivable					(798)	(806)	(1,009)	(202)	(798)	(806)	(1,009)	(202)
Reserves & Provisions					(5,139)	(2,273)	0	2,273	(5,139)	(2,273)	0	2,273
Health Care Income: Block Contracts	25,227	22,684	23,335	651	(166)	1	1,649	1,648	25,061	22,685	24,984	2,299
Total Reserves & Block Income	**25,227**	**22,684**	**23,335**	**651**	**(5,305)**	**(2,271)**	**1,649**	**3,920**	**19,922**	**20,413**	**24,984**	**4,571**
RETAINED SURPLUS/(DEFICIT)	**226,568**	**189,397**	**186,910**	**(2,487)**	**(247,067)**	**(206,171)**	**(207,305)**	**(1,135)**	**(20,500)**	**(16,773)**	**(20,395)**	**(3,622)**

Commentary

- The Trusts deficit is £20.3m year to date.
- MLTC is £2.7m overspent year to date as a result of nursing staffing cost overruns (Wards, capacity and specialist areas – £1.7m) and Medical agency cover for ED and Gastro.(£1.2m).
- Surgery is £1.9m overspent due to overspends mainly within Nursing £0.5m (Gen Surgery) and medics £0.5m (Anaesthetics) and Critical Care/Theatres (£0.4m).
- WCCSS is overspent by £0.9m driven by medical staffing overspends (£0.4m) mainly Paediatrics and non delivery of CIP (£0.9m).
- Corporate divisions overall are underspent by £1m. The underspend mainly coming from Informatics as a result of staff vacancies.
- Central Reserves shows a favourable variance. It should be noted that in arriving at the YTD position, £1.4m of RTT reserves is utilised leaving a balance of £0.2m remaining.
- The overall income position is down against plan, the underperformance largely a consequence of reduced Obstetric and outpatients activity.

Temporary Staffing Expenditure: April 2017 to January 2017 (Month 10)

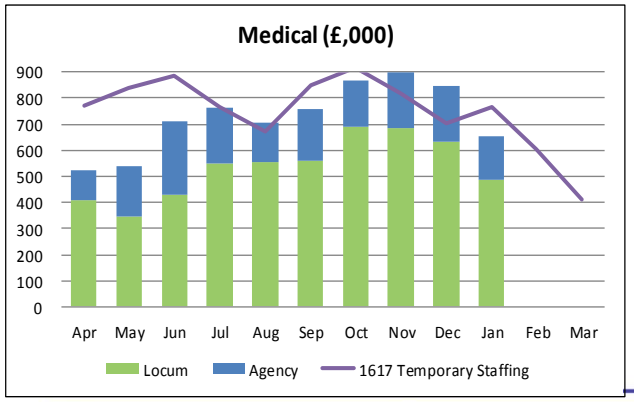


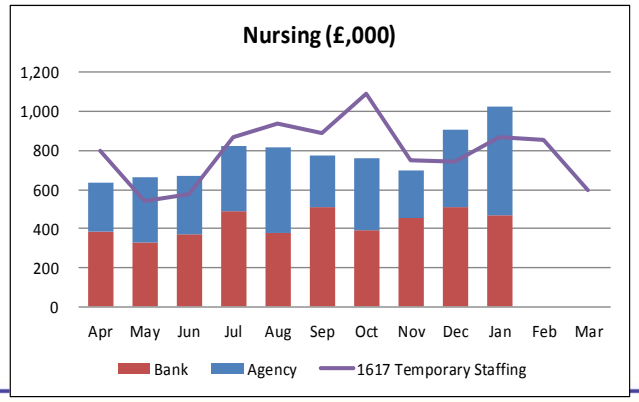
Commentary

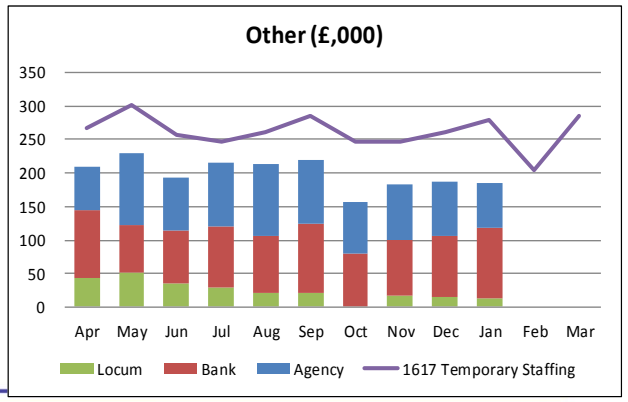
- Temporary staff costs totalled £1.861m in January 2018 (£1.916m January 2017), of which agency is £0.791m.
- The Nursing expenditure (as evidenced within the below chart) increased significantly over December and January for capacity and a change in risk profile.
- NHS Improvement target for the Trust is to spend no more than £7.0m on agency in 2017/18. The Trust revised plan for agency spend totals £8.2m, current trajectory would indicate a spending of circa £8.7m
- The Table below shows an annual forecast (in total on par with 2016/17)

Description	2017/18		*2016/17*
	Jan YTD £000's	Annual £000's	*Annual £000's*
Temporary worker	17,128	21,621	*21,649*
Agency	6,335	8,670	*10,932*

- In 2017/18, NHSI has set the Trust a target to reduce Medical agency spend by £1.2m against the 2016/17 outturn of £4.85m (this does not affect our agency spend ceiling of £7.0m)







Becoming your partners for first class integrated care

Safe, high quality care | Care at home | Partners | Value colleagues | Resources

Temporary Staffing Expenditure: April 2017 to January 2017 (Month 10)

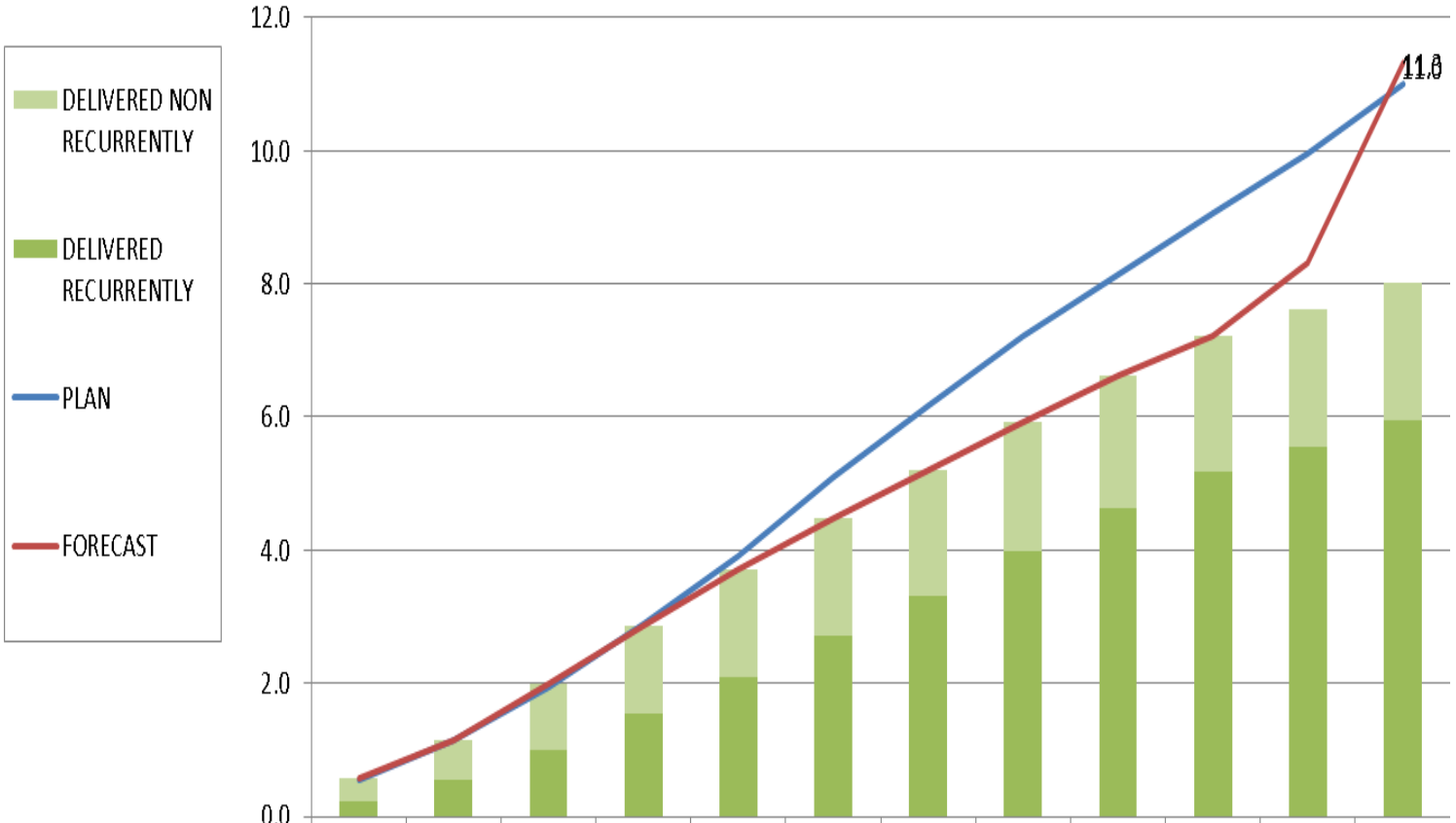
Agency	16/17				17/18										
	Jan	Feb	Mar	Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	272	269	156	4,852	114	189	280	213	153	194	174	317	215	169	2,017
PTB	36	13	21	345	6	18	21	19	23	11	15	-6	1	14	122
Nursing & Midwifery	442	420	220	4,284	247	330	301	332	432	264	367	244	392	555	3,465
Other Staff Groups	133	83	152	1,452	59	87	59	77	84	83	62	89	78	53	731
Agency Total This Year	**883**	**784**	**548**	**10,932**	**426**	**625**	**660**	**641**	**692**	**553**	**618**	**644**	**686**	**791**	**6,335**
Monthly Movement	63	(98)	(236)		(123)	199	35	(19)	51	(139)	65	26	42	105	

Bank	16/17				17/18										
	Jan	Feb	Mar	Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PTB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nursing & Midwifery	428	435	377	5,230	386	330	370	489	382	511	393	454	512	467	4,294
Other Staff Groups	73	71	80	970	101	72	79	91	85	104	79	83	93	105	892
Bank Total This Year	**501**	**506**	**458**	**6,200**	**487**	**402**	**449**	**580**	**466**	**616**	**473**	**537**	**605**	**571**	**5,186**
Monthly Movement	(61)	5	(48)		29	(85)	46	131	(114)	149	(143)	64	68	(34)	

Locum	16/17				17/18										
	Jan	Feb	Mar	Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	493	334	252	4,138	411	348	430	551	553	561	691	683	630	486	5,344
PTB	39	38	31	376	43	51	35	30	22	21	16	17	14	13	261
Nursing & Midwifery	0	0	0	0	0	0	0	0	0	0	0		0		0
Other Staff Groups	-0	0	1	3	0	0	0	0	0	0	0		0		1
Locum Total This Year	**532**	**372**	**285**	**4,517**	**454**	**399**	**465**	**581**	**575**	**582**	**707**	**700**	**644**	**499**	**5,607**
Monthly Movement	204	(159)	(88)		169	(55)	66	116	(6)	7	125	(7)	(56)	(145)	

Grand Total	1,916	1,663	1,291	21,649	1,367	1,426	1,574	1,802	1,733	1,750	1,798	1,881	1,935	1,861	17,128

Cost Improvement Target Achievement: April 2017 to January 2018 (Month 10)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.3	0.6	1.0	1.3	1.6	1.8	1.9	2.0	2.0	2.0	2.1	2.1
DELIVERED RECURRENTLY	0.2	0.5	1.0	1.5	2.1	2.7	3.3	4.0	4.6	5.2	5.6	5.9
PLAN	0.6	1.2	1.9	2.9	3.9	5.1	6.2	7.2	8.1	9.0	9.9	11.0
FORECAST	0.6	1.2	2.0	2.9	3.7	4.5	5.2	5.9	6.6	7.2	8.3	11.3

Headlines & Commentary

Cost Improvement Programme Target for 2017/18 is £11m.

YTD Delivery

- Year to Date delivery at month 10 totalled £7.2m against a plan of £9.0m, giving an under-delivery of £1.8m
- Of the total savings achieved £2m is delivered non-recurrently

Full Year Plan

- The full year delivery forecast totals £11.3m with a number of schemes still remaining as medium to high risk.
- Work continues with the FIP(2) programme to support the delivery of future schemes.
- £8m has been delivered full year for 2017/18 of which £5.9m has been delivered recurrently.

Capital Programme

Capital Schemes 2017/18	2017/18 Plan £'000	Actual Expenditure 2017/18 £'000	Remaining Balance £'000
Estate			
Life cycle – estate maintenance	2,006	1,182	824
Integrated Critical Care Unit	7,800	3,912	3,888
Maternity	5,200	85	5,115
Accident & Emergency	2,000	156	1,844
Pharmacy Retail Development	0	0	0
Treatment Rooms	0	0	0
Medical Equipment Replacement	800	225	575
Gamma Camera	300	416	(116)
Information Management & Technology			
Hardware & Software	400	144	256
Total Mobile	0	554	(554)
Contribution to SLR	0	0	0
Total Cost of Capital Schemes	**18,506**	**6,674**	**11,832**

Commentary

- The Trust's capital expenditure totals £6.7m as at the 31st January 2018. This is below plan mainly due to the delay in the commencement of the ICCU, A&E and Maternity schemes.
- The Gamma Camera is also part funded through a League of Friends donation and the Trust's Charitable Funds.
- The Outline Business Case for the A&E development has been submitted to NHS Improvement for review.
- A review of the programme will be completed to confirm the required capital resource limit with NHSI.

Statement of Financial Position

Statement of Financial Position	as at 31/03/17	as at 31/01/18	Movement
	£000	£000	£000
Non-Current Assets			
Property, plant & Equipment	133,168	134,319	1,151
Intangible Fixed Assets	1,010	1,052	42
Total Non-Current Assets	**134,178**	**135,371**	**1,193**
Current Assets			
Receivables less than one Year	14,603	22,381	7,778
Cash (Citi and Other)	1,705	1,073	(632)
Inventories	2,107	2,042	(65)
Total Current Assets	**18,415**	**25,496**	**7,081**
Current Liabilities			
NHS Payables less than one year	(6,561)	(3,510)	3,051
Payables less than one year	(22,896)	(30,493)	(7,597)
Borrowings less than one year	(31,183)	(56,250)	(25,067)
Provisions less than one year	(420)	(420)	-
Total Current Liabilities	**(61,060)**	**(90,673)**	**(29,613)**
Net Current Assets less Liabilities	**(42,645)**	**(65,177)**	**(22,532)**
Non-current Assets			
Receivables greater than one year	1,119	1,156	37
Non-current liabilities			
Borrowings greater than one year	(131,346)	(128,439)	2,907
Total Assets less Total Liabilities	**(38,694)**	**(57,089)**	**(18,395)**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	56,318	58,318	2,000
Revaluation	12,752	12,607	(145)
Income and Expenditure	(107,764)	(107,619)	145
In Year Income & Expenditure	0	(20,395)	(20,395)
Total TAXPAYERS' EQUITY	**(38,694)**	**(57,089)**	**(18,395)**

Commentary

Non Current Assets

- The movement year to date is due to depreciation and amortisation being greater than the capital expenditure incurred to date.

Current Assets

- Receivables have increased by £7.78m since 31st March 2017. Invoiced debtors has increased by £1.91m net in month and primarily reflects monthly SLAs with the Trust's main commissioner, prior year reconciliation issues, invoicing for Q3 drugs and M7 maternity pathways.
- Cash is £0.6m lower than the balance at 31st March 2017 as the Trust attempts to reduce the level outstanding creditor balances.

Current Liabilities

- Payables have increased by £4.5m net, and primarily reflects the delays in cash settlement of creditor invoices due to cumulative effect of the non-payment for NHS invoicing and continued overspending. The Trust has taken deficit loan and capital loan support totalling £25.1m in year at the end of January.

Provisions

- The balance of provisions has remained unchanged in April and reflects the non-clinical provisions held by the NHSLA, and a fines provision.

Tax Payers' Equity

- Income & Expenditure reflects the current deficit of £20,395k and shows the brought forward balances on the revaluation reserve and Income & Expenditure Reserve.

Cash Flow Statement

	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	(12,907)
Depreciation and Amortisation	5,732
Donated Assets Received credited to revenue but non-cash	(248)
Fixed Asset Impairments	0
(Increase)/Decrease in Trade and Other Receivables	(7,815)
Increase/(Decrease) in Trade and Other Payables	5,155
Increase/(Decrease) in Stock	65
Increase/(Decrease) in Provisions	0
Interest Paid	(7,507)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	(17,525)
Cash Flows from Investing Activities	
Interest received	17
(Payments) for Property, Plant and Equipment	(7,284)
Receipt from sale of Property	0
Net Cash Inflow/(Outflow)from Investing Activities	(7,267)
Net Cash Inflow/(Outflow) before Financing	(24,792)
Cash Flows from Financing Activities	24,160
Net Increase/(Decrease) in Cash	(632)
Cash at the Beginning of the Year 2016/17	1,705
Cash at the End of the Month	**1,073**

Commentary

Cash Flow

- The Trust made an adjusted operating deficit of £12,907k at the end of January and received cash of £5,732k in respect of depreciation and amortisation.
- Trade and Other Receivables increased over the period (a negative impact on cash).
- Trade and Other Payables increased over the period (a positive impact on cash).
- The Trust spent a total of £7,284k in relation to payments for outstanding capital projects from 2016/17 and current 2017/18 projects.
- The Trust has received a total of £25.10m against the temporary borrowing loan facility by the end of January to support working capital payments, and £2.0m in returned PDC.

BOARD/COMMITTEE REPORT

Meeting	**Trust Board**	**Date:** 1st March 2018	
Report Title	Performance and Quality Report for January 2018	**Agenda Item: 18** **Enclosure No.: 15**	
Lead Director to Present Report	Director of Finance & Performance, Russell Caldicott		
Report Author(s)	Head of Performance & Strategic Intelligence - Alison Phipps		
Executive Summary	The report format aligns all of the indicators to the organisational strategic objectives. **SUMMARY OF THE KEY POINTS:** Areas of note are:- 1. **A&E: Time Spent in A&E (within 4 hours): Target 95%:** Performance declined slightly to 82.68% compared to 83.38% in December and remained below the trajectory of 87%. 2. **Ambulance Handover:** The number of delayed ambulance handovers totalled 296 which was a slight increase compared to 281 in December. Of these the number delayed by more than 1 hour increased to 37 from 35. 3. **Cancer** – All 7 national cancer metrics achieved in December. The 62 day consultant upgrade local target failed to achieve, reporting 85.71% against a 91% target. Agreement has been reached to reduce this target to 85% with effect from January 2018.Unvalidated performance for January shows achievement of all 8 metrics. 4. **18 Weeks Referral to Treatment Incomplete: Target 92%:** January's performance improved to 82.48% from 80.99% in December. There was 1 patient waiting more than 52 weeks on an incomplete pathway. 5. **Diagnostic waits:** This achieved the 99% target (99.54%). 6. **HSMR (HED) & SHMI** - October HSMR rate was 81.70. September SHMI changed to 93.04 from 97.81 in August. There were 139 deaths in January. 7. **Infection Control** – There were no reported cases of C Difficile and MRSA. 8. **Pressure Ulcers – (category 2, 3 & 4's) – Avoidable per 1000 beddays** – The rate for November was 0.53. December and January are pending RCA outcomes. 9. **Falls** - The rate of falls per 1000 bed days improved to 5.11 from 5.79 in January and was within the target of 6.63. There was 1 fall resulting in serious injury. 10. **Open Contract Performance Notices** – Six remain open in January. 11. **CQUINS** – Work continues on schemes for 2017-19. A forecast summary is included.		

Purpose	**Approval**	**Decision**	**Discussion**	**Note for Information**
	☒	☐	☒	☐

<table>
<tr><td><u>Recommendation</u></td><td colspan="2">The Committee is asked to NOTE the content of the paper and DISCUSS any areas of concern.</td></tr>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>As above</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>As above</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>As above</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>As above</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr>
<tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☒</td></tr>
<tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Areas of significant underperformance are expected to be reported within Corporate/Divisional Risk registers.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Not applicable to this report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Many of the metrics are defined within the national NHS contracts and contracts agreed with Commissioners.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Trust Quality Executive – 16/02/2018
Performance, Finance & Investment Committee – 21/02/2018
Quality and Safety Committee – 22/02/2018</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The Performance and Quality Report is shared with all Commissioners as part of a contractual requirement.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
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Walsall Healthcare NHS
NHS Trust

Performance & Quality Report

February 2018
(January 2018 Results)

Author: Alison Phipps – Head of Performance and Strategic Intelligence
Lead Director: Russell Caldicott – Director of Finance and Performance

Becoming your partners for first class integrated care

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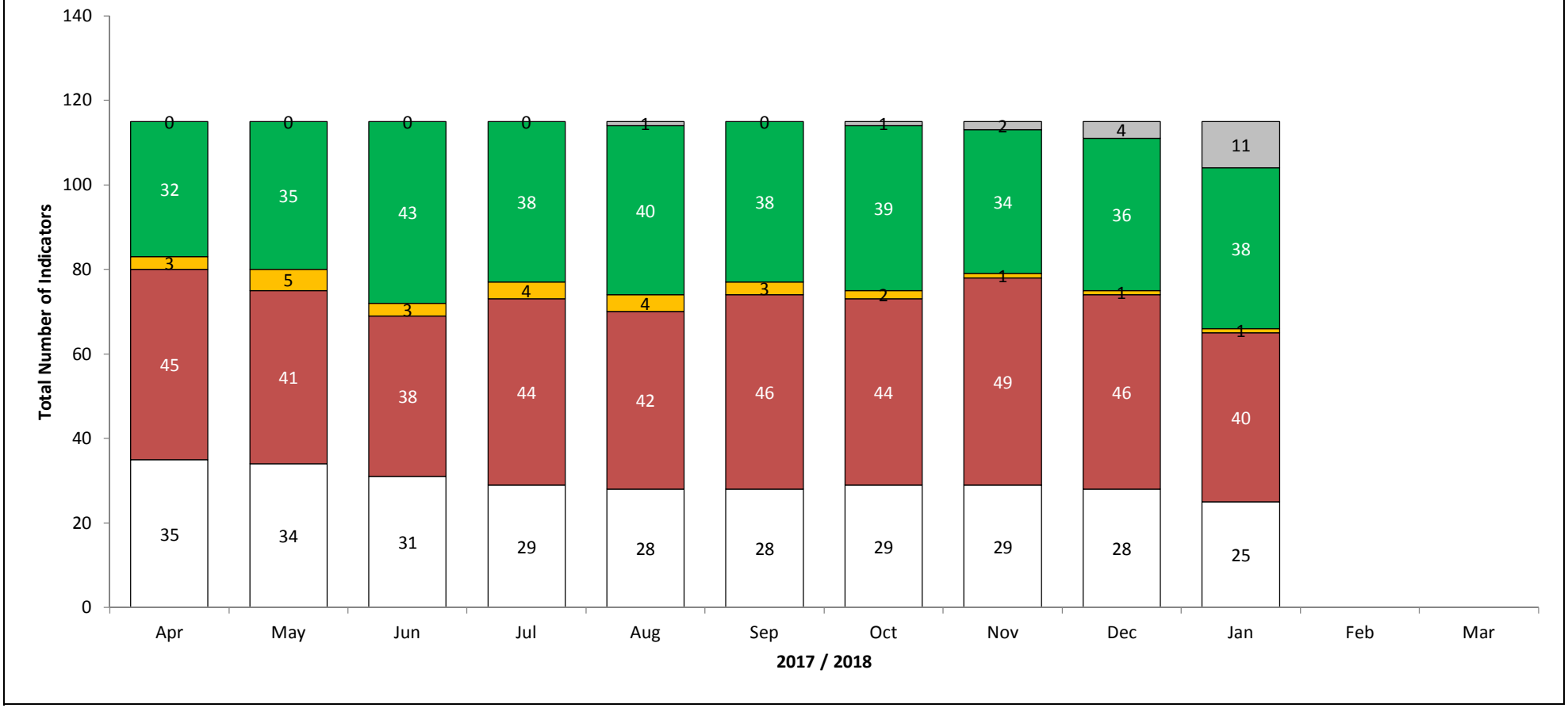
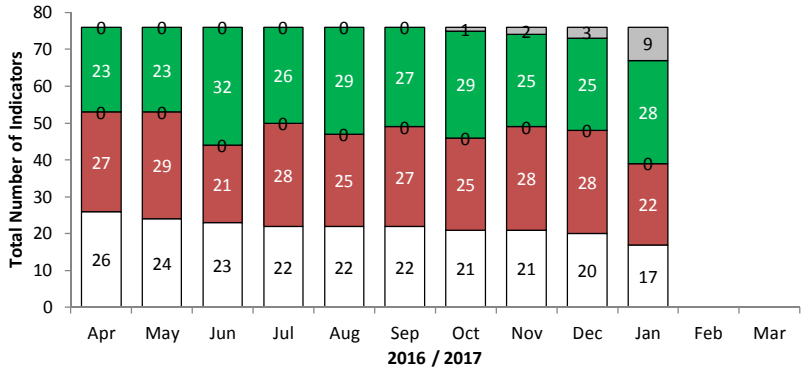
TRUST PERFORMANCE FRAMEWORK

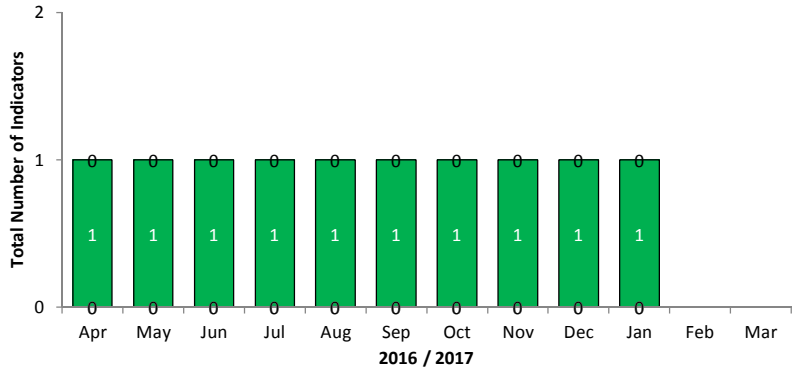


TRUST STRATEGIC VALUES FRAMEWORK

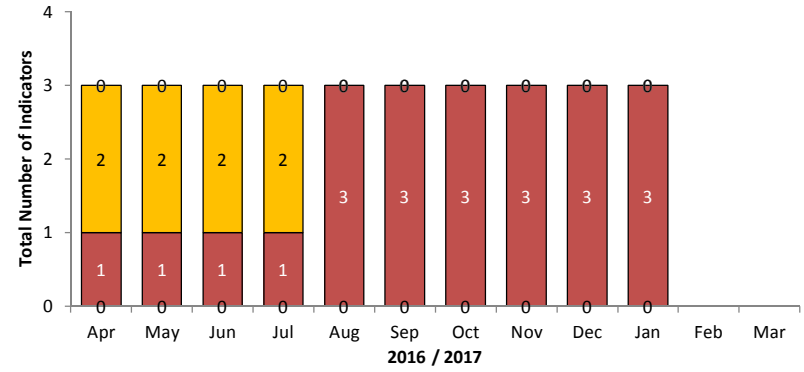
Provide Safe, High Quality Care Across All Our Services



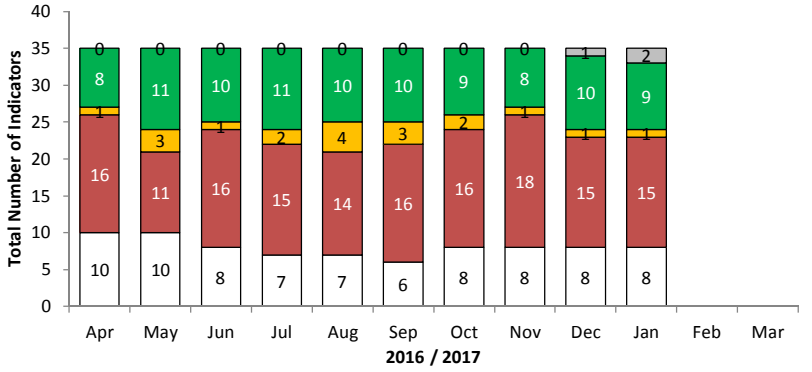
Care For Patients at Home Whenever We Can



Value Our Colleagues So They Recommend Us As A Place To Work



Use Resources Well to Ensure We Are Sustainable



Indicators with No Targets

Failing to meet Target or Major Variance from Plan

Minor Variance from Plan

Achieving Target or On Plan

Indicators reported in Arrears or not yet available in Month

Walsall Healthcare NHS
NHS Trust

Quality and Safety Committee

Becoming your partners for first class integrated care

Quality & Safety Committee – Key Messages

Please refer to dashboard and exception pages for further detail

Quality & Safety Committee

PERFORMANCE ACHIEVED – OF NOTE: There were no cases of C Difficile reported in January. C-Section rates achieved the target of less than 30% in January at 27.14%.

PERFORMANCE NOT ACHIEVED: There was a reduction in the number of mixed sex accommodation breaches in January from 9 to 3 and this was within the monthly trajectory of 11. There were 8 avoidable category 3 and 4 pressure ulcers reported for November. December and January figures are provisional. There was one fall resulting in severe harm in January. VTE declined to 91.30% in January compared to 93.45% in February. There were 9 serious incidents (Acute) reported in January which exceeds the monthly trajectory of 7. The number of serious incidents (Community acquired) increased to 8 in January compared to 4 in December and failed to achieve the monthly trajectory of 2. One to one care in established labour narrowly failed to achieve the 100% target with performance of 98.98%. Emergency Readmissions within 30 days did not achieve in December with performance of 11.44%. EDS compliance failed to achieve in January however improved to 91.63%. Dementia screening improved significantly to 80.79%, against a target of 90%, however methodology to determine performance of this metric is still under review. 3 FFT areas failed to achieve however this an improvement compared to last month when 6 areas failed to achieve.

TO NOTE:
The number of deaths slightly increased from 137 in December to 139 in January. This is the first month that Compliance with MCA stage 2 tracking is reported and shows performance of 71% in January. A target is to be agreed from next month. The percentage of medication incidents resulting in harm has temporarily been removed from the dashboard, whilst a validation process is established to align the numbers reported between pharmacy and safe guarding. It is anticipated that this will be completed for Q4.

NONE APPLICABLE

NONE APPLICABLE

PERFORMANCE NOT ACHIEVED – OF NOTE: Total births remain the same as last month and are below the expected number.

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE

2017-2018

Safe, high quality care | Care at home | Partners | Value colleagues | Resources

		AUG	SEP	OCT	NOV	DEC	JAN	YTD Actual	17/18 Target	16/17 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no	Sleeping Accommodation Breaches	15	4	7	6	9	3	**56**	0	**105**	N
no..	HSMR (HED)	98.93	80.86	81.70				**92.37**	100.00		N
no..	SHMI (HED)	97.81	93.04						100.00		BP
no	Number of Deaths in Hospital	91	63	86	80	137	139	**941**		**1123**	BP
%..	% of patients who achieve their chosen place of death	34.78%	58.82%	66.00%	73.81%	46.30%	63.04%	**55.59%**			
no	MRSA - No. of Cases	0	0	0	0	0	0	**0**	0	**0**	N
no	Clostridium Difficile - No. of cases	0	2	1	0	4	0	**11**	18	**21**	N
%..	Percentage of patients screened for Sepsis (CQUIN audit - quarterly)	93.59%	93.48%	92.75%	92.19%	95.00%		**93.59%**	90.00%		
no..	Pressure Ulcers - (category 2, 3 & 4's) - Avoidable per 1000 beddays	0.37	0.35	0.61	0.53	0.12	0.06				BP
no	Pressure Ulcers - No. of Avoidable (category 2, 3 & 4's) - Trust	6	5	9	8	2	1		0	**19**	BP
no	Pressure Ulcers - (category 2, 3 & 4's) - Hospital	7	5	14	12	11	7			**167**	
no	Pressure Ulcers - (category 2, 3 & 4's) - Community	19	12	16	15	9	17			**143**	
no	Falls - Total reported	89	98	96	83	95	88	**848**		**932**	BP
no..	Falls - Rate per 1000 Beddays	5.55	6.80	6.46	5.50	5.79	5.11		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	0	1	0	2	1	1	**8**	0	**22**	BP
%..	VTE Risk Assessment	88.30%	90.75%	90.45%	89.95%	93.45%	91.30%	**87.37%**	95.00%	**90.90%**	N
no	National Never Events	0	0	0	1	0	0	**2**	0		N
no	Local Avoidable Events	0	0	0	0	0	0	**0**	0		L
no	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	6	6	7	16	9	9	**98**	102	**102**	L
no	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	7	5	4	5	4	8	**68**	50	**49**	L
no	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	17	18	22	31	28	22	**220**		**218**	L
no	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	6	4	10	4	2	16	**77**		**55**	L
%..	% of incidents resulting in moderate, severe harm or death as a % of total incidents	2.19%	2.29%	3.06%	3.27%	3.09%	3.31%	**2.82%**		**2.41%**	L
%..	Deteriorating patients: Percentage of observations rechecked within time	90.13%	89.80%	91.30%	90.16%	88.19%	88.72%	**90.04%**	85.00%		
%..	Medication Storage Compliance		95.00%	95.00%	95.00%	93.00%		**95.00%**			
%..	Controlled Drug Compliance (quarterly audit)		80.50%					**80.50%**			
%..	% of Pharmacy Interventions made based on charts reviewed			20.15%	20.00%	26.56%		**22.61%**			
no..	Midwife to Birth Ratio	1:29.2	1:28.1	1:25.7	1:25.4	1:25.4	1:24.8	**1:25.4**	1:28	**1:30.6**	N
%..	One to One Care in Established Labour	93.62%	95.50%	99.07%	98.96%	98.91%	98.98%		100.00%	**100.00%**	N
%..	C-Section Rates	27.96%	26.84%	25.77%	28.62%	32.86%	27.14%		30.00%		

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE

2017-2018

		AUG	SEP	OCT	NOV	DEC	JAN	YTD Actual	17/18 Target	16/17 Outturn	Key
%..	Instrumental Delivery	12.20%	12.83%	11.95%	11.47%	8.93%	14.36%				
%..	Induction of Labour	36.17%	33.89%	35.74%	33.33%	33.45%	32.01%				
%..	NHS Safety Thermometer - Maternity - Women's Perception of Safety	82.40%	100.00%	96.20%	64.30%	95.50%	77.80%				
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital	10.64%	11.43%	10.75%	10.35%	11.44%		**10.52%**	10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	88.03%	87.35%	88.30%	85.38%	89.73%	91.63%	**89.12%**	100.00%	**88.40%**	N/L
%..	Dementia Screening 75+ (Hospital)	55.16%	49.07%	60.52%	44.47%	80.79%		**57.95%**	90.00%	**87.24%**	N
%..	Compliance with MCA 2 stage tracking						71.00%	**71.00%**			
no	Complaints - Total Received	33	23	22	15	13	24	**235**		**327**	BP
%..	Complaints - Percentage responded to within the agreed timescales	100.00%	96.30%	100.00%	92.00%	100.00%	100.00%	**83.53%**	70.00%	**47.75%**	BP
no	Clinical Claims (New claims received by Organisation)	10	8	13	9	10	10	**109**		**124**	L
no	No urgent op to be cancelled for a second time	0	0	0	0	0	0	**0**	0		N
%..	Number of RN staffing Vacancies Metric	11.08%	10.94%	9.74%	8.85%	9.78%	9.96%	**9.96%**			
%..	Friends and Family Test - Inpatient (% Recommended)	97.00%	94.00%	95.00%	92.00%	91.00%	93.00%	**93.00%**	96.00%		N
%..	Friends and Family Test - Outpatient (% Recommended)	90.00%	91.00%	91.00%	90.00%	91.00%	91.00%	**91.00%**	96.00%		N
%..	Friends and Family Test - ED (% Recommended)	77.00%	75.00%	73.00%	76.00%	77.00%	75.00%	**75.00%**	85.00%		N
%..	Friends and Family Test - Community (% Recommended)	98.00%	97.00%	97.00%	99.00%	99.00%	97.00%	**97.00%**	97.00%		N
%..	Friends and Family Test - Maternity - Antenatal (% Recommended)	88.00%	88.00%	73.00%	82.00%	80.00%	97.00%	**97.00%**	95.00%		N
%..	Friends and Family Test - Maternity - Birth (% Recommended)	100.00%	88.00%	89.00%	94.00%	83.00%	100.00%	**100.00%**	96.00%		N
%..	Friends and Family Test - Maternity - Postnatal (% Recommended)	83.00%	92.00%	100.00%	79.00%	85.00%	97.00%	**97.00%**	92.00%		N
%..	Friends and Family Test - Maternity - Postnatal Community (% Recommended)	71.00%	100.00%	87.00%	100.00%	100.00%	99.00%	**99.00%**	97.00%		N
	RESOURCES										
no	Total Births	336	304	293	279	280	280	**3061**	4200	**4190**	L

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

Becoming your partners for first class integrated care

Performance, Finance & Investment Committee – Key Messages

Please refer to dashboard and exception pages for further detail

Performance, Finance & Investment Committee

PERFORMANCE ACHIEVED – OF NOTE: All national Cancer measures (7) achieved in December.

PERFORMANCE NOT ACHIEVED: The ED 4 hour performance slightly declined to 82.68%. ED median waiting time was slightly longer in January. The number of delayed ambulance handovers increased in January to 296 compared to 281 in December, of these the number delayed by more than 1 hour also slightly increased to 37 from 35. Cancer 62 day consultant upgrade failed to achieve the current local target in December. The target for this metric has been revised and agreed at 85% by WCCG and takes effect from 1st January 2018. Unvalidated performance for January forecasts achievement of all 8 cancer targets. 18 weeks Incomplete RTT for January improved to 82.48%. There was 1 patient reported as waiting more than 52 weeks at the end of January. The percentage of stroke patients who spent 90% or more of their stay on a stroke unit failed to achieve for the fourth consecutive month. The number of open contract notices remained at 6.

TO NOTE: Applying the national cancer breach allocation guidance to the 62 day cancer targets for the validated December results would not have impacted on the pass / fail results. The national cancer breach allocation guidance aims to provide a fairer method of cancer breach allocation when treatment is delayed between referring and treating organisations involved in the cancer pathway.

NOTHING OF NOTE.

NONE APPLICABLE.

PERFORMANCE ACHIEVED – OF NOTE:

PERFORMANCE NOT ACHIEVED: DNA Rates for Acute and Community improved in January with performance of 12.11% however did not achieve the monthly trajectory of 9.37% . Average length of stay failed to achieve the 7.01 target reporting 7.50 days. Delayed transfers of care did not achieve the 2.5% target in January (3.11%).

FINANCE: Please refer to Finance report.

TO NOTE: The Theatres metric has been revised and is now reported as Touch Time Utilisation replacing In Session Theatre Utilisation which was previously reported. The touch time percentage reported for January was 58.16%, a target is to be agreed for inclusion next month.

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

2017-2018

		AUG	SEP	OCT	NOV	DEC	JAN	YTD Actual	17/18 Target	16/17 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Total time spent in ED - % within 4 hours - Overall (Type 1, 3 and WiC)	80.72%	81.82%	82.75%	82.03%	83.38%	82.68%	**82.84%**	95.00%	**84.10%**	N
no	Total time spent in ED - No. of Trolley waits over 12 hours	0	1	0	0	0	0	**3**	0	**2**	N
no	Median Waiting Time in ED Metric (average in mins)	177	179	177	171	179	181		120		
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	60.21%	69.33%	62.19%	70.04%	58.42%	59.73%	**64.78%**	100.00%	**65.44%**	BP
no	Ambulance Handover - No. of Handovers completed between 30-60mins	144	110	193	122	246	259	**1584**	0	**1765**	N
no	Ambulance Handover - No. of Handovers completed over 60mins	16	4	35	8	35	37	**206**	0	**249**	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	93.82%	94.49%	97.13%	95.88%	97.42%	95.16%	**95.03%**	93.00%	**96.12%**	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	93.65%	94.92%	97.14%	96.88%	100.00%	94.12%	**95.98%**	93.00%	**96.15%**	N
%..	Cancer - 31 day second or subsequent treatment (surgery)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**98.66%**	94.00%	**99.07%**	N
%..	Cancer - 31 day second or subsequent treatment (drug)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	98.00%	**100.00%**	N
%..	Cancer - 31 day diagnosis to treatment	98.08%	100.00%	100.00%	100.00%	100.00%	98.57%	**99.27%**	96.00%	**99.16%**	N
%..	Cancer - 62 day referral to treatment from screening	95.65%	100.00%	100.00%	100.00%	100.00%	100.00%	**97.64%**	90.00%	**96.20%**	N
%..	Cancer - 62 day referral to treatment of all cancers	94.51%	86.05%	87.65%	85.51%	90.12%	87.80%	**88.33%**	85.00%	**87.10%**	N
%..	Cancer - 62 day referral to treatment from consultant upgrade	85.32%	85.53%	82.89%	87.84%	85.71%	88.06%	**86.48%**	85.00%	**92.03%**	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	84.74%	85.06%	84.75%	83.57%	80.99%	82.48%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	2	1	2	1	1	1	**13**	0	**97**	N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Admitted	1	3	1	1	0	1	**9**	0	46	N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Not Admitted	0	2	0	1	0	0	**8**	0	165	N
%..	Diagnostic Waits - % waiting under 6 weeks	99.42%	99.05%	99.64%	99.53%	99.15%	99.54%	**99.13%**	99.00%	**99.24%**	N
%..	Elective Cancellations - No. of last minute cancellations on day of operation or after patient admission	0.37%	0.44%	0.73%	0.58%	0.51%	0.19%	**0.46%**	0.75%	**0.65%**	N
no	Elective Cancellations - No. of last minute cancellations not rebooked within 28 days	0	0	0	0	0	0	**0**	0	**3**	N
no	No urgent op to be cancelled for a second time	0	0	0	0	0	0	**0**	0		N
%..	Stroke - % of Patients who have had an acute stroke who spend 90% or more of their stay on a stroke unit	86.67%	80.65%	77.27%	78.95%	74.29%	68.97%	**81.43%**	80.00%	**89.42%**	BP/SS
no	Rapid Response Team - Avoidable admissions	180	176	206	237	248		**1726**			
no..	FES Avoided Admissions Metric (New metric under development)										
%..	Number of RN staffing Vacancies Metric	11.08%	10.94%	9.74%	8.85%	9.78%	9.96%	**9.96%**			
no	No. of Open Contract Performance Notices	9	9	6	6	6	6	**6**	0	**6**	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	6.68%	6.98%	6.89%	6.50%	7.00%	6.71%	**6.80%**	7.00%	**7.03%**	BP
	RESOURCES										
%..	Clinic Utilisation Rate	85.59%	87.07%	92.27%	92.15%	91.14%	90.13%	**89.56%**	90.00%	**87.27%**	L
%..	Outpatient DNA Rate (Acute and Community)	12.29%	11.98%	11.99%	11.77%	14.36%	12.11%	**12.38%**			
no..	New to follow up ratio - WHT	1.94	1.83	1.94	1.93	2.03	2.04	**1.98**	2.14	**1.95**	BP
%..	Theatre Utilisation - Overall In Session Utilisation (%)	88.47%	89.13%	87.58%	75.44%				85.00%	**81.91%**	BP
%..	Theatre Utilisation - Touch Time Utilisation (%)	66.61%	64.64%	65.08%	61.11%	66.31%	58.16%				

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

2017-2018

		AUG	SEP	OCT	NOV	DEC	JAN	YTD Actual	17/18 Target	16/17 Outturn	Key
no..	Length of Stay	6.90	6.80	6.46	7.06	7.51	7.50	**7.14**	7.01	**7.32**	BP
%..	Delayed transfers of care	1.22%	1.58%	3.16%	3.27%	2.16%	3.11%	**2.35%**	2.50%	**2.35%**	L
no	Hospital beds open at month end	443	435	468	468	483	532			470	L
%..	Day case rates	88.06%	87.42%	88.41%	90.32%	88.82%	90.32%	**88.26%**		87.98%	BP
%..	Bank & Locum expenditure as % of Paybill	7.24%	8.26%	8.11%	8.48%	8.53%	7.29%	**7.43%**	6.30%	**6.22%**	L
%..	Agency expenditure as % of Paybill	4.81%	3.81%	4.25%	4.41%	4.69%	5.39%	**4.36%**	2.75%	**6.35%**	L
£	Surplus or Deficit (year to date) (000's)	-£10,918	-£11,361	-£14,923	-16976	-£20,342	-£20,395	**-£20,395**		**-£21,392**	L
£	Variance from plan (year to date) (000's)	-£1,285	-£1,872	-£2,088	-3093	-£3,991	-£3,622	**-£3,622**		**-£15,192**	L
£	CIP (£) (000's)	£3,701	£4,476	£5,180	£5,924	£6,620	£7,213	**£7,213**	£560	**£6,600**	L
%..	CIP % delivered (year to date)	57.80%	61.00%	64.00%	68.00%	71.00%	72.30%	**72.30%**	100.00%	**71.00%**	L
£	Income variance from plan (year to date) (000's)	-£226	-£877	£456	£653	£464	£640	**£640**	£0	**-£5,423**	L
£	Expenditure - Variance from Plan (year to date) (000's)	-£1,016	-£941	£1,500	£2,245	£4,271	£3,991	**£3,991**	£0	**-£9,537**	L
£	Cash Against Plan (variance) (000's)	£32	£111	£94	£858	£526	£73	**£73**		**£700**	L
£	Capital spend YTD (000's)	£2,969	£3,415	£4,031	£4,818	£5,663	£6,674	**£6,674**		**£4,660**	L
no	Monitor Risk Rating (Actual YTD)	1	1	1	1	1	1	**1**	3	**1**	BP
no	Total Referrals (Contracted)	8324	7887	8449	7699	6419		**71969**		**89125**	BP
no	Total Elective Activity (Contracted)	288	299	290	275	218	250	**3145**		**3422**	L
no	Total Non Elective Activity (Contracted)	56	27	34	53	138	61	**533**		**689**	L
no	Total Outpatient attendances (Contracted)	18588	19189	20653	20830	15371	15932	**187219**		**248452**	L
no	Total Day Case Activity (Contracted)	1826	1893	1957	2147	1500	2089	**18618**		**21515**	L
no	Total Emergencies Activity (Contracted)	2605	2649	2845	2747	2689	2815	**26637**		**30275**	L
no	Total ED Attendances Type 1 Pbr (Excl Badger) (Contracted)	5935	6232	6637	6417	6577	6551	**61357**		**64686**	L
no	Total AHP Activity (Contracted)	1774	1736	1846	2145	1337	1811	**17551**		**24338**	L
no	Total Critical Care Days (Contracted)	921	904	994	863	1232	990	**9598**		**10760**	L
no	Total Unbundled Chemo Delivery Activity (Contracted)	331	350	359	359	241	323	**3223**		**3425**	L
no	Total Maternity Pathway	1146	1046	1083	894	720	881	**9896**		**12382**	L
no	Total Community Contacts (Contracted)	19657	18184	21720	20614	13823	23589	**294014**	379962	**344377**	L
no	Total Births	336	304	293	279	280	280	**3061**	4200	**4190**	L

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

Walsall Healthcare NHS
NHS Trust

People and Organisational Development Committee

Becoming your partners for first class integrated care

People & Organisational Development Committee – Key Messages

Please refer to dashboard and exception pages for further detail

People & Organisational Development Committee

NOTHING OF NOTE.

NONE APPLICABLE

PERFORMANCE NOT ACHIEVED: Sickness absence declined from 5.81% in December to 6.23% in January. PDR's improved in January to 78.24% but remained below the 90% target. Mandatory training declined slightly and remains below the compliance target.

FINANCE: Turnover remains within target. Please refer to Finance report for further details.

Walsall Healthcare NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

2017-2018

		AUG	SEP	OCT	NOV	DEC	JAN	YTD Actual	17/18 Target	16/17 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Number of RN staffing Vacancies Metric	11.08%	10.94%	9.74%	8.85%	9.78%	9.96%	**9.96%**			
	VALUE COLLEAGUES										
%..	Sickness Absence	4.64%	4.73%	5.76%	5.55%	5.81%	6.23%	**5.29%**	4.00%	**4.59%**	L
%..	PDRs	77.74%	74.43%	75.19%	76.25%	75.90%	78.24%	**78.24%**	90.00%	**84.66%**	L
%..	Mandatory Training Compliance	79.73%	79.50%	79.71%	78.69%	79.65%	78.14%	**78.14%**	90.00%	**80.71%**	L
	RESOURCES										
%..	Bank & Locum expenditure as % of Paybill	7.24%	8.26%	8.11%	8.48%	8.53%	7.29%	**7.43%**	6.30%	**6.22%**	L
%..	Agency expenditure as % of Paybill	4.81%	3.81%	4.25%	4.41%	4.69%	5.39%	**4.36%**	2.75%	**6.35%**	L
no	Staff in post (Budgeted Establishment FTE)	4092	4097	4094	4073	4100	4100	**4100**		**4201**	L
%..	Turnover	9.25%	8.58%	8.79%	8.89%	8.93%	8.77%	**8.77%**	10.00%	**9.39%**	L

Exception Pages

Total time spent in ED - % within 4 hours - Overall (Type 1, 3 and WiC)

Walsall Healthcare NHS Trust

Total time spent in ED - % within 4 hours - Overall (Type 1, 3 and WiC)	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
Percentage of patients arriving in ED who are subsequently admitted or discharged within 4 hours of arrival	95.00%	85.00%	82.68%	82.84%	▼	

What is driving the reported underperformance?

Performance results:

Performance in January was 82.68% which is a slight decline compared to 83.38% in December and below the agreed monthly trajectory of 85%.

Based on Calender Month	Nov-17	Dec-17	Jan-18
Type 1 attenders	6639	6416	6576
Type 3 attenders	3617	3324	3547
WiC attenders	-	3659	3723
Breaches	1747	2293	2420
Admissions from ED	2149	2253	2224
% of Patients Admitted	32.37%	35.12%	33.82%
Ambulances to ED	2713	2989	2848
All Discharges	6308	5435	6334
Trolley Waits over 12 hours	0	0	0
ED Median Waits (mins)	171	179	181

In line with national agreement attendances at the Walk in Centre have been included within the calculated results as from 1st December 2017.

The Trust was at escalation level 04 for 4 days and on level 03 for 27 days compared to zero and 28 days in December.

- Average attendances per day were 213 compared to 212 (Dec)
- Average breaches per day were 78 compared to 74 (Dec)
- Admissions per day were 72 compared to 73 (Dec)
- Discharges per day were 204 compared to 175 (Dec)

There were significant daily variations in performance, at its lowest it was 78.02% and at its highest 88.62%.

Benchmarking:

For January, our position was 90th out of 133 and 8th out of 14 regionally compared to the previous month's respective ranks of 80th and 6th.

Contractual Status:

CQN/First Exception report remains open. Monthly penalties will be applied by WCCG £120 per breach based on the agreed trajectories. Fines for January equate to £38,880.

What actions have we taken to improve performance?

New Actions:

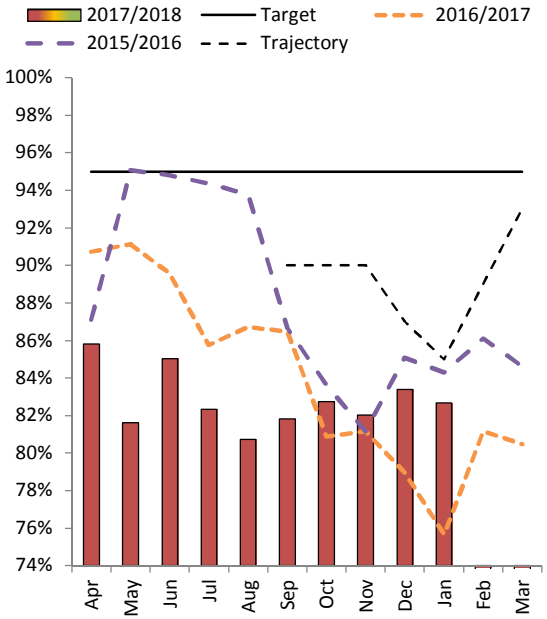
- A Patient Flow Steering Group has been established and is chaired by the COO. This has representation from all Divisions and is supported by Transformation Managers to develop key actions for improving patient flow.
- The Emergency Care Intensive Support Team (ECIST) have spent time on site meeting with the Clinical and Operational Teams across the Divisions of Surgery and Medicine. They have provided recommendations to the Trust and will return to support the implementation of the recommendations made during February and March.
- Care Group Managers within the Division of MLTC have developed and signed off their SAFER role descriptor which details the daily support they provide to their wards to enable earlier discharges and increased use of Discharge Lounge.
- AMU have a weekly Patient Flow User Group in place with Senior Nurse Teams and the Bed Managers. They are meeting regularly to discuss Patient Flow and develop improvements to stream line patie moves, handovers and enable timely transfers across the wards.

Continuing Actions:

- Ward Managers continue to attend Capacity Meetings throughout the day with the newly established Discharge Plans that are produced.
- General Managers continue to carry out daily rounds to the wards to support discharge planning and 7 day LOS review with clinicians.
- The Discharge Lounge continues to open from 9am (weekdays) to enable patients to move off wards earlier.
- Regular escalations continue with Health & Social Care to review the Medically Fit lists and continue to remove and reduce delays to discharge.
- An Acute Physician is still allocated to ED to support admission avoidance and assist in reducing trolley waits in ED.
- The ED Medical team continue to support the Ambulance Handover Nurse with Medical Led Triage during times of peak pressures and to support in reducing handover waiting times.

Contractual Financial Penalties (LCA)

YTD £ £972,360



Trajectory					
Apr	May	Jun	Jul	Aug	Sept 90.00%
Oct 90.00%	Nov 90.00%	Dec 87.00%	Jan 85.00%	Feb 89.00%	Mar 93.00%
Expected date to meet standard	To Be Agreed				
Lead Director	Chief Operating Officer				

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Number of clinical ambulance handovers completed between 30 and 60 minutes of recorded time of arrival at ED Number of clinical ambulance handovers completed over 60 minutes of recorded time of arrival at ED	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
The number of clinical handovers completed over 30 minutes of recorded time of arrival at ED (Performance excludes ambulances with no handover time recorded)	0		259	1584	▼	
	0		37	206	▼	

What is driving the reported underperformance?

Performance results:

Ambulances with a handover time recorded between 30 to 60 mins and over 60 mins were 259 and 37. This is an increase in numbers compared to 246 and 35 respectively recorded in December. Handover performance was 59.73% (where no handover time was not recorded)

	Dec-17		Jan-18	
<15mins	1731	57.02%	1679	57.84%
15-30	951	31.32%	836	28.80%
30-60	246	8.10%	259	8.92%
>60	35	1.15%	37	1.27%
No Time	73	2.40%	92	3.17%
Total	3036		2903	

*Please note the percentages reported in the table above reflect all ambulances arriving to ED irrespective of whether or not a handover time was recorded, whereas the percentage reported on the main dashboard is calculated as a percentage of those ambulances where handover times were not recorded.

Performance continues to be impacted upon by:

- Pin entry and no cubicle capacity due to peaks in capacity pressures (when ambulances arrive simultaneously).
- Average number of ambulance arrivals to ED per day was 94, which is a decrease compared to 98 in Dec.
- There were over 90 ambulance arrivals to the department on 18 days during the month, a decrease compared to Dec (25) and there were 7 days where the Trust saw over a 100 ambulances to ED a decrease compared to the previous month (15).

Benchmarking:

The Trust is ranked 3rd regionally out of 14 Trusts for January which is an improvement when compared to the previous month ranking of 6th.

Contractual Status:

As stipulated in the national contract, £200 will be applied for every handover recorded between 30 and 60 minutes and £1,000 will be applied for any handover over 60 minutes. For January a fine of £88,800 will be incurred.

What actions have we taken to improve performance?

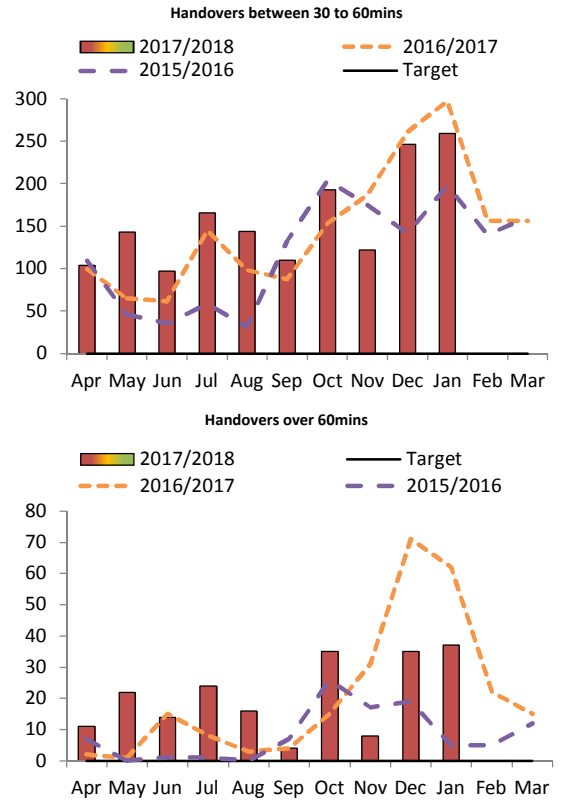
New Actions:

- Two additional Registered Nurses (an additional Triage Nurse and an additional Ambulance Handover Nurse) have been block booked through Nurse Bank to cover peak evening hours.
- A new protocol has been developed to support patient flow form A&E by reducing handover dealys from AMU & SAU to the wards.

Continuing Actions:

- The ED Boarding Protocol continues to be carried out when there are more than 10 boarded patients in ED.
- The Discharge Lounge continues to open daily from 9am (on weekdays) to pull patients from wards and provide early capacity.
- The Ambulatory function for the FES has co-located with the AEC on Ward 29. The service supports a Frailty Model that will operate as a “front door” Assessment Unit and establish direct admissions from WMAS to avoid AMU admissions. Agreement to the details of wards and medical support is due.
- WMAS continue to attend the joint meeting with commissioners, WHT and Urgent Care Providers to support service improvements within ED and Urgent Care.
- Monthly ED dashboard and relevant analysis is discussed at the ED Senior Management Group meetings with particular focus on ambulance arrivals and ambulance handover.
- Patient details of re-attenders by ambulance continue to be shared with community teams to identify support that can be provided to safely avoid attendance to the ED.
- ED Medics continue to support medical led triage with WMAS arrivals during escalation periods.
- The HALO provided during Winter Pressures continues to be in place and works closely with the Ambulance Handover Nurse in ED to support patient handover upon arrival.

Contractual Financial Penalties (LCA)	YTD £	£522,800



Expected date to meet standard	New trajectories have been proposed by the MLTC Division and are pending Executive approval.
Lead Director	Chief Operating Officer

National Contract	X	#NAME?	X	Best Practice		CQUIN	

Walsall Healthcare NHS
NHS Trust

Cancer - 62 Day Referral to Treatment from Consultant Upgrade	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	91.00%		85.71%	86.37%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No contractual penulties	YTD £

Performance results (Validated December 2017):
Performance of 85.71% in December is a decline compared to 87.84% in November and does not achieve the current locally agree target of 91%. Application of the new cancer breach allocation guidance would still have resulted in a failure to achieve this metric.

Unvalidated performance for January 2018 shows achievement of the target. (Against the newly agreed 85% target).

There were 3.5 breaches reported out of 24.5 treatments.

- Lung: 2 patients - 2.0 breaches. Treated on days 118 (multiple investigations) & 170 (complex pathway).

- Upper GI: 1 patient - 1.0 breach. Treated on day 82 (multiple investigations).

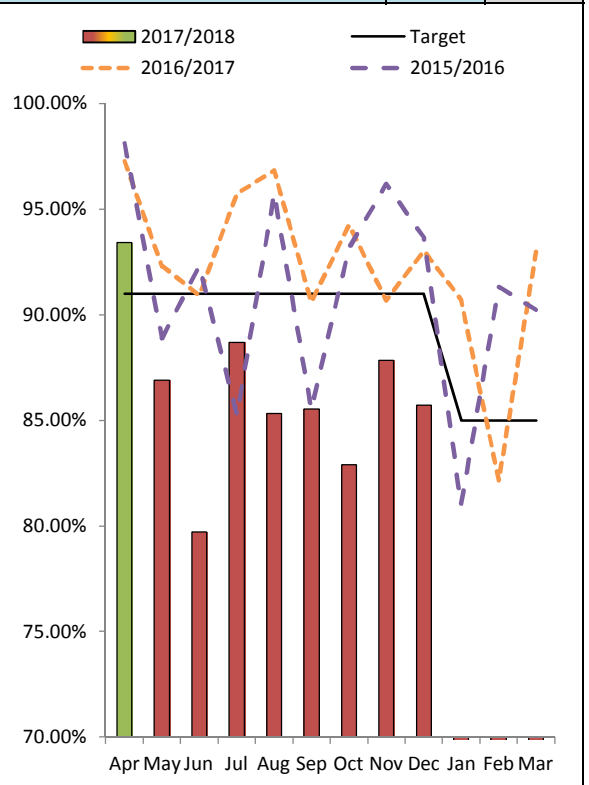
- Head & Neck: 1 patient - 0.5 breach. Shared breach with University Hospitals Birmingham NHS Foundation Trust. Referred on day 59. Treated on day 77 (multiple investigations).

Benchmarking:
For Quarter Three 17/18, the Trust ranked 85th nationally out of 133 and 11th out of 14 regionally compared to Quarter Two respective ranks of 81st and 11th.

Contractual status:
Contractual requirements apply.

New Actions:
- The target has now been revised and agreed at 85% by WCCG and take effect from 1st January 2018. This was formally agreed at the EAPG meeting held in January 2018.
- The Trust has a new Cancer Lead who will be meeting with all MDT leads to reinforce the monitoring of the upgrades.

Continuing Actions:
- NHSI is working with UHB and Wolverhampton regarding the tertiary process in order to streamline the pathway.
- From January 2018 UHB are introducing an electronic tertiary referral process which will incorporate additonal clinical information. This should result in a reduction in delays.
- The Trust continues to work with the cancer alliance to improve communication and the tertiary process.
- Cancer upgrade patients PTL is an item on the weekly Cancer PTL meeting agenda.
- Capacity issues at tertiary centres are contributing towards delays. There are specific difficulties at University Hospitals Birmingham (UHB) tracking patients progress through their pathway. Delays are escalated in line with the Cancer Escalation Policy.
- Cancer trackers review and escalate issues for patients daily across all sites.
- All breaches are referred to the monthly Clinical Harm Group for assessment.
- Continue monitoring of bronchoscopy delays escalating to the Division of Medicine for recovery plans.



Expected date to meet standard	January 2018
Lead Director	Chief Operating Officer

National Contract		Local Contract		Best Practice		CQUIN	

Walsall Healthcare NHS Trust

18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	92.00%	86.20%	80.99%		▼	

What is driving the reported underperformance?

Performance results (Validated December 2017)

The Trust failed to achieve the national standard with performance of 80.99%, a decline compared to 83.57% in November and below the 86.20% proposed recovery trajectory. This is the lowest reported performance since resuming national submissions in November 2016 (Octobers data). As part of the winter plan the Trust postponed a number of non urgent elective surgery which may have impacted upon the peformance. In addition, poor weather also increased the number of patient cancellations

		Oct-17	Nov-17	Dec-17
PTL Size		16790	15931	15632
No. over 18 Weeks		2561	2617	2972
No. over 52 Weeks		2	1	1
Clock Stops	Total	6807	6854	4851
	Admitted	915	995	673
	Not Admitted	5892	5859	4178
Specialties achieving 92%		10	12	7

Performance of Divisions (target 92%):
- MLTC achieved 79.72% compared to 81.86% in November.
- Surgery achieved 78.72% compared to 81.82% in November.
- WCCSS achieved 95.01% compared to 96.51% in November.

Benchmarking:

For December, the Trust ranked 118th out of 127 Acute Trusts nationally who submitted information and 11th out of 14 Trusts regionally. 72 Acute Trusts reported breaches of over 52 week waits in December.

Contractual status:

Contract Query Notices remain open with Walsall Clinical Commissioning Group (WCCG) and NHS England (NHSE). National monthly penalties of £300 per service user apply where the number of service users waiting more than 18 weeks at the end of the month exceeds the tolerance permitted by the 92% threshold. The £5000 fine for any patient waiting more than 52 weeks remains in place.

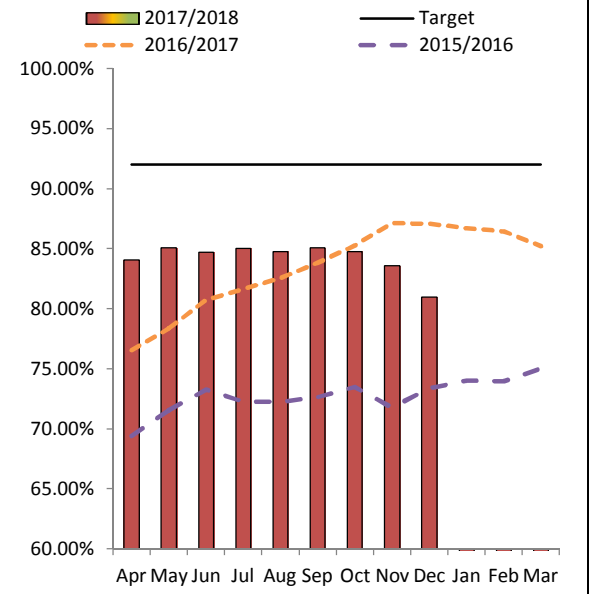
What actions have we taken to improve performance?

Data Quality:
- Work continues to validate access plans beyond the guaranteed appointment date. Robotic software procured and project initiated in January to validate follow up backlog pre 2017, trial of issuing letters to patients is planned for February .
- Cashing up of clinics (ensuring all required data following a clinic attendance has been entered into Lorenzo) continues to be an area of focus to maintain the 100% standard. Daily clearance of completed e.outcome forms improved during the month. Issues with non completion of forms continues. Care Groups have been asked to focus on this.

Capacity Improvements:
- WLI clinics in place to support cancer delivery and long waiters in RTT.
- Work is on going with KPMG to identify opportunities to increase capacity. Daily ops meetings in place to review bookings and replace cancellations for theatres and outpatients. Review of clinic running times is underway to optimise sessions and reduce waste. KPIs have been developed, with trajectories to increase activity during February and March.

Scrutiny:
- Weekly via PTL operational meeting, diagnostics meeting, divisional meeting, long wait report meeting, specialty meeting.
- Monthly via PFIC, EAPG and Divisional Board.
- All 52 week breaches are referred to the clinical harm group for assessment, only low harms have been identified to date.

Contractual Financial Penalties (LCA) — **YTD £** £3,999,000



Proposed Trajectory

Apr	May	Jun	Jul	Aug	Sept
84.00%	84.60%	85.10%	86.20%	86.20%	86.20%
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
86.20%	86.20%	86.20%	87.00%	88.20%	89.10%

Expected date to meet standard	Proposed revised trajectory has been submitted to WCCG for consideration
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Stroke 90% Stay	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
Patients who have had an acute stroke who spend 90% or more of their stay on a stroke unit	80.00%		68.97%	81.43%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance Results

The 80% target for patients spending over 90% of their stay on a stroke unit was not achieved during January with performance of 68.97%. This is the fourth consecutive month this measure has not achieved and is a significant decline compared to 74.29% reported in December.

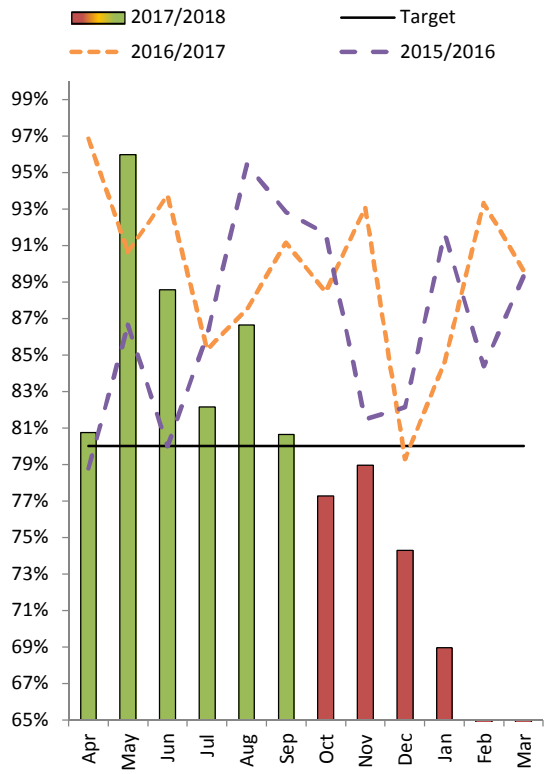
This measure was not achieved due in part to limited availability of beds on the stroke ward as there were general capacity pressures across the Trust which led to General Medical patients being placed there. In addition, the number of patients who were medically fit for discharge also increased.

Benchmarking:

There are no formal national reports published for this metric.

Continuing Actions:-

- The Capacity Team remain fully aware that the ring fenced beds on the Stroke ward must be protected for allocation to stroke patients where at all possible.
- Additional beds were opened beyond the funded bed base to support the capacity pressures across the Trust.
- Work was implemented in November in conjunction with Walsall Council around reconfiguring the discharge pathways for patients who are medically fit, which should lead to a reduction in the numbers of these patients within the Trust. This will alleviate pressures on the dedicated stroke beds.



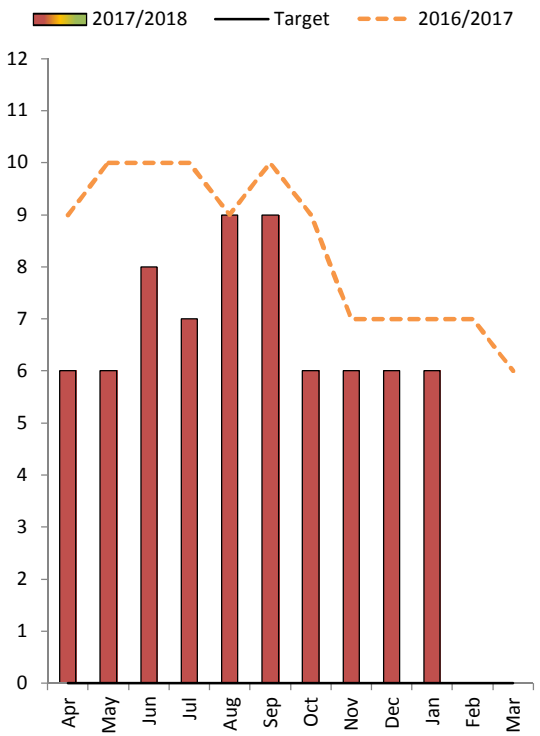
Expected date to meet standard	To be agreed
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Number of Open Contract Performance Notices

Walsall Healthcare NHS Trust

Number of Open Contract Performance Notices	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
Total number of Open Contract Performance Notices	0		6		-	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties for numbers open - applied to individual performance areas.	YTD £
As at 31st January 2018, there are 6 formal contract notices that remain outstanding. The 6 notices which remain open relate to the following areas:- - Two contract notices relating to 18 Weeks Referral To Treatment (RTT) Pathways. • One remains open from Walsall Clinical Commissioning Group (CCG) • One remains open from NHS England for Oral Surgery RTT. - Total Time Spent in A&E Overall 4 Hour - escalated to first exception notice - An Information breach notice (EOL) - VTE initial assessment	All contractual notices are subject to formal communication on a regular basis. Open contract notices are a standing agenda item at the monthly Contract Review Meeting held between commissioners and WHT. Please refer to the individual exception pages for further details.		

Expected date to meet standard	See individual exception pages
Lead Director	Director of Finance

National Contract	X	Local Contract		Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Outpatient DNA Rates	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
		9.00%	12.11%	12.38%	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance Results

This indicator measures the number of outpatient appointments where the patient 'Did Not Attend' against the total number of outpatient appointments.

The information is taken from a report on the InfoHub derived from data entered into the patient administration system (Lorenzo). It looks at outpatient activity for community and acute contracts. It calculates the number and percentage of DNAs (where listed as a DNA or a patient attended late or was not seen) against the number of appointments. The figure excludes any cancellations.

DNAs have an enormous impact in terms of cost and waiting time, significantly adding to delays along the patient pathway.

Performance of 12.11% in January has improved by 2.25% compare to December (14.36%) but does not achieve the agreed monthly improvement trajectory of 9.00%.

The higher DNA rate reported in December 2017 was partly attributable to adverse weather conditions (week commencing 11th December 2017) and the Christmas period (week commencing 25th December 2017).

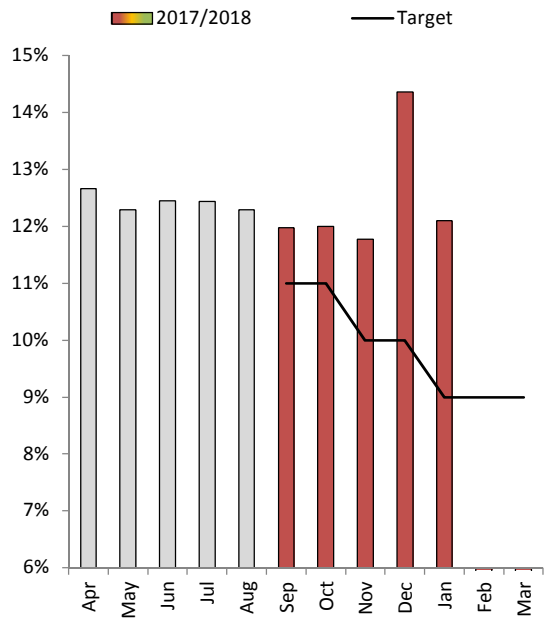
Divisional Performance
- MLTC = 12.72% (compared to 14.31% in December)
- SURG = 11.34% (compared to 13.56% in December)
- WCCSS = 12.49% (compared to 15.32% in December)
.

New Actions:-
- It is anticipated that the DNA rate will reduce with the on-going roll out of text messaging by specialty and ensuring that correct telephone numbers are captured for patients.

- DNA rates are monitored via the Outpatients Improvement Workstream which is chaired by the Divisonal Director of Ops for Surgery.

Continuing Actions:-
- This metric is covered within the Outpatients Improvement Programme, the Executive Lead is the Chief Operating Officer and the Operational Lead is the Corporate Director.

- The Trust continues to roll out the text reminder service. Approximately 86% of all live acute clinics are currently included within the text messaging service.



Trajectory					
Apr	May	Jun	Jul	Aug	Sept 11.00%
Oct 11.00%	Nov 10.00%	Dec 10.00%	Jan 9.00%	Feb 9.00%	Mar 9.00%
Expected date to meet standard	To be agreed				
Lead Director	Chief Operating Officer				

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Length of Stay	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
	7.01		7.50	7.14	▲	

What is driving the reported underperformance?

Performance results:
Overall performance for LoS in January was 7.50 days. This is a slight improvement compared to 7.51 days in December. This indicator is not a contracted measure but is a core metric utilised by Trusts to monitor average LoS. The criteria for measuring patient's average LoS, based on definitions within the technical guidance, excludes patients with a zero length of stay and obstetric patients.

Divisional Breakdown:

	Ave LoS Dec	Ave LoS Jan	% LoS <72hr	% LoS of "0"
MLTC	8.75	8.93	51.18%	26.72%
SURG	6.99	6.03	68.58%	20.95%
WCCSS	2.53	2.92	89.87%	65.27%

The average LoS for Medicine and Long Term Conditions and Women, Children's and Clinical Support Services declined during January compared to December however for Division of Surgery, January saw an improvement compared to December.

The following specialties saw the highest increases in the month:

- Colorectal Surgery - 28.80 days in January compared to 18.50 days in December.
- Urology - 5.49 days in January compared to 4.31 days in December.

Benchmarking:
No formal national reports.

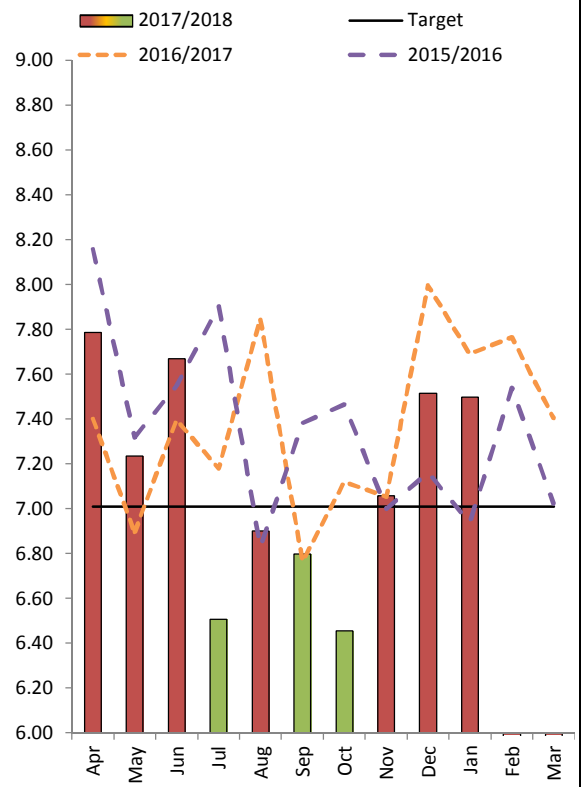
Contractual status:
No contractual requirements apply.

What actions have we taken to improve performance?

New Actions:
The Emergency Care Improvement Team is working with the Trust on a range of areas; initially focusing on LOS reduction

Continuing Actions:
- The Patient Flow group continues to meet and develop new actions as outlined above.
- Work continues to embed SAFER and Red and Green approach at ward level with clinically led discharges.
- As part of the ED Board System Recovery Plan there are proposals to introduce a multi-disciplinary assessment team at ward level who will focus on supporting earlier discharge. The aim is to increase the percentage of patients discharged within 24 to 48 hours who will be eligible to receive therapy treatment, support and continuing healthcare assessments out of the hospital environment. This will help to reduce the number of patients on the medically fit for discharge list.
- The role of the in-reach matron has changed to be aligned to all of the community place based teams. This supports reducing length of stay and prevention of readmission when a patient from the caseload is admitted.

Contractual Financial Penalties | **YTD £**



Expected date to meet standard	To be agreed
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Sleeping Accommodation Breaches	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
	0	11	3	56	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties (LCA)	YTD £	£6,750

Performance results:
There were 3 patient breaches reported within the Trust during January. This is an improvement in performance compared to 9 reported in December and is within the monthly trajectory of 11.

For the 3 patient breaches reported in January the length of breach incurred for each patient was one day. All 3 patients breached on the 10th January and were from Walsall CCG. On the day of stepdown the Trust was on Escalation Level 4 and one of the patients couldn't be transferred to the required ward as it was closed due to infection.

Bed capacity issues within the Trust continue to impact on the timely step down of patients from the Critical Care Unit. As regionally agreed, the rules which apply within HDU are that a patient on critic care should only be counted as a breach if another patient is ready step down whilst the first patient is still there. Patients should be transferred within 4 hours of decision to step down.

Performance is impacted upon by Estates configuration of the unit at present as there is no area for ring fenced step down beds.

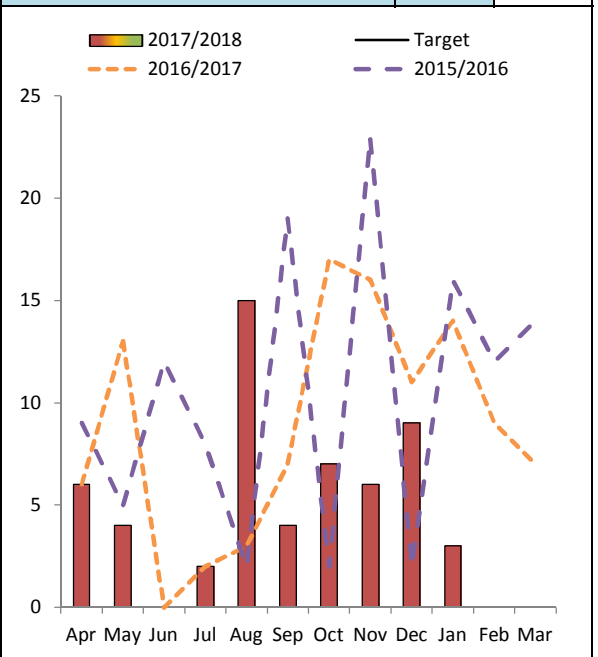
Benchmarking:
Latest benchmarking for January shows that 53 out of 137 Acute Trusts reported sleeping accommodation breaches.

Contractual status:
Mixed Sex Accommodation is a contractual indicator in 2017/18 with a financial penalty attached of £250 per patient involved, per day impacted upon.

* In compliance with the recommendation of the NHS national emergency pressures panel the CCG has temporarily suspended sanctions for this metric.

New Actions;
Agreement has been made with Walsall CCG to extend the 4 hour step down tolerance to 12 hours which is in line with other Trusts, with effect from January.

Continuing actions:
- RCA documents are completed for reported breaches. The RCA documents are shared with the patient flow team and are tabled at Divisional Quality Meetings for discussion/learning to prevent future breaches.
- The critical care outreach team have transferred over to the Surgery Division. Once the team has been embeded they will produce a procedure to support the patient flow process
- A trajectory to achieve small improvement across the year was shared with WCCG and this has been agreed.
- The weekly meeting between Performance and the Care Group manager continues when necessary. This has supported timely dat validation and RCA's being undertaken as soon as possible after the breach has been reported. The receiving Ward of the patient will be approached to contribute to the RCA in order to identify any learning which could improve earlier step down.
- The business case for the new Intensive Critical Care Unit was approved by NHSI in March, this will have single sex accommodation. The project started in April and the anticipated date for completion is Winter 2018.
- Mixed Sex Accommodation breaches are a specific risk on the Critical Care Risk Register.
- All breaches are raised as an incident on the Safe Guard System.
- The critical care unit continues to focus on operating a "push" model
- Emphasis of the importance of the critical care step downs continues within bed bureau.



Trajectory to be agreed with WCCG					
Apr	May	Jun	Jul	Aug	Sept
					10
Oct	Nov	Dec	Jan	Feb	Mar
10	11	11	11	10	9
Expected date to meet standard	Due to limitations with Estates and capacity pressures, on occasion breaches may be unavoidable				
Lead Director	Chief Operating Officer				

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

HSMR (HED) SHMI (HED)	Year Standard	Monthly Trajectory	Oct-17	YTD	Change on last month	Year End Forecast
	100		81.70	92.37	▼	
	100					

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance results:
Hospital Standardised Mortality Ratio (HSMR) compares a Healthcare provider's mortality rate with the overall average rate. The Trust receives this information from the HED system but historically received this from Dr Foster. Due to methodology differences, each system returns a different result. The latest published results report that HSMR was 81.70 for October 2017. For the financial year 2014/15 HSMR was 95.96, for 15/16 was 92.21 and for the financial year 2016/17 HSMR was 94.17. Previous months have been refreshed to reflect the latest published results.

HED have begun publishing a metric defined as the number of excess deaths within the HSMR, it is the difference between the expected deaths and actual deaths. For April 2017 to March 2018 (ytd) there were 42 less deaths than expected.

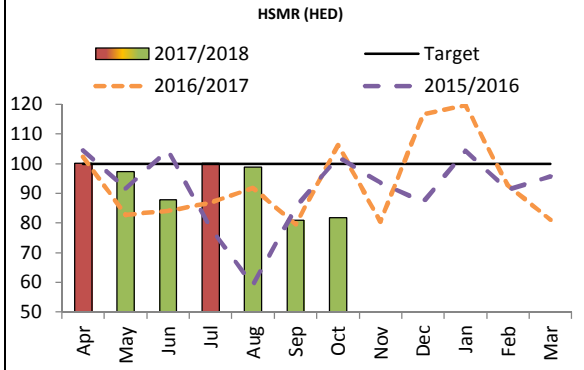
SHMI is a measure of mortality which includes all in hospital deaths and all deaths within 30 days of an inpatient episode. SHMI is published in 2 ways, as a monthly metric by HED and as a rolling 12 month metric published quarterly by NHS Digital. HED monthly SHMI for September was 93.04.

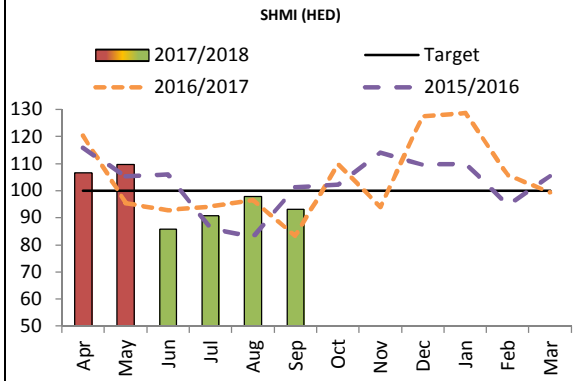
SHMI Benchmarking Based on NHS Digital Data:
SHMI published by the NHS Digital has been released for the period from April 2016 to March 2017 which shows a SHMI rate of 1.06. This ranks the Trust 92nd nationally and 8th regionally.

Contractual status:
No contractual requirements apply.

New actions:
- Review December & January deaths for patients admitted out of hours and with a LoS of 0-1 days.
- Escalate poor performance in reviewing deaths to DDs & CDs
- Review local data for deaths occuring in December to identify any themes and inform reviews required
- Align the actions to address poor documentation to the CQC PCIP work.

Continuing actions:
- RCP Training commenced in October with additional training dates agreed for January & February.
- After discussions with DWMHPT, the identification and support of multi agency reviews for mental health patients has been added to th Learning from Deaths policy.
- A review of deaths coded with COPD is to be undertaken as this diagnosis group appears to be an outlier in relation to the number of deaths. This review will be led by the respective Head of Nursing, Matron and Lead Clinician.
- A review of deaths for patients with pneumonia is to be undertaken as there appears to be a theme of patients who have had a Fractured NOF developing pneumonia. This review will be led by the respective Head of Nursing, Matron and Lead Clinician.
- The Learning from Deaths policy was ratified at TQE and has been included on the internal and external websites.
- The new multi functional mortality reporting process is currently being reviewed with the Business Manager to the Medical Directorate to establish roll out of the reports moving forward.
- Continue to maintain strong relationships with Public Health and the Walsall wide Mortality Group with CCG and GP's to develop health economy wide approaches to improving patient outcomes.
- Working with CCG & Social care to develop shared practice around patients with learning difficulties.





Expected date to meet standard	HSMR Achieving SHMI Achieving
Lead Director	Medical Director

National Contract		Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Infection Control	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
CDiff - Total number of cases of Clostridium Difficile recorded in the Trust	18	2	0	11	▲	
MRSA - total number of cases of MRSA recorded in the Trust	0		0	0	–	

What is driving the reported underperformance?

Performance results:
There were no cases of C.Difficile attributed to Walsall Healthcare NHS Trust during January 2018.

There were no cases of MRSA bacteraemia attributed to Walsall Healthcare NHS Trust during January 2018.

Benchmarking:
CDiff:
Data published one month in arrears by Health Protection England confirms that for December 2017, there were 4 cases of hospital attributable C.Difficile toxin at Walsall Healthcare. This compares to 1 case at Dudley and 1 case at Wolverhampton.

MRSA:
Data published one month in arrears shows there were 3 cases of MRSA recorded regionally for December 2017:
- 1 case at Burton Hospitals NHS Foundation Trust
- 1 case at The Royal Wolverhampton NHS Trust
- 1 case at University Hospitals of North Midlands

Contractual status:
CDiff:
The contract for 2017/18 invokes financial penalties if the number of avoidable cases during the year exceeds 18.

MRSA:
The national contract for 2017/2018 stipulates zero tolerance of MRSA cases. Consequence of breach is £10,000 in respect of each incidence in the relevant month.

What actions have we taken to improve performance?

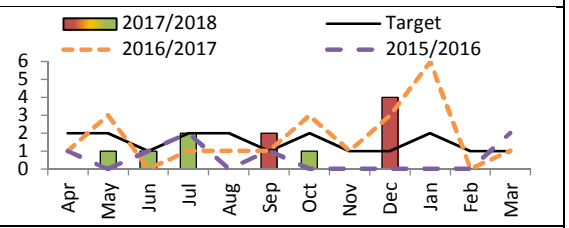
New actions:
CDiff: - As there were no C.Difficile cases reported in January 2018, there are no specific new actions currently being taken.

MRSA: - As there were no MRSA cases reported in January 2018, there are no specific new actions currently being undertaken.

Continuing actions:
CDiff: - Infection Control continue to monitor the Matrons monthly environmental audits and carry out one audit a month for assurance. These are reported at Infection Control Committee monthly.
- Trust wide focus on re-iterating importance of cleanliness of equipment and cleanliness of the Trust environment.
- Infection Control Team are involved, from the beginning, in any meetings and discussions relating to new wards and decant facilities.
- Actions in relation to C.Difficile continue to be monitored at the Infection Control Committee as part of the on-going Infection Control action plan.
- For areas that have reported cases of C.Difficile, a checklist audit is undertaken by the Infection Control Team as part of routine practice to ensure standards are maintained.
- On-going assessment against national standards continues, which includes weekly C.Difficile ward rounds.
- Reviews and assessment of avoidability will be discussed at the bi-monthly RCA meeting, which is attended by Walsall CCG and Public Health representatives.
MRSA: - The "CleanIT" campaign education continues throughout the Trust.
- Work continues with the Continence and Urology services to improve the care of urinary catheters. This will be monitored via the NHS Safety Thermometer.
- The Infection Control nurses continue to follow up all positive MRSA results and re-screen at 28 days post admission.
- Increased patient information on peripheral cannulas.

Contractual Financial Penalties | **YTD £**

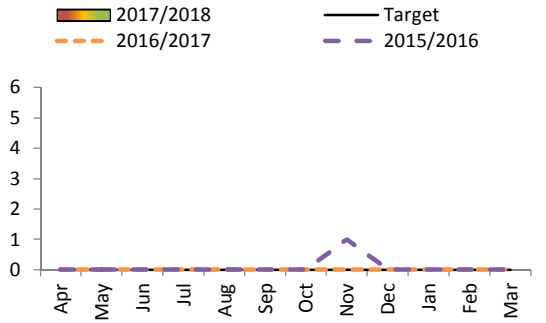
CDIFF



Trajectory

Apr	May	Jun	Jul	Aug	Sept
2	2	1	2	2	1
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2	1	1	2	1	1

MRSA



Expected date to meet standard	February 2018
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Pressure Ulcers - (category 2, 3 & 4's) - Avoidable per 1000 beddays	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
Figures based on all avoidable pressure ulcers acquired within the Trust			0.06		▲	

What is driving the reported underperformance?

Performance results:

Previous month's figures have been updated to reflect the outcomes of RCAs. Please note unstageable PU's are now reported as incidents and included in the table below.

		Hospital	Community
		Total ***(Avoidable)***	Total ***(Avoidable)***
Nov-17	Cat 2	7 **(3)**	11 **(0)**
	Cat 3	1 **(1)**	1 **(0)**
	Cat 4	0 **(0)**	0 **(0)**
	Unstage	4 **(2)**	3 **(2)**
*Dec-17	Cat 2	10 **(2)**	7 **(0)**
	Cat 3	1 **(0)**	0 **(0)**
	Cat 4	0 **(0)**	0 **(0)**
	Unstage	0 **(0)**	2 **(0)**
*Jan-18	Cat 2	4 **(1)**	9 **(0)**
	Cat 3	0 **(0)**	1 **(0)**
	Cat 4	0 **(0)**	0 **(0)**
	Unstage	3 **(0)**	7 **(0)**

Rate per 1000 Beddays					
Nov-17	0.53	*Dec-17	0.12	*Jan-18	0.06

*Figures for these months are still being validated - please note there are 2 Unstageable PU's for November still awaiting final validation but initial discussions have already taken place with the ward involved.
There were 27 PU related incidents reported in November.
The highest reported area of prevalence continues to be on patients heels. There have been 8 incidents confirmed as avoidable in November. The themes identified were:
Hospital – Gaps in waterlow reassessment, delay in air mattress/ delay in reporting & unplugged mattress due to extra beds
Community – missed visit monthly PU check

Contractual status:

2 year CQUIN for 2017-19 worth approx. £258K per year aimed at improving the assessment of wounds. The Q2 report approved by WCCG. Improvement trajectories agreed for Q4.

What actions have we taken to improve performance?

Ward/ Team Actions Taken for avoidables:

All action plans include raising awareness of issues within the team. Hospital - audits in place for extra capacity beds Community - Review of documentation and recruitment in integrated care team.

Education

Annual training programme will commence in Feb with core sessions. The TV team have been reduced since November so training has not been completed but mandatory sessions continue. The team have not been able to repeat sessions for nursing home staff.
Some support sessions have taken place in January and February for A&E and this is ongoing to support busy staff only able to attend short sessions.

Equipment

The new process for ordering air mattresses has not been adhered to by hospital staff or supported by the mattress company as agreed. Further meetings have now taken place and agreement is set to relaunch the new process at the beginning of February.
No agreement has been reached to fund an equipment coordinator to support embedding and sustaining the new process.

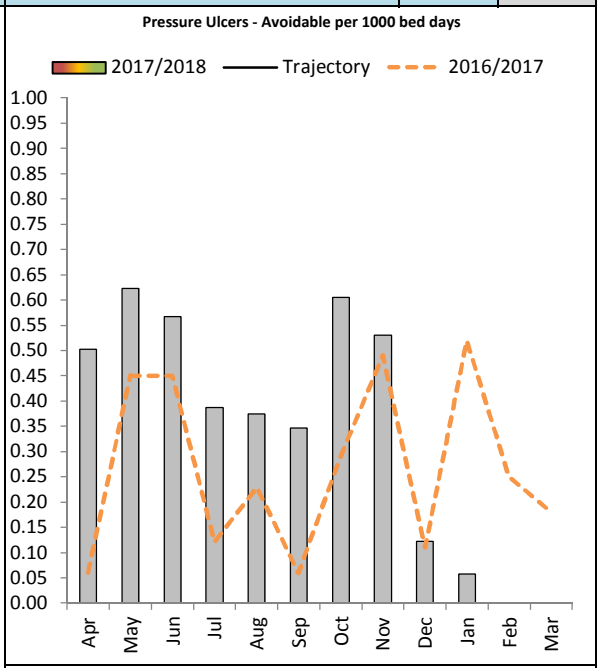
Documentation

Admission document & comfort rounds are undergoing slight alteration to include new proposed SKIN bundle form. The PU prevention pack will incorporate Waterlow/ SKIN bundle and patient infomation in one document, This will be part of the admission document. Patient information is to be perforated but community staff plan use as stand alone to replace previous patient infomation as this is no longer funded and old copies diminished. Clarity is needed for how this will be funded/ obtained. TV will support with this.

Wound Care Formulary Group

The wound care formulary group continue meet monthly with good represention from both hospital and community staff to look at dressing products that will offer savings to the Trust without compromising the patient needs.

Contractual Financial Penalties | **YTD £**



Trajectory (10% reduction by year end on Q1 Baseline)

The original proposal is now being reviewed by the Senior Nursing Team

Apr	May	Jun	Jul	Aug	Sept
Oct	Nov	Dec	Jan	Feb	Mar

Expected date to meet standard	To be agreed
Lead Director	Director of Nursing

National Contract		Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Falls - Number of Falls reported Falls - Rate per 1000 Bed Days	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
			88	848	▲	
	6.63		5.11		▲	

What is driving the reported underperformance?

Performance results:

There were 88 falls reported during January 2018, equating to a rate of 5.11 falls per 1000 beddays for the month which is an improvemei compared to 5.79 in December and achieves the Trust target of 6.63.

Based on Calendar Month		Nov-17	Dec-17	Jan-18
Count of Falls	Total	83	95	88
	MLTC	65	67	64
	Surgery	16	24	23
	WCCSS	1	1	0
	Comm / Corporate	0	2	1
	Other	1	1	0
Rate per 1000 beddays - All Falls		5.50	5.79	5.11
Rate per 1000 beddays - Moderate & Severe Falls		0.27	0.18	0.12

There were 15 reported incidents of patients falling more than once in January which is less than in December. In total these patients had 37 falls. The highest no.of falls were reported on Ward 04 (13 falls), Ward 11 (9 falls), Ward 03 (8 falls), Ward 16 (7 falls) & Swift Discharge (7 falls).

There was one fall resulting in severe harm, located on Ward 14, with the patient suffering a fractured NOF and one fall on Ward 9 resulting in moderate harm with the patient suffering multiple injuries to wrists & femur.

NHS Safety Thermometer results for January show performance of 0.10% of Falls resulting in harm.

Benchmarking:

National benchmarking is via the National Inpatient Falls Audit 2015 which is endorsed by the RCP. National figures for falls are 6.63 per 1000 occupied bed days. Serious & Moderate Harm caused by falls is 0.19 per 1000 occupied bed days.

Contractual status:

No contractual requirements apply.

What actions have we taken to improve performance?

New actions:

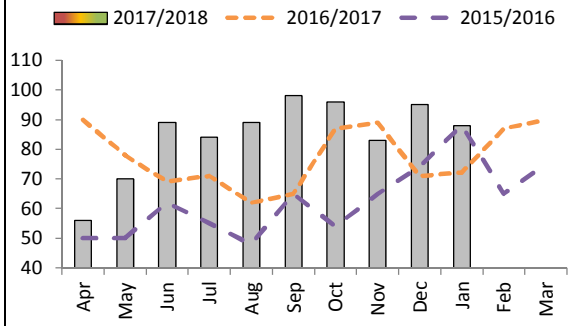
- Falls steering group continues with good representation across both community and acute trust. Terms of reference have been circulated for agreement.
- An audit is planned following the rollout of new risk assessment and care plans
- Falls prevention policy is being reviewed
- The Trust has been accepted as part of a collaborative with NHSI regarding enhanced care

Continuing actions:

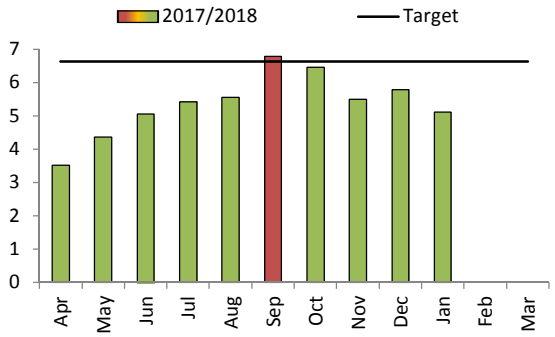
- Monthly falls audits continue
- Falls dashboard is shared with all wards and is monitored via the ward review process.
- All incidents relating to falls are recorded within the Safeguard system.
- Safety huddles on wards continue.
– Moving and handling training includes Falls scenarios and includes completion of the falls and bedrail assessments.
- A monthly monitoring meeting is held between the Corporate Senior Nurse and the Performance & Information Team. This meeting ensures there is a robust process for tracking and chasing outstanding RCA's for falls and ensures action plans are in place for all avoidable incidents and lessons learnt are shared.
- New format of NICE risk assessment has been taken to each ward and explained to staff. New care plans for Falls Prevention and Post Fall Care have been supplied to all wards and explained how and when to use.
- E-learning options being considered regarding Falls prevention
- Findings from audits completed on Wards 3, 4 & 9 found that the majority of patients were at high risk of falls. Also, there was duplication of paperwork and care plans were not personalised. a re-audit of falls recorded on these wards will be undertaken if the new documentation is improving care given to patients.

No Contractual Financial Penalties | **YTD £**

Number of Falls reported



Rate per 1000 Bed Days



Expected date to meet standard	Achieved in January 2018
Lead Director	Director of Nursing

National Contract		Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

VTE Risk Assessment	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
Number of patients who have had a VTE risk assessment	95.00%	95.00%	93.45%	86.91%	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance Results (Validated December 2017):
VTE Risk Assessment did not achieve in December 2017 with performance of 93.45% against a 95% target. This is a significant improvement compared to November's performance of 89.95% but does not achieve the trajectory of 93.50%.

During December, 4348 patients who were admitted to the Organisation were eligible for VTE Risk Assessment and of those, 4063 patients had an assessment recorded within 24 hours. These results have been submitted to the Department of Health. Monthly performance is submitted to the national data system on a quarterly basis.

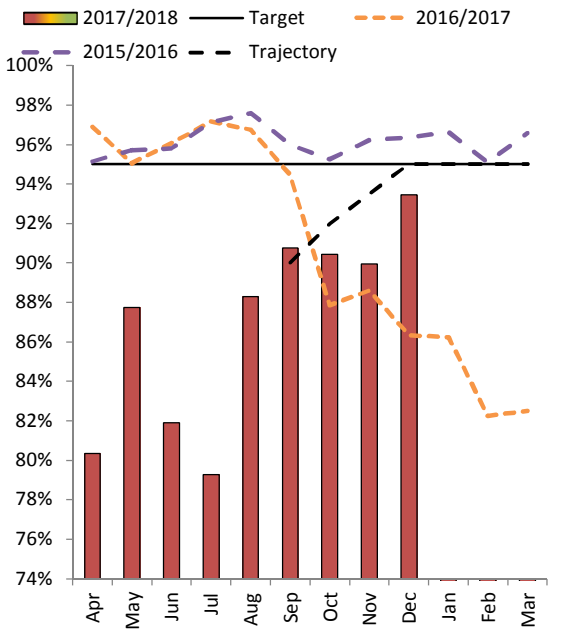
Divisional performance for December 2017 was as follows:-
- Surgery: 95.13% (93.07% in November)
- MLTC: 88.70% (79.64% in November)
- WCCSS: 96.71% (95.50% in November)

There are a number of patients who receive their VTE assessment outside the 24 hours. This latency issue is being addressed.

Benchmarking:
For Quarter Two 2017/2018, the Trust ranked 127th out of 134 nationally and 13th out of 14 regionally.

Contractual Status:
A contract performance notice relating to non achievement of this target was received from WCCG in August. A full response including a trajectory to achieve the target was made in September.

New Actions:-
- As part of the PCIP the following actions are/have been taken to improve VTE performance;
• Daily performance reports are circulated to all Divisional Directors, Clinical Directors, Divisional Directors of Nursing and Maternity Leads
• Provide a ward/clinical area weekly summary report to all DDs, CDs, Consultants, DDON, Senior Ward Sisters
• Provide Vitalpac training on induction for all medical staff
• Provide training for ACPs and lead nurses in AMU and Swift Ward and other adhoc training as requested
• Include VTE performance in the divisional quarterly reviews as part of the Divisional Accountability Framework
• Implement a local process for assessing VTE risks for patients attending fracture clinic requiring plaster casts
• Daily review of the performance report and escalation to responsible consultants and CDs regarding outstanding VTE
• Education and engagement with junior doctors at educational forums
• Standing agenda item for Medical Advisory Committee
• Senior Ward Sisters to monitor compliance during morning board rounds and review during afternoon handover. None compliance to be escalated to the Medical Director
• Senior nurse led daily spot checks in admission areas
• Inclusion of the patient information leaflet in all admission assessment packs
• Proposal for paper based assessment for patients assessed in ED, to be carried out in vitalpac by senior nurses once transferred to an inpatient ward



Trajectory					
Apr	May	Jun	Jul	Aug	Sept 90.00%
Oct 92.00%	Nov 93.50%	Dec 95.00%	Jan 95.00%	Feb 95.00%	Mar 95.00%
Expected date to meet standard	End of Quarter Three 17/18				
Lead Director	Medical Director				

	X	Local Contract	X	Best Practice		CQUIN	

Serious Incidents (inc cat 3&4 pressure ulcers, HCAI's & Falls)

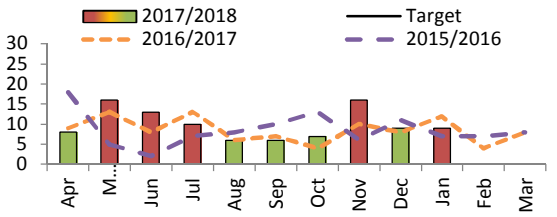
Walsall Healthcare NHS Trust

Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
	102	7	9	100	▼	
	50	2	8	68	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?
There were 17 Serious Incidents reported to WCCG in January 2018, an increase in reporting compared to the 13 Serious Incidents reported in December 2017. Breakdown of Serious Incidents:- • 6 x non-pressure ulcer related incidents • 1 x category 3 pressure ulcer – community acquired • 7 x unstageable pressure ulcers – community acquired • 0 x category 3 pressure ulcer – hospital acquired • 3 x unstageable pressure ulcers – hospital acquired Non-pressure ulcer Serious Incidents include: • 2 x sub-optimal care of the deteriorating patients • 2 x patient falls • 1 x diagnostic issue • 1 x surgical/invasive procedure	Please see monthly Serious Incident Report New trajectories will be considered for the year 2018/19.

Contractual Financial Penalties — **YTD £**

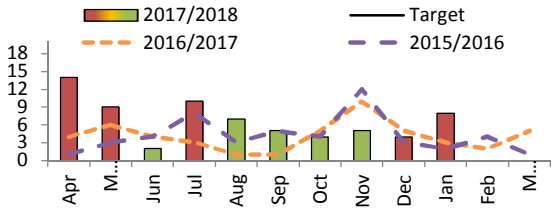
Serious Incidents - Hospital



Trajectory - Hospital

Apr	May	Jun	Jul	Aug	Sept
18	5	2	7	8	10
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
13	6	11	7	7	8

Serious Incidents - Community



Trajectory - Community

Apr	May	Jun	Jul	Aug	Sept
1	3	4	8	3	5
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
4	12	3	2	4	1

Expected date to meet standard	Targets currently based on last years activity.
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

% of Emergency Readmissions within 30 Days of a discharge from hospital	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	10.00%		11.44%		▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance results:
The percentage of emergency readmissions within 30 days of a discharge from hospital is reported one month in arrears.

This metric measures the percentage of patients who were an emergency readmission within 30 days of a previous inpatient stay (either elective or emergency). The criteria excludes Well Babies, Obstetrics and patients referred to the Early Pregnancy Assessment Unit. Performance is reported a month in arrears.
The performance for December is 11.44% which is a decline compared to 10.35% in November 2017.

Of the patients who were re-admitted in December:-
- Approximately 19% of the readmissions were aged under 30 (a decrease compared to 22% in November).
- Approximately 37% of the readmissions were aged over 70 (an increase compared to 33% in November).

The average number of days between the original admission and the re-admission is 10 which is an increase compared to 9.5 days in November.

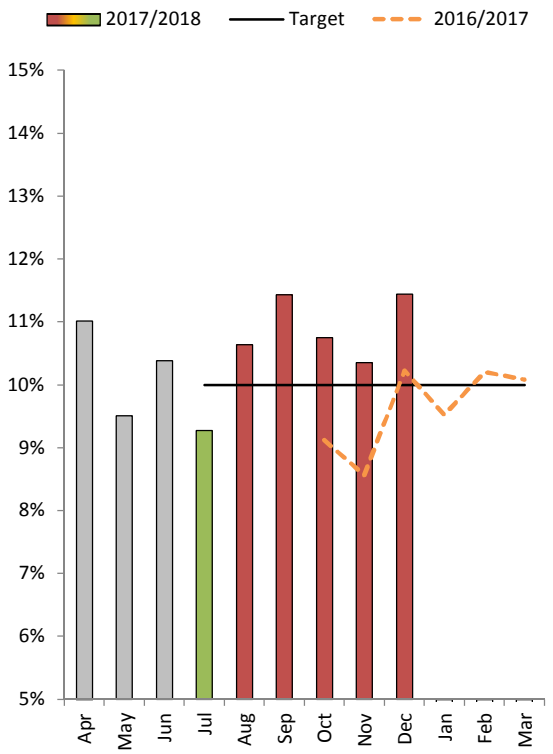
For those patients discharged in the month who were an emergency readmission within 30 days, the average length of stay of the readmission was 4.4 which is an increase compared to 4.3 in November.

Benchmarking:
There are no formal national reports published for this metric.

Contractual status:
No contractual target, however performance is reported monthly to commissioners.

New Actions:
- The review of the GAU readmissions has identified a cohort of patients (a sub group of gynae patients) that are not eligible for inclusion in this metric. Reporting systems will be updated and reflected from next month.

Continuing Actions:
- The community services review all frequent admissions known to their caseloads and have demonstrated a reduction in admissions over the past year. Following a revised methodology to determine the performance for readmissions a robust piece of work will be undertaken in Month 6 to analyse trends and determine strands of work to be undertaken to review causation for key cohorts of patients.
- In line with this, work will be developed to link the work currently being done in the community around frequent admissions to those who are readmitting within 30 days to aid a better understanding of why these patients are frequently being admitted.



Expected date to meet standard	To be agreed.
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Electronic Discharges Summaries (EDS) completed within 48 hrs

Walsall Healthcare NHS Trust

Electronic Discharges Summaries (EDS) completed within 48 hrs	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
Number of EDS completed within 48 hrs of the point of patient discharge	100.00%		91.63%	89.12%	▲	

What is driving the reported underperformance?		No Contractual Financial Penalties	YTD £	

Performance results:

This indicator measures the percentage of EDS completed within 48 hours of the point of patient discharge. Performance has improved significantly in January to 91.63% compared to 89.73% in December and is above the pefrmance acheived in January in the previous two years. However this does remain below the locally agreed target of 95%.

Divisional performance for January 2018 was as follows:-
- Surgery: 91.78% (91.25% in December)
- MLTC: 91.19% (89.30% in December)
- WCCSS: 92.08% (88.94% in December)

Benchmarking:

No national or regional benchmarking available for this measure.

Contractual status:

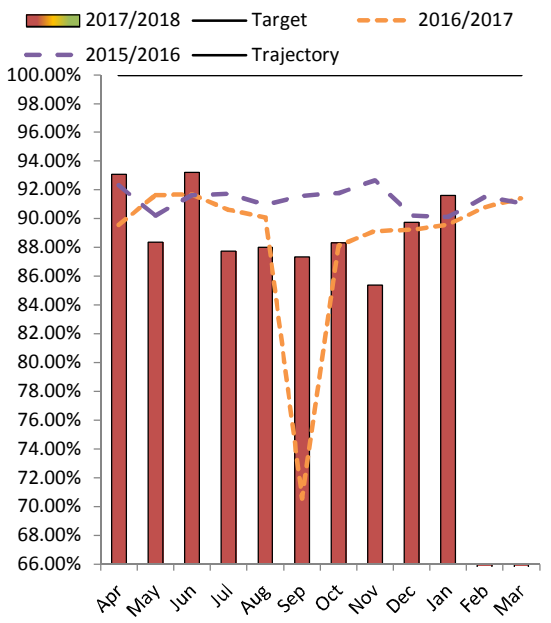
The NHS contract states when transferring or discharging a Service User from an inpatient or daycase or accident and emergency service, the Provider must within 24 hours following that transfer or discharge issue a Discharge Summary to the Service User's GP and/or Referrer and to any third party provider, using an applicable Delivery Method. The Trust has a local agreement to monitor against 48 hours. No financial penalties apply for failure to achieve.

New Actions:

- Review and scrutiny of underlying areas of underperformance is to be undertaken in April working alongside clinical teams with specific attention on clinical processes.

Continuing Actions:

- A review of the discharge summaries is to take place to ensure all summaries are sent out and in a timely manner.
- Quantitave analysis that was presented at MAC to review EDS performance will be shared at the Ground Round meeting to reinforce the importance of accurate information being recorded
- Clinical Coding Lead has presented a qualitative analysis of EDS at MAC demonstrating poor quality information having a potential impact on income via coding. All the CDs have been requested by the MD to reinforce the importance of documentation with their teams.
- Medical champions have been identified for all ward areas who will be dedicated to working with all stakeholders to deliver the Quality and Safety agenda which includes documentation and communication. The Divisional Directors and the Clinical Directors will be responsible for ensuring EDS are completed.
- The Business Manager and the MD are following up outstanding EDS on a daily basis with intensive communication.
- The Organisational Development (OD) are running a programme of education and development sessions for middle grade doctors, topics will cover documentation and EDS.
- The GMC facilitated 2 sessions targeting all medical staff to focus on documentation and communication
- All clinical documents are now electronically sent to GPs.
- Trajectory to be reviewed and considered in conjunction with WCCG.



Trajectory					
Apr	May	Jun	Jul	Aug	Sept
Oct	Nov	Dec	Jan	Feb	Mar

Expected date to meet standard	Trajectory to be reviewed and considered in conjunction with WCCG.
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Dementia Screening 75+ (Hospital)	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	90.00%		80.79%	57.95%	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties apply	YTD £	

Performance results (Validated December 2017):
The national dementia return continues in 2017/18 as a requirement of the standard contract for all acute trusts. This data collection reports on the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours in England who have been identified as potentially having dementia, who are appropriately assessed and who are referred on to specialist service The target for all 3 requirements (screen, assess and refer) remains at 90%.

During December 2017 the Trust failed to achieve the 90% screening target for patients aged 75 years and over with performance of 80.79%. This is an improvement compared to the reported result in November 2017 (44.47%).

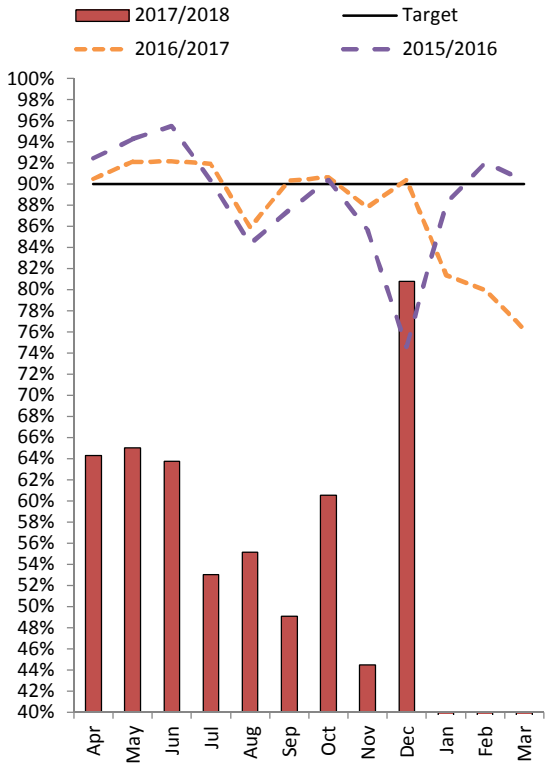
In agreement with WCCG and the Trusts executive lead, the reporting methodology has changed to utlising an audit approach rather than against the full cohort as it was not possible to capture the assessments for all applicable patients due to electronic system limitations. As a result the performance reported in December is considered to be a much more accurate reflection of the Trusts acheivement against this metric.

Benchmarking:
Latest benchmarking (based on November's performance) ranks the Trust 120th out of 125 Acute Trusts who submitted data. Regionally, the Trust ranked 14th out of 14 Trusts.

Contractual status:
No national penalties apply.

Actions:
The Trust submitted the monthly Dementia data and explained the change in methodology to Unify (national data collection portal). However at present this has not been accepted by Unify, however they are sympathtic to the difficulties in collating all of the data electronically. A briefing paper will be drafted for Execs to discuss this issue and following this a further discussion will be held at the Clinical Quality Review Meeting with Walsall CCG.

Continuing actions:
- Wards continue to be requested to support with the data collection process, health records library are supporting the retrieval of notes when requested
- The revised paper assessment tool, which makes the process clearer and easier to undertake, has been circulated to wards and made available on stationary stores for wards to order.
- A revised flow chart has been circulated outlining the dementia screening process and emphasing that the screening can be done at any point during the patients stay in the hospital and must be noted on the EDS.
- Increased education and awareness of delirium and 6 CIT to support effective completion of screening process.
- Consideration of an IT solution is still an option.



Expected date to meet standard	End of Quarter Four 2017/18
Lead Director	Director of Nursing

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Friends & Family Test - ED (% Recommended) Friends & Family Test - Inpatient (% Recommended)	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
	85.00%		75.00%		▼	
	96.00%		93.00%		▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £	

Performance results:

This page relates to all of the areas covered by the Friends & Family measure.

Measure	Target	Dec	Jan
Inpatient	96%	91%	93%
Outpatient	96%	91%	91%
ED	85%	77%	75%
Community	97%	99%	97%
Maternity-Antenatal	95%	80%	97%
Maternity-Birth	96%	83%	100%
Maternity-Postnatal Ward	92%	85%	97%
Maternity-Postnatal Community	97%	100%	99%

Posters have been displayed within areas informing patients about the process to provide feedback on their care. Patients have the option to opt out of the electronic method by either informing the staff within the area or responding to the text message issued which provides an opt out opportunity.

Benchmarking:

For ED, the latest benchmarking (December) ranks the Trust 121st out of 129.

For Inpatients, the latest benchmarking (December) ranks the Trust 120th out of 132.

Contractual status:

NHS standard contract applies but no contractual financial penalties.

New Updates/Actions:

- Maternity Services currently on paper FFT surveys since 1st Jan 2018 for all touch points. Delay in Ipads/tablets re-configuration from IT team has pushed implementation towards end of February or early March 2018.

Inpatients:

- MLTC and Surgery are still trying to secure funding for FFT ipads. WCCSS are hoping to trial them in a few areas. Ipads will make FFT more inclusive, help improve response rates and be cost effective.
- The 'Quiet Protocol' to promote rest and sleep for inpatients agreed by DON, funding awaited for rollout materials.
- Observe & Act programme in the testing stage (originally developed in partnership with NHSE and NHSI).

ED:

- Paediatric ED selected as potential area for rollout of the Always Event® programme in collaboration with the Patient Experience team.
- ED patient journey map and Service Video being progressed with Communications team involvement.
- Volunteers supporting to improve waiting area experience.
- ED team's National survey and FFT action plan progressing. Patient Experience team providing support.

Outpatients:

- Team leaders promoting FFT to patients and discussing results within their teams. Focus on improving the patient registration information quality.

Maternity:

- Re-configured Ipads/tablets' usage to start towards end of February or early March 2018

Community:

- Maintaining current level of support with Community Teams.

Continuing actions:

- FFT results reports regularly presented at the PEG, TQE, TSC & Trust Board.
- Increase use of 'Sound Bites' (audios of patient feedback)
- FFT results available to staff online and via printed weekly reports.

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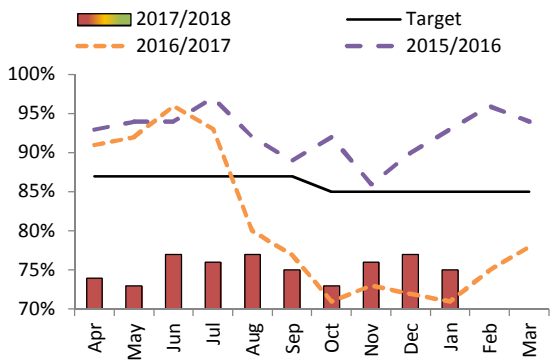
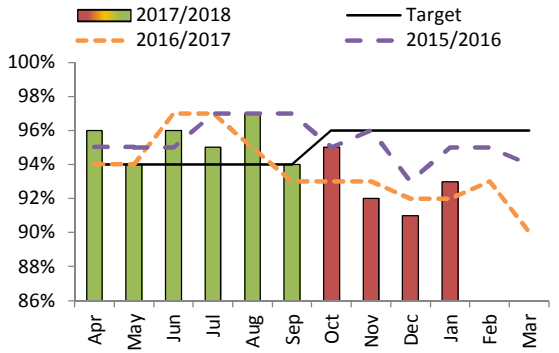
Friends & Family Test - ED (% Recommended)



Friends & Family Test - Inpatient (% Recommended)



Expected date to meet standard	ED - End of Quarter 4
Lead Director	Director of Nursing

National Contract	X	Local Contract		Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Sickness Absence	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
	4.00%		6.23%	5.29%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £

Performance status:
Sickness levels declined in January with performance of 6.23% compared to 5.81% in December 2017 and did not achieve the target of 4.00%. This represents a rise of 1.11% compared to same period 2016/17.

Monthly short-term sickness during January 2018 totalled an estimated cost of £266k and long-term sickness totalled an estimated cost of £304k.

There were 191 long-term episodes of sickness during January 2018 and 14 LTS cases extend to 6 months or more.
The largest cause of absence during January 2018 was Anxiety/stress/depression/other psychiatric illnesses - 1518 FTE Days across 98 episode(s) including 60 long-term.
The second largest cause of short-term absence was Cold, Cough and Flu Influenza - 1419 FTE Days across 298 episode(s) including 9 long-term.
The sickness absence during the past 12 months stands at 5.18%, 1.79% above the Trust target.

Benchmarking:
No national or regional benchmarking available for this measure.

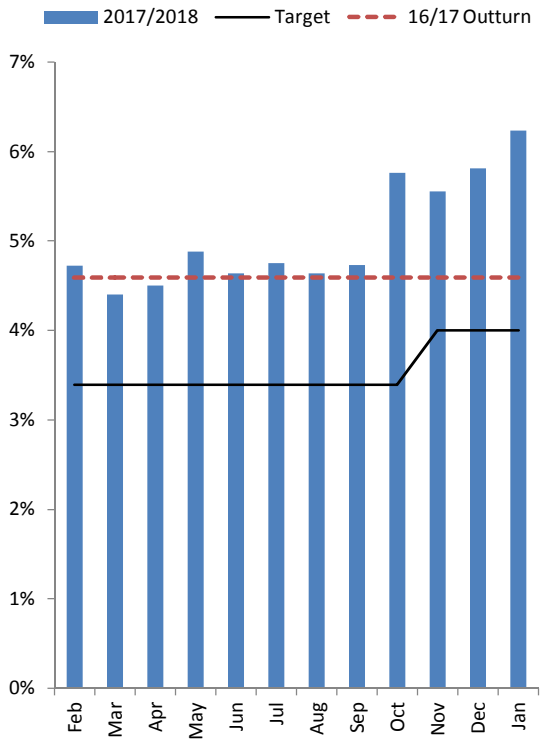
Contractual status:
No contractual requirements apply.

Continuing Actions:
- We have identified a delay with managers closing down episodes of sickness absence. This can contribute to apparent increases in absence; something which is monitored and addressed by the HR Ops Team.

- In respect to Mental Health the OH department offers weekly Stress Management groups for staff. Walsall & Dudley Mental Health Trust are putting on training sessions for Managers around Resilience and Stress Management. OH triaging referrals for staff to the Listening Centre for 1:1 counselling support. Access to psychologist from OH. Mindfulness training is also available to all staff.

- The Health & Well-being hub continues to roll out schemes and embed/promote heathy lifestyle benefits.

- The HR Team have developed KPIs to support attendance management and continue to work with Occupational Health on a case by case basis.



Expected date to meet standard	March 2018
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

PDR Compliance	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
	90.00%		78.24%	78.24%	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £

Performance status:
The appraisal rate at the end of January 2018 was 78.24%, an increase on December's 75.90%. This represents a rise of 2.34% month on month.

There were 144 Band 7 & above colleagues requiring an annual appraisal at the end of January 2018, resulting in a 75% compliance rate for this group.

All divisions experienced a rise in compliance levels over the past month, of between 1% and 3%.

The Women's, Children's & Clinical Support Services division has the highest level of compliance at 87.71%.

Benchmarking:
No national or regional benchmarking available for this measure.

Contractual status:
No contractual requirements apply.

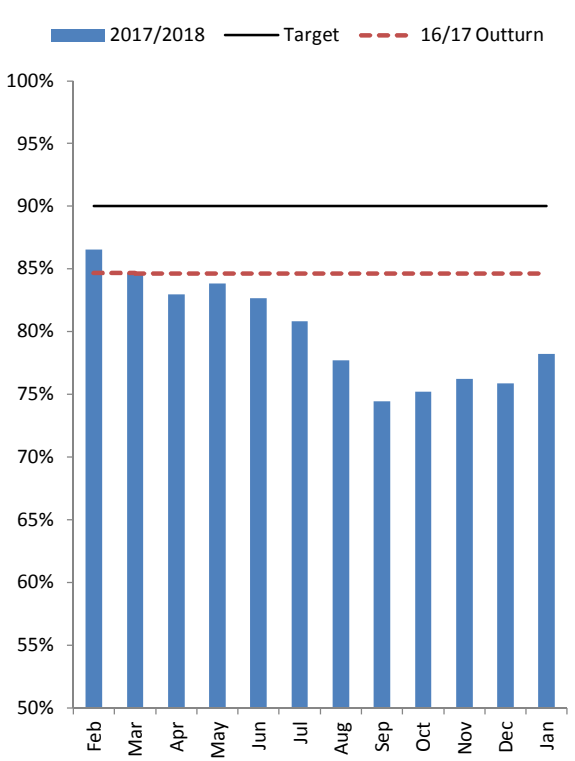
Continuing Actions:
- HR KPI reports have been developed based upon line management, rather than organisational, hierarchy lines.

- This will allow managers to focus on the performance of their individual teams, with easy to follow updates released on a weekly basis.

- It is hoped that this alternative approach to KPI reporting will promote a culture of ownership and competition.

- Allied to this will be the upcoming publication of HR KPI league tables, with the performance of services ranked in a meaningful and engaging way.

- This approach to performance management has been implemented within other local organisations successfully, with tangible improvements evidenced when both managers and service leads share not only performance levels openly but also best practice.



Expected date to meet standard	March 2018
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Mandatory Training Compliance	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
	90.00%		78.14%	78.14%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £

Performance status:
Mandatory training compliance levels in January have declined to 78.14% compared to 79.65% reported in December. A fall of 1.51% month on month. This represents a fall of 1.36% since the end of Q2 17/18 and a fall of 3.80% compared to the same period last year.

The largest improvement owed to Conflict Resolution, whereby compliance rose by 0.28% month on month.
All divisions have experienced a fall in compliance levels over the past month, of between 1% and 8%.

Women's, Children's & Clinical Support Services holds the highest level of divisional compliance, at 87%; which is 3% below the Trust target for Mandatory Training compliance.
Medicine & Long-Term Conditions holds the lowest levels of compliance, at 69%; this is 21% below agreed target levels.

Benchmarking:
No national or regional benchmarking available for this measure.

Contractual status:
No contractual requirements apply.

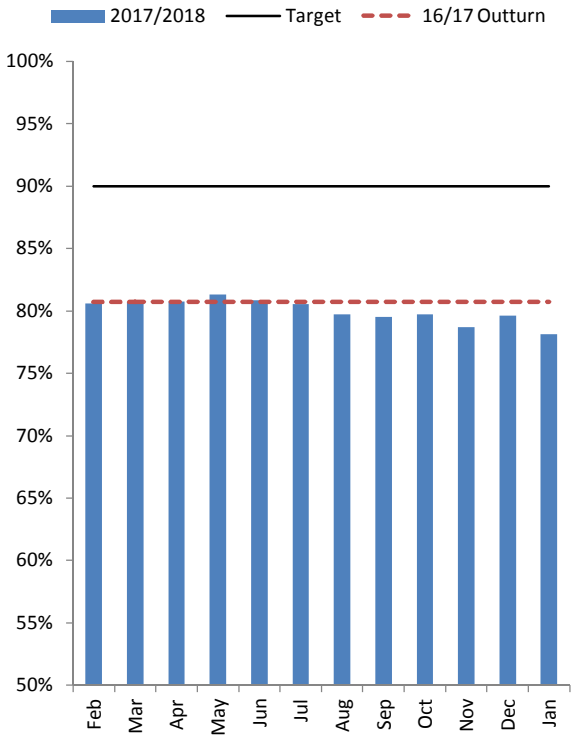
Continuing Actions:
- HR KPI reports have been developed based upon line management, rather than organisational, hierarchy lines.

- This will allow managers to focus on the performance of their individual teams, with easy to follow updates released on a weekly basis.

- It is hoped that this alternative approach to KPI reporting will promote a culture of ownership and competition.

- Allied to this will be the upcoming publication of HR KPI league tables, with the performance of services ranked in a meaningful and engaging way.

- This approach to performance management has been implemented within other local organisations successfully, with tangible improvements evidenced when both managers and service leads share not only performance levels openly but also best practice.



Expected date to meet standard	August 2018
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

CQUINs

2017/18 CQUIN SCHEMES - Status as at 31st January 2018 (values based on initial contract & are subject to change if the contract value changes.)

	Total year 1	Q1 - Confirmed	Q2 - Confirmed	Q3 - Available (Submitted)	Q4 - Available	ELEMENTS / Progress
Walsall CCG		**Risk Rating**				
NHS Staff Health & Wellbeing Director of OD	£460,151				£153,384	**Introduction of Health & Wellbeing Initiative** **By QTR 4:** Achieving a **5% point improvement in two of the three** NHS **annual staff survey questions on health and wellbeing, MSK and stress** or a set percentage. The two questions do not have to be pre-selected before the staff survey results, with 50% of the value of this indicator relating to performance in one question and the remaining 50% of the value relating to performance in a second question. The 5% point improvement should be achieved over a period of 2 years, with the baseline survey being the 2015 staff survey. For 18/19 this requires a 10% increase from the 2015 baseline or achieving the minimum threshold. Sliding scale for payment applies per question for improvements over 3%. **Question 9a**: Does your organisation take **positive action on health and well-being**? Providers will be expected to achieve an improvement of 5% points in the answer "yes, definitely" compared to baseline staff survey results or achieve 45% of staff surveyed answering "yes, definitely". Sliding scale for payment applies per question for improvements over 3%. Baseline 2015: 25.8%; Year 1 target 30.8% & Year 2 target 35.8%. **Status**: Initial results = 28% resulting in no payment (based on less than 3% improvement)
						Question 9b: : In the last 12 months have you **experienced musculoskeletal problems (MSK) as a result of work activities**? Providers will be expected to achieve an improvement of 5% points in the answer "no" compared to baseline staff survey results or achieve 85% of staff surveyed answering "no". Sliding scale for payment applies per question for improvements over 3%. Baseline 2015: 75.45%; Year 1 target 80.45% & year 2 target 85%. **Status:** initial results = 74% no payment (no improvement)
						Question 9c: During the last 12 months have you **felt unwell as a result of work related stress**? Providers will be expected to achieve an improvement of 5% points in the answer "no" compared to baseline staff survey results or achieve 75% of staff surveyed answering "no" Baseline 2015: 58.44%; Year 1 target 63.44% & year 2 target 68.44%. **Status:** initial results = 58% no payment (no improvement)
					£19,173	**Healthy food for NHS staff, Visitors & Patients** **By QTR 4:** WCH will be expected to build on the 2016/17 CQUIN by: Firstly, maintaining the 4 changes that were required in the 2016/17 CQUIN. a.) The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS) .
					£19,173	b.) The banning of advertisements on NHS premises of HFSS;
					£19,173	c.) The banning of HFSS from checkouts;
					£19,173	d.) Ensuring that healthy options are available at any point including for those staff working night shifts. 50% payment for maintaining the above. Sliding scale for payment applies per question for improvements over 3%. **Status**: Letter to be drafted between the Trust and food providers committing to keep the changes and a paper to be drafted to go to board during Q4 summarising progress made to date. Meeting booked with WCCG early January 2018 to confirm Q4 submission requirements. **Risk:** Steering group confirmed to keep all this element at risk.
					£25,564	Secondly, introducing three new changes to food and drink provision. a.) 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). 2018/19 - increases to 80%.
					£25,564	b.) 60% of confectionery and sweets do not exceed 250 kcal. 2018/19 - increases to 80%.
					£25,564	c.) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g 2018/19 increases to 75%. **Status**: meeting with WCCG took place early July, initial visual audit shows good compliance, detailed audit conducted during September for Blakemore's (SPAR), national guidance received in October, audit to be repeated. Meeting with WCCG planned for Jan 18 to agree Q4 submission content. Elior had signed up to the voluntary scheme to reduce SSB's to zero. **Risk:** Agreed by Exec Director lead and H&WB steering group place this element all at risk.
					£76,692	**Improve uptake of flu vaccinations for front line staff** **QTR 4:** Year 1 - Achieving an uptake of flu vaccinations by frontline clinical staff of 70% by February 28th 2018. Sliding scale for payment applies. year 2 increases to 75%. **Status:** Campaign has commenced, latest data (Jan) shows 63.5% compliance. **Risk**: Agreed by Exec Director lead and H&WB steering group place this element at partial risk, i.e.
					£76,692	achieving 50 - 60% compliance would provide 25% payment, 60-65% = 50%, 65-70% = 75%. 70%+ =
Sub totals	£460,151	£0	£0	£0	£460,151	

Improving services for people with mental health needs who present to A&E COO	£257,685.00	£25,769				**Improving services for people with mental health needs who present to A&E** **QTR 1:** MH trust and acute trust to review most frequent A&E attenders who have attended 10-15 times or more within the last 12 months (i.e. throughout 2016/17). Jointly identify subset of people who would benefit from assessment, review, and care planning with specialist mental health staff. Record the number of attendances as baseline. Assure WCCG that work has been undertaken with partners to identify if the identified cohort also present frequently at other UEC system touch points. **Status: Confirmed by WCCG Achieved**. Baseline: there are 13 patients who fulfil the criteria with a corresponding 197 ED attendances in 2016/17.
			£25,769			**QTR 2:** To work with DWMHPT to identify whether the presentations of the identified cohort were coded appropriately in A&E HES dataset. Submission deadline 29th September extension granted till 20th October. **Status:** Joint meeting took place 17 October 2017 (slippage on the date). Internal audit of A&E mental health coding completed, following the findings plans agreed for regular sharing of data regarding people attending A&E. The cohort has been reduced down to 10 patients (159 attendances)
						QTR 2: Establish joint governance arrangements to review progress against CQUIN and associated service development plans. **Status:** Draft arrangements shared and agreed in principal, formal governance process to be confirmed.
			£25,769			**QTR 2:** To work with other key system partners as appropriate/necessary to ensure that: • Care plans (co-produced with the patient and written in the first person) are in place for each patient in the identified cohort of frequent attenders; • A system is in place to identify new frequent attenders and ensure that care plans are put in place swiftly;• Care plans are shared with other key system partners (with the patient's permission). **Status:** Draft arrangements shared and agreed in principal, formal governance process to be confirmed. **Confirmed by WCCG Achieved.**
			£51,537			**QTR 2:** Bringing in other local partners as necessary/appropriate, agree service development plan to support sustained reduction in A&E frequent attendances by people with MH needs. This is likely to include enhancements to: • Primary care mental health services including IAPT; • Liaison mental health services in the acute hospital; • Community mental health services and community-based crisis mental health services; This work is likely to need to be undertaken with other partners outside of the NHS, including social care, public health and voluntary sector partners. **Status**: Draft arrangements shared and agreed in principal, formal governance process to be confirmed. **Confirmed by WCCG Achieved.**
				£25,769		**QTR 3:** Jointly review progress against data quality improvement plan and all confirm that systems are in place to ensure that coding of MH need via A&E HES data submissions is complete and accurate, to allow confidence that Q4 submissions are complete and accurate. Assurances provided to CCGs accordingly. **Status: Q3 submitted.** Monthly audits continue, no coding issues identified to date. Joint meetings with DWMHPT continue. Baseline recalculated to 10 patients (now includes 3 replacement patients following [illegible]
					£103,074	**QTR 4:** 20% reduction in A&E attendances of those within the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. Target: No more than 106 attendances. Sliding Scale for payment applies.
Sub totals	£257,685.00	£25,769	£103,074	£25,769	£103,074	
Improving the assessment of wounds DoN	£257,685					**Improving the assessment of wounds** Aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment **QTR 1:** Establish clinical audit plan. **Status**: Audit template designed, shared and agreed with WCCG.
			£128,843			**QTR 2: By 30 November 2017:** Completion of Clinical audit to provide a baseline figure for the number of patients with chronic wounds that have received a full assessment. Full audit report and improvement plan with trajectory to be provided for commissioner. **Status:** Audit has been completed, compliance rate is 39.33%, an improvement trajectory of 55% has been agreed. **Risk: Confirmed by WCCG Achieved.**
					£128,843	**QTR 4: By 31 May 2018:** Repeat clinical audit to demonstrate an improvement in the number of patients with chronic wound who have received a full wound assessment. Target is 55%. Sliding scale applies. 2018/19: Sustain the reduction for the selected cohort and reduce total number of attendances to A&E by 10% for all people with primary mental health needs. (Q4 18/19 compared to Q4 17/18)
Sub totals	£257,685	£0	£128,843	£0	£128,843	

NHS e-Referrals D of S&T	£257,685	£64,421				**NHS e-Referrals:** relates to GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service. All providers to publish ALL such services and make ALL of their First Outpatient Appointment slots available on e-RS by 31 March 2018 **QTR 1:** Providers should supply a plan to deliver Q2, Q3 and Q4 targets to include: A definitive list of all services/clinics accepting 1st O/P referrals and details of the NHS e-RS services they are mapped to, identifying any gaps to be addressed through this CQUIN. A trajectory to reduce Appointment Slot Issues to a level of 4%, or less, over Q2, Q3 and Q4. **Status:** plan submitted to WCCG. Baseline 39% of clinics published, ASI rate 83%. Project team established, fortnightly meetings scheduled. ASI rate target of 4% or less challenged with WCCG & NHS Digital.
			£64,421			**QTR 2:** 80% of Referrals to 1st O/P Services able to be received through e-RS. Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment Slot Issues by service reducing to 4% or less in line with the agreed trajectory set in Q1. **Status**: Q2 submitted, 85% of specialities are now mapped to the DOS. ASI rates achieved 62.45% in September. (July 74% and August 70%). **Risk:** Targets; 80% available slots & 70% ASI rate.: **Confirmed by WCCG Achieved**
				£64,421		**QTR 3**: As Qtr. 2 except 90% of Referrals to 1st O/P Services & achieve ASI issues in line with agreed trajectory (36%) **Risk: Q3 Submitted:** Services published to the DOS (based on the Q1 listed services as agreed with WCCG) is 90%, this achieves the 90% target. ASI rates continue to reduce, December rate was 0.414 against an original trajectory of 0.36, however a request has been formally made to WCCG & NHS E to revise Q3 target to 0.5 and Q4 target to 0.2. WCCG to advise of their decision.
					£64,421	**QTR 4**: Same as Qtr. 2 except 100% of Referrals to 1st O/P Services & achieve 4% or less ASI issues. **Risk:** As above.
Sub totals	£257,685	£64,421	£64,421	£64,421	£64,421	
Offering advice and guidance D of S&T	£257,685	£64,421				**Offering advice and guidance** The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative. **QTR 1: 30 July 2017:** Agree specialties with highest volume of GP referrals for A&G implementation. Agree trajectory for A&G services to cover a group of specialties responsible for at least 35% of GP referrals by Q4 2017/18. Agree timetable and implementation plan for introduction of A&G to these specialties during the remainder of 2017/18. Agree local quality standard for provision of A&G, including that 80% of asynchronous responses are provided within 2 working days **Risk: Confirmed by WCCG Achieved.**
			£64,421			**QTR 2: 31 October 2017:** A&G services mobilised for first agreed tranche of specialties in line with implementation plan and trajectory. Local quality standard for provision of A&G finalised and a Baseline data for main indicator provided **Status**: Project team established, fortnightly meetings scheduled. Consultant Connect currently provides 10.97% (Gen. surgery, gastro, urology, diabetics and endocrinology). plans to be agreed when WCCG decommission this service to transfer these services over to ERS. **Risk:** Q2 submitted **Confirmed by WCCG Achieved.**
				£64,421		**QTR 3: 31 January 2018:** A&G services operational for first agreed tranche of specialties. Quality standards for provision of A&G met, Data for main indicators provided and Timetable, implementation plan and trajectory agreed for rollout of A&G services to cover a group of specialties responsible for at least 75% of GP referrals by Q4 2018/19 **Risk: Q3 submitted** meeting scheduled with WCCG for the 15th February to discuss A&G and tariff. During Q3 activity was recorded using Consultant Connect providing evidence that A&G is operational.
					£64,421	**QTR 4: 31 May 2018:** A&G services operational for specialties covering at least 35% of total GP referrals by start of Q4 and sustained across the quarter, Quality standards for provision of A&G met and Data for main indicator provided **RISK**: Q4 at risk. Consultant Connect is due to be switched off meaning those services that have used this system will need to move to using ERS A&G. Dermatology due to commence pilot 12th February.
Sub totals	£257,685	£64,421	£64,421	£64,421	£64,421	
Personalised care and support planning DoN	£257,685		£64,421			**Personalised care and support planning: to introduce the requirement of high quality personalised care and support planning** **QTR 2: (end of Sept 17)** Submission of a plan to ensure care & support planning is recorded by providers. Status: Agreed with WCCG definition of long term conditions. Plan created. Linking into the Total Mobile b. Plan produced but recording system not in place = 50% of proportion of CQUIN value c. Plan produced and recording system put in place = 100% of proportion of CQUIN value Risk: none. **Confirmed by WCCG Achieved.**
				£38,653		**QTR 3**: identify the number of patients as having multiple LTCs and who will be prioritised for personalised care and support planning (establishment of cohort) compared to the total number of patients served Q3 submitted to WCCG.
					£77,306	**QTR 4a:** To confirm what proportion of relevant staff have undertaken training in personalised care and support planning.
					£77,306	**QTR 4b:** To confirm the number of patients identified for the cohort who have one or more LTCs and have been assessed as having a low activation level
Sub totals	£257,685	£0	£64,421	£38,653	£154,611	
Preventing ill health by risky behaviours – alcohol and tobacco DoN	£276,091	£69,023				**Preventing ill health by risky behaviours – alcohol and tobacco** **QTR 1: each element worth 33% of Q1** **a)** completing an information systems audit; b) training staff to deliver brief advice, c) collect baseline data (on elements a) to e)) Risk: **Confirmed by WCCG Achieved**
			£3,451	£3,451	£3,451	Tobacco screening: Percentage of unique adult patients who are screened for smoking status AND whose results are recorded **Q2 Confirmed Achieved Q3: Target 90% Actual 92% . Q4 target = 90%**
			£13,805	£13,805	£13,805	Percentage of unique patients who smoke AND are given very brief advice **Q2 Confirmed Achieved Q3: Target 75% Actual 80%. Q4 target 80%.**
			£17,256	£17,256	£17,256	Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication. **Q2 Confirmed Achieved Q3 target 50% Actual 52%. Q4 target 60%.**
			£17,256	£17,256	£17,256	Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems **Q2 Confirmed Achieved Q3 target 80% Actual 90%. Q4 target 90%.**
			£17,256	£17,256	£17,256	Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral. **Status:** Q2 submitted and expected to achieve. Monthly audits continue (10 patients per ward) close monitoring of compliance and follow up with wards who are not performing the audit in full or have low compliance. Meeting arranged with WCCG during December to agree improvement trajectories. **Q2 Confirmed Achieved Q3 target 80% Actual 84%. Q4 target 85%.**
Sub totals	£276,091	£69,023	£69,023	£69,023	£69,023	

Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) MD	£257,685	£8,053	£8,053	£8,053	£8,053	**Timely identification of sepsis in emergency departments** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis The indicator applies to adults and child patients arriving in hospital as emergency admissions A minimum of 50 records per month after exclusions for ED. 90% Target. Sliding scale 50-89% = 10%. **Status:** The audit methodology of NEWs scores continues not to identify the full required number of patients and continues to be time consuming. A centralised database is being created during Q3 to support the audit process. Risk: **Q1 achieved 95.33%. Q2 achieved 94.85% Q3: 95.77% Achieved.** Q4 at risk
		£8,053	£8,053	£3,221 £4,832	£8,053	**Timely identification of sepsis in acute inpatient settings** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis. The indicator applies to all patients on acute in-patient wards. A minimum of 50 records per month after exclusions for Inpatients. 90% Target. Sliding scale 50-89% = 10%. **Status**: as ED. Risk: **Q1 achieved 90%. Q2 achieved 90.91%. Q3: 88.73%. partial achievement 10%.** Q4 at risk
		£3,221 £4,832	£3,221 £4,832	£3,221 £4,832	£8,053	**Timely treatment for sepsis in emergency departments** The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour. Applies to adults and child patients arriving in hospital as emergency admissions. 90% Target. Sliding scale 50-89% = 10% **Status:** Actions taken; additional teaching, grand round presentation, raising awareness through care groups, wards and mandatory training. **Risk:** Q1 86.21% partial achievement 10%. Q2 88.57% partial achievement 10%. **Q3: 89.34% partial achievement 10%.** Q4 at risk.
		£3,221 £4,832	£3,221 £4,832	£3,221 £4,832	£8,053	**Timely treatment for sepsis in acute inpatient settings** The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour. The indicator applies to adults and child patients on acute in-patient wards. 90% Target. Sliding scale 50-89% = 10% **Risk:** Q1 53.57% partial achievement 10%. Q2 63.27% partial achievement 10% **Q3 61.54% partial achievement 10%**. Q4 at risk.
		£16,105				**Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours** Review to show; Stop, IV to oral switch, OPAT (Outpatient Parenteral Antibiotic Therapy), Continue with new review date, Continue no new review date, Change antibiotic with Escalation to broader spectrum antibiotic, Change antibiotic with de-escalation to a narrower spectrum antibiotic, Change antibiotic e.g. to narrower / broader spectrum or as a result of blood culture results. Local audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal. Perform an empiric review for at least 25% of cases in the sample **Risk: Q1 achieved.**
			£16,105			Perform an empiric review for at least 50% of cases in the sample. Local audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal. **Risk: Q2 achieved.**
				£16,105		Perform an empiric review for at least 75% of cases in the sample. Local audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal. Risk Q3 Submitted. 98.51% compliance.
					£16,105	Perform an empiric review for at least 90% of cases in the sample. Local audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal.
					£21,474	**Reduction in antibiotic consumption per 1,000 admissions** 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions: Target 2% reduction for those trusts with 2016 consumption indicators above 2013/14 median value. **Status:** Improved processes for; follow up of restricted antibiotics, surveillance and system to drive better prescribing.
					£21,474	**Reduction in antibiotic consumption per 1,000 admissions** 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions. Target 1% reduction for those trusts with 2016 consumption indicators above 2013/14 median value **Status**: Antimicrobial review rounds targeting high users.
					£21,474	**Reduction in antibiotic consumption per 1,000 admissions** 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions. Target 2% reduction for those trusts with 2016 consumption indicators above 2013/14 median value **Status:** New guidelines implemented in April 2017 to encourage the use of alternative antibiotics.
Sub totals	£257,685	£48,317	£48,317	£48,317	£112,737	
Supporting Proactive and Safe Discharge – Acute Providers COO (a&c) D of S&T (b)	£460,151		£184,060			Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories **Q2:** i) Map and streamline existing discharge pathways across acute, community and NHS-care home providers, and roll-out protocols in partnership across local whole-systems. ii) Develop and agree with commissioner a plan, baseline and trajectories which reflect expected impact of implementation of local initiatives to deliver the part b indicator for year 1 and year 2. As part of this agree what proportion of the part b indicator for each year will be delivered by the acute provider and what proportion will be delivered by the community provider. Achievement of part b will require collaboration between acute and community providers **Status**: **Confirmed by WCCG Achieved.**
		£69,023				Emergency Care Data Set (ECDS) To have demonstrable and credible planning by the end of Quarter 1, in order to commence timely submission of data from 1st October 2017 Q1: Type 1 or 2 A&E provider has demonstrable and credible planning in place to make the required preparations (e.g. by upgrading IT systems and training staff) so that the Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017. **Status:** plan submitted pending WCCG decision on payment. **Risk: Confirmed by WCCG Achieved**.
				Q3 moved into Q4 as agreed with WCCG	£11,504	Q3: Go live with ECDS. **Status:** Due to the delay with the Lorenzo upgrade by the system provider it was not possible to achieve the Q3 requirements , following our request WCCG have agreed to move the CQUIN requirements from Q3 into Q4. project plan is progressing, initial data flows have commenced, **Risk: 50% payment for going live - subject to confirmation this has been achieved.**
					£2,301	Q3: Submitting data at least weekly **Status:** as above, initial data flows have commenced, project is aiming to deliver weekly flows by the end of Q4. **Risk:** Q4 at risk.
					£4,602	Q3: 95% of patients have both a valid Chief Complaint . Chief complaint should be any value from the ECDS Chief Complaint code set (SNOMED CT). **Status:** As above. Sliding scale for payment: <90% = zero, 90-95% = 50%, >95% = 100%. Current position for January = Chief Complaint = 89.74% **Risk:** Q4 at risk.
					£4,602	Q3: 95% of patients have a Diagnosis (unless that patient is streamed to another service) Diagnosis should be any value from the ECDS diagnosis code set (SNOMED CT). **Status:** As above. Sliding scale for payment: <90% = zero, 90-95% = 50%, >95% = 100%. Current position for January Diagnosis = 36%. **Risk:** Q4 at risk.
					£184,060	Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17) Baseline = 47.84%.
Sub totals	£460,151	£69,023	£184,060	£0	£207,068	
Sub Total WCCG	£2,742,503	£340,973	£726,580	£310,603	£1,364,349	

NHS England – Specialised Commissioners						
Paediatric Networked Care – non-PICU Centres COO	£15,151		£15,151			**Paediatric Networked Care – non-PICU Centres** **Part 1:** Local acute hospitals will be required to work with their regional PICU provider in providing fully completed PCCMDS data over a six month period August to December 2017 (request to extend to January) in order for the lead provider to submit a summary report by February 2018. Conduct a self assessment and submit data to PICU - due mid October. **Status:** Monthly audit data being submitted to BCH. Potential to utilise Lorenzo to record data is currently being considered.
	£11,363				£11,363	Partake in the lead PICU provider's review of referring acute hospitals against the Paediatric Intensive Care (PICS) standards in order for the lead PICU provider to submit a report.
	£11,363				£11,363	Ongoing participation with West Midlands Paediatric Critical Care Network meeting, including representation at meetings and implementation of clinical protocols as agreed by the Network. Risk: no risk forecast.
Sub totals	£37,878	£0	£15,151	£0	£22,727	
GE3: Hospital Medicines Optimisation MD	£25,221	£6,305	£3,153	£3,153	£3,153	**GE3: Hospital Medicines Optimisation** **Trigger1:** Adoption of best value generic/ biologic products in 90% of new patients within one quarter of guidance being made available. Adoption of best value generic/ biologic products in 80% of applicable existing patients within one year of being made available (except if standard treatment course is < 6 months **Status:** NHSE confirm CQUIN only to be pursued from Q2 when 2nd rituximab biosimilar on market. New template received from NHS E, pharmacy are working on completing the data. Meeting was scheduled for 20 Nov to clarify requirements for Q3 & Q4 has been cancelled by NHS E and is currently being rearranged. **Risk: Q1 & Q2 achieved. Q3 submitted expected to achieve - 100% of new and existing patients**
			£3,153	£3,153	£3,153	Adoption of best value generic/ biologic products in 80% of applicable existing patients within one year of being made available (except if standard treatment course is < 6 months **Status:** NHSE confirm CQUIN only to be pursued from Q2 when 2nd rituximab biosimilar on market **Risk**: **Q2 achieved. Q3 submitted expected to achieve - 100% of new and existing patients switched to biosimilar or generic drugs.**
	£12,993			£6,496	£6,496	**Trigger2**: Improving drugs MDS data quality to include dm+d as drug code in line with ISB 0052 by June 2017 or in line with agreed pharmacy system upgrade as well as all other mandatory fields All hospitals submit HCD data in agreed MDS format fully, accurately populated on a monthly basis and bottom line matches value for drugs on ACM **Status:** Q3 submitted. WHT awaiting national position on MDS from eMIS - date and actual MDC to be confirmed
	£25,221	£2,293			£22,928	**Trigger3**: Increase use of cost effective dispensing routes for outpatient medicines:- Implementation of agreed transition plan for increasing use of cost effective dispensing routes for outpatient medicines (plan to be developed by drug category to take into account patient population). Discussion between NHSE and Director of Pharmacy during January 2018 - Trust position on wholly-owned subsidiary approved at WHT Quarterly CRM. Proposed financial arrangement (i.e. via WOS) provides greater long term benefit to NHSE compared to Homecare **Risk**: **Q1 achieved. Q4 at risk.**
	£12,993	£1,529	£1,911	£5,732	£3,821	**Trigger4**: Improving data quality associated with outcome databases (SACT and IVIg) :– All hospitals submit required outcomes data (SACT, IVIg) in agreed format fully, accurately populated in agreed timescales. Implementation of agreed transition plan for increasing data quality. **Status:** plan to be approved. Require clarity from NHSE re: transition objectives. SACT plan to be agreed by service and submitted during Q3. **Risk: Q1 & Q2 achieved .** Q3 IVIG supplementary information received showing 100% - achieved. No SADT data published for Q3 yet.
Sub totals	£76,427	£10,127	£8,216	£18,533	£39,551	
WC5 Neonatal Community Outreach DoN	£9,470		£9,470			**WC5 Neonatal Community Outreach** **Trigger1:** All units to present their 2016/17 average occupancy rates for their funded cots and patient flow data. National Definitions on discharge criteria for outreach care, to be developed by neonatal intensive care CRG. All Units to present to their ODNs their current discharge definitions and criteria for outreach support. (ODNs will assess and analyse the difference between their current state definitions and criteria and the National Definitions for babies that fall into the criteria for outreach support.)
	£18,939			£18,939		**Trigger2**: Providers that have presented information to their ODNs outlining the number of babies that would have been discharged (linked to the new criteria) and the impact that this would have had on occupancy rates. To work with NICU to scope the additional support required to provide an outreach service in line with the National Definitions and discharge criteria. Plan adopted to create outreach units and target reduction in occupancy levels agreed. Status: Q3 submitted. Options appraisal submitted.
	£9,470				£9,470	**Trigger3**: Providers (with support from ODNs) to recruit outreach teams to support all parts of the network to comply with national occupancy rate standards Risk: Q4 at risk, resource required to expand operational hours.
Sub totals	£37,878	£0	£9,470	£18,939	£9,470	
	£152,183	£10,127	£32,837	£37,473	£71,747	
NHS England – Public Health Dental						
West Midlands Secondary Care Dental Contract COO	£34,962.00	£17,481				An initial audit shall be completed by 30 June 2017 and a report of the audit prepared and available for discussion with NHSE by 21 July 2017 Status: Audit complete, summary report to be compiled. Risk: **Achieved confirmed NHS E.**
						Subject to any issues being identified during the audit, a plan to be shared by the end of Quarter 2 to address/correct these by 30 Sept 2017
					£17,481	**Achieved confirmed NHS E.**
Sub totals	£34,962.00	£17,481	£0	£0	£17,481	
Total Schemes	£2,929,648	£368,581	£759,417	£348,076	1,453,578	

Glossary

KPI Monitoring - Acronyms

A
- ACP – Advanced Clinical Practitioners
- AEC – Ambulatory Emergency Care
- AHP – Allied Health Professional
- Always Event® - those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system
- AMU – Acute Medical Unit
- AP – Annual Plan

B
- BCA – Black Country Alliance
- BR – Board Report

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

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

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

F
- FEP – Frail Elderly Pathway
- FES – Frail Elderly Service

G
- GAU – Gynaecology Assessment Unit
- GP – General Practitioner

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

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

K
- KPI – Key Performance Indicator

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

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

KPI Monitoring - Acronyms

N
- NAIF – National Audit of Inpatient Falls
- NCEPOD – National Confidential Enquiry into Patient Outcome and Death
- NHS – National Health Service
- NHSE – NHS England
- NHSI – NHS Improvement
- NHSIP – NHS Improvement Plan
- NOF – Neck of Femur
- NPSAS – National Patient Safety Alerting System
- NTDA/TDA – National Trust Development Authority

O
- OD – Organisational Development
- ORMIS – Operating Room Management Information System

P
- PE – Patient Experience
- PEG – Patient Experience Group
- PFIC – Performance, Finance & Investment Committee
- PICO – Problem, Intervention, Comparative Treatment, Outcome
- PTL – Patient Tracking List
- PU – Pressure Ulcers

R
- RAP – Remedial Action Plan
- RATT – Rapid Assessment Treatment Team
- RCA – Root Cause Analysis
- RCN – Royal College of Nursing
- RCP – Royal College of Physicians
- RMC – Risk Management Committee
- RTT – Referral to Treatment
- RWT – The Royal Wolverhampton NHS Trust

S
- SAFER – Senior review - All patients will have an expected discharge date - Flow of patients - Early discharge – Review
- SAU – Surgical Assessment Unit
- SDS – Swift Discharge Suite
- SHMI – Summary Hospital Mortality Indicator
- SINAP – Stroke Improvement National Audit Programme
- SNAG – Senior Nurse Advisory Group
- SRG – Strategic Resilience Group
- SSU – Short Stay Unit
- STP – Sustainability and Transformation Plans
- STS – Short Term Sickness
- SWBH – Sandwell and West Birmingham Hospitals NHS Trust

T
- TACC – Theatres and Critical Care
- T&O – Trauma & Orthopaedics
- TCE – Trust Clinical Executive
- TDA/NTDA – Trust Development Authority
- TQE – Trust Quality Executive
- TSC – Trust Safety Committee
- TVN – Tissue Viability Nurse
- TV – Tissue Viability

U
- UCC – Urgent Care Centre
- UCP – Urgent Care Provider
- UHB – University Hospitals Birmingham NHS Foundation Trust
- UTI – Urinary Tract Infection

V
- VAF – Vacancy Approval Form
- VIP – Visual Infusion Phlebitis
- VTE – Venous Thromboembolism

W
- WCCG/CCG – Walsall Clinical Commissioning Group
- WCCSS – Women's, Children's & Clinical Support Services
- WHT – Walsall Healthcare NHS Trust
- WiC – Walk in Centre
- WLI – Waiting List Initiatives
- WMAS – West Midlands Ambulance Service
- WTE – Whole Time Equivalent

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date:** 8 March 2018
Report Title	Performance Finance and Investment Committee Highlight Report and Minutes			**Agenda Item:19** **Enclosure No.: 17**
Lead Director to Present Report	Non-executive Director and Performance, Finance and Investment Committee Chair, Mr John Dunn			
Report Author(s)	Non-executive Director Performance, Finance and Investment Committee Chair, Mr John Dunn and Trust Secretary, Linda Storey			
Executive Summary	The report provides a highlight of the key issues discussed at the most recent Finance Performance and Investment Committee Meeting held on 21st February 2018 together with the confirmed minutes of the meeting held on 24th January 2018. Both meetings were quorate. The meeting held on the 24th January 2018 was chaired by Mr Sukhbinder Heer, Non-executive Director Committee Member and the meeting held on the 21st February 2018 was Chaired by Mr John Dunn, Non-executive Director and Chair of the Committee.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Board is recommended to DISCUSS the content of the report and raise any questions in relation to the assurance provided.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>-</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>-</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr><tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☒</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Link to Board Assurance Framework Risk Statements:
No. 6 ‘That we are not able to recover performance on the national elective standards including referral to treatment and cancer as planned’.
No. 9 ‘That we are not able to deliver our plan within the resources available’.
No. 10 ‘That we cannot deliver our planned programme of hospital estate improvement including a plan for the Emergency Department’.
No.11 ‘That our governance remains “inadequate” as assessed under the CQC Well Led standard’.
No. 12 ‘That the Service Improvement & Cost Improvement programmes do not deliver the financial impact resulting in non-delivery of the financial plan’.
No. 14 ‘New entrants into the market will succeed in attracting services resulting in income loss to the Trust’.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">There are no resource implications raised specifically as a result of this report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Compliance with Trust Standing Orders.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The Committee reports to the Trust Board on a monthly basis following its meetings. The Board receives the approved minutes from the previous Committee meeting and a highlight report on the key issues raised at the most recent meeting.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The minutes from the Committee meeting held on 21st February 2018 will be submitted to the Board at its meeting in April 2018 at which the Board will also receive a highlight report from the Committee meeting to be held in March.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

FINANCE PERFORMANCE AND INVESTMENT COMMITTEE HIGHLIGHT REPORT

1. INTRODUCTION

The Committee reports to the Trust Board each month following its meeting. The Board receives the approved minutes from the previous Committee meeting and a highlight report on the key issues raised at the most recent meeting. The report covers the key issues from the meeting held on the 21st February 2018 together with the approved minutes of the meeting held on the 24th January 2018.

2. KEY ISSUES FROM MEETINGS HELD ON 21st FEBRUARY 2018

2.1 The meeting was quorate and Chaired by Mr Dunn, Non-executive Director and Committee Chair.

2.2 Financial Performance Month 10 and Forecast Outturn for 2017/2018

The Committee received information outlining the best, most likely and worst case predictions for the year end position and noted that the best case was no longer possible. The likely outturn would be dependent on the resolution of a number of revenue issues but the risk of further slippage remained. The main drivers for the position were winter pressures (revenue and extra capacity), nursing risk profile change and under performance of the recovery plan.

KPMG presented the status of the recovery plan and were challenged on the progress with traction and delivery and in particular, concerns about the timeliness of escalations.

Of considerable concern was the under delivery with escalations still outstanding some taking 3 weeks.

A discussion was held about temporary staffing and the nursing issues in particular. The Committee received confirmation that there was now a stronger focus on grip and control but noted the impact of this on the year end outturn.

2.3 2018/2019 Plan

A discussion was held on the 2018/19 Plan and the likely exit run rate at £2m+ adverse and further discussions would be held with NHSI. An Extraordinary Performance, Finance and Investment Committee has been arranged prior to the Public Board Meeting on Thursday 8th March to discuss the final submission.

2.4 Constitutional Standards

The Committee received the Constitutional Standards Report and Some good news regarding performance, especially with cancer targets and the plan to close capacity.

2.5 Award of Contracts

The Committee reviewed the following contract awards and recommended them for approval by the Trust Board for award:

- Supply of Arthroscopy Consumables
- Wheelchair Approved Repairer
- Laundry & Linen
- Special Laundry

2.6 Gastroenterology Investment

The Committee received a request for investment into gastroenterology to support JAG accreditation. The committee concluded that it supported the case in principle and requested some further work be undertaken on the report for the Chair of the Committee to endorse. An update would be provided at the next committee meeting.

3. RECOMMENDATION

The Board is recommended to DISCUSS the content of the report and raise any questions in relation to the assurance provided.

Walsall Healthcare NHS
NHS Trust

MINUTES OF THE PERFORMANCE FINANCE AND INVESTMENT COMMITTEE HELD ON MONDAY 24th JANUARY 2018 AT 2.00 P.M. IN MEETING ROOM 10, MLCC

Present:	Mr S Heer	Non-executive Director (Chair of Committee)
	Mr R Kirby	Chief Executive
	Mr R Caldicott	Director of Finance and Performance
	Mr D Fradgley	Director of Strategy & Transformation
	Mr A Khan	Medical Director
	Mrs L Ludgrove	Interim Director of Human Resources and Organisational Development
	Ms D Oum	Trust Chair
	Mrs L Storey	Trust Secretary
	Mr P Thomas-Hands	Chief Operating Officer
In Attendance:	Ms J Longden	Divisional Director of Estates & Facilities (Item 160/17 only)
	Mr C O'Toole	KPMG (From Item 161/17)
	Dr K Gnanaolivu	KPMG (From Item 161/17)
	Mrs C Dawes	Executive Assistant (Minutes)
Apologies:	Mr J Dunn	Non-executive Director
	Mr J Silverwood	Non-executive Director

Mr Heer opened the meeting and advised he would be chairing the meeting in the absence of Mr Dunn. Everyone was welcomed and it was noted that the meeting had been called in accordance with the Trust's Constitution and the Terms of Reference of the Committee. The meeting was declared quorate.

Mr Heer outlined changes to the running order of the agenda, requesting the presentation of the Forecast Outturn 2017/18 and Financial performance reports before the KPMG reports on FIP2 Phase 3 and 4 as these had since progressed and were now out-dated.

157/17 Declarations of Interest **ACTION**

There were no declarations of interest.

158/17 Minutes of the Meeting held on 27th November 2017

Resolution:
The minutes of the meeting held on 27th November 2017 were approved as an accurate record. **JD**

159/17 Matters Arising and Action Sheet

The Committee received the status of the actions. It was noted that updated reports had been completed for several items due in January but had been deferred until February at the request of Mr Dunn.

Resolution:
The Committee noted that a number of updated reports had been deferred to the February meeting at the request of Mr Dunn.

160/17 Presentation from the Division of Estates and Facilities

Mr Heer welcomed Ms Longden to the meeting and introductions were made. He clarified the purpose of the presentation was to outline the current position and to highlight any issues.

Ms Longden highlighted the following key issues:

- At month 6 the division was underspent by £38k, however the position at month 9 was an overspend of £557k.
- Overspends were driven by slippage on the CIP targets, delays in car parking increases and additional facilities services required for cleaning and deep cleaning of wards due to additional open capacity over the winter period.
- Key drivers were also spends on portering bank to cover increased levels of sickness, increased postage costs for increased number of clinical letters, waste management costs and costs for purchase of replacement bleeps (not budgeted).
- The proposed leasing of accommodation to overseas nurses and doctors had not materialised in the current year.
- The expected energy savings had not materialised.
- Reviewing costs of small items e.g. cleaning products, working with Dietitians on patient menus, looking to change menus to reduce waste

Questions and Comments

The Committee noted that the divisional position and acknowledged the majority of overspends were not within the control of the division. It was noted the division had a good track record of delivering their financial targets.

A discussion was held on ways the division could streamline their business e.g. changing contracts earlier and Ms Longden clarified that such avenues had been explored by the team. Changes made had included moving cleaning staff from office areas to work in clinical areas as a priority and attendance at the morning daily bed meetings to know about admissions/discharges and potential deep cleaning to alert housekeepers and catering staff. There was also more engagement from the clinical teams.

Ms Longden gave examples of items within the gift of the division to make improvements which included reviewing the cleaning products and working alongside dieticians to change the process for menu ordering from the day before to on the day. It was explained that the change would eliminate considerable waste.

A discussion was held about the reasons for the slippage in CIP delivery and the requirement to learn from the current position about the fragility of a number of the income lines and the requirement to have strong mitigations in place for income CIPs.

The Director of Strategy & Transformation commented as the executive

lead for the division that the operational divisions needed to work more closely with the E&F division and plan for funding for the winter pressures. The Chief Operating Officer commended the portering services who had responded well over the last few weeks. It was noted that there was a requirement to build the service into the winter plan next year.

The Chief Executive advised the Divisional Quarterly Review had taken place earlier that week and the division had been tasked with improving on the £500k overspend.

Mr Heer thanked Ms Longden for her presentation noting the division's coordinated and pro-active approach.

Resolution:
The Committee noted the content of the Divisional presentation from Estates and Facilities.

Ms Longden left the meeting at this point

Mr O'Toole and Dr Gnanaolivu joined the meeting at this point.

Mr Heer welcomed Mr O'Toole and Dr Gnanaolivu and explained the agenda running order changes about the Phase 3 close out and the Phase 4 programme reports. It was explained that the committee's focus would be on how KPMG would be assisting the workstreams and divisions over the coming eight weeks to deliver the 2017/18 Financial Plan.

161/17 FIP2 Phase 3 Close Off Report

The Committee welcomed the report and noted the requirement for Phase 4 to be more focussed and strategic. The focus of the Committee needed to be on what KPMG could do to assist the Trust in the forthcoming eight weeks.

Mr Heer reminded the Committee that the Board had undertaken to deliver an outturn of a £20.5m deficit plan for the 2017/18 financial year. The current gap to delivery was between £7m to £8m gross with some mitigation. There was a requirement to understand how the gap could be bridged in the next eight weeks and how KPMG could assist the Trust. Mr Heer noted that the actions taken to address the position as outlined in the report were the right actions but there was insufficient pace and success, particularly on addressing temporary workforce expenditure and the outpatients and theatres workstreams. The target to achieve was therefore clear and greater clarity was required as to who and how the plans would be achieved.

Resolution:
The Committee received and noted the FIP 2 Phase 3 Close Off Report.

161/17 Forecast Outturn 2017/2018

The Director of Finance and Performance gave an overview of the 2017/2018 Forecast Outturn and highlighted the following:

- The Trust had a £20.5m deficit target for 2017/18. Key reporting of

performance on a monthly basis had shown:
- An increasing adverse variance to financial plan (month on month).
- Corporate Risk Register (high risk to delivery).
- Board Assurance Framework (high risk to delivery).
- Commissioned KPMG as FIP (2) partner to support delivery.

- Previous reports had indicated high financial risk to attainment of the outturn, endorsing a recovery plan for ensuring attainment of the 2017/18 outturn

- The Trust was now reporting a £4m adverse variance to plan as at month 9 (a further deterioration from month 8).

- The key risks and mitigations in delivery of the financial plan have been identified.

The Director of Finance & Performance advised that details of how the financial challenge could be met, with the support of the KPMG commission, would be provided at the next meeting and the committee to take a view on revising the forecast position. The Trust Board and NHS Improvement had been made aware of the risks.

A document was tabled by the Director of Finance & Performance outlining the high level financial recovery actions following discussions at the Performance and Finance Executive meeting the previous day and the following key messages were noted:

- There was a £7.2m adverse variance to plan.

- Incremental changes were anticipated due to improvements in Divisional positions and Workstreams for Theatres, Outpatients and Temporary Workforce.

- Financial adjustments were anticipated due to asset sales, winter allocation, balance sheet and the Apprenticeship Levy.

- The remaining gap would be £1.5m if all of the above actions were delivered.

- Workstream stretch targets and Divisional challenges were required to close the £1.5m gap.

- December recorded the highest costs and the lowest income due to outpatient non-attenders and resulting in lost income.

- Need to refocus for the 4th quarter and remodel trajectories to close the gap.

- Meetings had taken place with consultants and clinical colleagues to share the benefits and incentives of the delivery of the financial plan.

<u>Questions and Comments</u>

Mr Heer commented the document was helpful in highlighting the

challenge but asked to see a breakdown plan of the actions to be taken and who was responsible and accountable for their delivery.

There was a discussion about the size of the challenge and the level of confidence in its delivery. The Medical Director explained that following a meeting with clinicians earlier that day the clinical teams would be reviewing records to ensure the coding of attendances had been completed. The Chief Operating Officer reported the divisions were checking on income levels for the different specialties and how to deliver higher income clinics and asked for a briefing paper on the financial benefits to share with the divisional triumvirate teams.

Mr Heer was encouraged by the collectiveness of the discussion that highlighted the confidence that the financial challenge was achievable. A request was made to articulate the underlying actions to support the delivery of the plan. This would include key milestones, action owners and resources required from KPMG. The plan was requested to be completed by 31st January 2018. **RC/COT**

In addition, a weekly update tracker was requested over the next eight weeks to give assurance to the Committee and the Trust Board on progress. The tracker to be sent to the Chair of the Trust Board and Chair of the Committee setting out any mitigation to close gaps. **RC/COT**

It was noted that monitoring of the quality impact would be carried out by the Medical Director and Nursing Director through the Quality Impact Assessments submitted by the workstreams.

The committee requested confirmation that the theatres and outpatients workstreams had plans underpinned with actions, including timeframes and responsibilities to close the gap.

Mr Heer advised that the Phase 3 Close Out report would be deferred until after the close of Phase 4 in order to consider the outcome in the round. **RC/COT**

Resolution:
The Committee received and noted the update on the 2017/2018 Forecast Outturn.

162/17 First Cut Financial Plan 2018/2019

The Director of Finance and Performance presented the first cut of the Financial Plan 2018/2019 advising that a high level 3 year Financial Plan would be presented at the February meeting. The following points were highlighted:

- The process for drafting the plan was explained which had included meetings and roadshows with the divisions. Each budget manager had been met with for a discussion and sign off of their start position for 20182019. It was noted that meetings had taken place with the Clinical Directors and their concerns had been taken into account to produce an activity baseline for the budgets.

- A £13m CIP was proposed for the year which was more than the Trust had ever done before and which would pose a significant challenge. A

key message was that due to the work undertaken in 2017/2018 the Trust had started half of 2018/2019 early which was a good starting point.

RC/PTH

- The current position was indicating a deficit of £27m which was £40m without the CIP. The model was one of investment rather than a sustainability model. Further challenge would be required and the figure would reduce.

- The Trust was working to produce a two year plan but guidance had not yet been received from NHSI. A more detailed plan to be presented to Committee in February and March and then Trust Board in April.

Questions and Comments

The Director of Strategy and Transformation asked if the unclaimed Sustainability and Transformation Funding from the current year as a result of missed targets would be reallocated into the options for the control totals. The Director of Finance and Performance explained that it would not be as it would be used as a contingency.

Mr Heer questioned why the Estates Division figure was up by £2.8m. The Director of Finance and Performance explained that their bid included £2m relating to NHS Property Services increased charges. It was further explained that this would be removed from the figures together with the bids for non-pay inflation related to energy and utility bills.

The Chief Operating Officer asked whether the weekend ward rounds for consultant had been included within the Medicine Division's figures. The Director of Finance and Performance explained that the bids were being reviewed and a meeting could be held to discuss the issue.

The committee noted the content of the first cut of the Financial Plan for 2018/19 and acknowledged more work was required for the final version at the next meeting. **RC**

Resolution:
The Committee:

- **Received and noted the content of the First Cut Financial Plan 2018/2019.**
- **To receive an updated Financial Plan at the next meeting in February.**

163/17 Constitutional Standards Operational Update

The Chief Operating Officer gave an overview of the Constitutional Standards relating to Emergency Department, Elective Access and Cancer. The A&E Board Recovery Plan 2017/18 was shared for information. The key messages were highlighted as:

Emergency/Urgent Care:

- December performance had increased to 83.38% compared to 82.03% in November.

- Focus continued on SAFER, Red to Green, ED processes, ward reconfiguration and Medically Fit for Discharge (MFFD).

- December saw continued high levels of ambulances to ED (90+ ambulance arrivals on 25 days in the month to the department). This was above all forecast levels with 80% of days in December with over 100 arrivals.

- Admissions per day had decreased from 97 in November to 93 in December.

- The trajectory for four hour performance was to achieve 90% in September with a dip in December performance and an improvement back to trajectory in February and March 2018. It was expected that the Trust would achieve an actual performance in the late 80%'s by the end of October.

- Ward 14 and Ward 10 had been opened in December (28 + 14 beds) with medical patients to maintain flow out of ED.

- Infection Control ward closures had impacted on patient flow but the closures had been successful and pragmatic.

- There were no 12 hour breaches.

- MFFD list was beginning to rise. Pilot integration of organisational teams implemented on 20th November with trajectory of 90 patients by end of November and 80 patients before Christmas had not been achieved finishing at 89 before Christmas.

Elective Access:

- Performance in December was just under trajectory at 80.99%.

- The resubmitted forecast was to achieve just below 92% at the end of March 2018. NHS Improvement had been in agreement with the trajectory, further work had been requested by the commissioners and a response was awaited from NHS England.

- Validation percentage could not be affected as the PTL was now clean which had highlighted clinical and theatre utilisation issues.

- The focus was to reduce WLI sessions and focus on improving the core utilisation in outpatients. Work was on-going with support from KPMG with both outpatient and theatre work streams.

- The trajectory assumed delivery without WLI activity.

- Key specialties of concern were:
  - Respiratory – 68.97%. Risk Summit had fed back to TQE with business case for more capacity being drafted for January 2018.

  - Dermatology – 65.57%. Division to review with clinicians a recovery plan

- ENT - 69.39% - Risk Summit to be called.

Cancer:

- All national cancer measures achieved in November. Initial un-validated performance for December shows achievement of all cancer measures with the exception of 62 day consultant upgrade.

- There was one 52 week breach in December

Diagnostics:
December performance was 99.15% thus achieving the 99% target.

Questions and comments:

The Chair summarised by noting the good results given the challenges teams dealt with over the winter period and questioned whether the winter plan had been effective. The Chief Operating Officer responded reporting that the MMFD figures went down but rose again in January and there were good working relationships with Social Care.

The Chief Executive expressed his thanks to the operational teams for managing over a difficult and challenging period.

There was a discussion on how the organisation would deal with 100+ ambulances per day moving forward. The Chief Operating Officer responded advised work would be done with WMAS and ECIP would provide assistance.

The Director of Strategy & Transformation commented that plans were better than previous years and community services were being utilised at the front door but that there was a requirement to build on the messages for external stakeholders.

Resolution:
The Committee:

- **Received and noted the content of the Constitutional Standards Operational Update.**
- **Noted the high level of activity and improved performance.**

164/17 Performance and Quality Report by Exception

The Performance and Quality Report was taken as read.

Resolution:
The Committee:

- **Received and noted the content of the report.**

165/17 Award of Contract (shoulder implants)

The Director of Finance and Performance gave an overview of the Award of Contract for shoulder implants confirming a tender exercise had been undertaken, the contract would save on costs and the details had been endorsed through the medical teams. The Committee received and noted

the report and agreed to recommend the contract award to the Trust Board for approval.

Resolution:
The Committee:

- **Received and noted the content of the Award of Contract for shoulder implants**
- **Agreed to recommend the contract award to the Trust Board for approval.**

166/17 ANY OTHER BUSINESS

Mr Heer advised he had been given three items by Mr Dunn to raise:

Patient Transport Services

The Chief Operating Officer explained that there was a potential requirement for an urgent decision to be made under the Trust's Standing Orders in relation to the Patient Transport Service. Further work was required before a formal request would be made.

Delays to EPMA

The Medical Director explained that issues had been discussed with the Executive Team relating to the electronic patient record trial on Ward 3. Serious clinical issues had been raised and details of the concerns were being provided in writing to NHS Digital.

Extraordinary Performance, Finance and Investment Committee meeting

Mr Dunn had previously requested that an Extraordinary Committee Meeting be arranged to receive the 3 year Financial Plan. This would now be received at the normal scheduled meeting on 21st February 2018.

167/17 Date of Next Meeting

The next meeting of the Committee would be held on of **Wednesday, 21st February 2018 at 2p.m.** in Room 10, Manor Learning and Conference Centre, Walsall Manor Hospital.

BOARD/COMMITTEE REPORT

Meeting	Trust Board		**Date:** 8 March 2018
Report Title	Use of the Trust Seal		**Agenda Item:20** **Enclosure No.: 18**
Lead Director to Present Report	Trust Secretary, Linda Storey		
Report Author(s)	Trust Secretary, Linda Storey		
Executive Summary	In accordance with the Trust's Standing Orders the report notifies the Trust Board that the Trust Seal has been used on the following occasion: 22nd February 2018 to the following documents relating to the Neonatal Unit and Maternity Theatres project: • Deed of Variation. • Independent Tester Agreement • Contractor Collateral Agreement		
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	The Board is recommended to note the report for INFORMATION.		
Trust Objectives	**Provide Safe High Quality Care Across all**	**Not Relevant**	

<table>
<tr><td rowspan="5"><u>Supported by this Report</u></td><td>of Our Services</td><td></td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Not Relevant</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Not Relevant</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Not Relevant</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Ensure our hospital estate is future proof and fit for purpose</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☐</td><td><u>Effective</u></td><td>☐</td></tr>
<tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☐</td></tr>
<tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Not applicable.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">None identified within the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">In accordance with Trust Standing Orders.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Not previously received.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Not applicable.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
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USE OF THE TRUST SEAL

1. INTRODUCTION

The Standing Orders of the Trust require the Trust Board to receive a report on the sealing of all documents under the seal of the Walsall Healthcare NHS Trust.

2. SEALING OF DOCUMENTS

2.1 The Trust Board is notified that the seal of the Trust was used on the following occasion in February 2018.

2.2 On the 22nd February 2018 the seal of the Trust was affixed to the following documents in relation to the Neonatal Unit and Maternity Theatres project:

- Deed of Variation.
- Independent Tester Agreement
- Contractor Collateral Agreement

The documents were signed by Mr Richard Kirby, Chief Executive in the presence of Ms Danielle Oum, Chair, and Mr Russell Caldicott, Director of Finance and Performance.

The register for the use of the seal was updated and the Register Numbers for the transactions is No. 157.

3 RECOMMENDATION

The Board is requested to note the report for INFORMATION.