Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD TO BE HELD IN PUBLIC ON THURSDAY 5TH APRIL 2018 AT 10.00 A.M.
IN THE LECTURE SUITE, MLCC, MANOR HOSPITAL, WALSALL

For access to Board Reports in alternative accessible formats, please contact the Interim Trust Secretary via 01922 721172 Ext. 7775 or linda.storey@walsallhealthcare.nhs.uk

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: Patient Experience App	Learning	Director of Nursing		**10.00**
CHAIR'S BUSINESS					
2.	Apologies for Absence	Information	Chair	Verbal	**10.30**
3.	Declarations of Interest	Information	Chair	ENC 1	
4.	Minutes of the Board Meeting Held on 8th March 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.	Serious Incident Report	Information	Director of Nursing	ENC 6	**10.40**
9.	Mortality Report	Information	Medical Director	ENC 7	**10.50**
10.	Quality & Safety Committee Highlight Report and Minutes	Discussion	Committee Chair R Beale	ENC 8	**11.00**
STRATEGY AND PLANNING					
11.	Improvement Academy Approach	Discussion	Director Strategy & Improvement	ENC 9	**11.10**

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
12.	Partnership Update	Discussion	Director Strategy & Improvement	ENC 10	**11.20**
13.	General Data Protection Regulation	Information	Director Strategy & Improvement	ENC 11	**11.30**
BREAK – TEA/COFFEE PROVIDED					**11.40**
PEOPLE AND CULTURE					
14.	Staff Survey 2017 & Staff Engagement Action Plan	Discussion	HR Director	ENC 12	**11.50**
PERFORMANCE AND FINANCE					
15.	Financial Performance Month 11	Discussion	Director of Finance & Performance	ENC 13	**12.20**
16.	Performance and Quality Report Month 11	Discussion	Director of Finance & Performance	ENC 14	**12.30**
17.	Performance, Finance & Investment Committee Highlight Report & Minutes	Discussion	Committee Chair J Dunn	ENC 15	**12.40**
GOVERNANCE AND COMPLIANCE					
18.	Audit Committee Highlight Report and Minutes	Information	Committee Chair S Heer	ENC 16	**12.50**

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

20. **DATE OF NEXT MEETING**
Public meeting on **Thursday 3rd May 2018** at 10.00 a.m. at the Manor Learning and Conference Centre, Manor Hospital

21. **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).

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date:** 5th April 2018
Report Title	Declarations of Interest			**Agenda Item:** 3 **Enclosure No.:** 1
Lead Director to Present Report	Chair of Trust Board, Ms Danielle Oum			
Report Author(s)	Trust Secretary			
Executive Summary	The report presents an updated Register of Directors' interests to reflect the interests of the Chief Executive. The register is available to the public and to the Trust's internal and external auditors, and is published on the Trust's website to ensure both transparency and also compliance with the Information Commissioner's Office Publication Scheme.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	To NOTE the updated Register of Directors' interests.			

<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>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</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, 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">Board Assurance Framework Risk Statement No. 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 highlighted in the detail of the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Compliance with NHS Code of Conduct and Trust Standing Orders.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Last update to the Board received in the Trust’s Annual Report in June 2017.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Declarations will be reported to the Board as the interests of individual Directors change throughout the course of the year. The next scheduled report to Board will be in June 2018 at the submission of the 2017/2018 Annual 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>
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Register of Directors Interests at December 2017

Name	Position/Role at Walsall Healthcare NHS Trust	Interest Declared
Ms Danielle Oum	Chair	Board Member: West Midlands Housing Group
		Board Member: Wrekin Housing
		Chair Healthwatch Birmingham
		Committee Member: Healthwatch England
Professor Russell Beale	Non-executive Director	Director, shareholder: CloudTomo- security company – pre commercial.
		Founder & minority shareholder: BeCrypt – computer security company.
		Director, owner: Azureindigo – health & behaviour change company, working in the health (physical & mental) domains; producer of educational courses for various organisations including in the health domain. .
		Academic, University of Birmingham: research into health & technology – non-commercial.
		Spouse: Dr Tina Newton, is a consultant in Paediatric A&E at Birmingham Children's Hospital & co-director of Azureindigo.
		Journal Editor, Interacting with Computers.
		Governor, Hodnet Primary School.
		Honorary Race Coach, Worcester Schools Sailing Association.
		Non-executive Director for Birmingham and Solihull Mental Health Trust with effect from January 2017.
Mr John Dunn	Non-executive Director	No Interests to declare.
Ms Paula Furnival	Associate Non-executive Director	Executive Director of Adult Social Care, Walsall Council.
Mrs Victoria Harris	Non-executive Director	Manager at Dudley & Walsall Mental Health Partnership NHS Trust
		Governor, All Saints CE Primary School Trysull
		Spouse, (Dean Harris) Deputy Director of IT at Sandwell & West Birmingham Hospital from March 2017

Name	Position/Role at Walsall Healthcare NHS Trust	Interest Declared
Mr Sukhbinder Heer	Non-executive Director	Non-executive Director of Hadley Industries PLC (Manufacturing)
		Partner of Qualitas LLP (Property Consultancy).
		Non-executive Director Birmingham Community NHS Foundation Trust (NHS Entity).
		Chair of Mayfair Capital (Financial Advisory).
Mr Philip Gayle	Non-executive Director	Chief Executive Newservol (charitable organisation – services to mental health provision).
Mr Richard Beeken	Chief Executive	Spouse, Fiona Beeken is a Midwifery Lecturer at Wolverhampton University.
Ms Barbara Beal	Interim Director of Nursing	Non-executive Director at University Hospital Coventry and Warwickshire.
		Managing Director – Griffis-Beal Healthcare Company Ltd.
		Associate Fine Green Limited
Mr Russell Caldicott	Director of Finance and Performance	Chair and Executive Member of the Branch of the West Midlands Healthcare Financial Management Association
Mr Daren Fradgley	Director of Strategy and Transformation	Director of Oaklands Management Company
		Clinical Adviser NHS 111/Out of Hours
Mr Amir Khan	Medical Director	Trustee of UK Rehabilitation Trust International
		Trustee of Dow Graduates Association of Northern Europe
		Director of Khan's Surgical
		Director and Trustee of the Association of Physicians of Pakistani Origin of Northern Europe
Mrs Louise Ludgrove	Interim Director of Organisational Development & Human Resources	Director of Ludgrove Consultancy Services Ltd.
Mr Philip Thomas-Hands	Chief Operating Officer	Non-executive Director, Aspire Housing Association, Stoke-on-Trent.
		Spouse, Nicola Woodward is a senior manager in Specialised Surgery at University Hospital North Midlands.

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 8TH MARCH 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 – Chair of Performance, Finance and Investment Committee 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 and Champion for Maternity and Neonatal Services
Professor R Beale	Non-Executive Director – Chair of Quality and Safety Committee and Champion for Information and Computer Technology
Mr P Gayle	Non-Executive Director – Chair of People & OD Committee and Champion for Patient Experience (including Ethics) and for Equality, Diversity and Inclusion
Mr R Beeken	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 & Improvement
Ms L Ludgrove	Interim Director of Organisational Development and Human Resources
Mrs L Storey	Trust Secretary
Mrs B Beal	Interim Director of Nursing
Mr N Rashid	Divisional Director of Medicine and Long Term Conditions
Miss J Wells	Senior Executive PA (Minutes)

Members of the Public 0
Members of Staff 2
Members of the Press / Media 0
Observers 1

241/17 Staff Story

Ms Donna Chaloner, Divisional Director of Adult Community Services attended the meeting with Dr Simon Harlin, Clinical Lead to provide an update to the Board regarding Adult Community Services. The following key points were highlighted;

- There were 7 community placed based integrated health and

social care teams with a cumulative caseload of 4500 patients.

- The teams consisted of;
  - District Nurses/Community Matrons
  - Palliative care
  - Wound care
  - Social Care
  - Mental Health.

- Services offered consisted of;
  - Out of Hours Community Nursing
  - Rapid Response Service
  - 4 Community Wound Care Clinics
  - Clinical Intervention Service
  - Intermediate Care Bed Based Service including Therapies
  - Falls Specialist/Osteoporosis
  - Community Podiatry Service
  - Nursing Home Case Management
  - Continence Service.

- The Adult Community Services had undergone an internal redesign which had enhanced integration, enhanced MDT and achieved financial sustainability.
- The service received an overall Outstanding CQC rating.
- Maintained a talented, engaged workforce.

- The challenges faced by the team were noted as;
  - Growing demand
  - Lone working
  - Growing expectations
  - Maintaining quality
  - Partnerships between multiple providers
  - Developing new ways of working, virtual clinics and acute outreach.

<u>Questions and Comments</u>

Ms Oum thanked Ms Chaloner for the inspiring presentation which underlined integrated care with lots of opportunity for more services to be integrated within the place based teams.

Mr Fradgley informed that it was a pleasure to work with the Adult Community Service. Though there had been challenges, the team had worked through problems and created solutions. Working with partners to create single thinking between community, social care and mental health had exceeded expectation and Mr Fradgley congratulated the team on their success. The scale of the service was noted, offering a total of 27 services.

Mrs Beal stated that she had shadowed Ms Chaloner some weeks previously and praised the team's work. The safety of staff lone working was of a concern but there was a Board commitment to support with security and non-tolerance of violence and aggression, which work was underway to address.

Professor Beale encouraged forward thinking ideas which would be supported by the Board. In terms of transforming culture and buy in of staff, Professor Beale asked how the Board could learn from the experiences of Adult Community Services to accelerate the process across other areas of the Trust.
Ms Chaloner replied that there was a large group of staff across five different areas. The service had been redesigned with focus on skill set and the management of change process. Challenges were encountered however promoting the positives and the benefit of the output along with staff involvement of redeveloping their areas proved successful.

Mrs Ludgrove thanked Ms Chaloner for the inspirational presentation and informed that Ms Chaloner had been working with the Workforce Transformation Lead to help to bring about change in other areas.

Mr Rashid informed that Multi-Disciplinary Team working had been successful.

Mr Beeken stated that he looked forward to meeting the team during community visits. Mr Beeken reiterated the use of multi-disciplinary teams in order to offer appropriate care to palliative care patients where an acute setting was not appropriate for their needs.
Dr Harlin replied that there was a Taskforce which reviewed patients, identifying those who were within their last 6 months of life.

Ms Oum summarised the discussion and highlighted the following actions;

- Additional support in relation to Service Level Agreements – Mr Fradgley to review.
- Consideration of Care Group structure.
- Management of violence and aggression – Mr Gayle to review.
- The importance of empowering staff and perseverance, ensuring that staff realise benefits of change was an important message for all.
- Reference to the broad use of MDT within the hospital – Mr Rashid to review.

242/17 Apologies for Absence

Apologies were noted from Mr A Khan, Medical Director. Mr N Rashid, Divisional Director of Medicine and Long Term Conditions deputised.

Ms Oum welcomed Mr R Beeken, Chief Executive.

Ms Oum welcomed Mr J Taylor from Healthwatch, observing the meeting.

243/17 Declarations of Interest

Ms Oum asked the Board members and attendees if they had any declarations of interest to make in relation to any of the agenda items. There were no declarations made.

An updated Register of Director's interests for information was presented.

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

244/17 Minutes of the Board Meeting Held in Public 1st February 2018
The minutes of the meeting held on the 1st February 2018 were agreed as a correct record.

Resolution
The Board approved the minutes of the meeting held on the 1st February 2018 as an accurate record.

245/17 Matters Arising and Action Sheet
The Board received the action sheet. It was noted that the red rated actions had agreed dates for committee review and the following updates were provided;

160/17 07/09/2017 – The Workforce Impact Assessment had not yet been presented to the People and Organisational Development Committee. Mrs Ludgrove advised that the delay had been due to a new Chair who had reviewed the structure, regularity and membership of the Committee. The March meeting had been deferred to April 2018.

219/17 02/02/2018 – Mrs Beal updated that a meeting had been arranged with Mrs Gough on 12th April in relation to caring for dementia patients. Mrs Gough attended Trust Board on 1st February to share her patient story.

225/17 02/02/2018 – Mr Fradgley advised that the Strategic Board Working Group had not yet met, though one to one meetings had taken place. It had been agreed that the Working Group would take place at 08:30hrs on a three weekly basis.

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

246/17 Chair's Report
Ms Oum presented the report which was taken as read.

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

247/17 Chief Executive's Report
Mr Beeken presented the report which depicted his first three days with the Trust and encapsulated the 100 day plan. The plan had been distributed to all colleagues and shared on social media.

Mr Beeken highlighted the focus of the Trust four key priorities;

- Continue our improvement journey - Getting out of quality

special measures. Outputs would be reviewed with metrics and good practice.

- Continue to develop the culture of the organisation – Inclusion of clinical leaders in making key decisions and moving forward together.
- Deliver the next stage of our journey of financial improvement – The route to financial sustainability would be through work described in the Staff Story earlier in the meeting with improving multiagency working and interventions for effective use of resources.
- Develop and deliver our service clinical services strategy – Focus on Walsall Together, integration and responsibility for safely sustainable services at a greater pace with other acute Trusts.

Ms Oum welcomed the clarity in language of the four priorities.

Questions and Comments

Mr Heer welcomed the clarity of the priorities and the 100 day plan. Mr Heer agreed that certain areas required reshaping and refocus and would like to know Mr Beeken's thoughts following the first 100 days. Mr Beeken replied that he would feedback the plan with an assessment of the organisation following the 100 days.
Mr Beeken added that he would to think that following the 100 days, all colleagues would be clearer than they currently were in terms of priorities and increased involvement and clarification of making decisions on a day to day basis from a senior management team perspective with a degree of increased hope and enthusiasm in what could be achieved.

Mr Dunn queried what the Board could do to assist and to ensure the Trust delivered on aspirations. Mr Beeken responded that challenge leaded to better outcomes and would encourage the Non-Executive Directors to put forward those challenges.

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

248/17 Risk Management Update
Ms Storey presented the updated Risk Management report and highlighted the following key points;

- The Board Assurance Framework had been refreshed and a review of the scores and detail for the year end position had been undertaken with Executives with a focus on the clarity of controls and assurance.
- The Risk Management internal audit recommended reviewing scoring; therefore the updated paper included further narrative of why the scores were recorded as they were.
- Risks for the next year needed to be reviewed by Executives with a view to amalgamation. Ms Storey suggested that a discussion took place at a future Board Seminar session.

- The Corporate Risk Register required further articulation of the risks which would be undertaken with the Risk Management Committee, chaired by Mrs Beal who was refreshing the membership.
- There was a requirement of dedicated Risk Register training. A package had been developed for mangers and would be rolled out across the organisation.

Ms Storey reiterated that focus in the next quarter should be around risk appetite, a Board Assurance Framework review at Board Seminar and resource for the Corporate Risk Register training.

Ms Oum thanked Ms Storey for the useful overview.

Questions and Comments

Mr Fradgley supported the content of the Board Assurance Framework but highlighted that some actions were broadly the same and that it would be beneficial to have a more focused response to allow a clearer line of slight to risks.

Professor Beale advised that the format was much clearer than it had been previously. Professor Beale noted that some long standing risks carried high scores but had not occurred and made an impact therefore the likelihood probably should not be as high as originally estimated.

Mr Heer had asked for articulated changes and mitigation to be included in the report which had made it clearer and sharper but asked whether there could be any collation under the four Trust priorities and aligned with strategy in order to deliver the objectives.

Mrs Ludgrove stated that the RAG ratings underlined the progress but though there was work underway behind the scenes, it may not be appropriate to change the score. Mrs Ludgrove suggested discussing the issues against individual risks once a quarter.

Mr Dunn observed the fact that that the Trust was still carrying a huge amount of risk and queried whether the Board had done enough to reduce the risk profile.
Ms Oum replied that Mr Beeken would be looking at the issues and it was anticipated there would be more pace in de-escalating some of the risks.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Agreed that the Board Assurance Framework would be reviewed at a Board Seminar and consideration given to the four priorities.**
- **Consideration by Mr Beeken for a designated risk resource.**
- **Agreed to continue the work started regarding risk appetite.**

- **A quarterly discussion at the Board Development or Board Seminar to review reasons and movements to risk.**

249/17 Patient Experience Report

Mrs Beal presented the report which was taken as read.

Ms Oum informed that Mrs Harris had become the Non-Executive Director Lead for Patient Experience.

Questions and Comments

Mr Heer advised that he had found the format of the report very difficult to read, though the information included in regard to benchmarking was good. Mr Heer was concerned that the Friends and Family scores in relation to maternity services were lower than previously reported.
Mrs Beal responded that a lot of work in maternity was underway and overseen by the Maternity Taskforce Group, which was ongoing. NHS Improvement had stepped down the scrutiny meetings as they had received a level of assurance. The Taskforce Group would include members from the scrutiny meeting.

Mr Gayle queried whether the Friends and Family Test were paper based survey results and asked whether the online test would be rolled out during April 2018. Mr Gayle added that the results indicated that staff attitude was still a top theme which was concerning.
Mr Fradgley replied that the survey was more effective electronically and was on track for delivery.
Mrs Beal acknowledged that staff attitude was a recurrent theme to focus on.
Mrs Ludgrove confirmed that in terms of issues regarding culture within the service, work had started on a significant change programme and it was anticipated that scores would start to improve.

Mr Thomas-Hands highlighted the result of 77% recommending the Emergency Department, which was concerning. Mr Thomas-Hands advised that the patient experience within the Emergency Department was not good. On numerous occasions there were 60 patients within the Emergency Department that only had a capacity of 40. Emergency Care Improvement Programme were on site and working with stakeholders and the findings would be reported when they were available. Support was required from the Board and Executives to deal with the issues.

Mr Beeken noted the significant difference in how Trust staff perceived the quality, safety and effectiveness of services. It was planned that an improvement programme was developed that focused on safety, experience, effectiveness of services and the involvement of staff with a view to shifting output measures.

Mrs Beal advised that she and Mr Khan would support Mr Thomas-Hands. There were a number of intentions ongoing such as the Emergency Care Improvement Programme, Red to Green and commissioning a West Midlands quality review.

Ms Oum stated that the Board were committed to improving patient experience and the importance of the Executive team working together to get it right. Ms Oum recognised the number of patients visiting the Emergency Department in a larger capacity than the facility was designed for and added that the outline business case for the redevelopment of the Emergency Department had been approved.

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

250/17 Serious Incident Report

Mrs Beal presented the report and advised that there was a review of pressure ulcers underway which was being led by the Deputy Director of Nursing. Two patients sustained severe harm following a fall and there were two cases of sub-optimal care of deteriorating patients.

Questions and Comments

Mr Dunn queried what good looked like, what the Trust were aspiring to do and what plans were in place for movement.
Mrs Beal replied that NHS Improvement and NHS England were issuing guidance regarding what good looked like. Learning lessons and changing practice shaped the next piece of work to be undertaken.

Ms Oum asked that the report was refreshed to take on board the comments raised for the next quarter.

Mr Gayle noted the rise of pressure ulcers reported and advised that training would hopefully reduce the number reported and that there had been an issue with clinical training attendance.

Ms Oum asked for clarity that staff were properly trained and confirmation that staff were attending training.

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

251/17 Quality and Safety Committee Highlight Report and Minutes

Professor Beale presented the highlight report from the most recent meeting held on 22nd February 2018, together with the approved minutes of the meeting held on 25th January 2018. The following key points were highlighted:

- VTE performance had seen an improvement but the Board could not be assured that 95% could be reached.
- The maternity improvement journey was discussed in relation to structures, behaviours and expectations required.
- Cancer targets had been achieved.
- The Emergency Care Improvement Programme visit report had been received and the Trust would be working with NHS

Improvement over the coming months focusing on specific work streams.

- Efficiency in theatres was discussed, however assurance that they were doing all they could had not been received by the committee.
- Estates and Facilities – Demand and staffing to clinical areas needed to be reviewed and prioritised.

Questions and Comments

Ms Oum advised that there were clear targets that the Board had committed to which were vital for patient safety and more work needed to be done in order to achieve them, particularly in relation to VTE.
Mrs Beal informed that a lot of work was underway behind the scenes and had been picked up on during confirm and challenge meetings.

Mr Rashid advised that processes were under review and that data quality needed to be proved as accurate.

Mr Thomas-Hands agreed that theatre efficiency needed to improve. Though there were some areas of improvement, sufficient assurance had not been given.

Mr Caldicott advised that the local commissioning group had raised issues in terms of contractual agreements. A plan was being returned at the end of the following week, which would be reviewed at the Quality and Safety Committee prior to submission.

Mr Fradgley stated that the cleanliness issues reported was disappointing, adding that there was a management of change process and contractual issues within housekeeping. Cleaning had been increased in clinical areas and assurance given that work was underway to resolve in the longer term.

Mrs Harris suggested a meeting between Richard Beeken and Non Executive Directors members of Q&S Committee to provide a more in depth overview of non executive perspectives and levels of assurance on quality and safety within the Trust.

Ms Oum agreed that there was a good opportunity to review all information reported and how it was presented in order to understand progress made and areas requiring further support.

Resolution

252/17 Walsall Together Case for Change

Mr Fradgley presented the Walsall Together Case for Change, advising that it was reviewed by the Board previously at the Board Development meeting on 26th February 2018. The following points were highlighted;

- The case was the biggest strategic case for some time and

consistent with the Five Year Forward View and the Black Country Sustainability and Transformation Plan.

- The Case for Change had been produced by the Walsall Together Board as an outline of change together with a proposal of the next steps for the next 12 months to establish a Host Provider Contract with Commissioners by April 2019.
- Assurance had been sought from KPMG in regard to demand and population.
- Collaborative networking, system wide was not yet available.
- Changes to models of care and how they looked needed to be made quickly.
- The programme of work in terms of governance structure and clinical operating models required investment. Plans needed to be visible and shared across the providers.
- An Engagement Plan needed to be created. Talks with Healthwatch, who were a member of the partnership, were taking place.
- There needed to be a credible Communications Plan. Statements of intent would be shared through the Provider Board.

Ms Oum requested the views of the Board members to commit to the statement of intent moving forward in working more closely together.

Questions and Comments

Mr Heer agreed that the approach was the right way to move forward and was an alignment of the larger Sustainability and Transformation Plan. There was however, concern that there was a number of partners involved but the view of their future and strategy was not clear. Mr Heer suggested creating a framework together to include a host provider as there were a number of unknowns. Certainty ought to be sought from the regulator.

Ms Furnival replied that the Sustainability and Transformation Plan was in a pause of leadership in governance. The three statements of intent were known and all were clear of the place based arrangement. Health Service colleagues wanted and needed to have better quality and sustainability with a wider determinacy of health.

Mr Beeken identified that the health and care economy had made lots of progress. There was a process of each organisation moving through the business case and creating achievable timescales.

Mr Dunn agreed with the statement of intent, though there were a number of unknowns, without investment the case could not move forward.

The Board agreed to endorse the statement of intent and that work was to continue in terms of governance.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Agreed to endorse the statement of intent for progression.**

253/17 Stroke Services Reconfiguration

Mr Fradgley presented the report which had previously been reviewed at Trust Board in July 2017 and October 2017. The following key points were highlighted:

- Clinical work streams have agreed the pathways, which included the provision of community rehabilitation services in Walsall.
- There were two outstanding risks which were outlined in the paper. Both were being mitigated but required a resolve.
- Plans for future provision of community beds were being reviewed with partners.

Questions and Comments

Mr Rashid agreed with the approach, advising that preparation had been ongoing for some time and teams were working on the transition phase.

The Board approved the Stroke Service Reconfiguration as outlined in the report.

Resolution
The Board;

- **Received and noted the content of the report.**
- **Approved the Stroke Service Reconfiguration.**

254/17 Intermediate Care Update

Mr Fradgley presented the Intermediate Care Update, advising that the model and phase 0-3 implementation was presented and approved by the Trust Board in September 2017. The report highlighted the progress of phases 0-3.

Questions and Comments

Ms Furnival informed that she endorsed the paper which outlined working closer together in a more integrated way. Phases 4-7 were significant, moving towards a shared vision of ensuring that patients only stayed in an acute bed for as long as they needed to be there and giving patients the best choice.

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

255/17 Trust Objectives Update

Mr Fradgley presented the update report to be taken as read. The Update had been reviewed at the relevant Board sub-committees with the exception of the People and Organisational Development

Committee. Ratings were represented in the dashboard format and narrative was included within.

Questions and Comments

Mrs Ludgrove was concerned that some areas of Quarter 1 were green which may not be a true reflection as work was still underway in some elements. Mrs Ludgrove would review with Mr Fradgley.

Mr Heer noted that embedding and engagement was marked green in Quarter 1 but revered back to amber in Quarter 2. The RAG rating was used for simplicity but didn't appear to be effective and suggested that Mr Fradgley reviewed the ratings moving forward.

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

256/17 People and Organisational Development Committee Highlight Report and Minutes

Mrs Ludgrove presented the highlight report from the People and Organisational Development Committee meeting held on 19th February 2018 with the confirmed minutes of the meeting held on 18th December 2017. The following key points were highlighted;

- Mr Gayle expressed disappointment that there was a lack of Executive Director attendance at the meeting in February, which was Mr Gayle's first meeting as Chair of the Committee.
- It had been agreed that the Committee would move to a bi-monthly schedule and the terms of reference would be reviewed.
- Violence and aggression toward staff was discussed. The Communications Team would relaunch the Respect Us campaign and a report would be later reviewed by the committee.
- Discussion had taken place in relation to IT issues with E-rostering and ESR.

Questions and Comments

Mr Fradgley updated that the ESR issues had been resolved however E-Rostering issues were ongoing which were largely localised to Paediatrics. Further updates would be reported to the committee.

Mrs Beal informed that she had taken responsibility for Health and Safety pending Linda Storey's departure from the Trust. A meeting had been arranged with the team.

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

257/17 Financial Performance Month 10

The Financial Performance for month 10 was reviewed and the following key points were highlighted;

- The Trust had a £20.4m deficit position to date with a targeted delivery of £20.5m for the year.
- The Trust was below plan on clinical income, largely as a consequence of reduced obstetric activity and outpatients/elective activity being below planned levels.
- Lots of discussion had taken place at committees and at an Extraordinary Performance, Finance and Investment Committee held earlier in the day.

Questions and Comments

Mr Dunn expressed disappointment of the outcome of delivery to date, adding that more was expected from the Financial Delivery Plan. Mr Dunn asked that lessons were learnt and that the Trust needed to move forward positively.

Mr Thomas-Hands informed that there had been improvements within theatres and outpatients but not at the level expected. KPMG had uncovered fundamental system problems which were under review to establish why the failures had not been addressed. It had been noted that some resources were stretched and response times may have been unrealistic. Performance issues uncovered were being dealt with by Mr Thomas-Hands.

Ms Oum expressed disappointment that targets had not been achieved which had been committed to. Moving forward, the Board required more robust assurance when defining targets and monitoring delivery progress.

Resolution

The Board received and noted the content of the report.

258/17 Performance and Quality Report Month 10

Mr Caldicott presented the Performance and Quality Report for month 10 and highlighted the following key points:

- A&E performance declined slightly to 82.68% against a trajectory of 87%.
- 18 Weeks Referral to Treatment performance had improved to 82.48% from 80.33% in December.
- All cancer metrics were delivered.

Mr Thomas-Hands advised that the highest ever attendance to the Emergency Department had been reported on Monday at 295 attendances. Snow and a flu epidemic had hindered performance figures, though cancer had continued to deliver throughout the winter period. An updated Winter Plan had been presented to the Performance, Finance and Investment Committee.

Questions and Comments

Mr Rashid acknowledged the struggles within the Emergency Department but remained proud of how the staff had dealt with the issues. Without doubt, the Emergency Department development would ease pressure.

Ms Oum referenced the challenges faced by the staff within the Emergency Department and asked for thanks and appreciation of the Board to be passed to colleagues who had worked especially hard throughout the winter period.

Mr Thomas-Hands advised that a commitment had been made to the Performance, Finance and Investment Committee to close an extra ward to admissions the previous week. Unfortunately due to snow and pressure within the Emergency Department, the ward was not yet closed. Discussions had taken place with teams to prepare for closure the following week. Mr Thomas-Hands added that there would be a financial impact of the ward not closing when it was anticipated.

Mr Heer queried the increase of the number of deaths and asked when the Mortality Report was issued.
Mrs Beal replied that there was an audit of the deaths from 0-1 days taking place on Tuesday the following week. The CCG formed part of the review. The Mortality Report would be reviewed at the next Trust Board meeting in April 2018.

Mr Rashid advised that the rise in number of deaths had been recognised. A multi-professional approach had been organised to review the cases, however a number of the patients typically were not appropriately placed within an acute setting.

Mrs Beal advised that Ruth May, Executive Director of Nursing at NHS Improvement was visiting the Trust on 21st March 2018 with a focus on infection prevention and control.

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

259/17 Performance, Finance & Investment Committee Highlight Report and Minutes

Mr Dunn presented the highlight report from the Performance, Finance and Investment Committee held on 21st February 2018 with the confirmed minutes from the meeting held on 24th January 2018. Mr Dunn gave thanks to the teams whose performance had stabilised and improved but again expressed disappointment in regard to reforecasting finance deficit. The report was taken as read.

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

260/17 Use of Trust Seal

Ms Storey presented the paper which outlined the sealing of documents and was taken as read.

Resolution

The Board received and noted the content of the report.

261/17 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 5th April 2018 at 10:00a.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

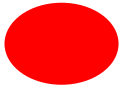
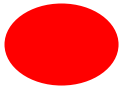
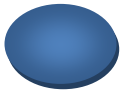
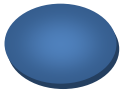
Resolution:

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 2

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~~ 03/05/2018	**Update** Trauma Network Revisit due in January. Report on compliance to be provided to February Quality & Safety Committee. Report deferred from February and March committee to April.	
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	
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 & 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	Chief Executive	~~01/02/2018~~ 21/02/2018	**Update** In progress. Report at the next PFIC on 21.02.2018	

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
	Committee.				
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.	
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 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**	

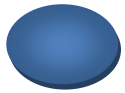
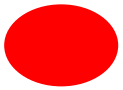
ENC 2

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status

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: 5th April 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>
<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 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 3rd 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>

CHAIR'S REPORT APRIL 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 MARCH 2018

Quality Improvement
I attended the Maternity Oversight Group Meeting where an update was provided on the Section 29A report and exception reports were reviewed. It was pleasing to see progress being made whilst noting the work being done to further improve Maternity services.

I participated along with other Executive and Non-Executive colleagues in the Trust's quarterly review with NHSI. Colleagues presented well on quality, financial and. operational performance and we had the opportunity to set out the Trust's approach to improvement going forward.

Financial Improvement
I met with the new Director of PMO and KPMG to discuss the key issues to be addressed in order to ensure that future efficiency and productivity improvements will be delivered.

Colleague Engagement
I was proud to cut the ribbon at the Pharmacy Robot grand opening.

Richard Beeken and I interviewed two candidates for the role of Interim Trust Secretary and Jacqueline White will join the Trust on 9 April for a period of three months.

3. RECOMMENDATION

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

BOARD/COMMITTEE REPORT

Meeting	**TRUST BOARD**		**Date: 5th April 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	My report is structured to reflect my observations on and intentions for key pieces of work, set against the organisational priority objectives for the coming year. With regard to the Integrated Improvement Programme, I am keen to ensure the Board gets chance to understand our current thinking on this and to influence the shape and content of it, via an informal Board workshop to be held on 9th April 2018.		
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☒
Recommendation	1. NOTE the Chief Executive's report. The Board are asked to note this report and discuss its content to ensure the intentions of both myself and the executive team, reflect their expectations on strategic direction against each of our 4 objectives.			

<table>
<tr><td rowspan="5">Trust Objectives Supported by this Report</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>
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<tr><td>Well-Led</td><td>☒</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Board Assurance Framework/ Corporate Risk Register Links</td><td colspan="2">Links to the financial and performance risks identified in the Board Assurance Framework.</td></tr>
<tr><td>Resource Implications</td><td colspan="2">No direct resource implications.</td></tr>
<tr><td>Other Regulatory /Legal Implications</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>Report History</td><td colspan="2">No previous consideration</td></tr>
<tr><td>Next Steps</td><td colspan="2">No direct next steps</td></tr>
<tr><td>Freedom of Information Status</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
5th APRIL 2018

CHIEF EXECUTIVE'S REPORT

PRIORITY OBJECTIVES FOR 2018/19

1. Quality improvement

During the last month I have been pleased to see the development work starting for our Integrated Improvement Programme (IIP). Sue Holden, Improvement Director, has been leading this work with senior colleagues in the Trust, all of whom have a keen interest in developing a more outcome focused, measurable approach to the incremental improvement of quality of services.

As colleagues are aware, as we move from being an organisation rated as "Inadequate" to one rated "Requires Improvement" and beyond, we need to move away from an improvement plan which focuses on tasks and inputs, to address the fundamental failings identified by the CQC, to a programme of work which reflects our quality priorities as a Board and organisation. We must develop a culture of continuous quality improvement which addresses the three pillars of quality in healthcare:

- Safety – a patient safety culture which is embedded at all levels, in which the Board and all staff participate so that we openly declare when things go wrong or when risks are unnecessarily faced, investigate what changes we can make to practice or procedure and then assure ourselves through robust oversight, that learning and changes are implemented. Key to this will be a more transparent and statistically significant reporting process and improvements to quality governance at Board and within our Divisions and Care Groups, so that we live and breathe our core responsibility as an organisation – to keep patients safe in our care
- Effectiveness – We will undertake a gap analysis against nationally accepted best practice in key areas of our clinical work. We will establish, much as with our work on patient safety, more effective assurance mechanisms that best practice is implemented and embedded
- Experience – We will use local and national survey results, together with improved local engagement with community groups and an enhanced approach to patient involvement (not just engagement), to develop incremental improvements to care of the whole person, not just management of a patient's physiological condition.

Another key element of our Improvement Programme will be our work on patient flow. Recently revised and relaunched with help from the National Emergency Care Improvement Programme (ECIP) and led by our Chief Operating Officer, this work will seek to deliver best practice in admission avoidance, inpatient care coordination and discharge. Poor patient flow and resultant bed occupancy remains one of our greatest risks as an organisation, given it is a driver to many other issues, such as mortality, outcomes and experience. There is much we can still do internally on this agenda and our IIP will incorporate this work and its intended outcomes.

2. **Financial improvement**

We are moving to a critical period for the delivery of our annual plan for 2018/19 and in particular, the finances and resources element of that plan. Key to this is the establishment of our own PMO function and a transfer of skills and infrastructure from KPMG partners to our own wider team, so that key work streams on operational productivity, Divisional CIP and temporary workforce reduction/control are delivered in a timely fashion. PFIC will want to test from a Board perspective, the robustness of that handover and the run rates being achieved against these larger schemes, on which we rely so much.

I am starting a series of meetings with executive leads and SROs to agree deliverables and critically, the accountability for delivery we expect in this programme. The PFIC will reinforce this work with a regular and rolling programme of exception reporting and oversight for each major scheme, involving in particular, the clinical leads for each scheme to assure us that front line clinical staff understand the task set and deliver against expectations. Changes to the Divisional Performance Review process, moving these to monthly, will give the executive a suitably intense and frequent oversight of each scheme so we can be in the best possible place to improve internal and regulatory confidence that a realistic and achievable financial plan, is on track in the critical first quarter.

3. **Improving staff engagement and development of a clinically led organisation**

The Trust has successfully and enthusiastically deployed the Listening into Action (LIA) method, to steer many localised improvements to safety and experience, for patients and staff. My early deliberations with our staff engagement and LIA steering group, has led us to conclude that we need to continue to use this valid and popular approach, but do so as part of a suite of quality improvement methods which we will deploy through our new Quality Academy and measure/oversee, through our Integrated Improvement Programme. Managing LIA as a discrete initiative, running parallel to much of our established governance, oversight and improvement work, seems counterintuitive in the longer term.

We will use the LIA “Pulsecheck” method to test the temperature and enthusiasm of staff for current and intended organisational aims and ambitions and then use this approach again later in the year, to establish whether our revised engagement approach, which will include clinical leaders taking an equal seat at our Trust Management Board for critical decision making, is having the desired effect.

The Trust has significant challenges with clinical and in particular, medical, leadership. There are current and anticipated future vacancies in important posts, which we need to fill with capable and enthusiastic people, so we can deliver our organisational priority objectives in a meaningful way, with 'culture carriers' in the organisation. To that end, I anticipate and have signalled, that new ideas and vision is required in certain services and the Board can anticipate us making external appointments to some of these crucial roles over time.

4. **Developing our Clinical Services Strategy through organisational collaboration**
There are two key strands to this work. Firstly, is the development of 'place based' integrated care, through partnership with primary care and other statutory partner organisations, via the Walsall Together programme. The Board agreed to move this development to the next stage, via approval of the outline business case last month. The Director of Strategy and I are now working with partner organisations to develop the structure, resources and initiation of the leadership team and programme of change, that will make our vision for the delivery of the Five Year Forward View, a reality. The Board can expect proposals on this for its May meeting.

   On acute services sustainability, I have had discussions with my opposite numbers at all the Black Country acute Trusts, to signal that Walsall Healthcare will take the emerging results of its sustainability reviews for its specialities/services and use these to drive collaboration and, where necessary, integration of services with other providers, to guarantee their safety and sustainability for the long term. We must accelerate the pace of this work, given some of our services have workforce or critical mass challenges, which we can neither ignore, nor fix ourselves in the current climate. This will necessitate a resourced programme of work and effective clinical leadership in its own right. The Board can expect more detail on both our sustainability review work and next steps on this programme, very shortly.

The Board is recommended to:

1. NOTE the Chief Executive's report.

Richard Beeken
5th April 2018

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board (Public)	**Date: 05/04/2018**
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 February 2018 o 13 Pressure Ulcers (4 Community acquired and 9 Hospital Acquired) o 3 Diagnostic related Issues o 1 Adverse media coverage or public concern about organisation. 2. Three Serious Incidents relating to diagnostics were reported, one case from each clinical Division with no commonalities identified. 3. The reporting of pressure ulcer reporting has increased predominantly in relation to unstageable grade across both the acute site and community setting. (13 incidents reported in February 2018 compared to 11 incidents in January 2018). 4. There were no Infection Control incidents reported in February 2018. 5. This report covers February 2018 but the Board is asked to note that a Never Event occurred in March 2018 relating to a gynaecological wrong site surgery which occurred within the Women's Children's & Clinical Support Services Division. An internal investigation has commenced to identify root causes and actions required to reduce the likelihood of recurrence.	

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>
<tr><td>Care for Patients at Home Whenever we can</td><td>Not Relevant</td></tr>
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<tr><td>Use resources well to ensure we are Sustainable</td><td>Not Relevant</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>
</table>

Serious Incident Report – February 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.
- One Never Event occurred in March 2018, outside the reporting period but included here to bring it to the Board's attention. A wrong site surgery incident occurred within the Women's Children's & Clinical Support Services Division. An internal investigation has commenced to identify root causes and actions required to reduce the likelihood of recurrence.

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

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

2. Total Incidents

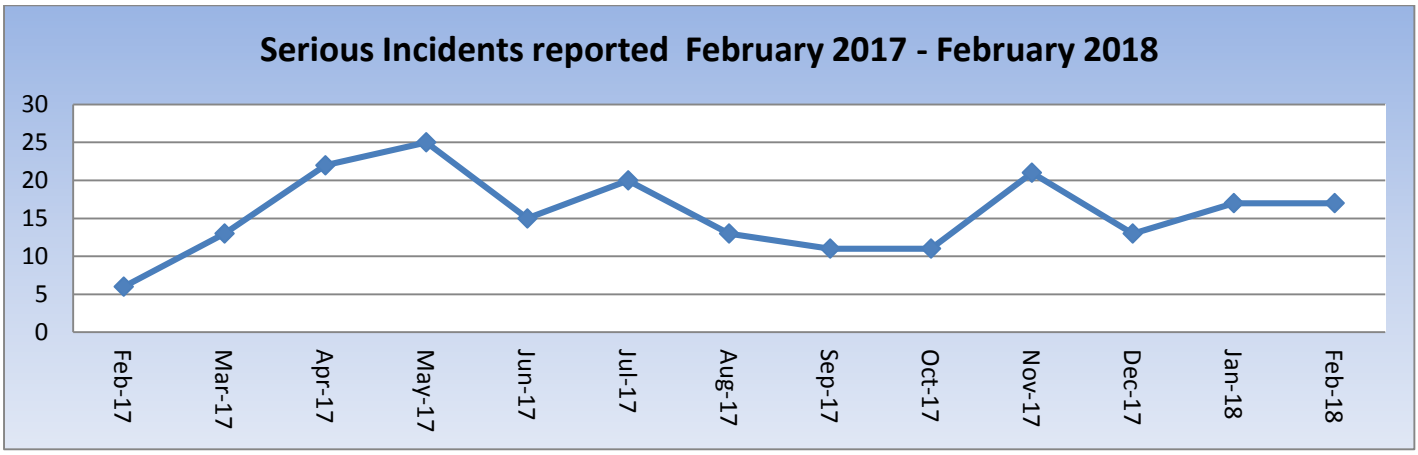
There were a total of 1129 incidents reported in February 2018
The breakdown of harm is shown below:-

Actual Impact	**Incidents reported**
Near Miss	21 (1.9%)
No Harm/Low Harm	1072 (94.9%)
Moderate Harm	31 (2.7%)
Severe Harm	5 (0.4%)
Catastrophic Harm (Death)	0 (0.0%)
TOTAL	**1129**

[1] NHSE Serious Incident Framework 2015

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.

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



4. Key Trends/Themes in new Serious Incidents

- Three incidents relating to diagnostics were reported, one case from each clinical Division with no commonalities identified between them
- 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 Serious Incidents

There were 17 new Serious Incidents reported in February 2018

- 13 Pressure Ulcers (4 Community acquired and 9 Hospital Acquired)
- 3 Diagnostic Issues
- 1 Adverse media coverage or public concern about organisation

6. Closed Incidents – Lessons Learned

	2017/13419		**Surgical Error**
	A patient underwent a gynaecological surgical procedure which was unsuccessful and required the patient to receive and undergo a secondary surgical intervention. The investigation identified that there was a surgical error during the initial surgery resulting in a failed operation. The patient was discharged home after recovery.		
Lessons Learned	• To ensure that there is adequate risk assessment and appropriate supervision at consultant level in gynaecology theatres of all new and rotational doctors at all times. • Timely recognition of an incident and reporting of such an incident are recommended in the future.		
Key Changes to Practice	• To assist the clinician involved and future clinicians to be vigilant when undertaking such procedures by sharing the findings of the investigation. • To improve the timely reporting of incidents within the Trust reporting system. • Aim to improve vision within the theatre for the assisting surgeon/supervising clinician. • Aim to improve the visual field of the assisting surgeon/supervising clinician		

	2016/29717		**Maternity incident (affecting mother)**
	A patient was admitted for planned caesarean section however there was a failure to comply with the Trust policy prior to the procedure. The patient required additional clinical intervention and was booked for further surgery in the post-natal period. The patient was discharged home after recovery.		
Lessons Learned	• The primary reason for Caesarean Section must be clearly stated in the patient record in order that appropriate protocols are followed. • The Safety Huddle at commencement of planned Theatre lists must re-check the reason for proceeding to Caesarean Section. • The Consultant responsible for the planned list must be different to the consultant responsible for emergency procedures		
Key Changes to Practice	• Recording of consideration of the adoption of ORMIS system and decision on future plan. • Staff awareness of requirement to undertake ultrasound to assess presentation of baby prior to taking to theatre. • New rotas in place. • Primary reason for CS stated and required pre-investigations completed. • Members of the division will have a raised awareness of the requirements for consent and recording.		

	2016/23721		**Maternity incident (affecting baby)**
	A patient attended the Delivery Suite at term gestation and initial assessment identified a fetal irregularity, There was a delay during the handover process to commence electronic monitoring of the baby. The baby was delivered in poor condition and required initial resuscitation and intensive treatment prior to transfer to another specialist provider organisation. The baby did not survive.		
Lessons Learned	• Improve the process for Electronic Fetal monitoring including timeliness, communication, assessment and escalation. • Accurate assessment of a depressed baby with airway concerns like cleft lip and palate at birth – intubation on the delivery suite of this type of patient, prior to transfer rather than PEEP or CPAP to ensure safe airway management. • Shorten the time required to prepare pre-medications, so that the intubation of a baby can be undertaken without undue delay, plan to intubate was made at 07:13 and commenced at 07:59. • Process for passive cooling requires review. • Identification, reporting and investigation of serious incidents must be carried out sooner.		
Key Changes to Practice	• Improve interpretation of continuous CTG • Accurate assessment of a depressed baby with airway concerns like cleft lip and palate at birth for need for continuing positive pressure ventilation via facial mask or laryngeal mask airway while awaiting senior help. • To shorten the time required to prepare pre-medications, so that the intubation of a baby can be undertaken without undue delay. • Achievement of target core temperature (33-34 C) within 6 hours for babies who have been decided to have therapeutic hypothermia • Instigate a robust and reliable ongoing process for reviewing incidents and undertaking the correct external report if required		

	2017/11235		**Diagnostic Incident**
	A patient underwent imaging investigations and abnormalities were not detected and subsequently unreported at the time. Further examination and follow-up did not take place as per policy and the staging of the patient's disease has progressed with primary and secondary cancers identified. The patient was referred to an Oncologist but has since died.		
Lessons Learned	• Establish individual Consultant Radiologists error and discrepancy monitoring • Revise the Terms of Reference of the Imaging Discrepancy Group to ensure greater assurance of the learning from incidents • Discuss case for learning and peer education as part of imaging discrepancy group. • Individual reflective learning with supervisors for those reporting images on 15/08/16 and 15/03/17. • Retrospective review of past 5 years Imaging Serious Incidents for trend analysis and to highlight learning. • Deep dive review of imaging reported incidents of all grades for assurance of learning and trends. • SOP for radiologist lead imaging referrals to be agreed at the Imaging Quality team. Once ratified, staff to be managed against this.		
Key Changes to Practice	• Highlight where areas of poor practice or individual and peer group training and development are required. • New Terms of Reference in place and operating • Shared learning and feedback of incident and associated actions. • Individual reflections for use in IPDR • Identification of trends and themes for action • SOP in place to ensure consistency of approach by all Radiologists		

	2017/14213		**Patient Fall**
	A patient was admitted with an existing left sided fractured hip and underwent surgery. During the inpatient recovery period, the patient was self-mobilising and suffered an unwitnessed fall and sustained a fracture to the right hip. The patient underwent a secondary hip surgery and was discharged home.		
Lessons Learned	• No documented evidence of review of previous unwell episodes noted in review night before. • Failure to take appropriate measures relating to identification of the cause of patient's confusion.		
Key Changes to Practice	• Training session to be delivered to MSK Nurses on picking up deteriorating /confused patients • Training session to be delivered on the use of catheter passports and safety thermometers to make sure catheters have strict time limits for how long they are insitu • Team session with Nurses regarding weekend working escalation • Education for staff regarding patients who require X-rays to investigate pain after they have fallen.		

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board	Date: 5th April 2018
Report Title	Hospital Mortality	Agenda Item:9 Enclosure No. 7
Lead Director to Present Report	Mr Amir Khan Medical Director	
Report Author(s)	Mrs J Adams Business Manager to the Medical Directorate	
Executive Summary	**In Month Performance** • HSMR December 2017 128.00 • SHMI November 2017 100.88 **Year to Date 2017/18** • HSMR December 97.06 • SHMI November 2017 98.59 **Reviewing and Learning** The revised approach to Learning from Deaths continues to be developed aligning to the National Quality Board recommendations. Representatives from the Trust will attend RCP mortality review training, 11 places have been secured up to February 2018. The Trust wide Policy, Learning form Deaths has been ratified and is available internally and externally. Further minor developments have been made to incorporate processes developed by the Oncology and Mental Health Teams and feedback of the regional comparator exercise. The development of a multipurpose data set is complete including the functionality to provide information relating to prevalence, demographics, flagging, tracking, review outcomes and a suite of reports. Further work is to be undertaken to embed the review process and determine lessons learnt from those deaths not formally managed via the safeguarding framework **Acting on Lessons Learnt** • Review of deaths for patients admitted with a fractured neck of femur • Review of deaths in ED • Review of the death of a patient receiving chemotherapy • Review of deaths for admissions with a 0-1 day LOS and admitted out of hours during December and January • Respond to recommendations determined through the safeguard process	

Purpose	**Approval**	**Decision**	**Discussion**	**Note for Information**
	☐	☐	☒	☐

Recommendation	1. NOTE the Trust's current hospital mortality performance and associated learning points and actions to be taken

<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>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>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 the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Embed continual service improvement as the way we do things linked to our improvement plan</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">Quality and Safety- to identify lessons learnt from hospital deaths and amend practice and process to improve clinical outcomes, patient experience, reduce hospital deaths and improve mortality performance. Shared learning and improve education and training for clinical staff.
Reduce Hospital Mortality
Assure performance against SHMI
Ensure correct coding to assure appropriate income is received
Collaborative working with the CCG to support the implementation and desired outcomes of the Living Longer in Walsall Strategy</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Ineffective coding resulting in loss of income
Reduce LOS</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Reducing mortality rates
Compliance to the NHS standard contract requirements
Complying with the NQB recommendations, Learning from Death</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">This report is produced on a monthly basis updating performance against the national indicators and activities relating to findings form the review of deaths</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Respond to the CQC Accountability , Candour, Learning recommendations
Respond to NHS NQB recommendations in relation to governance and reporting and transparency
Provision of education and development for medical staff in relation to accurate documentation
GMC led education sessions for medical staff relating to documentation and duty of candour.
Partnership working with the CCG to review causation of death across the health economy
Implement processes to identify deaths of patients with LD and MH issues
Reinforce and embed qualitative approach to reviewing deaths
Demonstrate lessons learnt
Ensure responsibility is taken for developing action plans and revising care pathways.
Develop a process for involving families and carers in investigations</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>

Mortality Report
Trust Board April 2018

Introduction

This report details the performance against the hospital mortality indicators, demonstrates the processes and actions being undertaken in the Trust to assure reporting, review of deaths, lessons learnt and actions are delivered to comply with national guidelines and recommendations in supporting a reduction in avoidable deaths and improved outcomes for patients and carers.

How We Are Performing

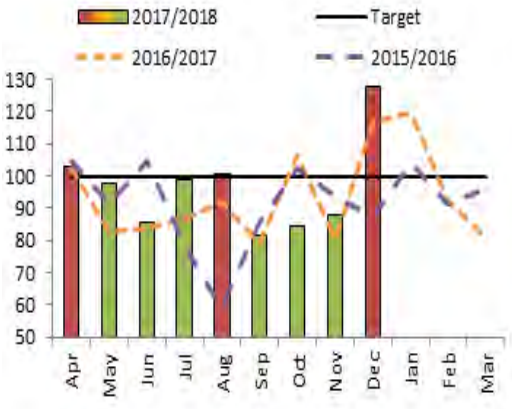
The Trust performance against the two key national indicators for mortality Hospital Standardised Mortality Rate and Standardised Hospital Mortality Index has been variable during the year 2017/18 (Appendix 1)

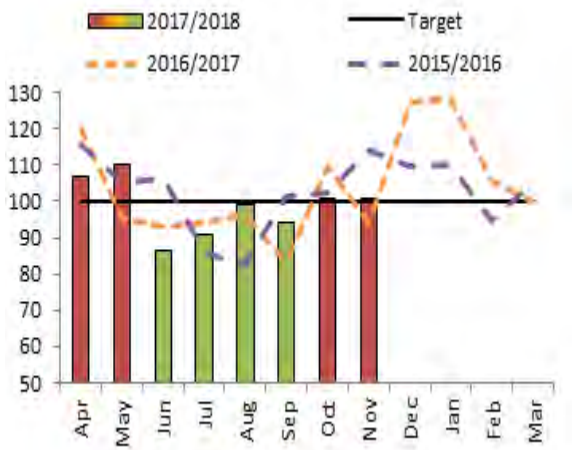
Performance in month for the current reporting period as below identifies that HSMR has risen significantly in December reflecting a significant rise in deaths and reflective of a similar trend seen in previous years. This reflects a similar trend for regional peers. This is the second time this year HSMR has been reported above 100 but remains below 100 YTD.
Similarly SHMI has demonstrated a rise reporting above 100 for 2 consecutive months but remaining below 100 YTD

Walsall Healthcare Hospital Mortality – Headline Indicators

Measure	Period (latest available)	Month	Year to Date	Comment
HSMR (index)	Dec 2017	128	97.06	Following rebasing in December HSMR has been reported at above 100 for 3 months, April, August and December, remaining below 100 YTD
SHMI (index)	Nov 2017	100.88	98.59	SHMI has reported as over 100 for 2 consecutive months, remaining below 100 YTD
Crude Mortality Rate/ 1000 bed days	Feb 2018	6.7	N/A	Crude mortality for has fallen significantly since December and January
Actual Deaths (no.)	February 2017	109	1055	February has started to see a down turn in deaths compared to December and January. February as for December and January demonstrates an increase compared to the same period last year and an increase for the YTD total.

HSMR Performance 2016-2017 **SHMI Performance 2016-2017**





Regional Comparison

The diagrams, Appendix 2, show the Trust performance for HSMR and SHMI compared to other Trusts within the region for 2017/18.

The diagrams show the Trust HSMR performance compared regionally has returned to 1/14 YTD .For the month of December the Trust ranks 12/14 due to a significant rise in HSMR performance

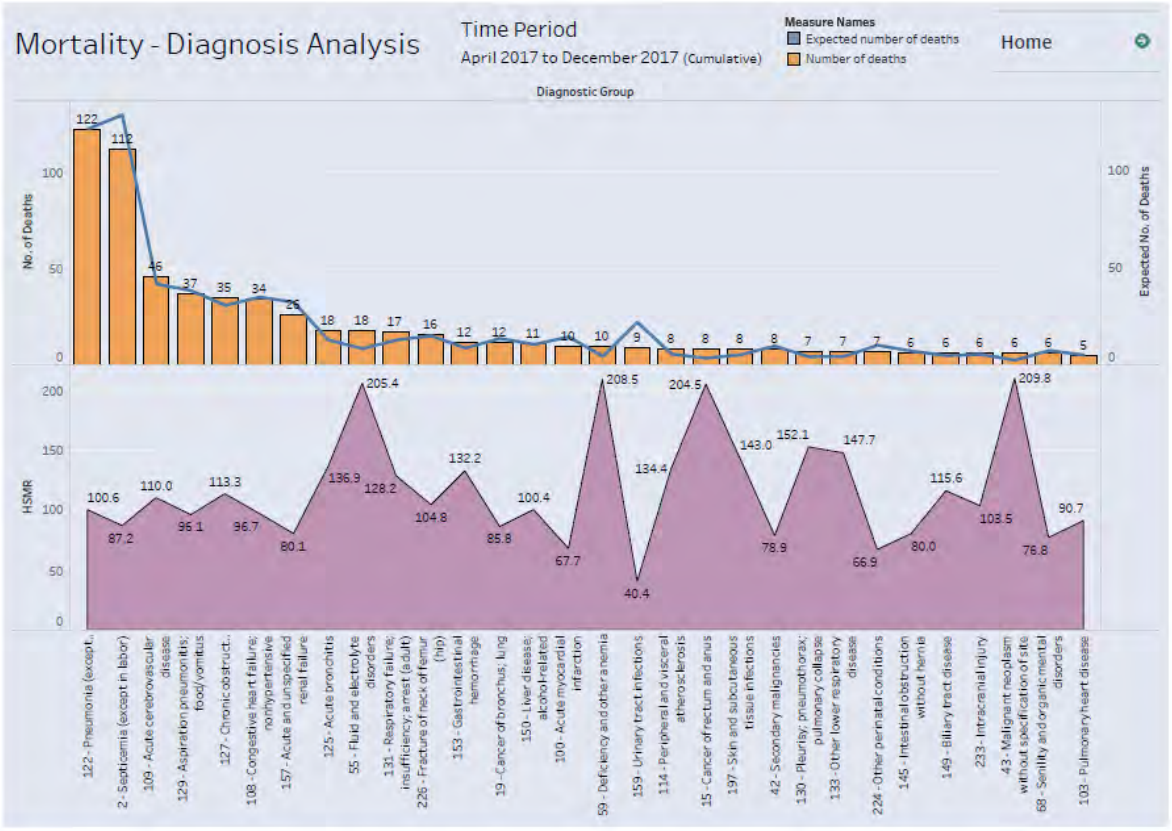
The Trust regional position for SHMI has been maintained as per previous months.

The number of deaths overall for the year are at a higher level for the same period in the previous year.

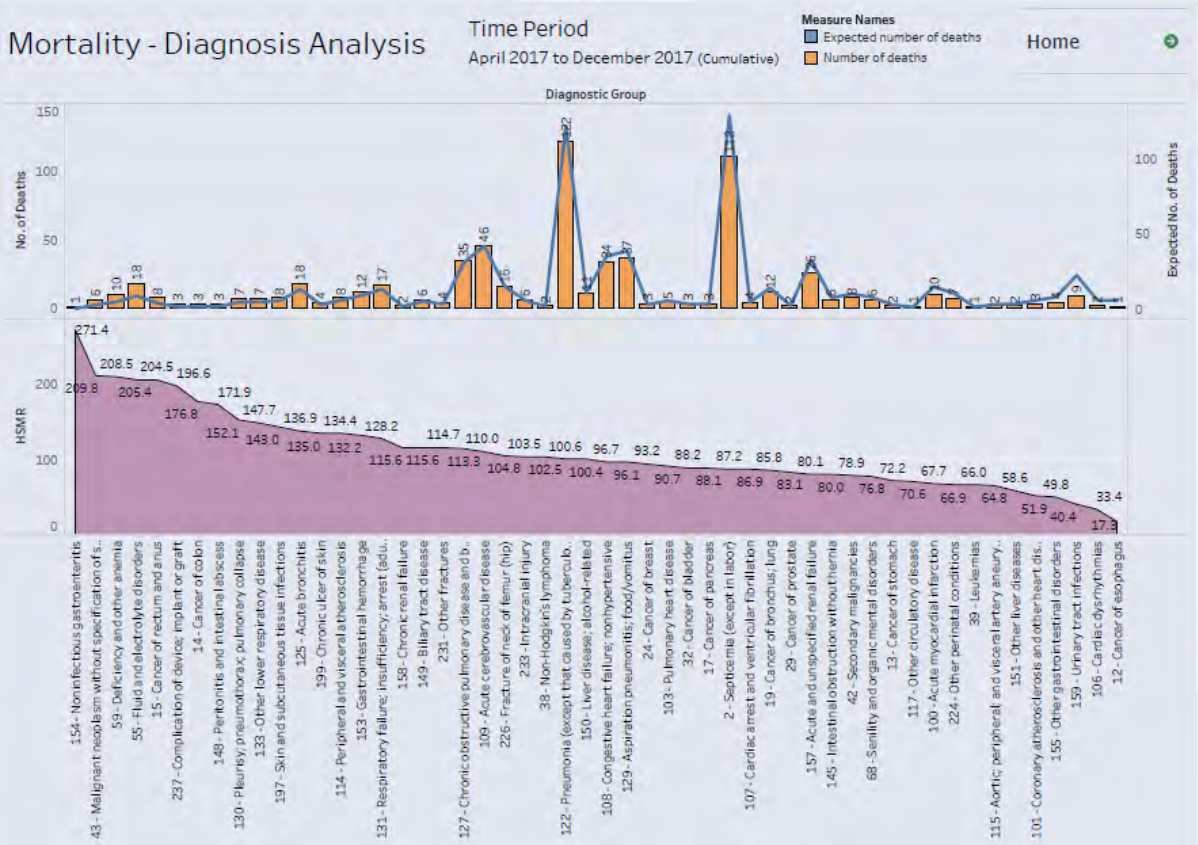
Diagnosis Specific Triggers and Alerts, CuSum

The following diagram identifies the highest number of deaths by diagnostic groups and associated HSMR for months 1-6.The diagram demonstrates the variance between expected and observed deaths.

The most significant variances from expected to actual has been seen as the months have progressed are for patient deaths relating to respiratory diagnosis.



The following diagram identifies the highest HSMR by diagnostic group.
A slight variance in expected related to seen is demonstrated for patients with a fracture neck of femur. The orthopaedic team are reviewing these deaths; their initial presentation identified a theme relating to hospital acquired pneumonia. The Matron and Clinicians as part of a multidisciplinary review are undertaking a second review to identify lessons learnt and actions that can be put into place to support in the reduction of HAP in this group of patients.



Performance alerts, CuSum, are produced to provide trusts with data relating to deaths in specific diagnostics groups. These alerts identify where specific diagnostic groups trigger alert indicators when the number of deaths for that diagnosis occur more frequently than expected.

A CuSum trigger for overall performance is 5, the trust performance for CuSum is currently 0.00, suggesting that there are no specific concerns identified through this route relating to the number of deaths for any diagnostic group.

Any key themes

Respiratory related diseases continue to contribute significantly to the numbers of deaths and higher HSMR based on observed greater than expected.
Deaths coded as fluid and electrolyte imbalance demonstrate a significantly higher HSMR than expected. Having undertaken a preliminary review of a number of these patients, specifically those with frequent readmissions identified patients with multiple comorbidities, advanced malignant disease, frail elderly and a number in nursing home environments.
Initial outputs from the MDT review of the January and December deaths identify similar themes.

The number of deaths as reported internally in December, January and February have risen significantly compared to the same period last year with December reporting a HSMR of 128.

Analysis of prevalence of the triggers identifies a number of trends for each month. Using a single trigger to identify trends can potentially suggest an issue for that group of patients, for example
For the period December and January the following trends were demonstrated

- 273 deaths in total
- 48 patients had a LOS of 0-1 day
- 133 patients were admitted out of hours

When multiple triggers are applied this combination reduces the prevalence of trends

- 20 of the patients who had a 0-1 day LOS were also admitted out of hours.

The trend analysis determined by the triggers predetermining the cohorts of patients to be reviewed must be used in conjunction with the review of the individual patients care to determine care or system issues. The trigger trend analysis, number of deaths and diagnostic trends can only be used as a guide as to where we should be reviewing patients deaths.
This suggests that the critical element to enable us to learn from deaths is robust case by case review. It is also essential to review the whole pathway including community care pre admission and post discharge from community teams and GPs.

Our Process for Learning from Hospital Mortality

During 2016 The National Mortality Case Record Review Programme in conjunction with the Royal College of Physicians (RCP) introduced a standardised methodology for reviewing case records of deaths in hospital using a qualitative analysis approach and a structured judgement review ,SJR tool
The recommended tool was launched within the trust in January 2017.A further review of the tool has been undertaken and is currently in the consultation phase. The revised tool supports clear identification of clinical and process issues that may have been as issue
The development of these recommendations has commenced. A senior clinician has been identified as the lead for mortality and specialty leads have been nominated.
The RCP training programme has commenced with training available for 11 clinicians up to February 2018.
The Clinical Directors for all care groups have agreed on the cohorts of patients to be included in the review process based on the NQB recommendations.
The group will include

1. All deaths where bereaved families and carers or staff have raised a significant concern about the quality of care provision
2. All patients with a learning disability
3. All patients with a mental health illness
4. All maternal deaths
5. All children and young people up to 19 years of age
6. All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work
7. All 0-1 day LOS who are not receiving specialist palliative care
8. All patients admitted out of hours who die within 5 days, excluding those receiving specialist palliative care

9. All elective surgical patients,
10. All none elective surgical patients
11. All patients readmitted within 30 days of discharge
12. All patients with more than 4 admissions within the previous 12 months
13. All unexpected deaths/ coroner reported
14. Deaths in critical care
15. A random selection of 20% of others not in the cohorts above
16. 20 patients per month to be reviewed by the palliative care team to review EOL care

Subsequently it is anticipated that not all deaths will require review but is proposed that 100% of the selected cohort will be reviewed. The revised process was implemented for deaths occurring in June 2017.

Flags Applied	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
1. All deaths where bereaved families and carers or staff have raised a significant concern about the quality of care provision	3	5	4	5	7	11	3	5	1
2. All patients with a learning disability	0	0	0	0	1	1	1	0	TBC
3. All patients with a mental health illness	0	0	0	0	0	0	0	0	TBC
4. All maternal deaths	0	0	0	0	0	0	0	0	0
5. All children and young people up to 19 years of age	0	1	2	0	0	0	0	0	5
6. All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work	0	0	0	0	0	0	0	0	0
7. All 0-1 day LOS who are not receiving specialist palliative care	11	13	12	8	21	13	23	22	12
8. All patients admitted out of hours who die within 5 days, excluding those receiving specialist palliative care	46	14	20	14	23	15	34	34	27
9. All elective surgical patients	0	1	0	2	0	2	0	1	0
10. All none elective surgical patients	10	13	11	3	8	10	11	15	13
11. All unexpected deaths/ coroner reported	-	-	-	-	5	19	21	TBC	TBC
12. Deaths in critical care	8	5	5	6	15	10	8	15	8
13. A random selection of 20% of those other than listed above	6	8	8	6	10	7	6	9	13
14. 20 patients per month to be reviewed by the palliative care team to review EOL care	20	20	20	20	20	20	20	20	20
15. All deaths were an internal indicator is flagged readmissions within 30days	9	7	10	8	12	7	12	10	8
16. All deaths were an internal indicator is flagged readmissions >4 in 12 months	13	10	10	5	6	14	23	18	15

The number of deaths and subsequent reviews required based on the cohorts identified from the triggers is demonstrated below.

June 2017		July 2017	
Total Number of Deaths	80	Total Number of Deaths	81
Total Number to be Reviewed	62	Total Number to be Reviewed	62
August 2017		September 2017	
Total Number of Deaths	88	Total Number of Deaths	62
Total Number to be Reviewed	52	Total Number to be Reviewed	35
October 2017		November 2017	
Total Number of Deaths	86	Total Number of Deaths	80
Total Number to be Reviewed	68	Total Number to be Reviewed	51
December 2017		January2018	
Total Number of Deaths	133	Total Number of Deaths	139
Total Number to be Reviewed	103	Total Number to be Reviewed	88
February 2018		March 2018	
Total Number of Deaths	109	Total Number of Deaths	
Total Number to be Reviewed	70	Total Number to be Reviewed	

Since the implementation of the national guidance the performance for reviewing deaths within the care groups is demonstrated in the table below.

Performance against the 100% review of all cohort patients continues to be poor. This has resulted in insufficient to be indicative of meaningful trends relating to the quality of care and processes to inform lessons learnt and associate actions and review of practice.

The clinical lead for Mortality is to raise a concern with the MD in relation to dedicated time for clinicians to undertake the mortality reviews.

Specialities	**June 2017**			
	Number of Deaths	**Number with at least 1 Flag**	**Number Returned**	**Return Rate**
Elderly Care	27	23	16	69%
Long Term Conditions	19	10	9	90%
Emergency Medicine	11	8	6	75%
Cardiology	2	2	2	100%
Gastroenterology	5	3	3	100%
MSK	3	3	3	100%
General Surgery	5	5	4	80%
Head and Neck	0	0		-
Urology	0	0		-
ITU	8	8	7	87.5%
Total Figures	**80**	**62**	**50**	**81%**

Secondary Review Required	Number Returned	Return Rate
2	2	100%
Number Requiring Reporting on Safeguard (< 3)	Number determined as SI	Number Requiring RCA
0	0	0

Specialities	July 2017			
	Number of Deaths	Number with at least 1 Flag	Number Returned	Return Rate
Elderly Care	23	11	11	100%
Long Term Conditions	20	7	7	100%
Emergency Medicine	16	13	12	92%
Cardiology	4	4	4	100%
Gastroenterology	1	1	1	100%
MSK	4	4	4	100%
General Surgery	7	7	8	100%
Head and Neck	0	-	-	-
Urology	0	-	-	-
ITU	5	5	4	80%
Paediatrics	1	1	1	100%
Total Figures	**81**	**53**	**52**	**96%**

Secondary Review Identified as scoring ≤ 3	Number Requiring Secondary Review	Return Rate
7	4	3
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA
0	0	0

Specialities	September 2017			
	Number of Deaths	Number with at least 1 Flag	Number Returned	Return Rate
Elderly Care	15	8	7	87.5%
Long Term Conditions	13	2	2	100%
Emergency Medicine	16	11	7	63%
Cardiology	3	1	1	100%
Gastroenterology	4	2	0	0%
MSK	1	1	1	100%
General Surgery	3	3	3	100%
Urology	1	1	1	100%
ITU	6	6	4	67%
Womens	0	-	-	-
Paediatrics	0	-	-	-
Total Figures	**61**	**35**	**21**	**74%**

Secondary Review Required	Number Returned	Return Rate
1	1	1
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA

Specialities	October 2017			
	Number of Deaths	Number with at least 1 Flag	Number Returned	Return Rate
Elderly Care	19	13	11	84%
Long Term Conditions	13	9	6	67%
Emergency Medicine	13	9	4	44%
Cardiology	4	4	4	100%
Gastroenterology	11	8	5	62.5%
MSK	6	6	6	100%
General Surgery	4	4	4	100%
Urology	0			
ITU	15	15	13	87%
Womens	0			-
Paediatrics	0			-
Total Figures	**86**	**68**	**53**	**78%**

Secondary Review Required	Number Returned	Return Rate
3	3	In progress
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA
1		

Specialities	November 2017				
	Number of Deaths	Number with at least 1 Flag	Number Notes Delivered	Number Forms Returned	Return Rate
Elderly Care	13	5	5	5	100%
Long Term Conditions	17	7	7	3	43%
Emergency Medicine	19	15	15	4	27%
Cardiology	2	2	1	1	50%
Gastroenterology	6	2	2	1	50%
MSK	2	2	2	2	100%
General Surgery	6	6	6	6	100%
Urology	0	-	-	-	
ITU	12	12	12	11	92%
Womens	0	-	-	-	-
Paediatrics	0	-	-	-	-
Total Figures	**77***	**51**	**41**	**34**	**66%**

Secondary Review Identified As Scoring <3	Second Review Required as Identified by Mortality Lead	Second Review Completed
4		1
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA

Specialities	December 2017				
	Number of Deaths	Number with at least 1 Flag	Number Notes Delivered	Number Forms Returned	Return Rate
Elderly Care	29	18	16	16	89%
Long Term Conditions	25	17	16	5	29%
Emergency Medicine	41	37	36	9	24%
Cardiology	5	4	3	3	75%
Gastroenterology	12	7	6	4	57%
MSK	4	4	4	3	75%
General Surgery	6	6	5	6	100%
Urology	1	1	1	0	0%
ITU	8	8	8	5	62.5%
Womens	1	1	1	1	100%
Paediatrics	0	-	-	-	-
Total Figures	**131***	**103**	**97**	**52**	**50%**

Secondary Review Identified As Scoring <3	Second Review Required as Identified by Mortality Lead	Second Review Completed
2	1	
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA

Specialities	January 2018				
	Number of Deaths	Number with at least 1 Flag	Number Notes Delivered	Number Forms Returned	Return Rate
Elderly Care	25	14	13	7	50%
Long Term Conditions	21	10	9	9	90%
Emergency Medicine	50	31	27	7	23%
Cardiology	2	1	1	1	100%
Gastroenterology	6	3	1	0	0%
MSK	4	4	3	2	66%
General Surgery	7	7	7	7	100%
Urology	2	2	1	0	0%
ITU	15	15	14	12	80%
Womens	1	1	1	1	100%
Paediatrics	0	-	-	-	-
Total Figures	**134***	**88**	**71**	**46**	**52%**

Secondary Review Identified As Scoring <3	Second Review Required as Identified by Mortality Lead	Second Review Completed
1		
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA

Specialities	February 2018				
	Number of Deaths	Number with at least 1 Flag	Number Notes Delivered	Number Forms Returned	Return Rate
Elderly Care	24	14	12	6	43%
Long Term Conditions	17	8	6	-	
Emergency Medicine	28	21	16	-	-
Cardiology	6	4	2	-	-
Gastroenterology	4	1	1	-	-
MSK	7	7	6	1	14%
General Surgery	6	6	5	4	67%
Urology	0	-	-	-	-
ITU	8	8	7	3	37.5%
Womens	0	-	-	-	-
Paediatrics	1	1	1	1	100%
Total Figures	**101***	**70**	**35**	**15**	**21%**

Secondary Review Identified As Scoring <3	Second Review Required as Identified by Mortality Lead	Second Review Completed
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA

All deaths reviewed will be assessed for overall quality of care with a score of 1-5. Any deaths scoring less than 3 will be subject to a second review by a senior

clinician and the Trust Lead Clinician for mortality supported by appropriate members of the MDT. This review will determine as to whether the death was avoidable, if this is found to be the case the death will be recorded in safeguard to determine the appropriateness of SI status and invoke duty of candour and investigation processes as per the trust policy.

All deaths determined as avoidable will be required to be reported nationally. The term avoidability and national benchmarking of organisations against this definition is currently being reviewed. The RCP have released a paper outlining the difficulty in determining avoidability and the use of an organisational league table.

To assure the quality of reviews once the RCP training has been undertaken a random selection of 10% of reviews undertaken will be reviewed by the mortality lead for each specialty and presented at their care group quality forums on a quarterly basis.

A trust learning from death policy has been developed, ratified and is available internally and externally via the internet. The policy is currently undergoing minor reviews following feedback from the regional comparator exercise.

As part of the process It is proposed that the reviews will be undertaken by the specialty leads for mortality, presented and discussed at Care Group Quality teams to develop action plans and determine lessons learnt and presented at the Mortality

Group for shared learning and reported through TQE, CQR and Trust Board. Appendix 4

At the CQRM in February the trust has been asked to support in a review of deaths of patients from care homes and deaths occurring within 30 days of discharge.
As part of the review of deaths occurring in December and January place of residence will be included in the review.

The Division of paediatrics continue to follow national protocols for reviewing paediatric and neonatal deaths and participating in regional and national forums and quality reviews.
For all Oncology patients who die within 30 days of receiving chemotherapy reviews will be undertaken as per the national guidelines.

Acting on Learning

Areas of learning are identified using a number of indicators from internal and external performance metrics.
The areas of learning are manged through he Care Group and Divisional Quality Teams and presented at the Mortality Group
Recent areas of learning have been identified as follows

Care Group	Review	What Have We Learnt	What Action Are We Taking	What Progress Have We Made	Owner	Review Date
Elderly Care	Patients who died and were diagnosed with aspiration pneumonia saw a rise in 2016	SaLT assessments were not timely SaLT resources were limited Relative patient and carer information was limited	An LIA was undertaken involving all stakeholders.	An action plan has been devised and implemented. Appendix 4	Dr Senthil Matron Julie Corns	~~**January 2017**~~ **October 2017 completed**
Palliative Care	Patients who died who were known to have a learning disability, to be reviewed as part of revised national guidance to support in reducing premature death	National evidence suggests that patients with LD are more likely to die prematurely and involvement of specialist support and involvement of carers is not always optimal	Undertaking a review of patients who have died in a 12 month period who we were able to identify as having a LD	A review has been undertaken which did not identify any concerns in relation to gaps in clinical care. There were no negative issues identified in relation to equality and diversity There was evidence to suggest that there was limited involvement of specialist teams to support with the care of patients with LD The Trust does not use an electronic identifier to support in notifying specialist teams of attendance or admission into hospital of patients with LD. The Trust are not able to identify all patients who have	Dr Esther Waterhouse Diane Rhoden Senior Nurse Quality and Safeguarding Mrs J Adams Kirstie Macmillan Sharon Thomas	~~**April 2017**~~ ~~**Aug 2017**~~ **May 2018**

				died in the Trust who have a LD. The leads for safeguarding are working collaboratively with the Business Change team, CCG and CSU to develop a sharing of information protocol and process to process to enable identification of this group of patients to enable analysis of care needs and any gaps in the models of care delivered The trust leads for Data Protection are seeking advice in relation to the use of flags for this group of patients in light of revised Data Protection Act guidance. A meeting has been convened with the trust DP leads, LD and safeguarding teams. An interim process to identify and report LD deaths has been developed pending the GDPR guidelines in Mat 2018		
Emergency Medicine	During December and January a significant rise in 0-1 day LOS deaths was observed		The lead clinician for AMU is to review these deaths and identify any learning points to be presented at the MGM in May 2017 The Care Group Manage for Community Services will review	Initial information has identified that a significant proportion of the patients with a 0-1 day LOS were or had received DN intervention, DC to undertake further case review to determine if there were any intervention that could have been undertaken to reduce admissions. Dr Ali has reviewed 0 day LOS patients admitted to	Dr Saim Donna Chaloner	~~**May 2017**~~ ~~**July 2017**~~ **complete**

			this group of patients to determine whether there are any learning points in relation to the community engagement	AMU during December and January. 1 patient receiving shared care has been referred for secondary review. No other specific issues were identified. Community services have reviewed the 0day LOS patient admitted during December and January. The review found that 5 patients had a community DNAR in place. Key areas of learning were identified in relation to recognition of the deteriorating patient and the early management of sepsis. KG will be working with the teams to implement actions as per an action plan developed as a result of the review. Appendix 5		
Palliative Care	During December and January a rise in the numbers of patients receiving specialist palliative care with and without EOL pathways in place was observed	EW presented findings following the review of a group of patients. The review found limited evidence of involvement of the palliative care team, EOL pathway and communication with relatives and carers	A meeting is to be convened with the MD, DD , CD , Matron medical and nursing teams	A meeting has taken place with the palliative care and clinical leads to agree on communication strategies and support required for the ward areas to ensure palliative care involvement at the earliest opportunity	Dr Esther Waterhouse Matron Karen Rawlings	**May 2017 complete**
Critical Care	VC reviewed deaths in critical care	Limited evidence of cause of death documented in the patient record	The clinical coding department will include the coding record in the	To commence May 2017	Sharon Thornywork	**May 2017 complete**

			patients notes for information for the reviewing clinician			
Critical Care	VC reviewed deaths in critical care	Limited evidence of consent being obtained for procedures form patients or information to patients, relatives and carers regarding procedures and interventions	A consent document to be developed for patients to sign on admission to critical care and a document for relatives to sign to document that they have been given information in relation to planned or potential procedures or intervention that may be required and are in best interest	A consent document has been developed for use in critical care for appropriate patients	Viktorijia Cerniauskiene	**June 2017 complete**
Long Term conditions	Review of patients recorded as PE contributing to deaths and development of a revised PE protocol and clinical guideline	Patients diagnosed or suspected to have massive PE are not suitable to be managed within a general acute admissions ward	Dr Selveraj to develop a revised guideline and protocol by where all patients with massive PE will be cared for in a CCU or Critical Care environment	Protocol and clinical guideline has been developed, to be presented at DQTs , QS and launched. EE is leading on the launch and clinical sign off of the guideline The final guideline will be received at DQB September 2017 The guideline has been uploaded to the trust intranet and circulated to all clinical groups for information and action	Dr Selveraj, JA	~~**August 2017**~~ **September 2017 Complete**
Elderly Care	Further review of patients with aspiration related deaths	Dr Senthil undertook further review of this group	D Rhoden and Donna Chaloner to liaise with the	KW community lead has developed a care plan used for those patients at risk.	DR, DC DR/CG/KW	~~**July 2017**~~ **October 2017**

		of patients, the review identified that a number of the patients developed aspiration pneumonia in a care setting in the community	community team to develop a specific SaLT care plan for careers at home and nursing homes	Issue to be presented at the next nutritional steering group for wider participation and consideration for the management of patients who are discharged with a feed at risk status		
Elderly Care	Review of deaths in elderly care	Dr Senthil undertook a review of deaths occurring in elderly care	The review found that not all MCA were completed for patients with DNAR in place Patient not consented for NIV Anuria for 23 hours not escalated	This is to be reinforced at CG and Grand round meetings. Seminar CPR/DNAR/MCA 27 September 2017 Medical staff to attend consent LIA 5 September 2017 Escalated to Matrons to reinstate fluid balance audits. Monthly audits of Vitalpac. Deteriorating patients to be a standing agenda item on CG Quality meetings.	VS/JA NT/JA Patient Safety Teams, VS	**October 2017 Complete**
Critical Care	Review of a patient with a CVP line	A patient was admitted to ITU and subsequently died. Mortality review undertaken and recorded as a concern on the safeguard system in respect of the management of the CVP line	A second review was undertaken and a table top exercise was undertaken supported by the patient safety team	The lessons learnt and action plan has been developed Key points Lack of widespread training for all Nurses across the Trust and then ability to the competency of this training Unable to currently monitor the amount of CVP lines in the Trust due to no team co-ordinating this. Ward round standards need to be updated to include the monitoring of CVP lines and		**August 2017 complete**

				to document the review in the notes Messages from reviews to be shared widely through screen savers Safety messages of the week being created and shared in AMU Moderate harm recorded Appendix 6		
Patient attending ED with low Hb	Review of a patient with a history of raised INR and haemoptysis	A secondary review has been undertaken and this incident has been recorded as an SI	Duty of candour and the Safeguarding Framework has been enacted	STEIS number 2017/19133.Cause of death recorded as PE as per post mortem. Low Hb and raised INR did not contribute to the death.RJ developing concise review and propose a downgrade . Lessons learnt discussed at ED CGroup. Concise report appendix 5	NA/RJ/DH	~~**September 2017**~~ **October 2017 Complete**
September 2017 Out of Hospital Deaths	A review of out of hospital deaths for the month of MAY 2017, contributing to 37% of all deaths	To agree a process at the CCG Mortality reduction Group September 22		A review is being undertaken of the group of patients by the community teams, findings will be presented at the next CCG Reducing Mortality meeting for potential further reviews. Report attached  Mortality Report.docx	KG/YH/NA/JA	**November 2017 Complete**
September 2017. Elderly Care Deaths	A review of a random selection of deaths occurring in Elderly Care during May and June			A review has been undertaken , issues identified, documentation, DNARCPR documentation and	VS	**November 2017 Complete**

	2017, a continued high prevalence has been seen for these 2 months			escalation of the deteriorating patient. To be discussed and action plans developed at the CG quality meeting in February. Documentation to be picked up as part of the CQC PCIP plan		
September 2017	A review of EOL care as part of the EOL working group	As part of the deteriorating patient work a group of patients have been identified as EOL care where resuscitation may have been futile due to underlying and critical comorbidities.		Appendix 6 Update required from RJ 12/01/2018	RJ	**November 2017 January Complete**
October 2017	Review of COPD deaths occurring in Q1. Expected against observed shows an increase			NA to meet with NP to identify a nominee to undertake the review. A cohort of patients has been identified focusing on cohort groups.	SN/VB/	**December 2017**
October 2017	Review of cross organisational policies and processes in relation to DNAR/CPR/MCA with the acute Trust and CCG			An initial task and finish group meeting has taken place and will reconvene in November to scope options of joint documentation and information flow for patients being admitted and discharged	NA	**December 2017**
October 2017	Review of deaths with a fracture neck of femur	The T&O clinicians have reviewed all deaths since august.	A presentation delivered by GS identified an underlying theme of hospital acquired pneumonia.	A second multidisciplinary review of this group of patients will be undertaken to identify any changes in practice to support in reducing HAP	LP/DR	**January 2018 Deferred to April**

October 2017	Review of a shared care death JA 100065728. Steis 2017/714529	This death was recorded as an SI and managed via the SI framework. The death was subsequently reported to the coroner	An RCA has been completed, the coroner's report is complete	RCA action plan attached. Action plan completed and coroners recommendations addressed.  Remedial Action Plan 2017-14529.docx	SA	**November 2017 complete**
November 2017	Review of a sepsis related death IM 100112855 STEIS 2017/29009	The death was reported on safeguard by the ICT reported as an SI	An RCA has been undertaken , outcome has been considered to be unavoidable Lessons learnt action plan development in progress	Due date for report 22 February 2017	LR	**March 2018**
November 2017	Patient AS	Death of a patient in MLTC. Recorded within safeguard, possible HCAI.		This has been recorded via safeguard, to be reviewed as SI. Reviewed not SI	SA	**February 2018 complete**
November 2018	Patient CW Steis 2017/29015	Death of a patient recorded on safeguard following deterioration and subsequent death		This has been recorded on safeguard as an SI, RCA complete lessons learnt identified and monitored through RMC  Final RCA 2017-29015 docx v5.	DH	**February 2017 Complete**
January 2018	Patient. SH. SI number 83455. Unit number 300440921	Medical patient died of a ruptured aneurysm during transfer to another provider		This has been recorded as an SI and an RCA is to be undertaken. RCA complete 25/1. Coroner 27/3.	SA	**March 2018**
January 2018	Patient BT SI number 83912. Unit number 300718440	Surgical patient. Deteriorating patient and		This has been recorded as an SI and an RCA is to be undertaken w/C 26/2.	JR	**March 2018**

		escalation processes followed by the team are to be reviewed				
January 2018	Review of ED deaths	Review of all deaths occurring in ED between Oct-Dec 2017. Identified poor documentation	Issues relating to poor documentation to be taken to the ED quality group in February Further review of 2 patients to be undertaken to provide more detail relating to the timeline of care. 100052183 100096746	Further review to be presented	DC	**March 2018**
January 2018	Pt 300799748	Patient receiving chemotherapy , review to be undertaken			NA/NA	**March 2018**
February 2018 MLTC	Review of deaths admitted out of hours with a LOS of 0-1 day					**April 2018**
February 2018	PT VS 300615177 steis 2018/912	Fracture following a fall		SI, RCA undertaken , referred to coroner		**April 2018**
February 2018	PT MS 300502778 Steis 2017/28914	Shared care urology and Gynae		SI,RCA, referred to coroner		**April 2018**

Conclusion

Year to date HSMR has remained below 100 but has risen to 128 for the month of December; the highest reported for 2 years, this is demonstrated at regional peers. SHMI has reported at above 100 for 2 consecutive months but remains below 100 year to date

Primarily there are no Cusum risks or any specific SHMI risks.

Respiratory disease related deaths contribute significantly to the total deaths seen.

Initial findings of review of high HSMR diagnostic groups and the deaths occurring in December and January admitted out of hours with a short LOS demonstrate trends relating to admissions that may have been avoidable for frail elderly patients and those with end of life requirements.

The revised process is supporting in identifying areas to review, lessons learnt and changes in practice. A robust data analysis and reporting system is in place. Although performance for undertaking reviews is below the expected standard. Review performance is not sufficient to be indicative for areas of concern in care or process. This is resulting in an inability to determine lessons learnt effectively. And implement changes in practice.

The provision of a dedicated resource is required and will be reviewed in conjunction with the proposal of a medical examiner resource.

The quality of documentation is a common theme during reviews of patient's medical record.

The trust is required to report avoidable deaths. Improved governance will be required to be embedded to assure that those deaths reviewed and determined to demonstrate substandard elements of care or process are managed via the safeguard framework and determined as to whether any elements of care or process contributed to the death.

Recommendations

- Undertake a review of COPD deaths occurring in Q1. SN April 2018.
- Undertake a review of patients with fracture neck of femur developing hospital acquired pneumonia. Mr Selzer and the T&O team. March 2018
- Review December and January deaths for patients admitted out of hours and with a LOS of 1-0 days. Initially JA. Full review by Dr Harlin, DDON, CCG representation and K Geffin April 2018
- Review trends relating to December and January deaths JA April 2018
- To achieve 100% reviews as per cohorts each month
- Escalate to DDs and CDs poor performance in reviewing deaths. Clinical audit team. On going
- Align the actions to address poor documentation to the CQC PCIP work relating to documentation. AHK/BB April 2018

Progress has been made to deliver the recommendations within the NQB guidance.

- Going forward the Trust will align to the NQB Learning from death recommendations reviewing key cohorts of patients. This may not be 100% of the total deaths but the Trust will be working towards reviewing 100% of the selected cohort.
- From June 2017 the revised cohort of patients has been selected for review commenced
- A further revision of the cohorts selected will be applied for deaths occurring in August to incorporate multiple admissions in year and those readmitted within 30 days of a previous discharge.
- A nominated trust Lead for Mortality has been identified. The Trust is represented at the BCA Learning from Deaths forum.
- Specialty leads have been identified to lead on mortality
- Training provided by the RCP has been secured for October and November for 11 clinicians. The SJR tool will be revised further
- Work has been completed on the development of a trust policy this has been circulated internally and externally to the trust appendix 3. A further revision has been undertaken following a peer comparison exercise
- Robust governance will be implemented within specialties to ensure the clinical leads are taking ownership of learning from deaths and reviewing, identifying issues, developing action plans and sharing learning through the Mortality Surveillance Group.
- Work is continuing with the clinical governance and patient safety teams to ensure all deaths under review via the safeguarding framework are captured within the reporting process
- Collaborative work is being undertaken with the information services and performance team to develop robust reporting systems. A suite of reports has been developed to contribute to the monthly mortality paper and presentation to the Mortality Surveillance Group to communicate themes and performance to the clinical teams
- The Trust continues to develop and embed a robust process for monitoring and reporting deaths aligning to national recommendations including engagement with Dudley and Walsall Mental Health Trust to develop a method of notification of deaths within the trust for patients with a mental health illness.
- Collaborative work is being undertaken with the CCG to share learning from mortality reviews to contribute to reducing deaths in hospital, support care closer to home, reduce inappropriate admissions and reduce LOS. The findings of reviews of deaths in hospital will be able to contribute to the commissioners' strategy of reducing death in Walsall.
- The mortality lead and representation from the medical directorate will represent the trust at the national medical examiner conference in March 2018

BOARD/COMMITTEE REPORT

Meeting	Trust Board			**Date: 5th April 2018**
Report Title	Quality & Safety Committee Highlight Report			**Agenda Item: 10** **Enclosure No: 8**
Lead Director to Present Report	Chair of Quality & Safety Committee, Non-Executive Director, Russell Beale			
Report Author(s)	Chair of Quality & Safety Committee, Non-Executive Director, Russell Beale			
Executive Summary	The report provides a highlight of the key issues discussed at the most recent Quality & Safety Committee meeting held on 29th March 2018 together with the confirmed minutes of the meeting held on 22nd February 2018 (appendix 1). Key items discussed at the meeting were: • VTE Compliance • Outbreak of Norovirus and actions being taken • Progress in Maternity Services • Mental Health and Capacity • Compliance with NatSSIP's and LocSSIP's Guidance • Never Event reported in November 2017 The meetings held on 22nd February and 29th March 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.			

<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>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>
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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 29th March 2018 will be submitted to the Board at its meeting on 3rd May 2018 at which the Board will also receive a highlight report from the Quality & Safety Committee meeting held on 26th 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>
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QUALITY & SAFETY COMMITTEE HIGHLIGHT REPORT
TRUST BOARD – 5TH APRIL 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 29th March 2018

The Committee was quorate and discussed a number of items. Minutes will be provided to the Trust Board in May. 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:

- **VTE** Although the 95% trajectory had not been achieved in February, there had been an improvement in performance to 93.18%. The committee were advised that the main area of concern was in relation to patients who had been clerked in the Emergency Department where there is currently no electronic solution for recording the VTE assessment. Options were now being considered to incorporate a paper solution for recording of assessments in the Emegency Deartment.
- **Norovirus Outbreak** There had been an outbreak of Norovirus over the past week which had resulted in the decision to close the majority of the hospital to visitors to try and reduce the spread of infection. The committee commended the clinical teams, nursing staff, infection prevention and control colleagues and housekeepers who had been under a considerable amount of pressure during this time. Portable sinks had been situated at all entrances to encourage hand washing for all staff and visitors. Visiting restrictions were due to be lifted for the Easter weekend.

4. Progress in Maternity Services

At the last Walsall Healthcare NHS Trust Oversight Group meeting held on 30th January 2018 it was formally agreed to conclude the work and merge it into the Trust Maternity Taskforce Committee. The first meeting was held on 16th March 2018 and progress with the four areas of improvement relating to the Section 29a Warning Notice was received. The committee noted the improvement in a number of performance indicators included on the maternity dashboard and there was a discussion about further improvements to be made regarding culture. The Listening

into Action Pulse Check would be undertaken in maternity services to understand whether there had been a shift in the culture. There were further discussions about the re-opening of the Midwifery Led Unit and a report had been requested for the April meeting of the Maternity Taskforce.

5. Mental Health and Capacity

Following a review of the serious incident report received by the Trust Board in September there appeared to be a recurrent issue relating to mental health and capacity. The Board requested that the Quality and Safety Committee look at the issue of mental health and capacity. The Director of Nursing provided a report which updated on performance and training with regards to Mental Capacity Asessments and Deprivation of Liberties Safeguards. The report outlined a number of actions being undertaken, however, it was recognised that there was a recurring issue of patients with severe mental health issues being admitted to the Trust. The Director of Nursing had arranged to meet with the Director of Nursing at the Mental Health Trust to improve engagement and ensure patients were getting the appropriate care.

6. Compliance with NatSSIP's and LocSSIP'S Guidance

The Committee received a report on progress made with the Patient Safety Alert for 'Supporting the Introduction of the National Safety Standards for Invasive Procedures' launched in September 2015 along with the next steps of implementation. A Clinical Lead had now been appointed and was working with the Governance Lead to implement local safety standards for invasive procedures (LocSSIP's) across the organisation to improve patient safety and experience.

7. Never Event reported in November 2017

The Committee received the final RCA report from the Never Event reported in November 2017 in relation to a retained foreign object post procedure (swab) in maternity. The committee received assurance on a number of actions that had been taken including a review of all policies and clinical documentation. Issues with the IT system had been discussed with the company and it had been agreed that a mandatory field would be generated to support with relevant documentation.

Walsall Healthcare NHS
NHS Trust

APPENDIX 1

MINUTES OF THE QUALITY & SAFETY COMMITTEE
HELD ON THURSDAY 22ND FEBRUARY 2018 AT 9.00 A.M
ROOM 10, MLCC, WALSALL MANOR HOSPITAL

Present:	Professor R Beale	Non-Executive Director (Chair)
	Ms 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
In Attendance:	Mr N Turner	Divisional Director, Surgery (Item 224/17)
	Mrs A Winyard	Divisional Director of Operations (Item 224/17)
	Mrs J Longden	Divisional Director, Estates & Facilities (Item 225/17)
	Miss S Garner	Executive Assistant (minutes)
Apologies:	Mrs B Beal	Interim Director of Nursing
	Mr P Thomas-Hands	Chief Operating Officer
	Mrs L Storey	Trust Secretary

210/17 Welcome and Introductions

Professor Beale welcomed everyone to the meeting.

211/17 Declarations of Interest

There were no declarations of interest.

212/17 Minutes of the Meeting Held on Thursday 25th January 2018

Resolution
The minutes of the meeting held on 25th January 2018 were agreed as a true and accurate record.

213/17 Action Sheet and Matters Arising

Resolution
The Committee received and noted progress on actions included on the live action sheet.

214/17 Performance & Quality Report

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

- There had been an increase in the number of deaths in January which had been expected as seen in previous years. A multidisciplinary analysis of deaths was being undertaken to include teams within the community.
- There had been an improvement with VTE performance so far in February. Actions were being taken by the multidisciplinary teams to ensure the assessment was being completed. Focussed work was being done with teams in the main areas of concern including AMU and cardiology.

Mr Gayle highlighted that the report included references for the People & Organisational Development Committee; however, this section had not been well populated and could not be triangulated with references to quality and safety.

Mr Caldicott identified that the midwife to birth ratio had been very high recently, however, the trajectory for 1-1 care in labour had not been achieved. Mr Khan confirmed that there had been a lot of discussion about this at the maternity taskforce meeting and it had been confirmed that there were often time constraints with mobilising staff to provide 1-1 care prior to delivery. It was however noted that this was a nationally mandated trajectory.

Professor Beale raised concerns regarding the lack of improvement with VTE performance and asked whether the clinical teams were taking ownership of this. It was noted that there had been an improvement in ownership and the Trust had recently launched the FEVERED campaign which also included the monitoring of VTE assessments. Mr Kirby highlighted that performance on AMU seemed to vary and suggested that increased focus with the matron through daily huddles may support the ward to improve their compliance. Committee members recognised progress made to date and further work to be done to achieve the agreed trajectory. **AK/KB**

<u>Resolution</u>
The Committee received and noted the content of the Performance & Quality Report.

215/17 Maternity Improvement Journey

The various reports on the maternity improvement journey were received and it was recognised that there were some specific differences in relation to how the CQC inspection was undertaken in maternity compared to the rest of the organisation.

There also remained an issue regarding 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.

There was a discussion about the need for further cultural changes and stronger engagement with the teams moving forward. It was recognised that there had been a lack of engagement previously which had resulted in changes in behaviour and quality of care.

Mrs Harris highlighted that issues regarding culture had been identified at a recent visit to maternity undertaken by one of the Non-Executive Directors. She also confirmed that she had met with the newly appointed Deputy Head of Midwifery and queried whether there was a plan to extend the current secondment which had been agreed for 6 months. Mr Khan advised that there were plans in place to change this to a permanent position.

Mr Khan informed members that he had recently met with representatives from Edgcumbe who were currently working with the team on cultural issues and it was noted that there were some individuals who remained resistant to changes being implemented. This was being picked up as part of the next phase of work being led by Edgcumbe and meetings were being arranged with individuals.

Members discussed the time allocation for senior clinical teams and whether this was sufficient for the obstetrics team with the current level of improvement required. Mr Khan assured that the Divisional Director and Clinical Directors were given the required amount of PA time.

Resolution

The Committee received and noted the various reports received regarding the Maternity Improvement Journey.

216/17 Trust Quality Executive Report

Ms Blackwell shared the report from the Trust Quality Executive meeting held on 16th February 2018.

Mr Khan confirmed that concerns had been raised regarding the Infection Control environmental audits which had highlighted issues with cleaning and the impact the current vacancies in housekeeping were having on this. Members agreed that this would be raised as part of the Estates & Facilities divisional presentation item later on the agenda.

It was noted that the Trust had faced a period of increased

pressure during winter; however, the clinical teams had been well-engaged in the preparation stage which had resulted in a reduction in quality issues. Mr Khan highlighted that a quality impact assessment of the winter plan would be undertaken and reported to the Trust Quality Executive and Quality & Safety Committee.

There was a discussion about the extra capacity areas that had recently been opened and it was noted that there was a plan in place to reduce admissions to some wards by the end of February with a view to closing them soon after. Mr Kirby added that ward 20C and endoscopy areas were no longer being used for medical outliers and some of the extra spaces on the wards had been closed. It was recognised that the closure of wards in previous years had resulted in some quality issues; therefore, this process would need to be closely monitored.

Professor Beale asked how the Trust's policy on mixed sex accommodation breaches considered delays in the Emergency Department. Ms Blackwell advised that single sex bays on the wards had been maintained throughout winter with very little impact on long waits. It was noted that it would be possible, in extreme circumstances, for a patient to be moved into a mixed sex bay to avoid further delays; however, this would be risk-assessed in the Emergency Department and had not yet occurred. There had been no 12 hour breaches reported in the Emergency Department.

Mr Gayle raised concerns regarding the increase in hospital acquired pressure ulcers this year. Ms Blackwell advised that there had been an increase in grade 2 pressure ulcers and a review of this was being undertaken including changes being made to current documentation for all patients. It was also noted that unstageable pressure ulcers had not been reported in previous years; therefore, this year's data would provide a benchmark for improvement going forward. Ms Blackwell confirmed that the Trust previously reported all pressure ulcers per 1,000 bed days; however, moving forward community acquired pressure ulcers would be reported per 10,000 CCG population in line with NHS England guidance.

Mr Gayle asked for some assurance regarding FFT scores in the Emergency Department. Ms Blackwell highlighted that there had been issues with the Lorenzo system; therefore, the department had been using the paper system for completing surveys. There seemed to have been a slight improvement recently and the team had attended the Patient Experience Committee to present on the actions in place to improve. The team had shown good ownership of this and a robust action plan was in place.

Resolution

The Committee received and noted the Trust Quality Executive report.

217/17 Implementation of the General Data Protection Regulation

Miss Macmillan attended the meeting on behalf of the Trust Secretary to present the report on the implementation of the General Data Protection Regulation (GDPR). The main quality and safety aspects of the GDPR were for Trusts to ensure that personal information held is accurate and up to date and that information is retained for the correct period of time. All staff were responsible for ensuring these aspects were in place.

It was noted that there was a robust action plan in place to manage the implementation of GDPR and the compliance and risk team were working with the relevant leads to pick up any data quality issues.

Mr Gayle recognised the importance of the regulation and the risks and financial impacts associated with this. He queried whether there was a robust training programme in place for staff. Miss Macmillan assured that there were a series of working groups in place initially focusing on back office functions and then being rolled out to the clinical teams and community sites. Current training was also being updated to include the changes associated with GDPR and information pages were being uploaded onto the staff intranet.

There was a discussion about confidence of community teams adhering with the new regulation due to the increased use of mobile technology. Miss Macmillan confirmed that the Total Mobile project provided some assurance as electronic information could be erased remotely if required; however, there was also a need to improve ownership of staff in relation to keeping electronic information secure.

Professor Beale queried whether the risk of financial impacts may prevent staff enacting Duty of Candour when required. Miss Macmillan agreed that this was a risk; however, further education would need to be provided to staff to ensure they have a good understanding of policies in place. It was also noted that the Trust currently reported a high number of information governance incidents which provided some assurance that staff understood the importance of reporting incidents.

Mr Caldicott asked for clarification on the guidance regarding Trusts not being able to charge for responding to a subject access request and raised concerns that there were costs associated with providing hard copies of health records to patients. Miss Macmillan advised that there were alternative

options for providing access to health records e.g. electronic copies or inviting patients into the hospital to view their records. She agreed to provide Mr Caldicott with the definition of the new guidance so that this could be further understood. The financial impact of this would then need to be reviewed. **KM**

Mrs Harris thanked Miss Macmillan for the report which she thought was clearly articulated for members to understand.

Resolution
The report on the Implementation of the General Data Protection Regulation was received and noted by the committee.

218/17 Report from the Emergency Care Improvement Programme Visit

The committee received the report which had been developed by NHS Improvement following the recent review of the systems in relation to the Emergency Care Improvement Programme (ECIP). Members were advised of the improvements identified in the report and the key recommendations made. It was noted that NHS Improvement would be working with the Trust over the coming months focusing on specific workstreams to improve flow for the organisation.

Professor Beale raised concerns at the lack of rigour with this work. It was noted that initial work had been completed and processes had been put in place, however, there was more work to be done to strength these and engage staff in the work being undertaken. Mr Kirby identified that there was a need to engage with teams across the whole organisation to improve staff understanding of patient flow and confirmed that this was not just the responsibility of the teams in the Emergency Department. The executive team had discussed the need to strength the medical leadership and support them in having difficult conversations to move patients through the system. Mr Kirby suggested that the NHS Improvement Project Lead, Lucy Roberts, be invited to a future committee meeting to talk about the work she was leading on. This was agreed by committee members. **PTH/SG**

Resolution
The report from the Emergency Care Improvement Programme Visit was received and noted by the committee.

219/17 Quarterly Annual Objectives Update

Mr Kirby presented the Quarterly Annual Objectives Update on behalf of the Director of Strategy & Transformation and identified

that good progress had been made against some of the quality and safety related objectives. The report was noted and it was agreed that the update would be submitted the Trust Board.

Resolution
The Committee received and noted the Quarterly Annual Objectives Update.

220/17 Risk Management Committee Information & Escalation Report

Due to the timing of the Risk Management Committee this month, the report provided an overview of the serious incidents reported in January only.

Compliance with NatSSIP's and LocSSIP's guidance
Mr Khan confirmed that a group had been established to review LocSSIPs and NatSSIPs and a programme of work had been agreed. It was agreed that a further update would be provided to the next meeting. **AK**

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

221/17 Monthly Nursing & Midwifery Quality & Staffing Report

Ms Blackwell presented the Monthly Nursing & Midwifery Quality & Staffing Report and the following points were noted:

- The number of vacancies had fallen during January 2018
- The Trust was compliant with 90% fill rates for registered nurses and care support workers for both day and night during January with the exception of two wards.
- The number of agency hours for registered nurses increased in January due to additional capacity areas including endoscopy, cardiology and ward 20C being used for medical outliers.

Ms Blackwell talked about the current work being undertaken to improve e-rostering and achieve compliance with the KPIs which included the e-roster pilot, roster clinics and further work on temporary staffing.

Mr Gayle queried whether the recent increase in bank rates had resulted in an increase in utilisation of bank staff. Ms Blackwell advised that this had been the case initially; however, more work was now being done to recruit to the bank.

Professor Beale highlighted that following discussions with staff on the ward, they were often aware of expected gaps in

workforce more than 6 weeks in advance and asked whether there was more to be done to fill those shifts earlier. Ms Blackwell confirmed that rosters were currently produced 8 weeks in advance and extending this would create a number of complications in relation to sick leave, maternity leave and staff resignation. Mr Caldicott supported this and confirmed that the Trust were currently working to achieve the 8 week trajectory.

Safe Staffing Internal Audit Report

The report was received by the committee and an anomaly with the outcome rating was acknowledged. Ms Blackwell agreed to clarify the discrepancies within the report and provided assurance that the recommendations identified had been incorporated into the action plan for the nursing workforce workstream which was established in January. It was noted that a repeat audit had been included in the audit programme for 2018/19. **KB**

Professor Beale asked for some assurance that the current actions agreed were sufficient. Ms Blackwell advised that some improvements had been seen as a result of actions being taken and confirmed that actions were on track for delivery in May as outlined in the action plan.

There was a discussion about issues with communication between the ESR system and Roster Pro and members raised concerns that staff could potentially be overpaid for the hours they had worked. It was suggested that an internal audit be undertaken to review the position with overpayments for nursing and medical staff. **RC**

It was noted that a review of outstanding annual leave for staff was currently being undertaken within the divisional teams and an annual leave standard operating procedure had been released which recommended staff to take annual leave within the appropriate timeframe. It was agreed that managers should consider payment for outstanding annual leave days if this would be beneficial for the financial position.

Temporary Staffing Internal Audit

The report was received by the committee and it was noted that although the report had been rated substantial there remained some areas for improvement. Mr Caldicott had raised some concerns with the internal audit team due to the link with some of the issues identified in the safer staffing internal audit report. The report would be submitted to the Audit Committee for final approval.

Plans for recruitment and retention

A report was received on current recruitment and retention plans for the Trust which provided an update on the Trainee Nursing

Associate posts and how these would be integrated into the nursing workforce. Ms Blackwell highlighted that a piece of work was being undertaken to develop retention plans for the nursing workforce and how that would fit in with the wider workforce strategy.

There was a discussion about offering flexibility to staff and also rotating trainees to give them opportunities to gain experience in different areas.

Professor Beale queried whether the nursing bursaries provided by Health Education England would be re-established. Ms Blackwell confirmed that this was not the case; however, more effort was being put into development of apprenticeships.

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

222/17 Mortality Report

Mr Khan presented the Mortality report and highlighted that the number of deaths had increased during December and January which would impact on the HSMR and SHMI rates for the Trust. It was noted that an increase had been seen in the number of deaths for patients with 0 – 1 day length of stay and work was being done with the community teams and CCG colleagues to understand what could be done differently to avoid admissions to hospital. There were ongoing concerns regarding the review process and work was ongoing with the consultants at the Mortality Review Group to agree a different process for reviews.

Mr Kirby was concerned that the number of deaths reported for December and January were the same and asked Mr Khan to clarify this. It was also noted that the graphs included on page 5 and 6 of the report were not eligible and therefore not useful for the committee. **AK**

Professor Beale asked for an update regarding the Clinical Lead for Organ Donation. Mr Khan advised that this post had now been filled.

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

223/17 Quarterly Patient Experience Report

Ms Blackwell presented the Quarterly Patient Experience report and discussions had previously taken place regarding further

work required to improve FFT scores particularly in the Emergency Department. Members were advised that there had been issues previously with representation at the Patient Experience Group meetings, however, this had improved significantly and there had been an increase in ownership from the divisional teams. The national maternity survey results had been received by the group and it was noted that the Trust had performed similarly to other trusts. An update on complaints was provided and it was noted that there had been a significant improvement in the timeframes for responses and 100% compliance had been achieved in January.

Mrs Harris advised committee members that the Chair had requested that she become the Non-Executive Director champion for patient experience. She confirmed that she would be getting involved in some of the work being undertaken by the Patient Experience Lead and Head of Patient Relations.

Mr Gayle queried the RAG rating on the graph on page 7 and highlighted that negative had been rated red and negative had been rated green. Ms Blackwell agreed to clarify this. **KB**

Resolution
The Committee received and noted the Quarterly Patient Experience Report.

224/17 Efficiency of Operating Theatres

Mr Turner and Mrs Winyard attended the meeting to provide a report on the efficiency of operating theatres following on from discussions at the previous meeting. It was noted that the position had been increasingly difficult throughout winter due to the number of medical outliers on ward 20C; however, day case activity had been increased during this time to continue with elective work.

An update was provided on the work being undertaken in relation to challenging late starts in theatres. It was noted that knife to skin time rates had increased by around 10% during the previous week. Mr Turner explained that further work was 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.

Mr Gayle commended the team on the improvements highlighted, however, asked for further clarity on the challenges faced by the divisional team regarding theatre utilisation and what support could be provided to further improve. Mrs Winyard advised that although there had been some physical barriers, most of the challenges faced were related to culture and

communication. Mr Khan supported this and explained that there had been some resistance to change by some staff in theatres.

There was a discussion about performance of individuals and it was recognised that this was often inconsistent due to the current number of vacancies within the team. The divisional team recognised that further support would be required from a Human Resources and Organisational Development perspective to address performance management.

Mrs Harris raised concerns that the information provided had not satisfied the brief given to the divisional team at the last meeting and the report did not clearly outline what actions were being taken to achieve the agreed trajectory. Mr Caldicott supported this and asked for clarity on the quantifiable improvements that could be seen as a result of further support and investment. Mrs Winyard agreed to get the divisional team together to agree what resources were required to improve further. Mr Caldicott agreed to ask KPMG representatives to support with this. **AW RC**

The divisional team were thanked for their report and left the meeting at this time. A confidential discussion took place between the Non-Executive Directors and the Executive Directors about some inappropriate discussions that had occurred during the meeting. Comments were also made regarding the lack of assurance received during discussions about what further actions could be taken to improve.

Mr Kirby confirmed that the Director of HR & OD would be leading on a piece of work which would include a developmental assessment process as part of the clinical leadership programme. It was also suggested that Professor Beale meet with Richard Beeken following his arrival to the Trust to discuss issues witnessed at the committee on two occasions. **RB**

It was also acknowledged that the theatre workstream would need some further project management support to ensure that the aims and expected outcomes were clear to board members. It was agreed that the productivity and efficiency of theatres would also be monitored by the Performance, Finance & Investment Committee (PFIC) and Mr Kirby suggested that Professor Beale and Mr Dunn, Chair of PFIC meet with Mr Caldicott and the divisional team to understand what further actions need to be taken. Professor Beale also agreed to advise the Chair of the current position with this workstream. **RB/JD/ RC**

<u>Resolution</u>
The Committee received and noted the report on the Efficiency of Operating Theatres.

225/17 Presentation from the Division of Estates & Facilities

Professor Beale welcomed Miss Longden to the meeting and explained that the presentation had been received and noted and welcomed any comments and questions from members.

Mrs Harris highlighted that the committee had been informed of infection control issues related to the current estate earlier in the meeting and she had also met with the Deputy Head of Midwifery who had raised some estates issues on the delivery suite. She asked whether there was a capital replacement programme in place and whether certain areas were prioritised. Miss Longden confirmed that there was a capital programme in place for the retained estate, and the replacement of the mortuary fridges had been prioritised this year. Further work was also being done in relation to the expansion of the Neonatal Unit and the second maternity theatre. Some maintenance work had been done on the delivery suite area, however, this was difficult to maintain. Miss Longden confirmed that a Listening into Action event had also taken place to discuss options to encourage staff to report issues quickly before they escalated into larger issues.

There was a discussion about the divisional Quality Commitment and it was noted that the team had agreed to develop some advanced priorities for their commitment to further improve processes within the division.

Mr Khan queried whether the current demand for housekeeping was manageable if the current vacancy gaps were filled. Miss Longden thought that this would need to be reviewed and she was currently in discussion with the Head of Infection Control regarding external solutions for deep cleaning. She also advised that work was ongoing with the Trust's workforce lead to review the housekeeping workforce and developing dual roles and a briefing report would be developed.

Mr Caldicott acknowledged that there were issues with recruitment and suggested that cleaning within the Trust be re-prioritised to ensure more focus was given to the clinical areas.

Miss Longden raised some concerns regarding the culture within the housekeeping teams and executive members offered some organisational development support to the division to resolve this.

Committee members thanked Miss Longden for the presentation.

Resolution

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

226/17 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 8th March 2018:

- VTE Performance and plans to achieve this
- Maternity Journey and lessons learnt
- Changes in 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
- Plans to improve efficiency of theatres being led by the theatre workstream

227/17 Any Other Business

It was noted that this would be Mr Kirby's final meeting before he left the organisation. Committee members thanked Mr Kirby for his commitment to the Committee and to the Trust as a whole and wished him good luck in his future career.

228/17 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.

229/17 Date & Time of Next Meeting

Thursday 29th March 2018, 9:00am
Room 10, MLCC

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	**Public Trust Board**	**Date: 5th April 2018**
Report Title	Quality Improvement Academy – Progress Report	**Agenda Item: 11** **Enclosure No.: 9**
Lead Director to Present Report	Daren Fradgley, Director of Strategy & Improvement	
Report Author(s)	Tom Johnson, Listening into Action lead Chris Harris, Service Improvement Programme Lead	
Executive Summary	The paper provides a progress and overview report for the Quality Improvement (QI) Academy launched on the 9th February 2018 • Listening into Action (LiA) is about creating a fundamental shift to the way we do things within the organisation. Engaging colleagues and improving the quality of patient care. • To date over 60 teams have used LiA as a way of engaging with stakeholders around improvements in their areas and the wider health economy. • A survey of these teams has highlighted some areas for potential improvements and provided Walsall Healthcare NHS Trust with an opportunity to advance the use of Listening into Action and increase the service improvement capacity within the organisation. • The QI Academy has been developed to support LiA Teams in maximising outcomes and increasing the sustainability of changes implemented through a package of QI tools training, access to specialist QI knowledge and experience and coaching support. The QI Academy was launched on the 9th of February and delegates included active Wave 4 LiA teams and LiA Sponsor Group Members. This launch event included the first of 3 half day QI Tools Workshop events.	

Purpose	**Approval**	**Decision**	**Discussion**	**Note for Information**
	☐	☐	☒	☒

Recommendation	1. NOTE the progress of the Quality Improvement Academy 2. SUPPORT recommendations made within the document

<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>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>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></td><td></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Failure to improve patient experience and staff engagement may result in the Trust failing to further improve against the 5 CQC Quality Domains.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">The Quality Improvement Academy will require careful planning as well as strong Executive support and Medical engagement to be successful.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2"></td></tr>
<tr><td><u>Report History</u></td><td colspan="2">N/A</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>
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Walsall Healthcare NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD
29th March 2018

QUALITY IMPROVEMENT ACADEMY: PROGRESS REPORT

Introduction

The Trust launched Listening into Action in an attempt to engage colleagues from right across the Organisation into the changes that matter most to them and the patients they see. Listening into Action is an inclusive way of working that encourages staff to take ownership of actions and brings together all those affected by change into the decision making process. Listening into Action was selected by the Trust due to its successful implementation in dozens of other NHS Trusts across the country including others who have used it to help them get out of special measures. LiA has been used for approaching 2 years within the organisation.

To demonstrate some of the clear improvements that have been made through LiA some examples from projects in Wave 3 are shown below.

- Infection prevention and 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. Early review has seen a 50% reduction in pressure ulcers.

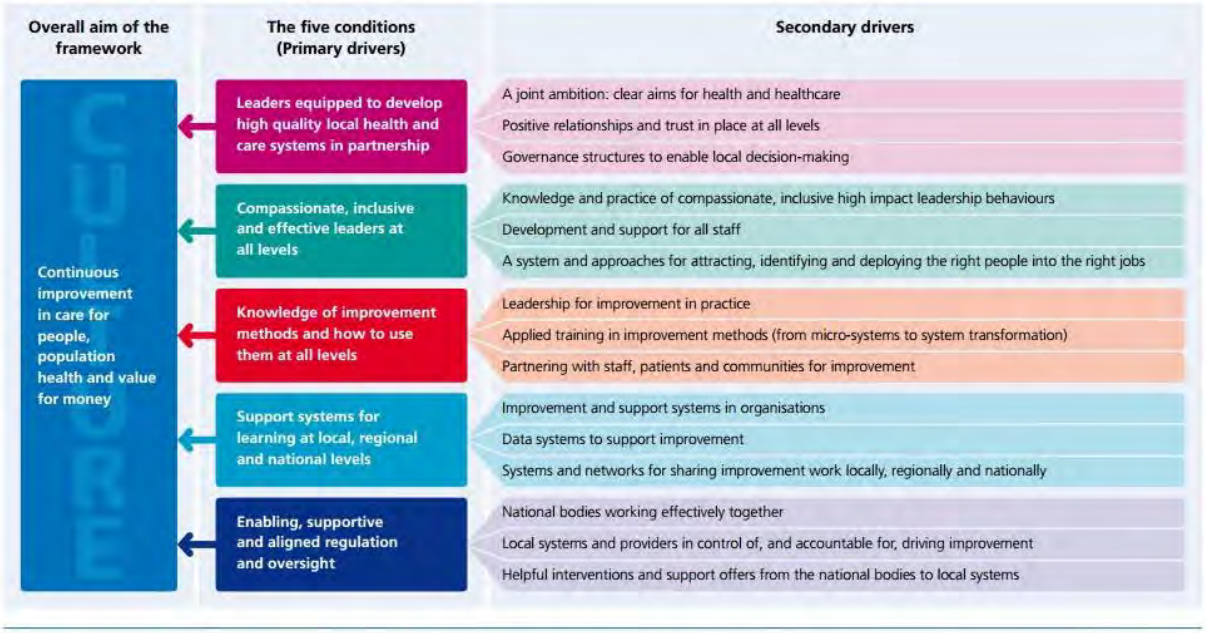
Listening into Action has been able to galvanise interest through strong communications and collaboration around local change. The introduction of a Quality Improvement Academy will provide specialist training to individuals and teams in the use of supportive QI tools and methodology whilst being the vehicle to deliver organisational capability for continuous improvement.

National Evidence and Context

There is a growing body of evidence from across the NHS that to ensure a sustainable journey of continuous improvement the leadership and improvement fundamentals have to be in place, and that the organic and collaborative approach is more suitable and effective; linking to LiA works well for Walsall Healthcare because

the teams have become familiar with the process and this approach encourages them to grow their projects and deliver them locally.

Developing People – Improving Care is an NHS Improvement (Appendix 1) developed evidence based framework to guide action on improvement skill-building, leadership development and talent management for people in NHS funded roles. The Driver diagram below outlines how the framework supports the QI agenda:



Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services

The Care Quality Commission have also identified that these are areas they will focus on during inspections and Professor Sir Dr Mike Richards explained in 2017 how through his in depth conversations during CQC inspections of Outstanding Organisations there were some common traits identified, as outlined below:

- A passion for high-quality, patient-centred care among the trust's leadership. This is observable not only in conversations in their offices but also when they are walking through the wards and corridors of their hospitals, talking to staff and patients.
- A clear strategic direction, based on a good understanding of the trust's strengths and weaknesses, and of the external environment.
- Good governance processes – knowing where problems are arising at the earliest opportunity and then dealing with them.
- Good engagement with and support for staff, listening and acting on issues that can be resolved. Management and staff being aligned on the central purpose of delivering the best possible care to patients
- The ability to take tough decisions when needed.
- **A focus on organisational development and quality improvement. These need to go hand-in-hand. The precise approach to quality improvement**

does not appear to be critical, as long as the trust has an agreed approach. Professor Sir Dr Mike Richards, 2017

This final statement is the key area the QI Academy will support through providing training and support to staff undertaking change projects.

Furthermore there is testing of these findings identified through the Single Oversight Framework and the Well-Led Framework (Joint with CQC) identifies the following three Key Lines of Enquiry which we will be tested against during any CQC inspection.

Single Oversight Framework

SOF Theme	Description
Leadership and improvement capability (well-led)	• **Continuous improvement capability:** We will consider assessments of learning, improvement and innovation within the well-led reviews undertaken by CQC or in developmental reviews using the well-led framework. • **Use of data:** Effective use of information is an important element of good governance. Well-led providers should collect, use and, where required, submit robust data. The well-led framework recommends that providers should adopt a measurement-for-improvement approach, using data to identify how improvements can be implemented and sustained, not just to understand current performance. • ***Triggers:*** *CQC assessment of RI or Inadequate or other material concerns against 'well-led' question*

Well-led framework (joint with CQC)

Key Line of Enquiry	Good Practice
KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation? **[reflected in CQC prompts W8.1, 8.2, 8.4, 8.5]**	• Leaders across the organisation can articulate and demonstrate their commitment to the **organisation's improvement approach**, across quality, operations and finance functions; • Senior leaders can evidence that they actively encourage the use of a **standardised improvement methodology** embedded across the organisation to improve the quality, efficiency and productivity of services • Senior leaders can evidence that there are **appropriate and effective mechanisms for teams to work together to resolve problems**, review team objectives, processes and performance on a regular basis
KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on? **[W6.1]**	• Senior leaders can evidence that there are **monthly dashboards** covering the most important indicators for the scrutinising committee. These dashboards are used effectively and present information to enable both **measurement for improvement** and for **measurement for assurance**.
KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? **[W7.1-4]**	• Senior leaders can evidence that staff at all levels are actively involved in **planning and delivery of significant service developments** and can evidence how staff input has influenced plans; • Senior leaders can evidence that there are appropriate and effective mechanisms to enable the organisation to **work proactively with local health and care system partners** to design improvements to create long term sustainability;

Therefore embracing and understanding these areas of focus is key for us to continue improving and moving to a CQC rating of Good and beyond.

Sustainability

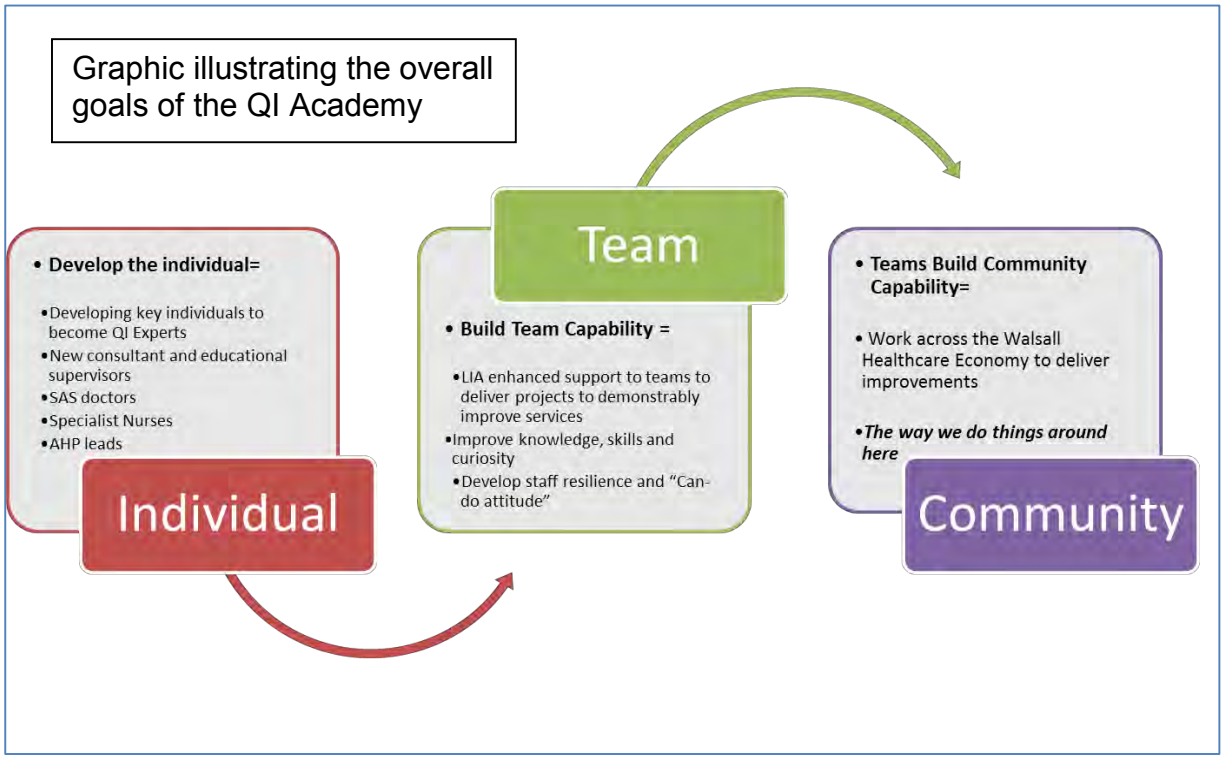
Listening into Action has now reached a crucial part of the journey whereby teams recognise LiA as a way of engaging stakeholders around idea generation and identifying potential changes, but a survey of previous LiA Wave Teams has identified some areas where additional support and expert guidance would have facilitated more impactful and sustainable change. A review into previous LiA teams has also identified some other areas for improvement including: -

- Relatively little uptake from medical workforce.
- Sense of dependency from LiA teams (lack of self-belief to make changes)
- Limited and variable rigor to projects.
- Limited evidence of outcomes.
- Poor spread and sustainability of projects.

NHS Improvement has recommended Quality Improvement (QI) as an evidence based and credible approach to service improvement. Examples of QI Faculties around the country have shown the potential benefit to staff, patients and the organisation. The introduction of a Walsall Healthcare Quality Improvement Academy will allow the organisation to build on the successes of Listening into Action to date and tackle some of the gaps within the current offer.

Capability

The strategic aim of the Quality Improvement Academy is to create a culture of continuous improvement across Walsall Healthcare NHS Trust, through increasing zeal, capacity and capability for QI.



The Quality Improvement Academy will be the institution with a stable and constant function. A QI Faculty are its members who will change depending on initiative and projects involvement. The QI Faculty members will provide the expert support, tuition and critique throughout the course of team projects.

Progress

The QI Academy was officially launched on the 9th February 2018 with the first Cohort attending Day 1 of three half day QI Tools Workshops. In attendance and making up Cohort 1 were team members representing the active LiA Wave 4 teams and colleagues from the LiA Sponsor Group. They were all offered the additional support of the QI Faculty to help maximise their outcomes and build their own personal QI capacity and capability.

The support on offer to the teams include: -

- Direct access to multidisciplinary faculty support, starting with the appointment of a Medical Consultant as QI Clinical Lead
- 1-2-1 Coaching
- An initial 3 half day QI Tools Workshops
- Access to library resources and specialist library support
- Walsall Healthcare app resource
- Use of QI Life project management online tool

The teams will continue to use the LiA process of stakeholder engagement and will present their outcomes at a LiA Pass it On Event on the 15th June 2018 in the Manor Learning and Conference Centre.

Approach Successes

Feedback obtained from those in attendance at workshop 1 has been extremely positive and teams have linked together to share ideas and cascade learning. There have also been two requests from delegates to join the QI Faculty in the future. Some written feedback from the session included the below comments.

"A very productive and useful session. Lots of important tips shared"

"Wonderful initiative and I love the way we are finally coming together as a Trust to solve problems, leadership and make sustainable improvements"

Organisational Offer

The aim of the QI Academy is to make QI accessible to all members of the organisation irrespective of job role, making QI everyone's business. The approach for Cohort 2 will to be engage with newly appointed Consultants and ask them to apply to join with multidisciplinary projects with a planned launch of Cohort 2 in May. Medical engagement through LiA has been limited and it is anticipated that this approach will re-energise the medical workforce.

The QI Faculty offering has already evolved in the short length of time that it has been functioning, with the appointment of a Medical Consultant as the QI Clinical Lead the first step in creating a truly multidisciplinary team. The Faculty are exploring options to align academic qualifications to add rigour and creditability to the projects. There is also scope to broaden to a Walsall wide approach to encompass end to end pathway thinking.

The QI Faculty will provide specialist QI Training and Support to an agreed number of delegates from within Walsall Healthcare NHS Trust. This will be as per the below breakdown.

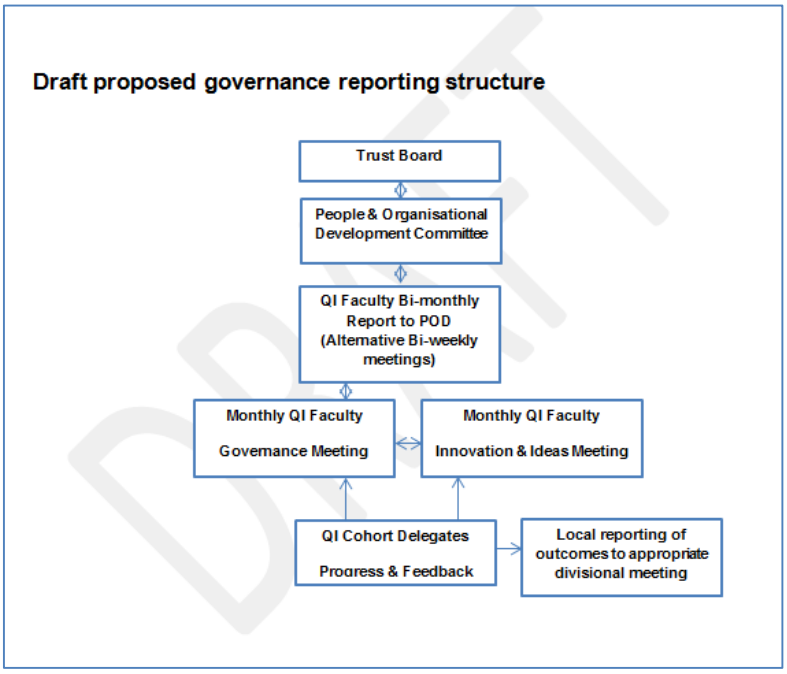
- Cohort 1 – 20 Delegates – Launch Feb 2018 – End June 2018
- Cohort 2 – 30 Delegates – Launch May 2018 – End November 2018
- Cohort 3 – 30 Delegates – Launch October 2018 – End April 2019

Following the successful conclusion of the QSIR (Quality Service Improvement and Redesign) Practitioner Training Programme, NHS Improvement Advancing Change Team (ACT) Academy requires that the Trust deliver training to a minimum number of 90 delegates through an internal programme of QSIR training during the 2019 calendar year. This will provide the content for QI training from this point onwards into the QI Academy year 2 and beyond.

Proposed Governance and Oversight

The Quality Improvement Faculty will meet bi-weekly, with a monthly focused steering group chaired by the Director of Strategy and Improvement. It is proposed that progress reports are submitted directly to the People and Organisation Development Board on a bi-monthly basis. Scrutiny of the progress of the improvement projects will take place at the QI Faculty meetings as well as allocated time for innovation and idea generation.

It is proposed that all completed team Quality Improvement presentations are delivered to the appropriate local reporting group for shared learning and education. This reporting route will be selected by the team's involved following consultation with in the reporting divisional leads.



Branding and Communication

A definitive and identifiable brand will be important as the growth of the QI Academy takes shape. This branding will be used on marketing materials and communications to allow colleagues to recognise QI Academy events and generate interest in the work being undertaken as well as given members who complete the course a sense

of pride and achievement. There are plans to develop a new Quality Improvement website that will be widely accessible to all stakeholders, showcasing the work being undertaken and resources available. Sharing success stories and staff feedback is key to ensuring staff are aware of the impact the Quality Improvement Academy is having on the organisation. As such a communication plan will need to be developed to support this. It is imperative that all actions are linked to the 5 CQC key domains. Sharing the stories in this way will increase colleague understanding of the changes being made as a direct link to the CQC report.

Requirements of the QI Academy

In order to fulfil the potential of the QI Academy and to make sustainable change across the entire organisation, the QI Faculty request the full support and backing from Trust Board, Executive and Divisional levels. The Faculty also propose to provide quarterly oversite of the progress of the QI Academy to the Trust Board.

Conclusions

This paper has provided an overview for the Quality and Safety Committee of progress of the Quality Improvement Academy. The paper also requests support against three highlighted actions for the Board to consider.

NHS Improvement

Building capacity and capability for improvement:

embedding quality improvement skills in NHS providers

Institute *for* Healthcare Improvement

collaboration trust respect innovation courage compassion

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

Introduction

This is a guide for NHS organisations seeking to begin or do more to build improvement capacity and capability in their organisations. It should be used in conjunction with **Developing People - Improving Care**[1] an evidence-based, adaptive national framework published in December 2016 to guide action on improvement skill and capability building, leadership development and talent management for people in NHS-funded roles in England.

"For improvement to flourish it must be carefully cultivated in a rich soil bed (a receptive organisation), given constant attention (sustained leadership), assured the right amounts of light (training and support) and water (measurement and data) and protected from damage." (Shortell et al, 1998)

The guide builds on 2012 work from the NHS Institute of Innovation and Improvement and draws on the experience of healthcare providers. NHS Improvement has worked with the Institute for Healthcare Improvement (IHI) which have provided subject matter expertise in the development of this co-produced document.

It outlines the IHI 'dosing' approach to embedding quality improvement (QI) skills that several NHS trusts have found useful. It:

- outlines the scale of training and development required to embed quality improvement into the fabric of your organisation
- introduces some of the challenges leaders face around building capacity and capability
- introduces the concept of 'dosing'
- makes recommendations on how to frame and plan the development of a system-wide strategy to build improvement capacity and capability.

Building capacity and capability for improvement is grounded in experiential learning and the application of the concepts, tools and methods to daily work. Both classroom and virtual learning are part of the design principles.

[1] https://improvement.nhs.uk/resources/developing-people-improving-care/

The principles are not unique to the IHI approach. Most evidence-based method applications (such as 'Lean' and 'Six Sigma') promote a platform, matrix or hierarchy of different people requiring different knowledge and skills in differing degrees and contexts.

The approach can support NHS bodies to become learning organisations, a clear message delivered by the Berwick report (2013), and promotes a shared, empowering leadership approach highlighted in recent reports (The King's Fund 2017, 2014).

1. Defining key concepts

Quality improvement (QI): Over the years there have been many definitions of quality and of improvement: there is no single definition. However, the key elements are 'a combination of a "change" (improvement) and a "method" (an approach with appropriate tools), while paying attention to the context to achieve better outcomes' (The Health Foundation 2013).

Science of improvement (SOI): This term is used by a wide range of people and professions to mean different things but an article by Perla et al (2013) provides an historical review of SOI and its application in healthcare settings. SOI is the integration of ideas, concepts, and models between scientific disciplines to develop robust improvement models, tools and techniques with a focus on practical application and problem-solving.

Capacity: refers to the following characteristics:

- the ability to receive, hold or absorb new knowledge and skills
- the maximum or optimum amount of knowledge and skills individuals can absorb and retain
- the ability to learn or retain information
- the power, ability or possibility of doing something or performing
- a measure of volume; the maximum amount that can be held.

Capability: If capacity represents the potential for improvement, capability is the demonstration of what can be achieved. Furnival et al (2017) provide a good summary of improvement capability: "The organisational ability to intentionally and systematically use improvement approaches, methods and practices, to change processes and products/services to generate improved performance." The key word here is 'use'. While capacity provides the potential for improvement, it is the active application and use of improvement approaches and practices that determine whether improved results will be realised.

Dosing: The SOI concept of 'dosing' was first developed over 12 years ago by Dr Robert Lloyd at the IHI. (For a detailed explanation, see Lloyd (2017), Chapter 11.) It is derived from the principles used to establish the appropriate dose of a medicine.

For example, a group of patients all suffering from high blood pressure would not all be given the same dose of blood pressure medicine. Some might get 5 mg; others 10 mg and still others 20 mg. The dosage of the medicine would be based on the patient's needs. In a similar manner the 'dose' of the SOI will differ depending on the needs of the individual and their role in the making the QI journey a reality within their organisation.

The dosing approach therefore establishes targeted levels of knowledge of and skill with improvement concepts, methods and tools through a variety of delivery mechanisms (including virtual learning, independent study, face-to-face workshops and, most importantly, experiential learning). It also articulates a progression of learning that begins with building general awareness throughout all roles in an organisation and culminates with a few individuals developed with deep expertise.

The key point of dosing is that not everyone in an organisation needs the same depth of knowledge about QI concepts, methods and tools. The deployment of improvement knowledge and practice must be fully aligned with the organisation's strategic aims, leadership approach and culture, and SOI dosing needs to be embraced by the senior management team and integrated into existing HR processes such as induction or annual performance reviews.

2. Background

Transformation of a system begins with transformation of the individuals working in the system. Deming (1994) offered a practical approach to help individuals transform their thinking. Throughout his career he stressed that if individuals want to improve the quality of their products or services they need to understand how four components interact to determine the quality of daily work:

- systems thinking (ie identifying all the systems involved in producing a product or service and the level of complexity in each system)
- understanding the variation that the different systems produce
- building knowledge about how and why work is done as it is
- appreciating the human side of change (that is, the psychology, motivation and engagement of everyone involved with the system, governance, management, staff as well as service users).

Understanding the inter-relations of these four components is essential for constructing successful capacity and capability building strategies. For example, deep knowledge of and skill with understanding variation is of no value unless placed in the context of the other three components. Individuals who receive a dose of all these four components will be better equipped to join in the improvement of a system but the challenge is to determine the appropriate doses for those who work at the point of care delivery, in middle management or supervisory roles, and at the top of an organisation.

The dosing approach helps leaders determine who needs to know what at each of these levels. (For more information on these four components and how they interact have a look at the IHI video explaining Deming's ideas in more detail.)

3. The dosing guide

The dosing approach does not prescribe a single set of numbers, percentages or mathematical formulae to determine the precise number of individuals to be trained. Doses vary depending on characteristics, including:

- size of organisation
- mix of services provided
- organisation history and current status of its quality journey
- resources committed to learning and employee development
- commitment of senior leaders to making quality the organisation's business strategy
- staff turnover rate.

Bearing in mind these characteristics, we offer a few general guidelines for different groups in an organisation:

- Everyone needs a general introduction to and awareness of QI concepts, tools and methods. This facilitates shared understanding, helps identify more opportunities for change and is essential to building an improvement culture. Typically this comes from virtual learning opportunities, new employee orientation and/or short workshops that provide overviews of the organisation's approach to QI. This work should be ongoing, with QI workshops at least once a quarter depending on the size of the organisation.
- All board members need to (1) agree and understand the organisation's QI approach and its components, (2) know how data is analysed in a QI context (ie looking at the variation in data over time rather than the use of summary statistics, aggregated data and red/amber/green reports), (3) know how to make the correct management decisions with data and (4) understand the strategic outcomes expected for the QI projects. This level of understanding is usually accomplished through brief presentations on QI and offering appropriate reading material and case studies.

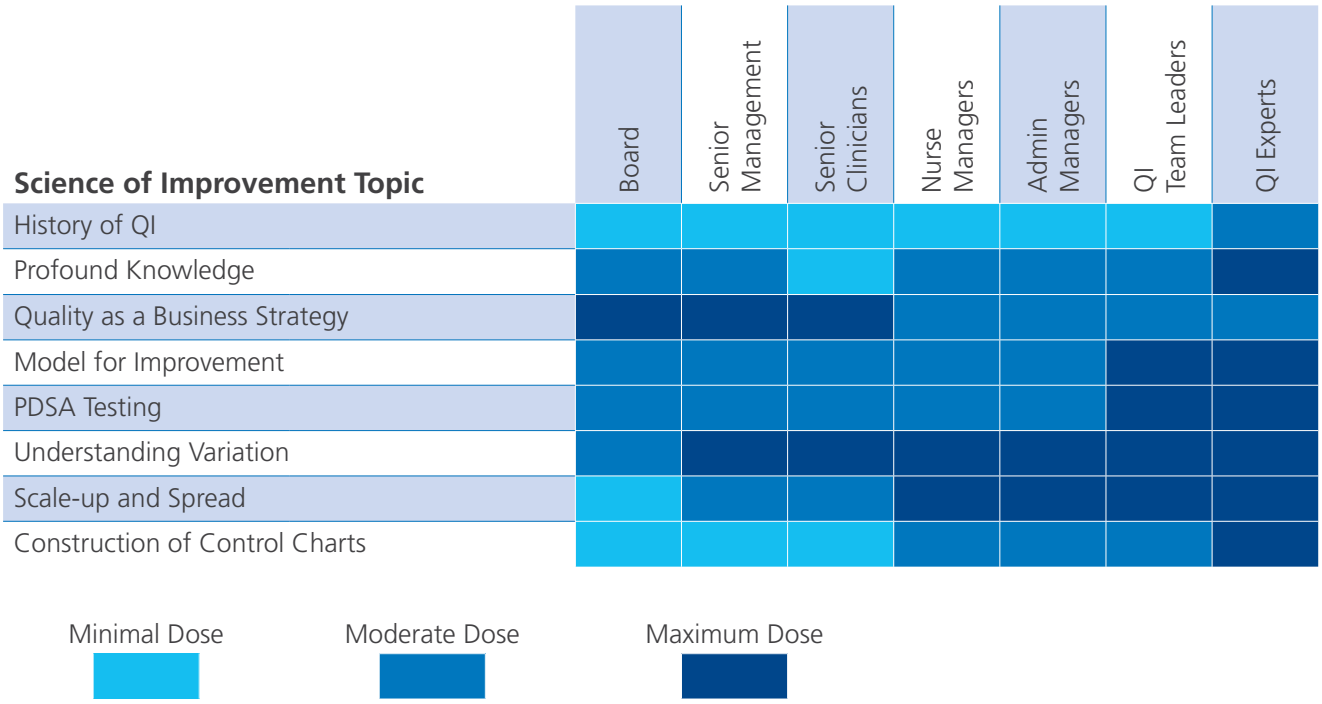
- All senior leaders need deeper knowledge of the SOI than board members. As senior sponsors for QI initiatives they need a working knowledge of the concepts, tools and methods, particularly how key measures are organised, and the difference between common cause and special causes of variation. They then need to be able to make the appropriate management decisions working with their teams when presented with each type of variation.
- All middle managers and supervisors need the same 'dose' as senior leaders but also need to understand the main aspects of being a sponsor and/or possible leader of an improvement team. This will involve understanding tools related to leading and coaching QI team meetings, organising and interpreting quality measures and helping staff members diagnose problems and develop and implement improvement strategies.

As well as the groups described above, an organisation needs two smaller groups of qualified staff to support day-to-day quality initiatives:

- Internal quality experts: As guides for the organisation's quality journey, these individuals need the deepest knowledge of the SOI in quantitative and qualitative methods, tools and concepts. They also need to be able to teach individuals at all levels of the organisation. The size of this group will depend on the size of the organisation and number of QI projects. An organisation with up to 4,000 employees would be likely to need approximately 15 to 20 quality experts.
- Quality coaches: Quality coaches are skilled in the human side of change and QI measurement and are able to use QI tools and methods to help teams achieve their aims. They coach colleagues to test new ideas and support teams with implementation and spread. Quality coaches should also have access to and the support of the quality experts. In many organisations the quality experts organise and manage the quality coaches. The number of quality coaches will depend on the number of projects. Typically, a quality coach who has protected time of roughly 20% to 25% as a coach can support three to four teams. Another way to estimate the number of quality coaches needed is to figure that roughly 5% of employees should be developed as QI coaches. Again for a 4,000-employee organisation this would be approximately 150 to 200 individuals developed as quality coaches over roughly five years.

Figure 1 illustrates how a dosing strategy might be laid out for an organisation. The rows indicate sample SOI content domains and the columns identify groups in the organisation that need a particular dose of the SOI. The shades of blue represent the intensity of the dose delivered to each group. The darker the blue, the deeper the required dose of the SOI. Again, the method of delivery (eg reading, computer-based training or workshops) will differ for each group and depend on resources.

Figure 1: Applying the dosing principle to an organisation



Note the intensity of the colour reflects the 'dose' of the science of improvement knowledge and skills that would be administered to each respective group. The mechanisms for administering the allocated dose would range fromm virtual learning (eg IHI Open School) to face-to-face workshops on the SOI.

Source: Lloyd R (2017) Quality Health Care: *A Guide to Developing and Using Indicators*, 2nd edition, Jones & Bartlett Publishing. Used with permission of R Lloyd and Jones & Bartlett Publishing.

4. Starting your journey

When an organisation starts its QI journey the 'doses' described in Figure 1 need to be administered gradually and over a period of time. Some organisations decide to start at the top of the organisation, while others send individuals who actually deliver care to training and developmental workshops. This can result in a disconnect between those developing a vision and strategy for the organisation and those delivering care. Organisations that succeed in embracing QI as a central business strategy, design a system of learning and application throughout the organisation.

We therefore recommend organisations to plan to gradually 'dose' key individuals throughout the organisation. Transforming an organisation into a centre for quality excellence is not a sprint but a marathon and requires a plan, momentum and a direction.

There is no prescription in relation to the sequence. Some organisations have trained a few QI experts and a large number of staff in core improvement skills while developing fluency at board level in parallel. Other organisations have trained experts, leaders and executives and taken a just-in-time (JIT) approach. This involves gradually building improvement skills through on-the-job support and/or intense improvement events; supporting frontline staff to deliver successful improvement projects and receive training at the same time.

The dosing approach is designed to strengthen both individual and organisational capacity and capability. Creating the conditions for Improvement is a vital aspect of this (Kaplan et al, 2010; Ovretveit, 2011; Lloyd 2017). The two aspects are interdependent. Organisations focused solely on filling individuals with content by sending them to training programmes will not necessarily improve capability.

Creating the conditions includes attention to the following:

- Leadership commitment: Many healthcare organisations have found it difficult to maintain constancy of purpose. They have been inconsistent in their approach to improving quality and as a result their efforts are not sustained. A 'flavour of the month' approach to improvement will not work and can lead to inefficient use of resources. In many ways constancy of purpose is more important than which model or approach is used, as it requires the leadership's commitment to making quality the real strategy for the organisation.

- Making a plan: A basic feature of the dosing approach is an organisation-wide plan for dispensing the appropriate dose of the SOI to the appropriate individuals. For example, senior leaders and board members do not need to know all the statistical nuances of control chart construction but they do need to know what a control chart is; why it is preferred over aggregated summary statistics and red/amber/green displays of data; how to determine common cause from special cause variation and, most importantly, what management decisions they should make when observing common cause or special causes of variation.
- Making it 'the way we do things here': Building improvement capability is an ongoing strategic and tactical commitment to the future; it is not a one-off event.
- Understanding key concepts: The concepts of QI and quality assurance are often misunderstood and used interchangeably. Quality assurance is primarily concerned with measuring compliance with standards. QI is about continuously improving processes to meet standards. It is vital that an organisation beginning its QI journey understands these key concepts and the implications of each for different phases of its work (Inglis, 2015).
- Recognising the limitations of 'tools': There are a variety of QI tools that can help diagnose, analyse and drive improvement work. They are critical to the success of improvement teams but should not be used in isolation, outside improvement approaches, strategies and action. It is easy to become enamoured with particular tools such as process maps, flowcharting or cause and effect diagrams but more important to understand when they should be used and how they fit into the QI approach.

These conditions are all important for keeping the QI journey on track.

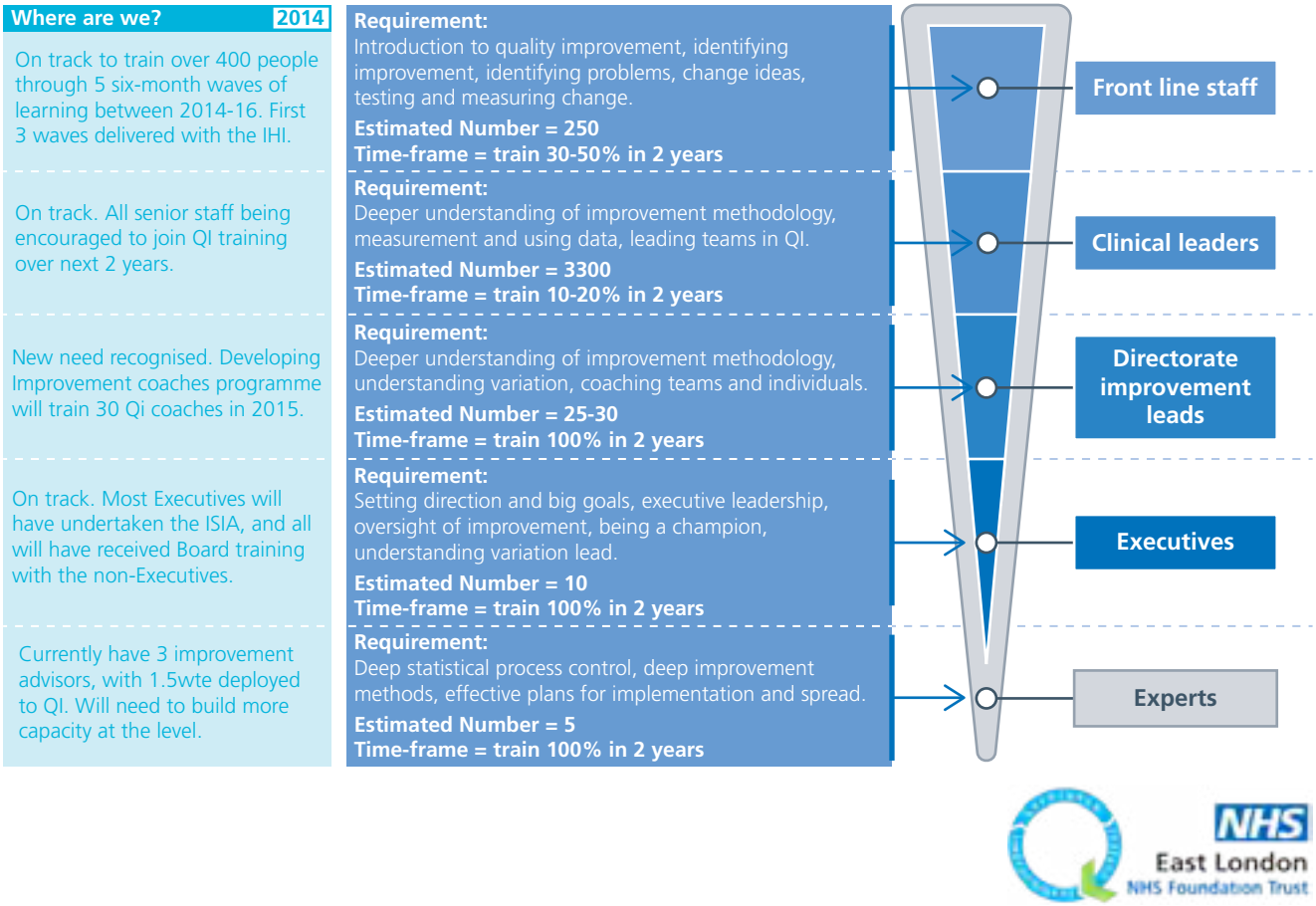
5. Building a strategy: case studies

Here are two case studies of NHS organisations that are developing their capability and capacity for quality improvement. We are keen to learn from and to share other provider experiences of leading this type of work. If you are interested in helping with this, we encourage you to share your story on our Improvement Hub or contact us at NHSI.DevelopmentTeam@nhs.net.

1: East London NHS Foundation Trust: building a dosing strategy

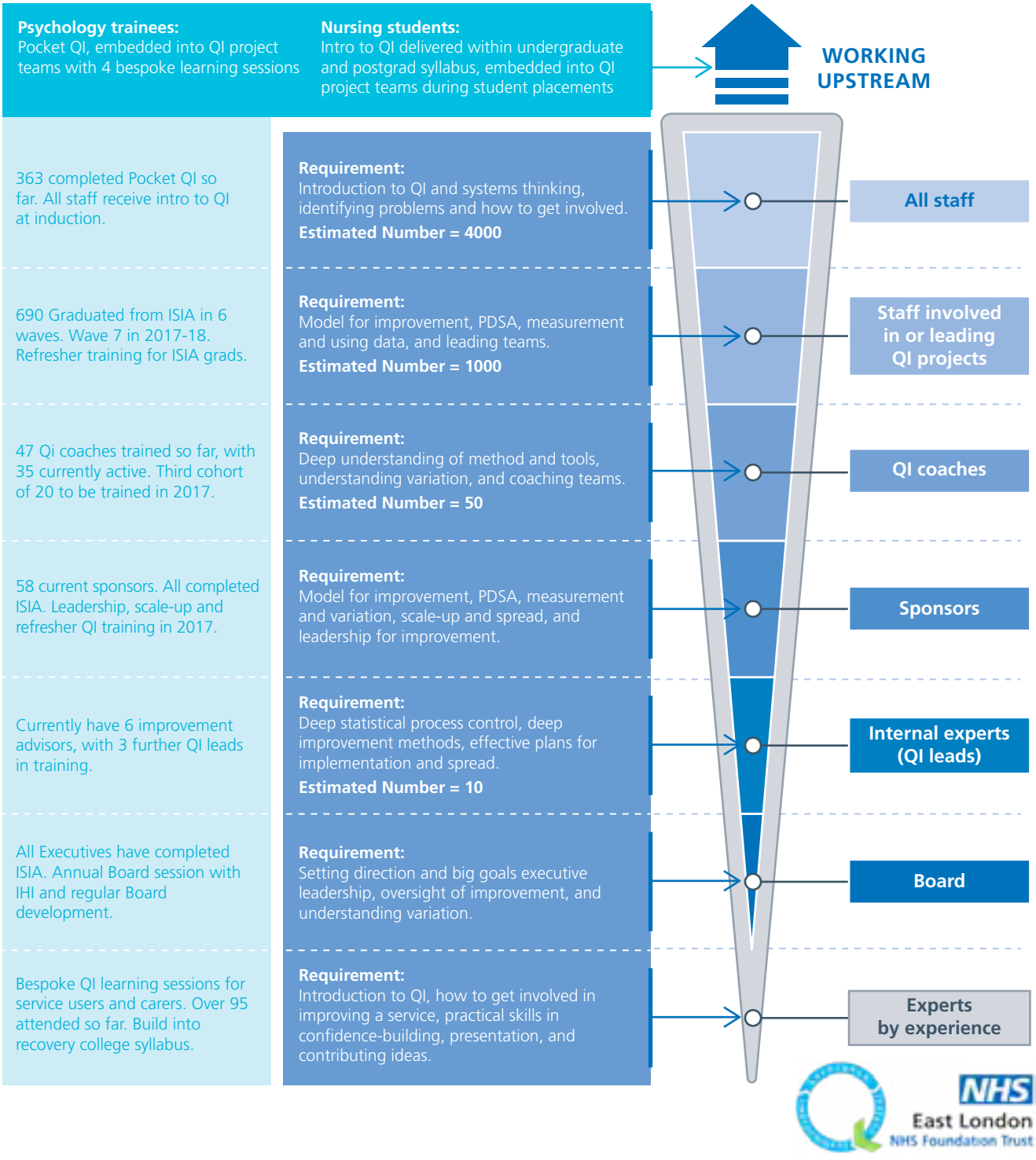
East London NHS Foundation Trust's quality journey began in 2014. IHI helped them identify strategic objectives for quality and safety, outline tactical plans for building capacity and capability and develop key indicators to track the progress. Figure 2 shows the first iteration of this work.

Figure 2: East London NHS Foundation Trust: building capacity and capability for improvement: draft strategy 2014



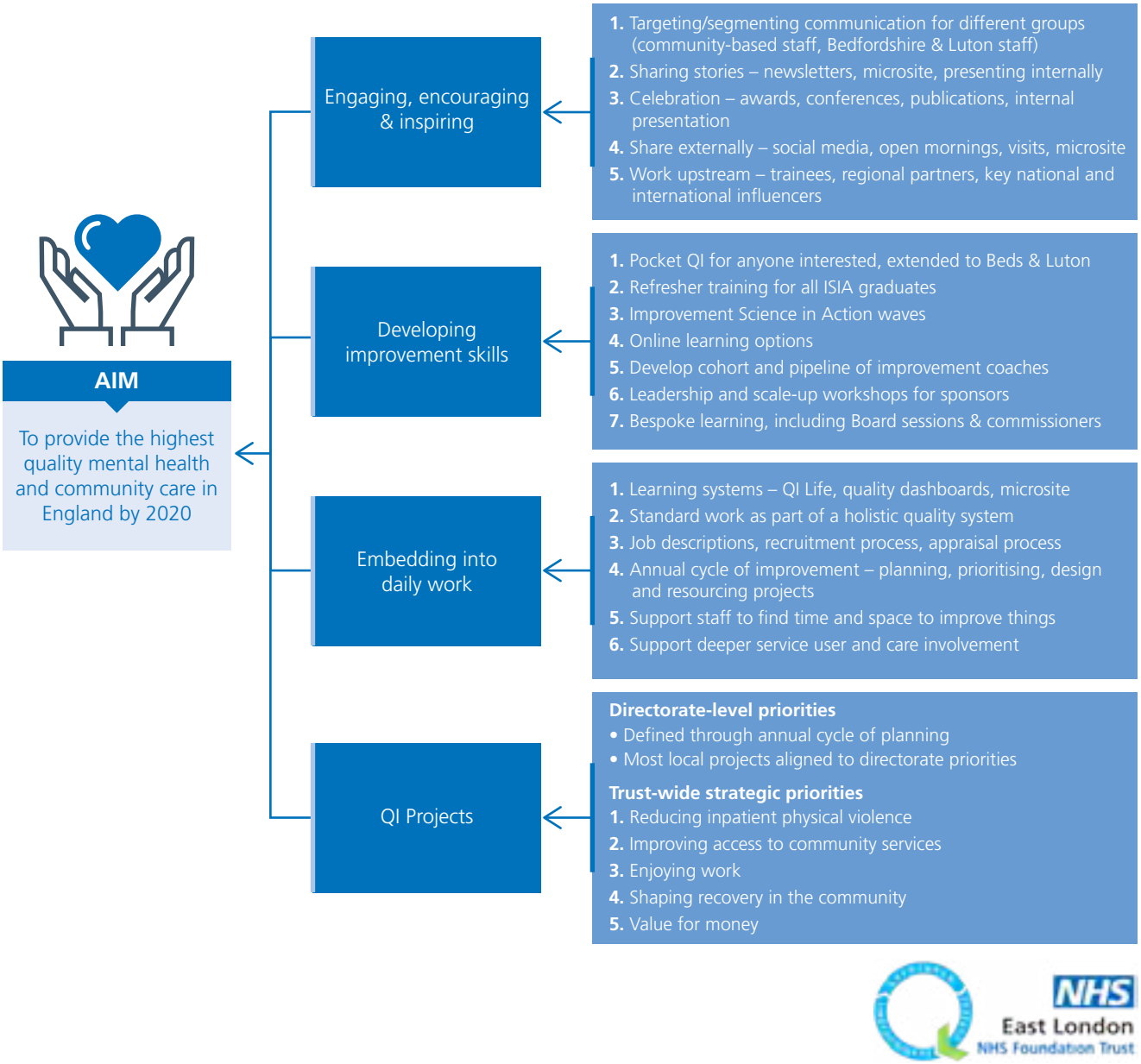
Building capacity and capability at East London is an ongoing, dynamic progress. The number of people receiving different doses and applying it through improvement projects regularly changes, while communication and delivery of the capacity and capability plans are adjusted as needs change. Figure 3 shows the updated 2017 version of the dosing strategy.

Figure 3: East London's follow up dosing strategy 2017



Building a renewable QI infrastructure not a one-and-done event. A one-off training session does not work when the aim is to build capacity and capability for the long run. Similarly, building capability is much wider than training. East London developed four pillars to illustrate its approach. Figure 4 shows how 'developing improvement skills' (dosing) fits into the overall organisational strategy.

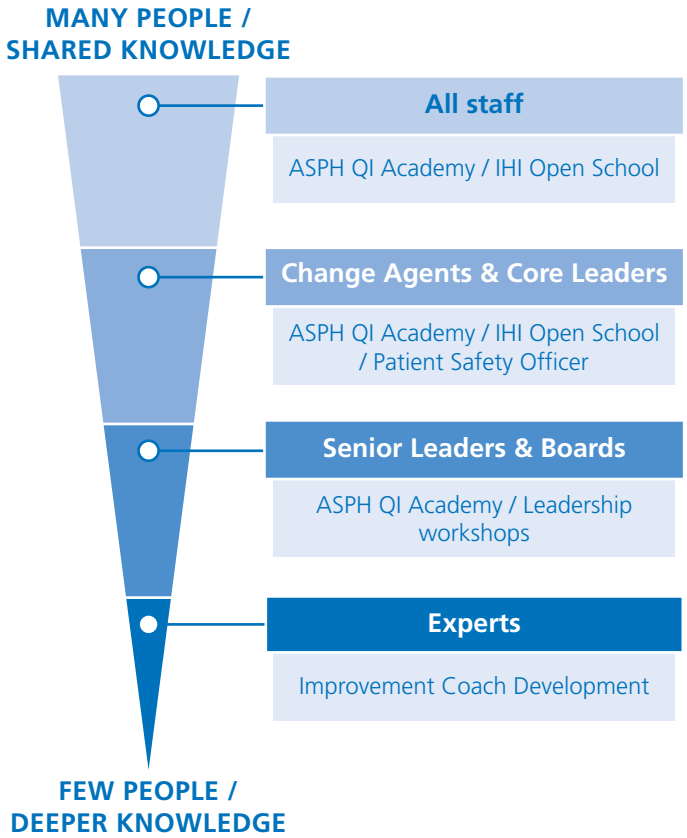
Figure 4: East London NHS Foundation Trust: how developing improvement skills (dosing) fits into the overall organisational strategy



2: Ashford and St Peter's Hospitals NHS Foundation Trust: developing capability in teams

Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH) began its QI journey in 2015, focused on developing capability for teams to make improvements as well as improving organisational culture and leadership. Recognising that building improvement capability at every level of the organisation would be key, ASPH created a dosing strategy to equip staff with the tools and coaching to make improvement a reality. Figure 5 shows the approach.

Figure 5: Ashford and St Peter's Hospitals NHS Foundation Trust dosing strategy



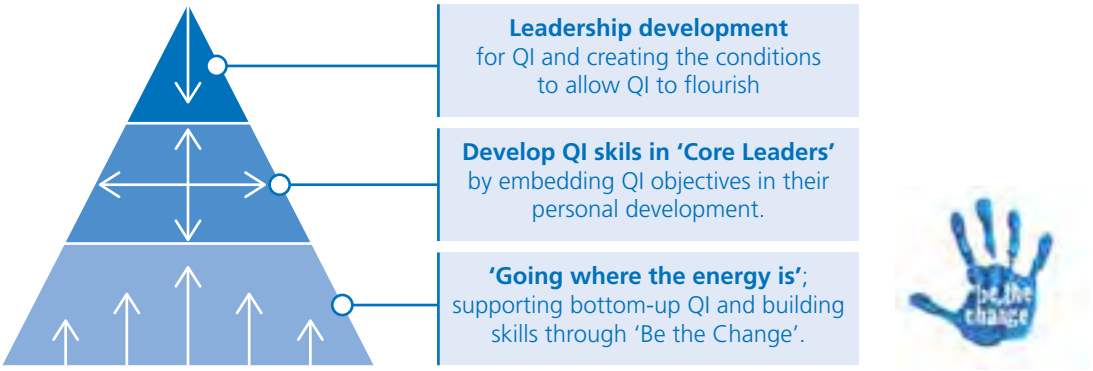
Since 2016, all staff have been able to access QI skills has via the ASPH QI academy and the trust works with IHI and uses its resources, including the online Open School and the Patient Safety Officer and Improvement Coach development programmes.

To maximise the take-up and engagement with these learning opportunities, ASPH carefully targeted its improvement capability-building. They took the approach of 'going where the energy is' and supporting bottom-up improvement projects and building skills through the 'Be the Change' programme.

They have gone on to develop QI skills in the trust's 'leaders' by embedding QI objectives and expectations in personal development; and placing QI training at the centre of the organisation's leadership framework and the core manager's toolkit.

ASPH is also working with on leadership development for quality improvement, creating the conditions to allow QI to flourish – a culture of 'curiosity and creativity' that is fair, open and supportive. Figure 6 shows details of the deployment strategy.

Figure 6: ASPH capacity and capability deployment strategy



Supporting quality improvement has enabled ASPH to empower teams to be creative and innovative, always looking for ways to improve their services and the care provided. They have created leaders who have supported the capability for learning, and therefore change, at scale. This has resulted in improved patient experience, patient safety metrics and improved the feel of the organisation.

A significant driver was a concern that the staff survey results at ASPH were at best average and in some indicators, worse than average. Over the past few years ASPH has started to see improvements. The 2016 results show a significant improvement of double-digit percentage increases in all four questions in the staff survey that relate to innovation and improvement over the last five years.

In 2017, ASPH won the Healthcare People Management Association Excellence Award for excellence in employee engagement.

6. Key messages

- Embedding quality improvement throughout an organisation requires a systematic, targeted effort such as 'dosing' to develop different levels of QI expertise for different groups of people.
- Dosing does not prescribe a single set of numbers, percentages or mathematical formulae.
- To be successful, 'dosing' should be structured around building both individual and organisational capacity and capability as the two are interdependent. Organisations that simply send individuals on training programmes will not achieve increased capability because the gap between theory and practice is significant. The impact will only be delivered with a clear organisational approach to support immediate and continuous skills application. Organisations should plan to gradually 'dose' key individuals' at all levels of the organisation. A starting point may look similar to Figures 1 and 4.
- The process of transforming an organisation is not a sprint but a marathon that requires a plan, a pace and a direction to build the foundations for Improvement. Have a look at the recent Health Foundation report Building the foundations for improvement. How five UK trusts built quality improvement capability at scale within their organisations for an account of five UK trusts' QI journeys.

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Further reading and references

Reading

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2. *Sustaining Improvement* (IHI 2016)
3. *Does Quality Improvement improve quality?* (Dixon-Woods, Martin 2016)
4. *Building the foundations for improvement. How five UK trusts built quality improvement capability at scale within their organisations.* (Health Foundation 2015)
5. *Skilled for Improvement* (Health Foundation 2014)
6. *Comparing lean and (IHI) Quality Improvement* (IHI 2014)
7. *Perspectives on Context. A selection of essays considering the role of context in successful quality improvement* (Health Foundation 2014)

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 Publication code: IG 36/17

Walsall Together
Joining up your health and social care

Placed-based Teams / MDT working

26th March 2018

Walsall Together
Joining up your health and social care

Multi Disciplinary Team working

- The last three months has been focused on organising the teams so that they are wrapping around each of the populations that they serve. There has been work to understand the needs of primary care and how this can be aligned. In addition there has been a developing understanding that often, the presence of the team is as useful to all providers as the MDT development itself. In principle the team are working as a constant virtual MDT.
- Work is underway to understand how the teams can start to map the case loads across the providers initially to understand the complexities and more importantly duplicate. Again this is work outside of the MDT and compliments the individual patient conversations that are planned through the specific meetings.
- A leadership (Action Group) group met on a weekly basis since From December to February to increase the pace and delivery of the project especially given the poor progress on primary care MDT's. This group has been focused on getting the basics right:-
  - Construction
  - Co location
  - Collaboration
- Team leader workshops were planned and well attended to operationalise the work that teams have to deliver and also make sure that the original vision remains the focal point. The outputs of these workshops are covered on the next slide but are now planned to be regular items to ensure that teams stay connected to the vision.
- The challenge of colocation remains mainly due to specific estate issues but the teams have a renewed focus to work through these problems with hot desking and single route of referral, and regular team meetings moving forward.
- Meetings are taking place with Voluntary sector leads to establish introductions with Place Based Teams to further facilitate integration

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MDT's - What's the difference

There has previously been some confusion around the different types of MDT's proposed. This has been discussed at length in the project group and the following approach has been agreed.

Team MDT's

These are run in the team location with the purpose of facilitating team work between all PBT members

They are for information sharing, collaboration and identifying where sharing of best practices will improve working for all.

They are for discussing patient caseloads, and complex patients cases that cross multiple agencies.

GP Led MDT's

These are led by the GP's and support collaborative working arrangements that surrounds/supports patients suffering from long term conditions/complex illnesses.

Support of 'a team around the patient'

The 'right professional' talking about the 'right patients' at the 'right time' with the 'right information'

The expected outcomes are, reduced GP appointments, reduced GP Visits and reduction in demand by removing duplication

Virtual MDT

When running efficiently the team MDT's will form a virtual MDT that is constantly reviewing complex cases, with the ability for any healthcare professionals to refer to the team for advice via the proposed single referral process that is being planned.

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Team MDT's

- The vision of the team MDT has been re affirmed and operationalised through the leadership workshops. The weekly action group has ensured implementation of the operational plan and managing the associated risks. A view of the plan is at the end of this slide deck and is constantly under review and updates
- Dates have been agreed where the team leaders and members of the team will meet on a regular basis. This is seen in the table below. These meetings will be monitored for content by the action group to establish key outcomes as well as a place to build local relationships
- The Team MDT's will collate, discuss and monitor the complex multi agency caseloads of patients.
- The teams are also developing a single referral process so duplication can be quickly spotted and responded too at the point of referral. This step is expected to develop over the next few months. The final step will also be to have a single outcome form.
- When running efficiently the team MDT's will form a virtual MDT that is constantly reviewing the complex cases, with the ability for any healthcare professionals, GP's etc able to call the team for advice, clarity etc.

Team MDT's

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Summary | Info Page

Team MDT's in Adult Community Service

Team	MDT Purpose	Frequency	Who Attends	Gaps
NORTH Integrated Health and Social Care placed based team	MDT discussion for Case Management of patient Care, team working etc	Healthcare daily at 14:00hrs Social Care Every Tue PM/Wed PM	Health Care workers , Social Care workers and Mental Health Care workers and Voluntary sector workers	Social Care attending on Tue afternoons, attendance has been good with one or two attending. Awaiting MH colleague to start
EAST 1 Integrated Health and Social Care placed based team	MDT discussion for Case Management of patient Care, team working etc	Healthcare daily at 15:00hrs Social Care Weekly	Health Care workers , Social Care workers and Mental Health Care workers and Voluntary sector workers	Awaiting feedback
EAST 2 Integrated Health and Social Care placed based team	MDT discussion for Case Management of patient Care, team working etc	Healthcare daily at 15:00hrs Social Care Weekly every Tue @ 14:30hrs	Health Care workers , Social Care workers and Mental Health Care workers and Voluntary sector workers	Social Care team attending meetings regularly. COPD team also attending Tue PM. Mental Health contact regular, usually by phone
SOUTH 1 Integrated Health and Social Care placed based team	MDT discussion for Case Management of patient Care, team working etc	Healthcare daily at 14:30hrs Social Care every Wed until 8th Feb then Every Fri AM **Team leaders from South 1 & 2 and Social Care team leader meet every Fri @ 10:00hrs**	Health Care workers , Social Care workers and Mental Health Care workers and Voluntary sector workers	Regular contact with Social Care, this has improved team MDT working **Mental Health post still vacant**
South 2 Integrated Health and Social Care placed based team	MDT discussion for Case Management of patient Care, team working etc	Healthcare daily at 15:00hrs Social Care every Thurs @ 15:00hrs **Team leaders from South 1 & 2 and Social Care team leader meet every Fri @ 10:00hrs**	Health Care workers , Social Care workers and Mental Health Care workers and Voluntary sector workers	Regular contact with Social Care **Mental Health post still vacant**
West 1 Integrated Health and Social Care placed based team	MDT discussion for Case Management of patient Care, team working etc	Healthcare daily at 14:30hrs Social Care Every Wed AM	Health Care workers , Social Care workers and Mental Health Care workers and Voluntary sector workers	Social Care are attending Wed AM meetings, need to confirm Mental Health attendance
West 2 Integrated Health and Social Care placed based team	MDT discussion for Case Management of patient Care, team working etc	Healthcare daily at 14:30hrs Social Care Every Wed AM	Health Care workers , Social Care workers and Mental Health Care workers and Voluntary sector workers	

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GP Led MDT's

- The project team have reviewed the position on GP lead MDT's and following suggestions from the Partnership Board agreed to run a series of pilot MDT's across the borough with supportive practices and GP's. The scope of this pilot has been kept small to ensure that the correct support is in place and issues can be resolved quickly and effectively. Again a principle of getting the basics right has been adopted with a member of the project team attending the pilot MDT's until such time as clear routine has been established.
- A MoU has been created and the latest draft is now being piloted MDT pilot practices – feedback after each MDT is used to verify if the MOU needs to be developed further before a decision is taken on a wider roll out. This process forms as a live audit process that is fed into the weekly action group where issues or best practice can be resolved or rolled out further.
- The MDT coordinator role has now been recruited too and the successful candidate starts in Apr. This post will hold a future coordinating role of the MDT's establishing a continuous audit process and feedback loop.
- The project team are also working on understanding the scale of the MDT requirement by each locality. It is clear that not every practice can be facilitated with an MDT so economies of scale are being explored as the project progresses and will be added to this report as options progress.

Walsall Together
Joining up your health and social care

GP Led MDT's

Key	
Blue	MDT Running - Fully
Green	MDT's Running
Amber	MDT's Planned
Red	MDT's To be agreed

Pilot - Phase One			
Practice Name	**Time & Date**	**Status**	**Comments**
Bentley Med Centre - West 1 Berkley Practice Kingfisher Practice Stroud Practice	**Monthly** Every 3rd Mon at 13:00hrs	Running	This MDT has now been running sucesfully since Aug 17
Lockfield Surgery - West 2	**Monthly** Every 2nd Tue at 11:30hrs	Running	This MDT has been runing over that last few months, originally attendance was an issue but the last MDT on Jan 9th was well attended
Northgate Practice - East 2	**Monthly** Every 3rd Tue at 12:30hrs	Running	First meeting went very well Monthly meetings now set for 3rd Tue every month Stats to be collected when MDT Co ordinator starts
Portland Practice - East 2	**Monthly** Every 3rd Tue at 12:30hrs	Running	Very positive response from all the GP's in the first meeting. They have requested attendance from a Heart failure nurse. (To be followed up) Monthly meetings now set for 3rd Tue every month
Moxley Practice - West 2	**Monthly** Every 3rd Wed at 11:30hrs	Running	Another very good MDT. GP is going to talk to two other practices and see if they want to join his MDT. Monthly meetings to be set for 3rd Wed every month
Bloxwich Practice - North	**2nd MDT** 28th Mar @ 12:15hrs	Running	A promising MDT, GP's keen to repeat. Future meetings to be held 6 weekly in between GSF meetings.
Pleck HC - South 1	**Awating Information (replacement from a failed MDT Pilot)**	Planned	(Ctrl) meeting with GP's to see if they agree to joinging the pilot

3/6/9 Month Plan

Walsall Together
Joining up your health and social care

Walsall Together
Integrated Health and Care Teams
3/6/9 Month Roll Out Plan

Product	Team/GroupOrg	Activity	RAG Status	3 month			6 month			9 month			Comments
				01-Jan-18	01-Feb-18	01-Mar-18	01-Apr-18	01-May-18	01-Jun-18	01-Jul-18	01-Aug-18	01-Sep-18	
MDT Roll out - Phase 1 - Implemention													
Implementation of GP Led MDT's at pilot practices	West	Discuss MDT options with Team leaders, and update PBT MDT Breakdown tables	MDT's Running										
	North		MDT's Running										
	South		MDT's Planned										
	East		MDT's Running										
Governance & Technology													
Data sharing agreements across all agencies	CCG	Create a single DSA in partnership	On Target										
Suite of working documents across all agencies	All	Single Assestment form	On Target										Delayed due to cancelation of Team leader event. Now scheduled for 26th Apr Timeline extended to end of Apr
		Outcome form	On Target										
		Formal activity reporting form/data set	On Target										
One Walsall Together Service Specification	CCG	Commissioner development of service specification and performance reporting, to include outcome	On Target										
Mobile Working	WHT	Rollout of Samsung Tablets to Community Teams	Complete										
		Rollout of TotalMobile application to Community teams tablets	On Target										On target for completion by end of Mar
Creation of MoU document for GP Led MDT's	PBT Group	Sign off MoU with appropriate Governance Bodies	On Target										Timeline extended to allow new MDT Co-ordinator to review MoU and update as required
Placed Based Teams													
Construction & Co Location	ASC/WHC/MH	Providing accommodation for multi agency staff to work together as Place Based Teams	On Target										Accommodation provided for all 7 teams, Hot desks available for drop in purposes
	ASC/WHC/MH	Provide suitable accommodation for East 1 and East 2 teams	Off Target-R										The two East location, Parkview and Anchor Meadow are not fit for purpose
Collaboration Sharing Duties/roles Sharing best practices	ASC/WHC/MH	Ensure health social care and Mental Health staff are fully engaged in the design and on-going development of place-based services	On Target										Delayed due to cancelation of Team leader event. Now scheduled for 26th Apr Timeline extended to end of Apr
	ASC/WHC/MH	Improving Place Based teams visibility within all aspects of the community	On Target										
	ASC/WHC/MH	Creation of a single referral form	On Target										
	ASC/WHC/MH	Creation of a single outcome form	On Target										
	ASC/WHC/MH	Ensure team collaboration continues and team events are held to continue Team development	On Target										
	CCG	Joint Organisational Development	On Target										
Comms Strategy													
Communication strategy	GP	Carry out briefings with all GP practices	Complete										Carried out by Shadia Abdalla during Oct /Nov
	ASC/WHC/MH	Team leader workshops	On Target										Two carried out to date, 1 in Set and 1 in Jan 18
	Programme Manager	Walsall Together reports to Project Group and Board	On Target										
	Programme Manager	GP Led MDT Pilot Group Comms	On Target										
	ASC/WHC/MH	Develop monthly newsletter	On Target										

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	**Public Trust Board**			**Date: 5th April 2018**
Report Title	Partnership Update			**Agenda Item: 12** **Enclosure No.: 10**
Lead Director to Present Report	Daren Fradgley, Director of Strategy & Improvement			
Report Author(s)	Daren Fradgley, Director of Strategy & Improvement Place Based Team Project Group			
Executive Summary	The paper provides a progress and overview report for the work that has been progressing to develop the next stages of Multi Disciplinary Team (MDT) working as part of the Walsall Together Partnership. This work is complimentary to the first steps of case for change that was approved by Trust Board last month. Work continues to establish a program team and work full work program on the case for change with our partners and is covered in the CEO report this month. In addition to this report I will provide the Board with a verbal update on the work we are discussing with partners on future collaborations across the Black Country STP.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☒
Recommendation	**NOTE** the progress of reported.			
Trust Objectives Supported by this Report	**Provide Safe High Quality Care Across all of Our Services**		**Embed the quality, performance and patient experience**	

<table>
<tr><td></td><td></td><td>improvements that we have begun in 2016/17</td></tr>
<tr><td></td><td>Care for Patients at Home Whenever we can</td><td>As above</td></tr>
<tr><td></td><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>As above</td></tr>
<tr><td></td><td>Value our Colleagues so they recommend us as a place to work</td><td>As above</td></tr>
<tr><td></td><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></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Partnership working and future service sustainability is covered within the BAF and Corporate Risk Register</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">None requested within this report</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">None reported in this report</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Walsall Together Partnership Board</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">N/A</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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BOARD/COMMITTEE REPORT

Meeting	Trust Board	**Date: 5th April 2018**
Report Title	General Data Protection Regulations	**Agenda Item: 13** **Enclosure No.: 11**
Lead Director to Present Report	Director of Strategy and Improvement	
Report Author(s)	Compliance and Risk Manager	
Executive Summary	The EU General Data Protection Regulation (GDPR) was approved in 2016 and will become applicable as law in the UK from the 25th May 2018. GDPR provides data subjects with increased rights regarding the processing of their personal data. GDPR is risk based with the emphasis on organisations being able to demonstrate compliance and have evidence of that compliance available for inspection. There are key changes from the current Data Protection Act 1998 to GDPR and these are: • New accountability requirement which means that organisations will be required to not only comply with the law but to also be able to demonstrate compliance. • Significantly increased penalties for breaching any aspect of the regulation, not just data breaches. The Information Commissioner's Office will have the power to fine organisations a maximum of €18M or 4% of annual turnover and the level of fine will be determined by the nature of the breach. • There will be a legal requirement to report personal data breaches to the Information Commissioner's Office within 72 hours where there is a risk to the data subject. • Organisations will no longer be able to charge (in most cases) for the release of patient or staff records as part of a subject access request. In addition, the timeframe for the release of this information will be reduced from 40 days to one month. • There will be stricter rules regarding consent where this is used as the basis for lawful processing of personal data. • It will be mandatory for public bodies to appoint a Data Protection Officer. • Data protection impact assessments must be completed for all high risk processing activities. • Data protection issues must be considered and addressed in all information processing activities at an early stage (privacy by design). • There will be a specific requirement for organisations to be transparent about how it uses data subjects' information.	

	The Trust's action plan for GDPR has been subject to an Internal Audit review and an opinion of substantial assurance was received. Two of the revised data protection principles will have an impact on quality and safety and these are ensuring that personal information will be: • Accurate and up to date • Not kept for longer than is necessary The Trust will need to demonstrate under the principle of accountability that the personal information it holds is accurate, up to date and held in line with agreed retention periods. Under GDPR consent for sharing special category personal information for health care purposes will not be required under the following article: Article 9(2)(h) – the processing is necessary for the purpose of medical diagnosis, the provision of health or social care or treatment of the management of health or social care systems This article however only relates to the processing of a patient's personal data and does not remove the need to gain consent for medical procedures or treatment.

Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation				

Trust Objectives Supported by this Report		
	Provide Safe High Quality Care Across all of Our Services	**Embed the quality, performace and patient experience improvements that we have begun in 2016/17**
	Care for Patients at Home Whenever we can	**Not Relevant**
	Work Closely with Partners in Walsall and Surrounding Areas	**Not Relevant**
	Value our Colleagues so they recommend us as a place to work	**Embed the quality, performance and patient experience improvements that we have begun in 2016/17**
	Use resources well to ensure we are Sustainable	**Tackle our financial position so that our deficit reduces**

<table>
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<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>None identified.</td></tr>
<tr><td><u>Resource Implications</u></td><td>Potential increase in administration for Subject Access Requests due to data subjects being made more aware of their right to access information and our inability to charge for it.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td>To be compliant with the General Data Protection Regulations, 2016 and any subsequent legislation due for release prior to 25th May 2018. The European Parliament adopted the GDPR on 14th April 2016.</td></tr>
<tr><td><u>Report History</u></td><td>The report was received at the Executive Team Meeting on Tuesday 20th February 2018. Reports are received at each bi-monthly Information Governance Steering Group.</td></tr>
<tr><td><u>Next Steps</u></td><td>Continued work to address the actions to ensure the Trust is ready for the implementation of GDPR in May 2018.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td>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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General Data Protection Regulations

Background

The EU General Data Protection Regulation (GDPR) was approved in 2016 and will become applicable as law in the UK from the 25th May 2018. Currently a Data Protection Bill is being debated within Parliament and post Brexit the bill will become the Data Protection Act 2018 and GDPR will no longer be applicable to the UK. However the Data Protection Act 2018 will cross reference to relevant provisions within GDPR.

GDPR provides data subjects with increased rights regarding the processing of their personal data, and the definitions of personal and sensitive data have also been widened.

GDPR is risk based with the emphasis on organisations being able to demonstrate compliance and have evidence of that compliance available for inspection from the Information Commissioner's Office as and when required.

Key Changes

There are key changes from the current Data Protection Act 1998 to GDPR and these are:

- New accountability requirement which means that organisations will be required to not only comply with the law but to also be able to demonstrate compliance.

- Significantly increased penalties for breaching any aspect of the regulation, not just data breaches. The Information Commissioner's Office will have the power to fine organisations a maximum of €18M or 4% of annual turnover and the level of fine will be determined by the nature of the breach.

- There will be a legal requirement to report personal data breaches to the Information Commissioner's Office within 72 hours where there is a risk to the data subject.

- Organisations will no longer be able to charge (in most cases) for the release of patient or staff records as part of a subject access request. In addition, the timeframe for the release of this information will be reduced from 40 days to one month.

- There will be stricter rules regarding consent where this is used as the basis for lawful processing of personal data.

- It will be mandatory for public bodies to appoint a Data Protection Officer.

- Data protection impact assessments must be completed for all high risk processing activities.

- Data protection issues must be considered and addressed in all information processing activities at an early stage (privacy by design).

- There will be a specific requirement for organisations to be transparent about how it uses data subjects information.

In addition, the main data protection principles have been reduced under GDPR from 8 in the current legislation to 6 and dictate that personal information will be:

- Processed fairly, lawfully and transparently
- Collected for a specific purpose
- Adequate and relevant
- Accurate and up to date
- Not kept for longer than is necessary
- Processed in a manner that ensures security of the data

Underpinning the 6 principles is the principle of accountability which states that organisations will be held accountable for ensuring the data protection principles are applied to every instance of processing of personal data within an organisation and evidence of compliance is maintained.

Alongside the revised principles GDPR also introduces 9 rights for data subjects which organisations will need to have processes in place in order to protect those rights and again be able to demonstrate compliance:

- Right to information
- Right of access
- Right to rectification
- Right to erasure (right to be forgotten)
- Right to restriction of processing
- Right to notification of rectification or erasure
- Right to data portability
- Right to object
- Right to object to automated decision making

Walsall Healthcare NHS Trust Preparedness
Work is ongoing to ensure the Trust is ready for the implementation of GDPR on the 25th May 2018. The work is being led by the Compliance and Risk Manager and Health Records Manager. The Executive Lead is the Director of Strategy and Transformation.

Key areas have included the creation of an action plan, citing the key steps that need to be completed to ensure the successful implementation of GPDR.

The action plan was subject to an Internal Audit review on the 1st February 2018 and an opinion of substantial assurance was received. The audit did make reference to some of the actions having a short deadline, which has been taken on board and where possible, timeframes have been amended.

Progress against the plan is discussed at Information Governance Steering Group. The action plan has been cross-referenced against the Information Commissioner's Office 12 step guide to implementing GDPR.

Another key area which is being explored is the need for data protection impact assessments (DPIA) which will be mandated by GDPR.

DPIA's are required for all high risk data flows, where new technology is being implemented or changes to service provision. DPIAs will need to become embedded into the working practice of the organisation to ensure the Trust meets the obligation of privacy by design (in essence the confidentiality and protection of personal information is considered and assessed at the beginning stage of every project, service change or procurement of new technology).

The action plan is primarily on target, with slippage against the approval of some policies.

Please refer to appendix one.

Under GDPR consent for sharing special category personal information for health care purposes will not be required under the following article:

Article 9(2)(h) – the processing is necessary for the purpose of medical diagnosis, the provision of health or social care or treatment of the management of health or social care systems

This article is absolute and therefore will not be subject to a public interest test.

This article however only relates to the processing of a patient's special category personal data and does not remove the need to gain consent for medical procedures or treatment.

GDPR mandates the appointment of a Data Protection Officer (DPO) and the role of the DPO is protected under GDPR and must be able to work independently with adequate resources.

The purpose of the role is to:

- Inform and advise the Trust and its employees about their obligations under GDPR
- Monitor compliance with GDPR
- Be the point of contact for data subjects, members of staff and the supervisory authority (Information Commissioner's Office)

The Data Protection Officer for the Trust is the Compliance and Risk Manager and will become the Corporate Governance Manager following the departure of the Compliance and Risk Manager.

Two of the revised data protection principles will have an impact on quality and safety and these are ensuring that personal information will:

- Accurate and up to date
- Not kept for longer than is necessary

The Trust will need to demonstrate under the principle of accountability that the personal information it holds is accurate, up to date and held in line with agreed retention periods.

The Trust's Data Quality Group is actively involved in trying to improve the quality of the data held about our patients and is aware there are issues of poor data quality which may have a negative impact on patient care but it will have an impact on the Trust's ability to demonstrate that the personal information we hold is accurate and up to date.

In addition loose filing needs to be merged with the main patient record to ensure the appropriate patient information is held in one place and therefore ensuring the information is accurate. Failure to do this will not only result in a breach of GDPR but also presents a clinical risk to the patient.

There is a mass of patient information held in offsite storage which needs to be reviewed to ensure it is being held in line with agreed retention periods. This work will be included in the electronic patient record programme.

The Information Commissioner's Office as supervisory authority will have the power to fine organisations a maximum of €18M or 4% of annual turnover for a breach of the data protection principles.

Article 15 rights of access by the data subject states that data controllers are not allowed to charge for responding to initial subject access requests which may result in a loss of revenue for the Trust. Article 15 does state that for any further copies requested by the data subject the data controller may charge a reasonable fee based on administrative costs.

Next Steps

Work will continue in line with the action plan, with regular reporting to Information Governance Steering Group. The results from the Internal Audit review will also help to determine the direction of travel for the Trust is positive.

BOARD/COMMITTEE REPORT

Meeting	**TRUST BOARD**	**Date: 5th APRIL 2018**
Report Title	**STAFF ENGAGEMENT – STAFF SURVEY SUMMARY, UPDATE ON ACTION PLAN & BOARD PLEDGE**	**Agenda Item: 14** **Enclosure No.: 12**
Lead Director to Present Report	Lead Director – Louise Ludgrove, Interim Director of Organisational Development and Human Resources	
Report Author(s)	Simon Johnson, Staff Engagement Lead	
Executive Summary	**BACKGROUND** • Our vision and strategy commit us to delivering a clinically-led, engaged and empowered organisation and in order to do this recognised an engaged workforce is paramount to achieving this vision. • An interim Staff Engagement Lead was employed in June whose last assignment saw a neighbouring Trust's engagement significantly improve. • A Staff Engagement Lead was employed as it was evident that further focus was needed to understand the 2016 Staff Survey results which were well below average compared with the national average of similar Trusts. Also, if the Trust is to achieve the longer term vision it is recognised that its staff must be engaged. • The Staff Engagement Lead spent time within the organisation and held a series of focus groups across the entire Trust's workforce to understand staff opinion. Those focus groups were looking at a number of topics that positively or negatively impact staff engagement. In addition he has met various other staff through day to day dealings, meetings, invites to events or approaches directly from staff. • The approach and style of the Staff Engagement Lead allowed an opportunity for staff to talk openly and confidentially with the subsequent feedback pulled in to a number of topics and themes that is included within these Board papers so that Board members have sight and awareness of what was fed back. • In addition The Staff Engagement Lead has reviewed all the topics with the Trust Executive members as well as senior leaders and agreed 5 key topics to focus on first, which are more likely to have the strongest positive impact. • In addition to the 5 areas Trust Executive have given approval to introduce 2 groups of staff to support the engagement work which are 'Engagents' and the Passionate for Engagement Group (PEG) which are also covered at the beginning of the Action Plan presented. • Through the Action Plan and drive for staff engagement, in addition to connected work such as Listening into Action (LiA) the objective is to see Walsall Healthcare Trust improve from 37th (2016 results) in the annual staff	

survey.

STAFF SURVEY SUMMARY 2017

Annually the NHS surveys staff with a series of questions to establish staff opinion relating to a number or areas and those questions are then grouped into 32 Key Findings. The results have been published and the summary report and full report is attached with this update for Board awareness.

The results of the Staff Survey have been shared with all colleagues through 'In the Loop' which has been done in 2 parts, with the second coming out imminently.

Here is some important information that we know following the results being published:

- 1536 of staff completed a survey representing 36% (the national average for Acute/Community Trusts was 40.4%)
- The Trust has improved by 2% or more from 2016 results for 42% of the survey (35 questions)
- The Trust has worsened by 2% or more from 2016 survey for 13% of the survey (11 questions)
- The Trust has stayed about the same (within 1%) from 2016 survey for 45% of the survey (37 questions)
- According to Listening into Action we have improved from 37/37 for Acute & Community Trusts to 35/37
- The 2017 results have remained relatively static measured against the Key Findings compared nationally to the 2016 survey with :
    - No change in 28 Key Findings
    - Improvement in 3 Key Findings
    - Worsening in 1 Key Finding

Some clear movement upwards or downwards in these results for specific questions:

- 5% more people say they are involved in deciding on changes introduced
- 4% more people say they are dissatisfied with their level of pay compared with 2016
- 4% more people stated communications between senior management and staff is effective
- 3% more people say they have suffered work-related stress compared with 2016
- 7% more people feel that the organisation would treat them fairly if involved in an issue
- 5% more people say they are given feedback about changes in response to reported errors, near misses and incidents
- 4% less people state they have received training, learning or development in the past 12 months
- 4% more people state that where they did receive development it helped them be more effective
- 8% more people agree they receive regular updates on patient experience in their areas
- 4% more staff stated that the last time they experienced physical violence they did not report it
- 9% more people agreed feedback received from patients is used to make informed decisions

Next steps:

- A meeting is being arranged between the HR Managers and Staff Engagement Lead with the intention of agreeing a template for divisional areas to identify 5 areas that require their focus. HR will have oversight of these plans and Divisional areas

<table>
<tr><td></td><td colspan="4">will have ownership and accountability for delivery of them.
• The Staff Engagement Action Plan will be utilised for anything Staff Survey related that is Trust-wide e.g. the template approach to divisional plans
• A review of what additional information can be extracted will be undertaken, relating to important information e.g. staff opinion in the Protected Characteristic groups, and then what actions might need to be taken relating to any areas of concern or promoting successes where they exist

<u>ACTION PLAN UPDATE (with some highlights)</u>
• Initial actions are going well with one area in amber (this relates to Appraisal LiA which was ran a second time due to a low turnout and then postponed due to poor weather and service priority). This has now taken place with the outcomes awaited
• Values have been established but not yet announced as there will be a Trust-wide announcement in the near future
• Wider launch will follow the initial announcement, which will include constructing the behavioural framework that will be produced once the values have been announced
• Feedback has been provided to some colleagues, as a result of the focus groups, to assist their future performance.
• Manager feedback sessions have been run to share best practice in delivering feedback
• 360 feedback is currently being piloted by Board, Exec through to Teams of Three Managers and their equivalents
• Now have 55 Engagents that are already being utilised for representative opinion e.g. policies

<u>BOARD PLEDGE</u>
Part of the Action Plan agreement with Board is the approval to create a pledge from the Board relating to a zero-tolerance towards bullying and harassment and a poster signed and used from a neighbouring Trust has been circulated with the Board prior to this Board update (a copy will be sent to accompany the Board's papers).
What is needed:
• The Board's input, which is likely to be discussed at a separate time, as to what WHT's pledge to staff would look like and whether the poster with the signatures is a way the Board would like to proceed.
• How best to achieve the outcome to suit the Board's desired approach.</td></tr>
<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">1. NOTE & DISCUSS the 2017 Staff Survey results
2. NOTE the Trust's Staff Engagement Action Plan update
3. DISCUSS & DECIDE the best approach for the Board Pledge</td></tr>
<tr><td rowspan="4"><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">Embed the quality, performace and patient experience improvements that we have begun in 2016/17</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">Embed an engaged, enpowered and clinically led organisational culture</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">Use resources well to ensure we are Sustainable</td><td colspan="2">Embed continual service improvement as the way we do things linked to our improvement plan</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">The Board Assurance Framework includes a risk relating to our inability to deliver sufficient cultural change during 2017/18.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="4">Dedicated resource through the Staff Engagement Lead included in our 2017/18 plan.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="4">NHS Improvement and the Care Quality Commission both want us to show improvement in organisational culture.</td></tr>
<tr><td><u>Report History</u></td><td colspan="4">Discussion at Executive away day, Trust Workforce Executive and People & Organisational Development Committee (POD), noting POD were provided with a summary rather than the full detail as that was also going to Board.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="4">Delivery of the actions for the initial action plan through Staff Engagement Lead, Engagents, PEG and any additional owners listed within the action plan.</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>
</table>

Please review the following appendices:

- Staff Survey Full and Summary reports
- Updated action plan for staff engagement
- Example of another Trust's Board Pledge

Initial Action Plan for Staff Engagement (April 2018) **Elements written in green are changes since the last version**

Theme	Overview	Progress and actions already taken	Actions still to take, owners and timescales	RAG rating and status
1. Setting up of working groups to support the engagement work/initial updating of engagement work to key groups				
1.1 **Engagents**	This group of staff is a cross section of all staff that want to become involved (Agents of Change/Engagement Champions essentially). The purpose of the group is to have a recognised reference group for staff to have a voice for a various number of things e.g. change, policy, an ear to the ground, organisational values and behaviours etc.	• 16 members of staff have agreed to become Engagents as already identified by the Staff Engagement Lead (SJ) • Internal Comms sent a communication to all staff in Daily Dose to recruit Engagents • Engagents, as a concept, has been shared with the executive via a number of meetings • Staff Engagement Lead has warmed some staff to the concept during focus groups • SJ attended LiA feedback event to promote concept and recruit • Agreed with OD Practitioner that the previous group known as 'Culture Club' will be disbanded and those members offered to become Engagents noting their work is closely aligned to the engagement work and so avoids duplication of effort • Collated a full list of all interested Engagents • Arranged and completed first meeting with Engagents (36 people attended) • Positioned the purpose of Engagents and provided a brief role profile for them • Culture Club contacted and offered to transfer across to Engagents • Ran a promotional stand as part of Trust Winter Gala for Engagents recruitment	• Continue to grow this list and plug gaps (SJ Ongoing and continued actions fall within 4.3)	Completed

1.2 Passion for Engagement Group (PEG)	Due to the size and scale of the actions/outputs required to truly have the required impact a group existing of various staff members needs to exist. This group can oversee the engagement work and can act as beacons in terms of updating all staff relating to actions already taken and remaining actions. This group needs to consist of (but not be limited to): • Executive Member(s) • Non-Exec Director(s) • Staffside representative • Engagents • FTSUGs • Patient Experience Mgr. • LiA Lead • HR/OD representative(s) • TOTs (and equivalents)	• Agreement to set up the group with the executives • Request for exec involvement has provided 3 execs happy to get involved • Collated full list of staff to be involved in PEG including NED • Secured admin support for PEG • Arranged and carried out first meeting • Positioned the purpose of PEG • Arranged further meetings bi-monthly		Completed
1.3 Groups to update	There are a number of groups of people to inform of the initial engagement work and to keep updated as and when there is information to share. Those groups include (but might not be limited to): • POD • EDIC • Engagents • Board (Public & Private) • TWE (or other Exec meetings) • Staff (e.g. 'In the Loop') *It is important to stress that for engagement work to have momentum there needs to be activity and for every meeting added to this list this is all time from 3 days currently having a Staff Engagement Lead per week	• Exec Away attended by Eng. Lead • TWE updated • POD updated (with initial overview) • Action Plan went to POD/TWE/Board • AP shared with Engagents • Attended EDIC • 3 'In the Loops' written & shared with staff		Completed and now BAU

2. Values				
2.1 Values **(Refresh of Trust values)**	Feedback via focus groups that Trust's values (promises) are not consistently known or applied. They are confused with the strategic objectives. They are not consistently used for recruitment. Whilst they do form part of the appraisal process, this does not seem to be greatly understood in terms of the importance of them and how they link to behaviour.	• Agreement to refresh the values but not the strategic objectives from Trust exec. • Ran survey asking all staff to provide 4 single word values of different meaning achieving c400 replies (1600 words) • Words chosen 6 times or more were clustered into 4 separate meaning values • Clustered words were then shortlisted by staff via Engagent feedback and through LIA/Engagement Leads floor walking and visiting Community • LiA even ran to choose final 4 values from 3 in each list – c85-90 people attended • Whilst 1 was established clearly 3 required further work so another day was spent with LIA Lead in Community, Town Wharf & hospital sites where final values established	• Work with Comms and Engagents relating to a launch campaign for new values (Comms/SJ – End of May 18) • Launch new values at Leadership Event (SJ - Provisionally May 22nd 18) • Leaders to help shape what behaviours might align to the values at the Leadership Event (SJ - Provisionally May 22nd 18) • Values to be included in Staff Handbook (HR/OD – End of Aug 18) • Embed refreshed values (TBC – by end of Dec 18)	On-going & within timescales
2.2 Values **(Values-based recruitment)**	It is imperative that Trust Values form part of the recruitment strategy.	• No actions yet taken as values need to be established	• Review overall programme and plan once values have been established (HR to own)	On-going & within timescales
2.3 Values **(Policies)**	In order to ensure that the new Values are reflected accurately and consistently, they need to be reflected within all policies and strategies.	• No actions yet taken as values need to be established	• Review overall programme and plan once values have been established (HR to own)	

2.4 Values **(Behavioural Framework)**	The feedback from staff included issues relating to the behaviour of colleagues that was unhelpful or unacceptable. This is covered in section 4. Currently behaviours are often not discussed explicitly and so good behaviour can go unrewarded and poor behaviour can remain unchallenged. This requires a structured approach.	• No actions yet taken as values need to be established • SJ has been given agreement from the executive that a framework is necessary	• Once the values have been established the Engagents to help SJ define the overall framework (SJ - End of Jun 18) • Seek overall staff input via Daily Dose before launching the framework (SJ/Comms End of July 18) • Framework to be included in all relevant leadership development (OD/L&D – End of Dec 18) • Framework to be discussed and shared with all new staff in induction (OD - End of July 18) • Framework to be included in Staff Handbook (HR/OD – End of Aug 18) • Include the behavioural framework in whatever launch event is created for the values so that all staff become familiar with it and its purpose (See 2.1)	

3. Recognition				
3.1 Recognition **(Ways to say 'thank you' and to recognise staff contribution)**	Staff appreciate things like awards and recognition. They talked about one of the most important things was being appreciated for their contributions day to day and receiving thanks for that in a number of ways. Many staff were unaware of what already exists in terms of the breadth of ways to recognise staff. There were some examples of staff talking about others taking credit for their work, which created disengagement. This will need to be included in what we do not expect to see within the behavioural framework as and when this has been created.	• There are various Trust initiatives to reward/recognise staff already in place either Trust-wide or divisionally (e.g. Bloomin' Marvelous award, Learning from Excellence award, thank you card scheme and Valuing our Colleagues recognition scheme) • Annual staff awards process takes place with follow-up promotion of winners, this year Engagents included in deciding the winners, offering a staff voice • LiA Wall of Thanks • Comms promoted existing Trust-wide recognition schemes • Daily Dose has featured numerous updates of recognition for staff and is ongoing • LiA arranged for 26/3/18 for staff to contribute on what future recognition should look like to meet staff requirement • CQC banners have been provided to recognise excellence and success • Yammer has been an ongoing source of recognizing colleagues and widely used in pockets but not as easy for ward staff • Engagement Lead has received some anecdotal feedback referring to hearing more recognition from seniors • All areas relating to staff feedback were shared 'In the Loop' including ensuring staff provide recognition for work to others if they did some of the work • A lot of evidence of Yammer being used to offer recognition for help from colleagues	• Winners of all schemes to be recorded and shared monthly for public recognition (Comms – Monthly starting End of Jan 18) • Continue to raise awareness of thanking staff for work e.g. presentations created, reports provided, going the extra mile, being a great team player, reliability etc. via 'In the Loop' (SJ – On-going) • Review the approach to the 2018 annual colleague awards in light of feedback from staff (OD Team - End of June 18) • Introduce a monthly recognition award scheme, which will align perfectly with the refresh of the values as a potential way to recognise staff – (SJ and LiA Lead to review then can agree who owns this – By End of Sept 18)	On-going & within timescales

3.2 Recognition **(Moments of Truth/feedback)**	Providing feedback to staff about good performance, positive behaviours, making a difference and generally assisting the organisation is highly important to staff and especially for engagement and to create a positive environment. Conversely when things are less positive, this is equally important to offer instant feedback ('Moments of Truth').	• Talked about 'Moment of Truth' (MOT) as a concept at POD • Various 'Manager Feedback Sessions' have been offered and well subscribed covering the approach to offering feedback both positively and developmentally using a specific feedback approach	• Launch MOT to leaders at Leadership Event (SJ – End of Jun 18) • Agree with Comms regarding how best to launch MOT to staff but might involve the following: Promotional comms (posters, update in existing comms, explanation (SJ & Int. Comms – End of June 18)	On-going & within timescales
3.3 Recognition **(Away Days)**	Staff said they felt that 'away days' were important and that these helped create a feeling of motivation, recognition and value. It was considered it was important to spend time away from the workplace with the wider team to encourage team building and an open environment.	• Actions are for Managers but feedback as whether away days take place or an equivalent can be provided by Engagents	• Senior management to actively encourage and ensure that their areas have away days or similar time together as a team and that the resource impact of this is properly planned for. (Senior Management across all areas – by Apr 18 and ongoing) – End • Seek feedback from Engagents relating to whether these have taken place. (SJ – End of Sept 18) • OD specialism to be promoted and offered relating to supporting areas running events/away days e.g. Resilience/Ice breakers (OD Specialists – End of July 18) • Spreadsheet to be created within OD for requests for assistance and who will support the request within OD (OD Specialist – End of July 18)	On-going & within timescales

4. Change Management / Improvements at Work				
4.1 Change Management / Improvements at Work **(Opportunities to collaborate and be involved)**	Some staff talked about improvements with regards to opportunity for change through LiA but there was still a lot of feedback that change is not too often collaborative. LiA is a gateway of endless opportunity for change and improvements, although many staff still do not appreciate it is available to them for day to day change from niggling issues to wider challenges. The 'Walsall Way' is regularly referred to, which is a description of how things are done from quite a negative perspective. In other words, this is the way that we do it and that's the way it will stay, stifling creativity and new ways of working, especially from newer staff. Staff talk about a feeling that the Trust is reactive and does not always think things through, in terms of overall impact and who decisions might affect.	• LiA has shown a number of successes in its first 12 months • Exec presented to all staff the financial situation and importance of not only reducing Trust spend but generating income through innovation/ideas/concepts • Daily Dose provided link to staff to send their ideas for helping the Trust to achieve financial targets • LiA has been promoted for various subjects for staff IPDR, Admin & Clerical, Recognition • LiA Lead and Engagement Lead have worked together relating to various operational areas that have approached e.g. Therapies, E&F, EDIC • LiA promotion is ongoing and to be part of wider QI Comms Plan which is being developed by Tina Faulkner • Requested consideration for award from Business Development Team – awaiting their recommendation • Comms have promoted to staff that there is an in-box for 'bright ideas' • Quality Improvement Faculty has been established and the recognition for staff innovation has been mentioned by Staff Engagement Lead as something to consider • In terms of ensuring staff have been considered in impactful change this was raised with Trust Secretary and agreed with new CEO (RB) that the process as to how reassurance would be captured can wait for the arrival of the replacement • Chair has offered opportunity to be shadowed and CEO factored in visibility regularly into 100 day plan)	• LiA successes and outcomes as a result of change to continue to be well shared and Engagents to help as messengers (LiA Lead/Engagents – On-going) • All future change that is presented through Executive/Senior/Board committees **must** be considered as to what process was adopted to seek staff opinion/feedback before agreeing and that impact analysis has been established (Executive – with Trust Secretary replacement to review standard paperwork to ensure this action is covered – End of Sept 18) • Continue to promote 'staff ideas process' in future communications (Comms – On-going) • Consider a reward for best idea of the month and promote via usual comms channels (Comms/Business Development – End of Jun 18) • Certificate or thank you for any ideas adopted by the team/organisation (Exec/Comms – End of Jun 18) • Introduce a new award as part of the staff awards, encouraging innovation and new ideas and promote well ahead of the awards themselves (Chief Executive/OD Team – End of Jun 18)	On-going & within timescales

4.2 Change Management / Improvements at Work **(Acute V. Community)**	It is apparent that in many Community areas people felt that there was still a divide between Acute and Community (this was not stated the other way around). This may have improved but needs to be actively addressed to discourage a 'them and us' scenario in the future. Many examples of this were provided ranging from where events take place, not forming part of the published structure etc.) This issue they feel is separate from the organisation and so change and improvements can seem remote and not always either specific to them or they had no opportunity to have a say.	• Encouraged inclusion of Community staff for the Staff Awards in an email to senior managers across the Trust • Raised the concern and strength of feeling at various forums attended by SJ, including the executives • Focus groups were carried out both inside Manor and out at Community venues to ensure relevant feedback was captured • Board/Exec provided details of issues for Community staff as disclosed in the focus groups • Board encouraged to ensure that Community are readily included in 'Board walks' and to listen to whether staff have ongoing examples of exclusion • Numerous Engagents have come from Community • Community staff agreed 3 Engagent meetings occurring at Palliative Care Centre would be sufficient • CQC banners congratulating Community efforts have been placed around Community sites and main hospital • LiA and Engagement Leads have visited many Community sites and others not situated at the Manor, with a good response	• Notwithstanding that there needs to be consideration for attendees, Chairs of meetings to consider how best to incorporate staff both from Acute and the Community(All Chairs of meetings – with immediate effect) • Exec/Board to consider carefully all events and/or communications to ensure that it incorporates Community colleagues (Immediate Effect & Ongoing) • Engagents to continue to provide an 'ear to the ground' relating to staff temperature check in the Community (Immediate Effect & Ongoing) • Seek further feedback and progress in future focus groups to be run in the summer (SJ – End of Sept 18)	On-going & within timescales

4.3 Change Management / Improvements at Work **(Engagents)** **See 1.1**	**See 1.1** Based on the success of the concept of a group of staff coming together to talk about all things engagement, from the Staff Engagement Lead's (SJ) last contract it is important to introduce Engagents. Staff agreed with and liked the idea of Engagents from those who were asked about it in the staff engagement focus groups. This group is a reference group to provide opinion on how the whole engagement culture might best land with staff, but also to seek and promote the great work as it is undertaken. They can provide feedback on all things from policy changes to award winners, to what is actually being spoken of at grass roots levels	• **See 1.1** – once these are established the on-going actions for Engagents will move from 1.1 into this section • Arrange dates for all Engagement meetings for 2018 • Engagents have already been included in asking for an opinion for staff award winners (previously an executive decision only), flexible working policy, Consultation on HEE Workforce, Annual Leave policy, Recruitment policy. • HR are aware that Engagents exist and can be referenced for future change • An Outlook distribution list has been created with all Engagents and promoted to Exec and Snr Mgmt. should a reference group be required • As of March 18 there are 55 Engagents • Engagents have already been hugely influential to the redefining of trust values • Spoken with Comms regarding the intranet page for Engagents and a photo and bio to accompany it	• **See 1.1** for initial actions/owners • Promote Engagent activities as they are undertaken to all staff (SJ/Comms – End of May 18 and on-going) • Introduce 'on the ground 'to Engagent monthly agenda (seeking feedback on what staff are saying but necessarily to management (SJ – From May meeting onwards) • Start to plug gaps for Engagents once names have been received initially (SJ – End of Jun 18 and on-going) • Engagents' role to be discussed and shared with all new staff in induction (OD - End of Jun 18) • Introduce a 'Meet your Engagents' page on the intranet (Comms – End of June 18) • Different Exec/Board member to attend Engagent meeting quarterly – (SJ to invite/arrange who from Jun 18 onwards allowing Engagents a settling in period)	

5. Bullying & Harassment (B&H) / Behaviour				
5.1 B&H / Behaviour **(Behavioural competencies and feedback to staff already identified)**	From the feedback established through the engagement focus groups and anecdotally there is work needed within the Trust to manage poor behaviour. This is supported via existing routes for staff opinion (staff survey, pulse checks and staff friends and family test), There is an overwhelming need to start holding those not behaving appropriately to account and consequences where this is a continued issue. Once the behavioural framework has been agreed all staff to be held to account for their positive performance or a plan for improvement implemented which must explicitly cover the consequences for on-going behavioural concerns.	• The behavioural framework has been covered as part of 2.4 to address behaviour in terms of recognition and those needing to improve • Staff Engagement Lead has met with FTSUGs relating to positioning the focus group and importance to correlate feedback through existing channels (Staffside, FTSUGs, Staff Engagement Lead, LiA pulse checks and HR) • Suggested approach to managing staff that have been named on a number of occasions has been provided to the interim HR/OD Director • Agreed the finalised approach in feeding back to all staff that were named to Staff Engagement Lead • Fed back to those above using an agreed feedback process placing onus on individual to then liaise with Line Manager • All actions within Section 5 have been shared with 'Collective Call to Action' (CCtA) committee that was been established in Aug 17 • Focus group specifically for BAME staff was undertaken and notes shared at EDIC committee in January. EDIC owning now with Staff Eng. Lead in support • Meeting undertaken with various colleagues to start improvement journey for BAME population • LiA planned for BAME colleagues	• See 2.4 for the Behavioural Framework that covers this ongoing • Continue to share all actions within Section 5 with the 'Collective Call to Action' (CCtA) committee (HR&OD Director - On-going)	Completed See 2.4 On-going

5.2 B&H / Behaviour **(Anti-bullying communications campaign)**	Campaign to remind people of the importance of acting appropriately at all times and what support exists where issues arise.	• Updated Comms regarding the Action Plan and assigned actions but still to decide best approach • Asked Comms to consider best approach but also requested a template from a neighbouring Trust that was used successfully for a poster relating to bullying • Comms have paused further promotion pending the replacement of a new FTSU Guardian as one left the Trust • Board pledge to be reviewed now have new members including CEO	• In partnership with Comms develop an anti-bullying poster campaign (Comms/SJ – End of Feb 18 to launch) • Consider with Comms other regular communications signposting staff to where they can see help or advice (Comms/SJ – End of Feb 18 and on-going) • Comms to consider other communications highlighting the importance of acceptable behaviour and Trust zero-policy towards it (Comms – End of Feb 18) • Board to create a pledge signed by them, Executives and Divisional Directors it relating to zero-tolerance (Board and Divisional TOT – End of Jul 18)	On-going & behind timescales in some elements
5.3 B&H / Behaviour **(Introduce training about B&H / behaviours)**	It was considered by staff that the education of managers and staff of what B&H is and is not is important. This does not currently exist. This provides an opportunity to feed in the behavioural framework once this has been established and how this should be utilised in terms of how staff behave.	• SJ established that there is not current training around bullying and behaviours within the Trust	• L&D to create a bespoke training course that incorporates what a manager would need to do/know and also a version for all staff (L&D – End of Oct 18) • Courses to include case study discussions (L&D – End of Oct 18) • Promote B&H/behaviour courses through usual communication channels (L&D/Comms – End of Oct 18 and on-going)	On-going & within timescales
5.4 B&H / Behaviour **(Workplace Support Advisers)**	Workplace Support Advisers (WSAs) were not widely discussed within the focus groups but are an existing supportive channel for staff that might want advice or to be signposted to where help my exist. Having staff in the Trust that are impartial and neither represent staff nor management was considered might encourage people to come forward with issues.	• WSAs are already in position • WSAs were recently promoted through Daily Dose • There have been no approaches currently through WSAs so no themes to review • At least 1 WSA is an Engagent	• Further promote and reinvigorate WSAs e.g. Induction, Daily Dose and Engagents (OD Specialist – End of Jul 18) • Ensure any future themes coming in to WSAs to the considered as part of any cultural themes (OD Specialist – End of Dec 18)	On-going & within timescales

5.5 B&H / Behaviour **(Additional route for staff to raise concerns confidentially)**	It is important that people have options beyond the traditional avenues of HR, Staffside and managers. The Trust has introduced, as all NHS Trusts were required to, Freedom to Speak Up Guardians. There are also WSAs in addition (see 5.3), which has offered further opportunity to establish behavioural issues within the organisation. There also needs to be consideration for staff that require that they remain completely anonymous and how they might raise concerns.	• SJ has asked how staff wishing to remain anonymous might do this and that is currently through the Whistleblowing Policy, which would require an individual to advertise themselves • Meeting between IT, Comms and Staff Eng. Lead to position options • Comms/IT working together to try and create an anonymous option using current incident reporting platform • Initial work to create the platform has commenced but at its infancy	• Seek an update from IT/Comms to ensure a platform is available and is compatible with current systems (IT – End of May 18) • Launch new service through usual comms channels assuming there is an option (Comms – End of July 18)	On-going & within timescales

5.6 B&H / Behaviour **(HR impact and tackling a face fits/ favouritism culture / inter-personal relationship)**	Staff talked about their concerns that the organisation needs to improve on addressing poor behaviour. One of the stumbling blocks was some staffs attitude towards HR. They see this as part of management as opposed to a place for all staff. Some staff spoke of raising issues but not knowing they were addressed but others said they would not go to HR, favouring Staffside if they had a concern. Some staff asked what happened with exit interview data feeling the organisation might not be learning. Furthermore, staff speaking of a face fits culture and favouritism existing in elements like who is selected for roles/promotions as well issues like nepotism and existing inter-personal relationships have some negative impact to some staff.	• Initial feedback has been provided to Interim Director of HR & OD • Trust has a policy relating to relationships at work • Exit interview data has been captured but is not currently used as effectively as it might be • Meeting took place within HR/OD to review current data and what future requirements should look like • Further meeting has been arranged to look at the exit interview process • HR/OD Director position was interviewed for but as not filled impacted HR ability to progress all elements until structure is defined • Exit interviews are voluntary – paper or electronic options are sent whilst working notice and once left • Opportunity to meet with manager or HR or Work Place Support Advisor or Union or FTSU Guardian. To date any issues raised on completed questionnaires are raised with HR Op's team and reviewed / actioned as appropriate • All ,casework is managed and issues and conclusion / outcomes fed back as appropriate (but not sanctions) • Incident Reporting via Safeguarding involving staff is reported • Relationships at Work policy is due for renew – however it was never mandated that staff had to declare a relationship. Policy is to be reviewed and communicated	• Exit interview process to be reviewed and agreed and incorporated into Recruitment Policy and Managers Toolkit (HR/OD –End of Sept 18) • Once the exit interview process has been agreed HR needs to review data and report upon (HR – End of Sept 18) • Exit interview data held at local level to ensure is raised with relevant manager/ Head of / Div Dir. - to progress formal collation of information (HR to oversee – End of June 18) • HR to run LiA event to review how they are perceived by staff in conjunction with HR Operational & ESR Teams and then create a relevant plan (HR – End of Sept 18) • HR to develop an acknowledgement system for Incident Reporting to confirm that incidents raised have been reviewed (HR– End of June 18) • Ensure that the Trust policy regarding relationships at work is fit for purpose, communicated and adhered to (HR – End of May 18) • Ensure Action plans at Div Board level agreed with HRM's for Staff Survey results (Div Board & HRMs – End of June 18) • Relationships at Work policy to be reviewed, ratified and promoted (HR & HR Sub-group – End of May 18)	On-going & within timescales

6. APPRAISALS				
6.1 Appraisals **(Promotion of benefits)**	Appraisal had some mixed feedback, with some good practice but also a lot of staff talking about it feeling like a "tick-box", thus losing impact and reinforcing recognition of staff and emphasising the difference they make and agreeing relevant development. There were examples of staff that had regular appraisal and connected 121 discussions, in various formats. Unfortunately, there were also examples of untimely appraisal and irregular 121 conversations. Essentially appraisers need to understand:: • Purpose and value of appraisals • The 'why' as well as the 'how' • Review team/individual performance • Regularity and ratio appraiser to appraisee • Measures of success	• Shared the feedback from the focus groups with the Leadership Development Manager • Survey completed by Leadership Development Manager to seek feedback from staff to shape LiA event • LiA has been arranged addressing some of the issues contained within section 6 • LiA was carried out initially but only a small number attended • Paperwork from other Trusts has been obtained to consider simpler approach • Additional LiA arranged for March had to be postponed due to adverse weather and staff required for service • Postponed LiA took place on 16/3/18 with suggestions under review	• Review all staff suggestions following LiA in Mar 18 (LiA Lead/Leadership Dev Mgr – End of Dec 17) • Feed overall feedback from focus groups into the sponsor group for LiA work to capture actions (SJ/Leadership Dev Mgr - 4th Dec 17) • Update this action plan with key agreed actions once the LiA has been undertaken (SJ/Leadership Dev Mgr - End Dec 17 and on-going)	On-going although timescales affected by poor turnout of first LiA and then second LiA postponed due to weather
6.2 Appraisals **(Review of training)**	Some staff said that often appraisals were not carried out as expertly as they would like and felt there should be improved training for all appraisers	• LiA has taken place and the outcomes currently being reviewed (see 6.1)	• Review training content and ensure feeds in requirements following LiA (Leadership Dev Mgr – End of Oct 18)	On-going and within timescales

6.3 Appraisals **(360° feedback)**	Staff commented that they saw the benefit of feedback through a 360 process and that could encourage positive discussion and help open channels where there might be difficulties. It was agreed that feedback should also be provided to appraisers from appraisees regarding how the experience feels from their perspective.	• Trust Executive agreed to kicking off a 360 feedback process • Established Trust does not have an existing 360 feedback template • Feedback template was created and initial users offered opportunity to contribute • Guidelines and template was provided to all staff from Exec to TOT & equivalents	• Seek feedback from users as to the initial experience once the deadline of end of Mar for completion passes and they have had their 121s with relevant Line Managers (SJ – End of Jul 18) • Amend 360 template according to said feedback (SJ - End of Aug 18) • Formalise the process and then Trust to consider how far through the organisation 360 feedback should go (Executive Directors – End of Oct 18)	On-going and within timescales

2017 National NHS staff survey

Results from Walsall Healthcare NHS Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2017 national NHS staff survey conducted in Walsall Healthcare NHS Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3, 4, 6 and 7 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

In section 5 of this report, the data required for the Workforce Race Equality Standard (WRES) is presented.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

Responses to the individual survey questions can be found in Appendix 3 of this report, along with details of which survey questions were used to calculate the Key Findings.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

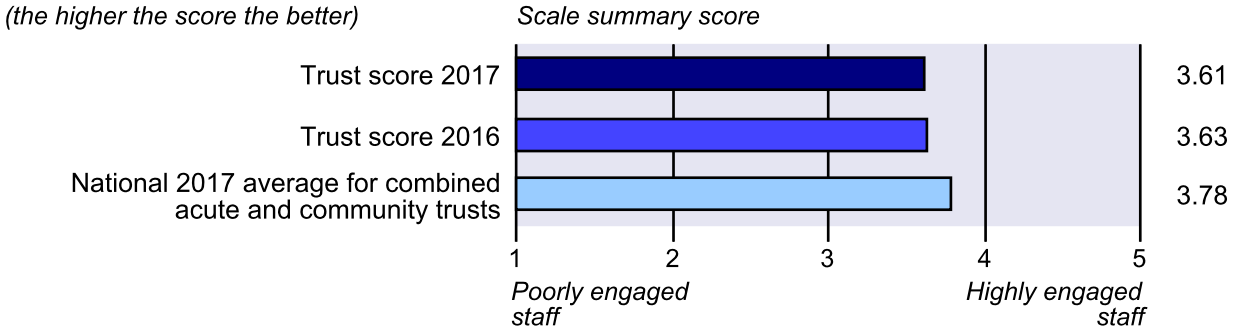
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	66%	75%	65%
Q21b	"My organisation acts on concerns raised by patients / service users"	65%	73%	65%
Q21c	"I would recommend my organisation as a place to work"	47%	59%	47%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	48%	69%	48%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.38	3.75	3.44

2. Overall indicator of staff engagement for Walsall Healthcare NHS Trust

The figure below shows how Walsall Healthcare NHS Trust compares with other combined acute and community trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.61 was below (worse than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how Walsall Healthcare NHS Trust compares with other combined acute and community trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Change since 2016 survey	Ranking, compared with all combined acute and community trusts
OVERALL STAFF ENGAGEMENT	• No change	! Below (worse than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	! Decrease (worse than 16)	! Below (worse than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	! Below (worse than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Below (worse than) average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

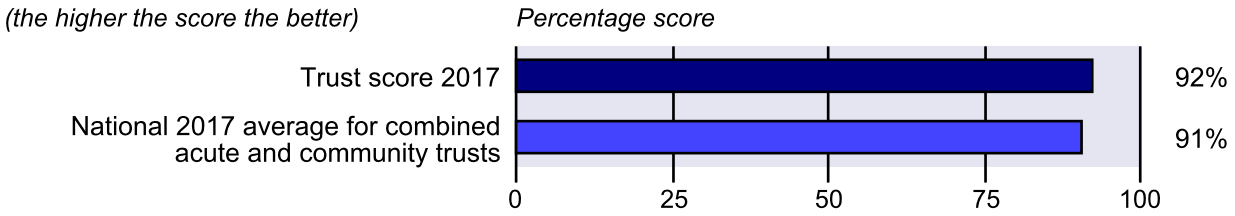
3. Summary of 2017 Key Findings for Walsall Healthcare NHS Trust

3.1 Top and Bottom Ranking Scores

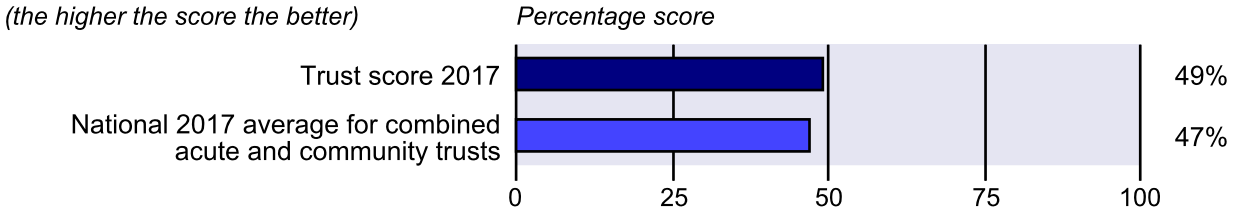
This page highlights the five Key Findings for which Walsall Healthcare NHS Trust compares most favourably with other combined acute and community trusts in England.

TOP FIVE RANKING SCORES

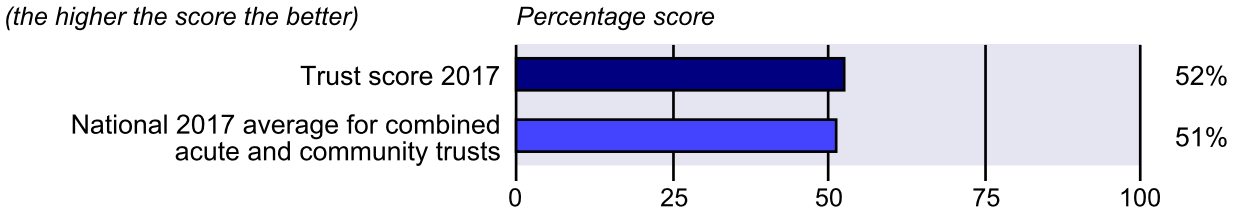
✓KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



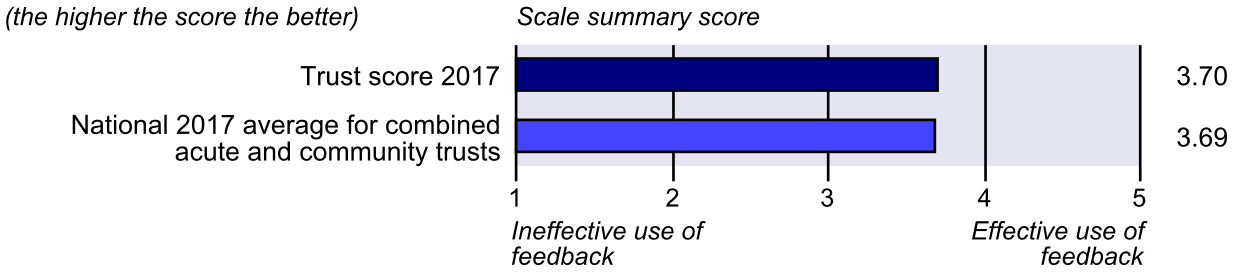
✓KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



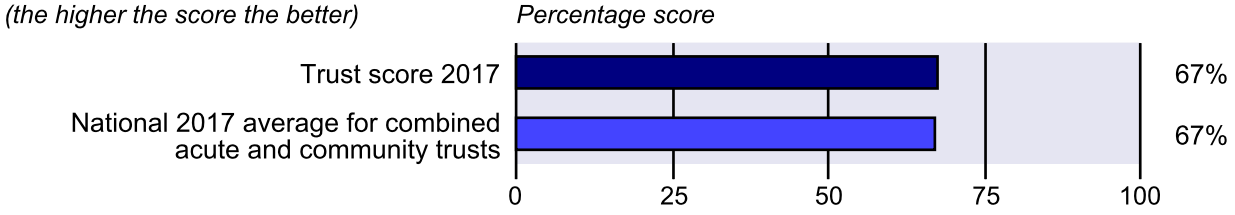
✓KF15. Percentage of staff satisfied with the opportunities for flexible working patterns



✓KF32. Effective use of patient / service user feedback



✓KF24. Percentage of staff / colleagues reporting most recent experience of violence



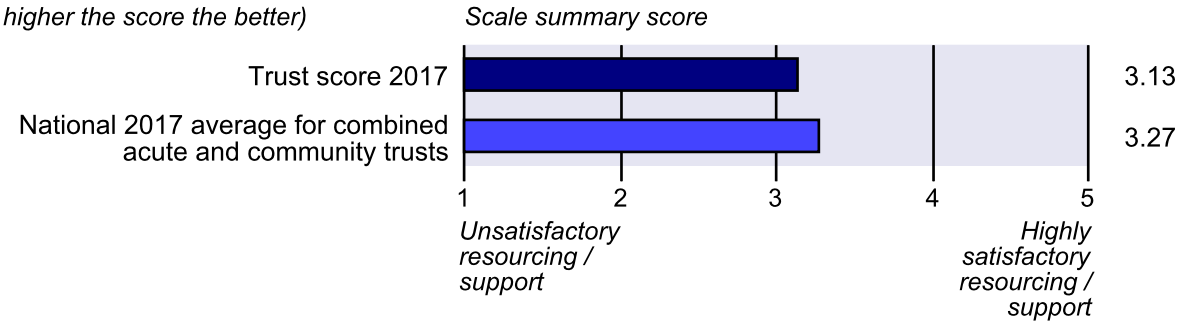
For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 43 (the bottom ranking score). Walsall Healthcare NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which Walsall Healthcare NHS Trust compares least favourably with other combined acute and community trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

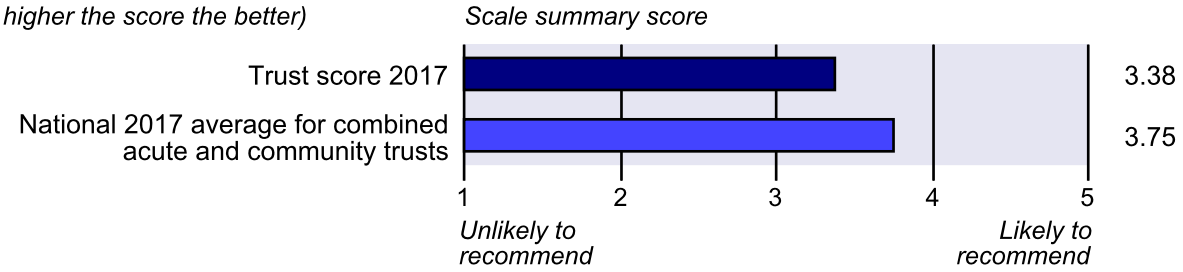
! KF14. Staff satisfaction with resourcing and support

(the higher the score the better)



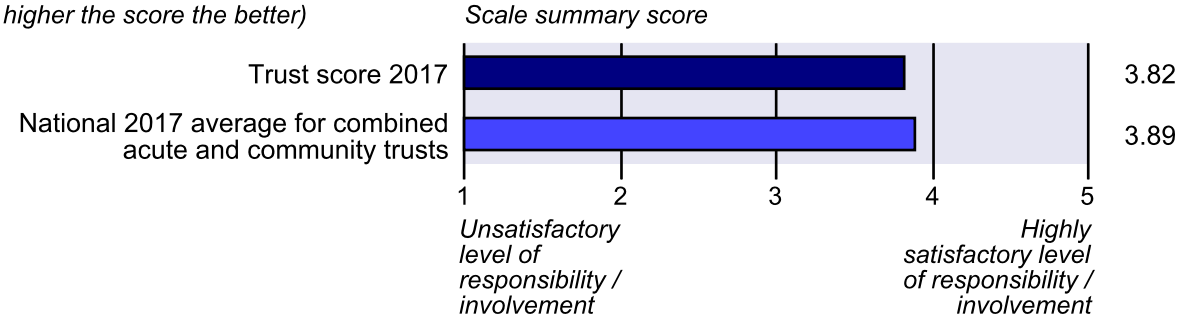
! KF1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



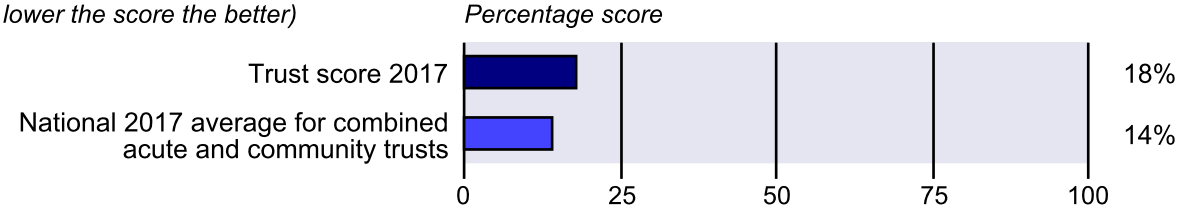
! KF8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



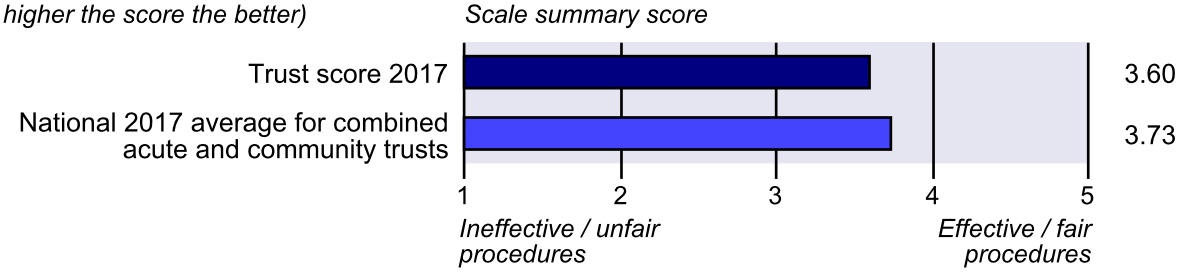
! KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



! KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



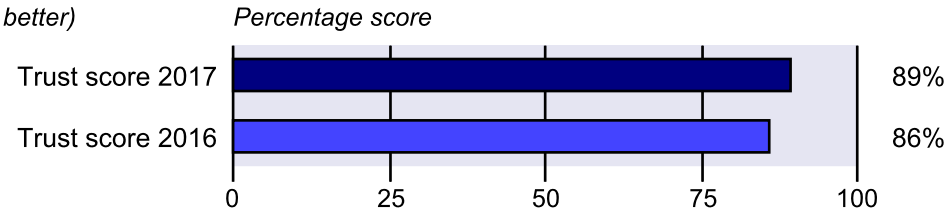
3.2 Largest Local Changes since the 2016 Survey

This page highlights the three Key Findings where staff experiences have improved at Walsall Healthcare NHS Trust since the 2016 survey. (This is a positive local result. However, please note that, as shown in section 3.3, when compared with other combined acute and community trusts in England, the score for Key finding KF3 is worse than average).

WHERE STAFF EXPERIENCE HAS IMPROVED

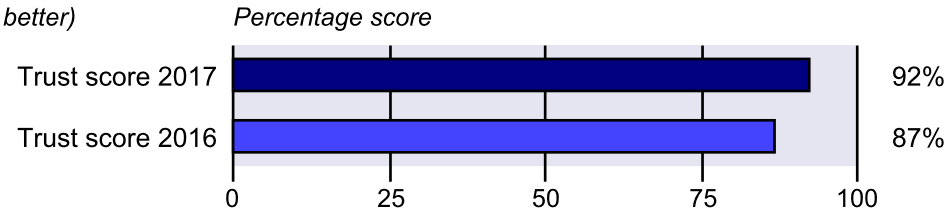
✓KF3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



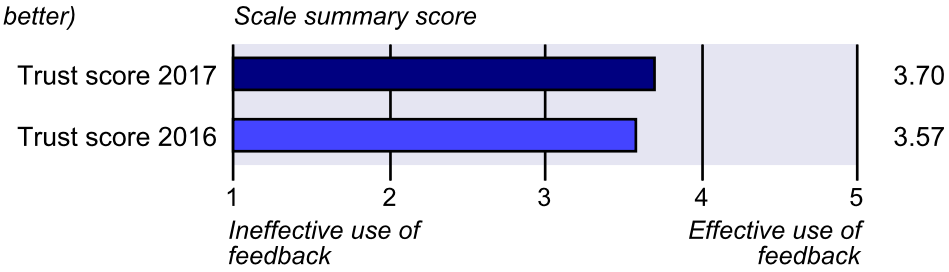
✓KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



✓KF32. Effective use of patient / service user feedback

(the higher the score the better)



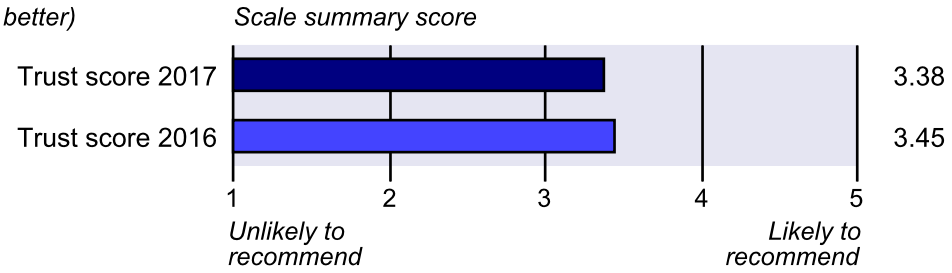
Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have improved the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the Key Finding that has deteriorated at Walsall Healthcare NHS Trust since the 2016 survey. It is suggested that this might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

! KF1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have deteriorated the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.3. Summary of all Key Findings for Walsall Healthcare NHS Trust

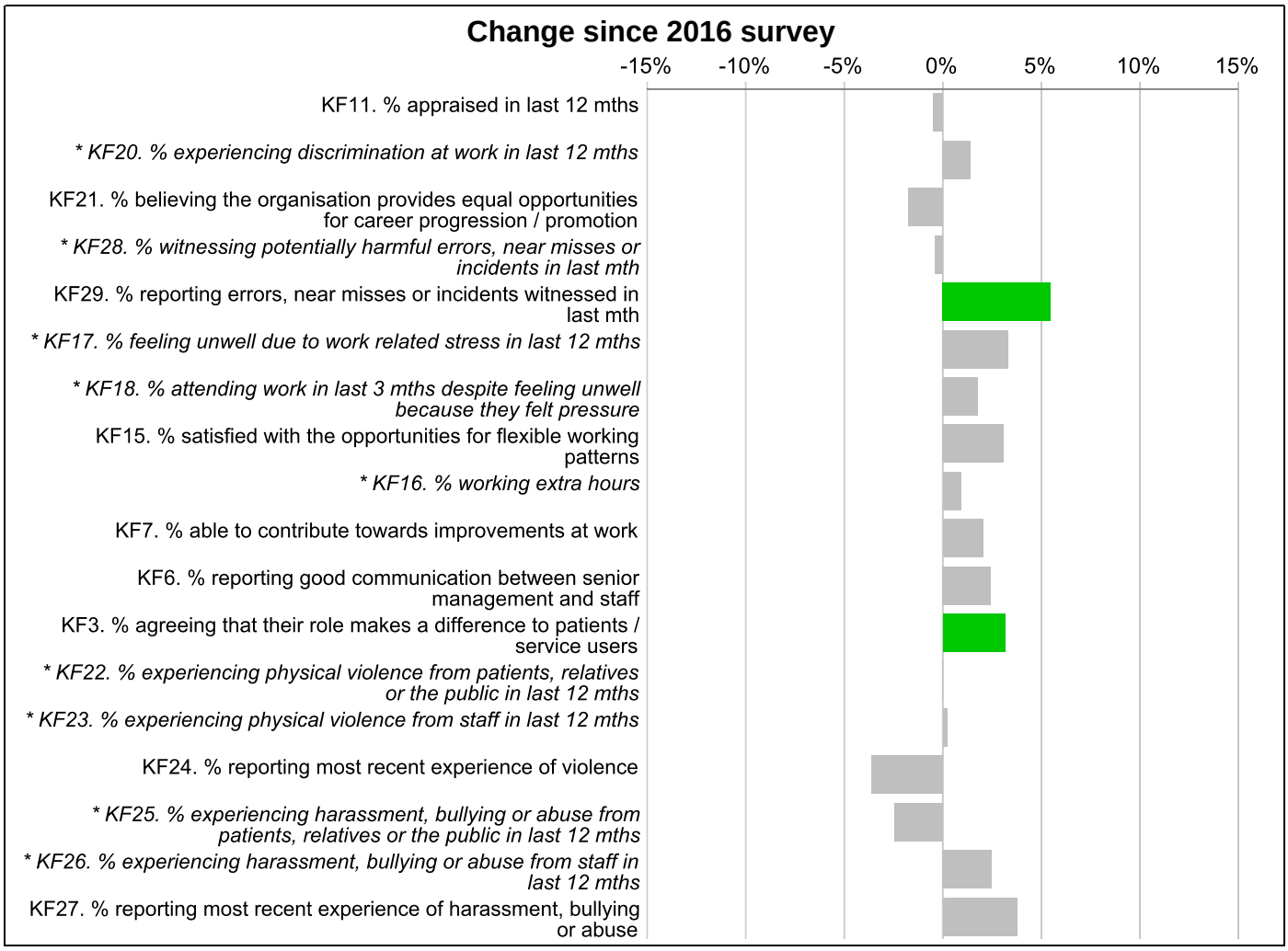
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Walsall Healthcare NHS Trust

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Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

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Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

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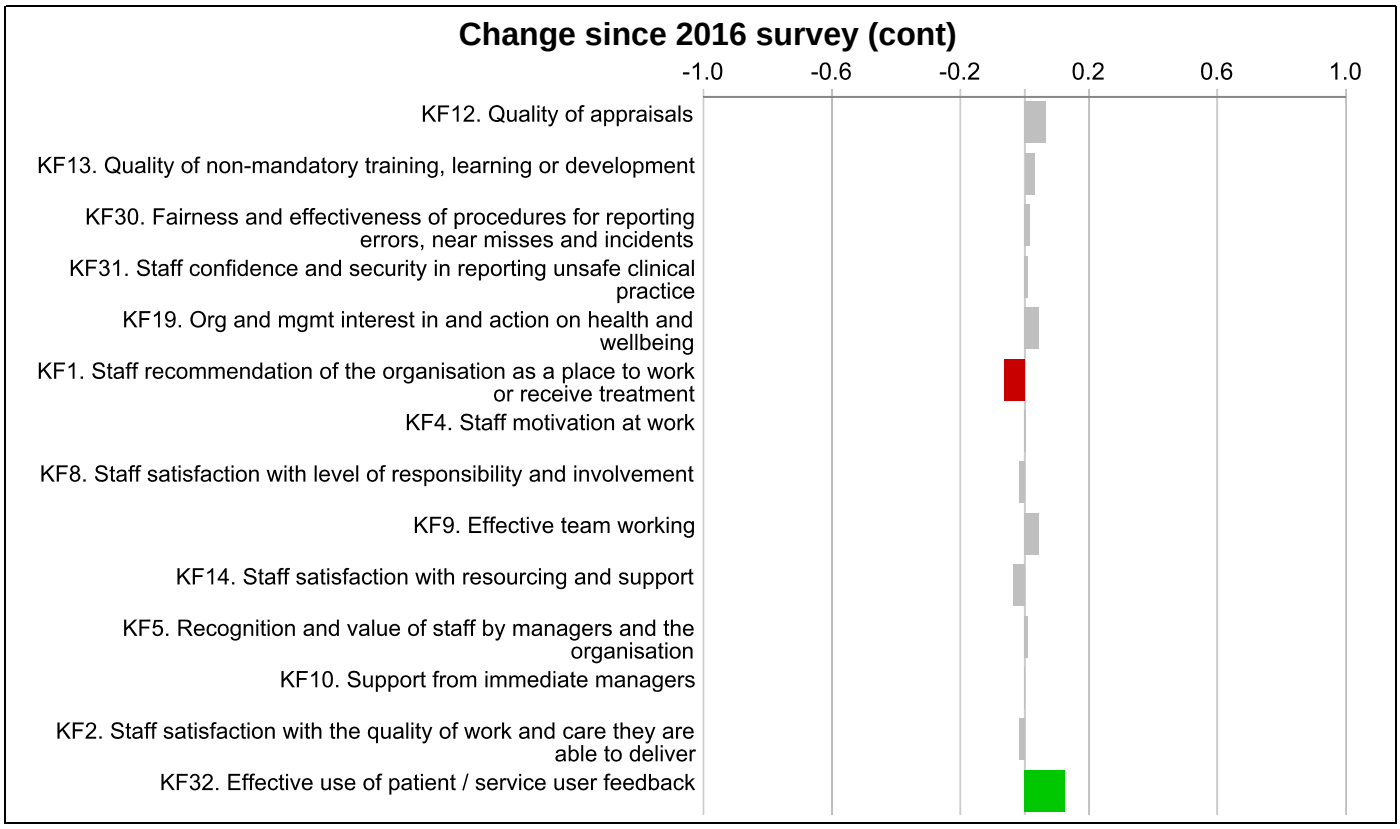


3.3. Summary of all Key Findings for Walsall Healthcare NHS Trust

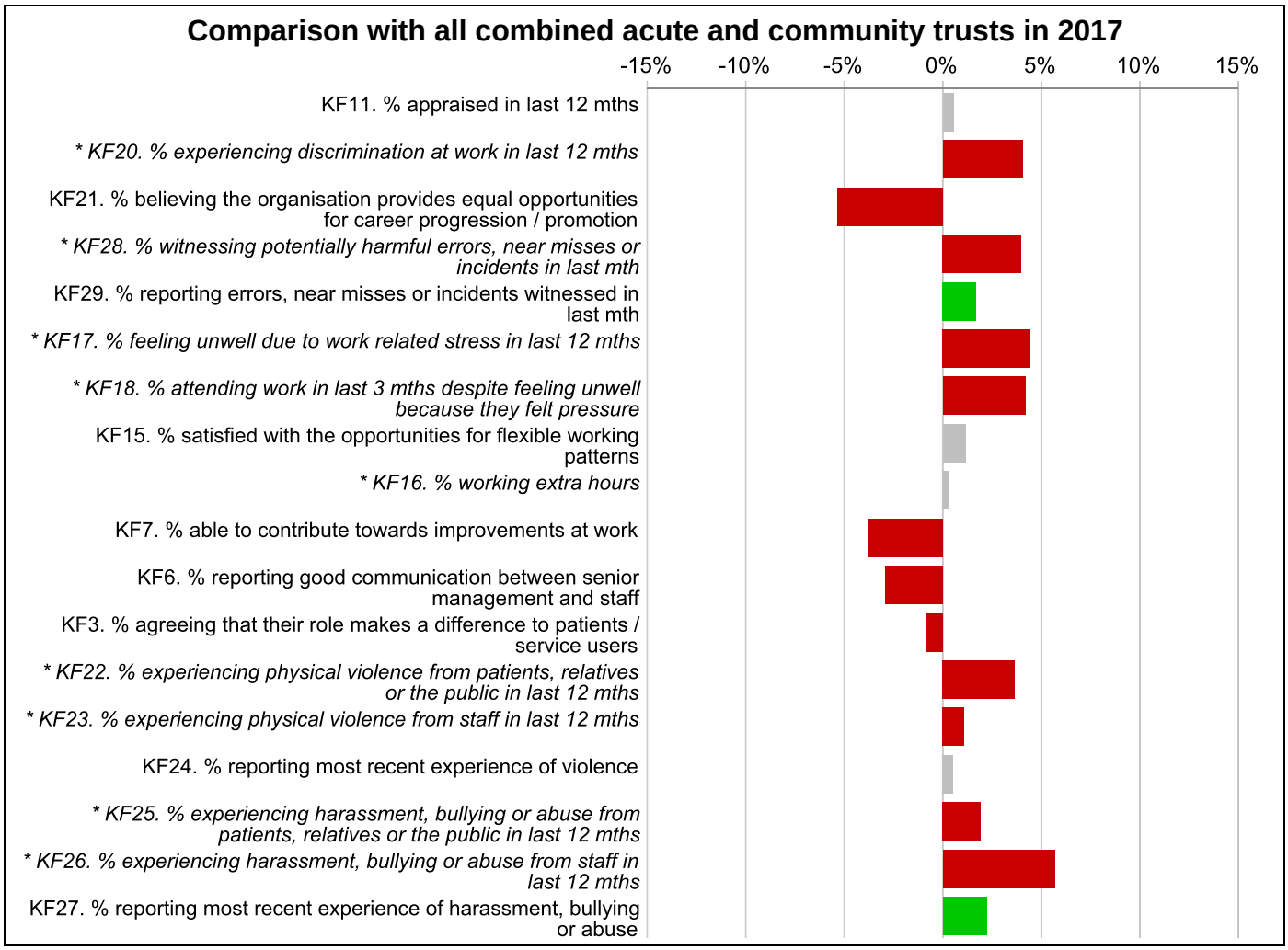
KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Walsall Healthcare NHS Trust

KEY

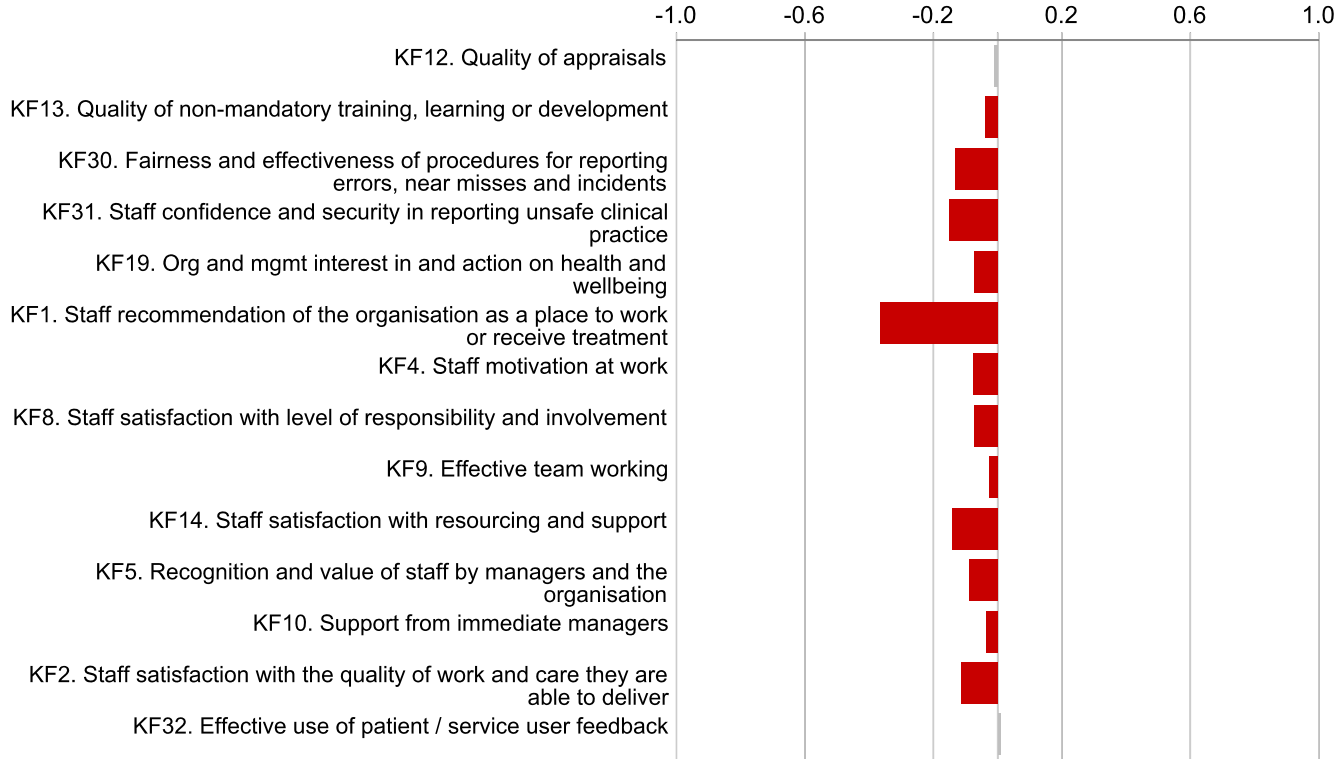
Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all combined acute and community trusts in 2017 (cont)



3.4. Summary of all Key Findings for Walsall Healthcare NHS Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2016.

! Red = Negative finding, e.g. worse than average, worse than 2016.

'Change since 2016 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2016 survey.

-- No comparison to the 2016 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2016 survey	Ranking, compared with all combined acute and community trusts in 2017
Appraisals & support for development		
KF11. % appraised in last 12 mths	• No change	• Average
KF12. Quality of appraisals	• No change	• Average
KF13. Quality of non-mandatory training, learning or development	• No change	! Below (worse than) average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	! Above (worse than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	! Below (worse than) average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	! Above (worse than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	✓ Increase (better than 16)	✓ Above (better than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	! Below (worse than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	! Below (worse than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	! Above (worse than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	! Above (worse than) average
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	! Below (worse than) average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	• Average
* *KF16. % working extra hours*	• No change	• Average

3.4. Summary of all Key Findings for Walsall Healthcare NHS Trust (cont)

	Change since 2016 survey	Ranking, compared with all combined acute and community trusts in 2017
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	! Decrease (worse than 16)	! Below (worse than) average
KF4. Staff motivation at work	• No change	! Below (worse than) average
KF7. % able to contribute towards improvements at work	• No change	! Below (worse than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	! Below (worse than) average
KF9. Effective team working	• No change	! Below (worse than) average
KF14. Staff satisfaction with resourcing and support	• No change	! Below (worse than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	! Below (worse than) average
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF10. Support from immediate managers	• No change	! Below (worse than) average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	! Below (worse than) average
KF3. % agreeing that their role makes a difference to patients / service users	✓ Increase (better than 16)	! Below (worse than) average
KF32. Effective use of patient / service user feedback	✓ Increase (better than 16)	• Average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	! Above (worse than) average
KF24. % reporting most recent experience of violence	• No change	• Average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Above (worse than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	✓ Above (better than) average

4. Key Findings for Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust had 1536 staff take part in this survey. This is a response rate of 36%[1] which is below average for combined acute and community trusts in England (43%), and compares with a response rate of 42% in this trust in the 2016 survey.

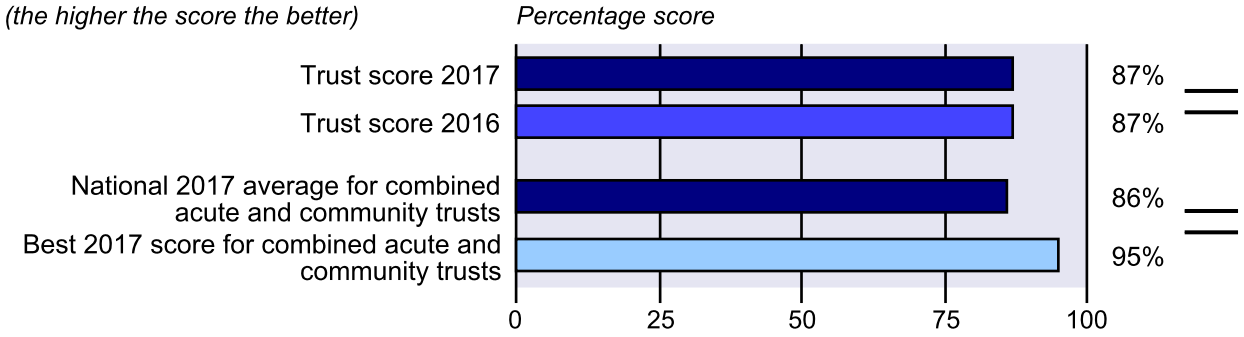
This section presents each of the 32 Key Findings, using data from the trust's 2017 survey, and compares these to other combined acute and community trusts in England and to the trust's performance in the 2016 survey. The findings are arranged under nine themes: appraisals and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience , and violence, harassment and bullying.

Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2016). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2016). An equals sign indicates that there has been no change.

Appraisals & support for development

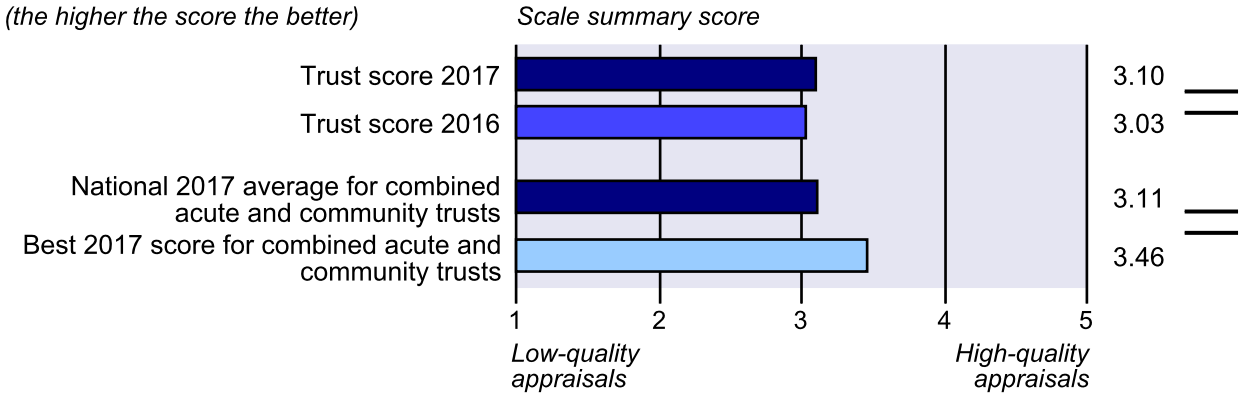
KEY FINDING 11. Percentage of staff appraised in last 12 months

(the higher the score the better)



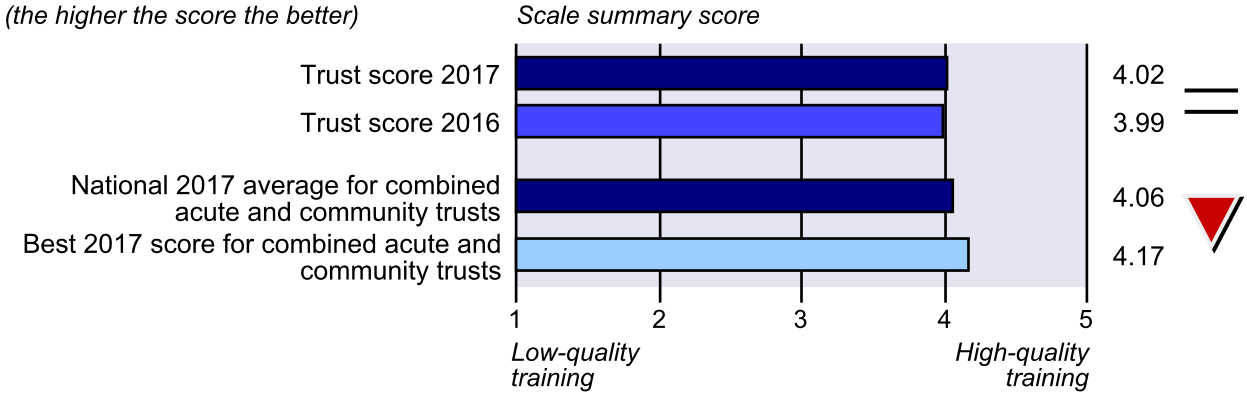
KEY FINDING 12. Quality of appraisals

(the higher the score the better)



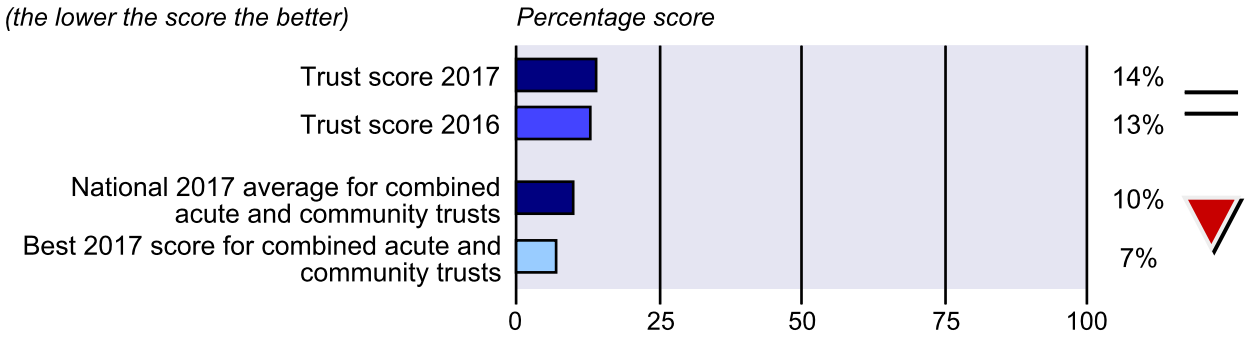
[1]Questionnaires were sent to all 4262 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

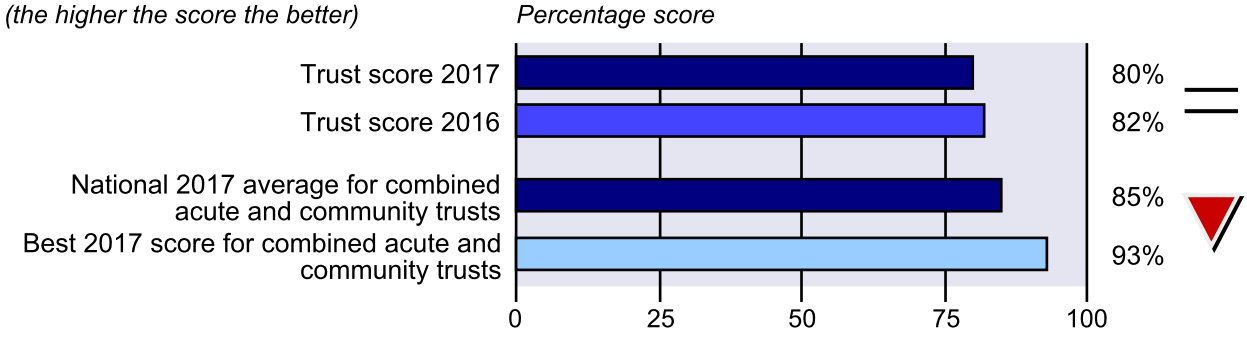


Equality & diversity

KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

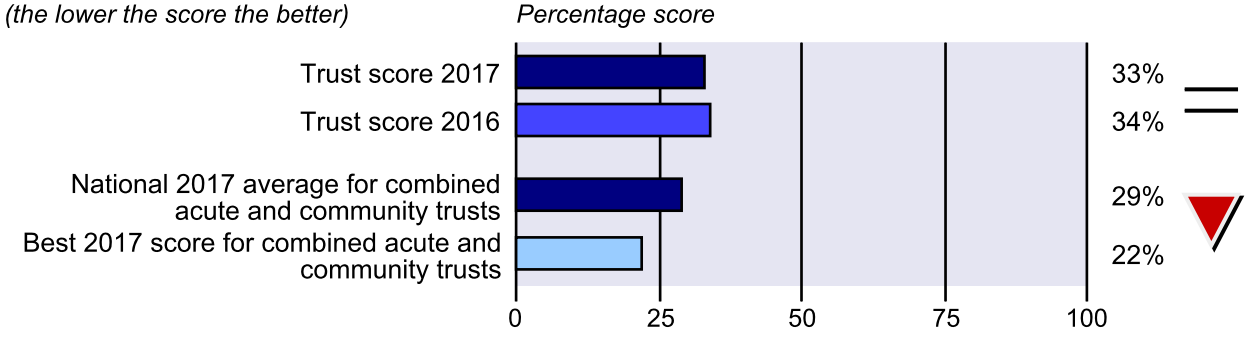


KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



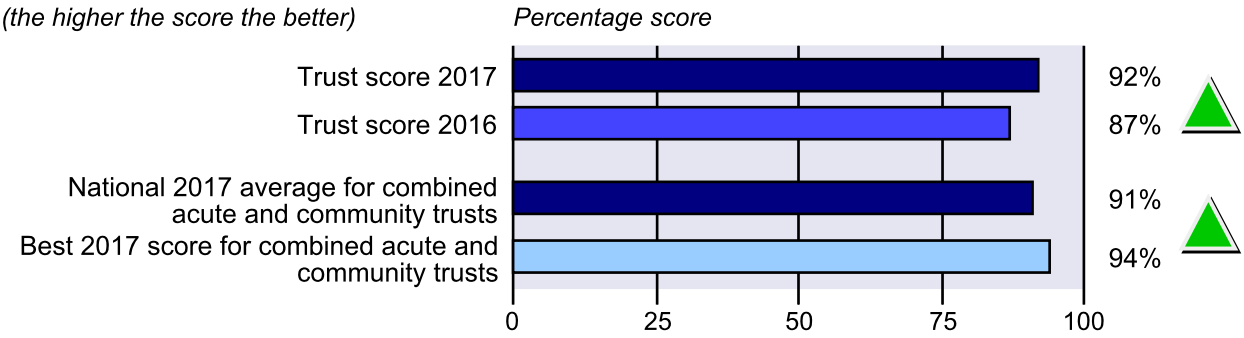
Errors & incidents

KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month



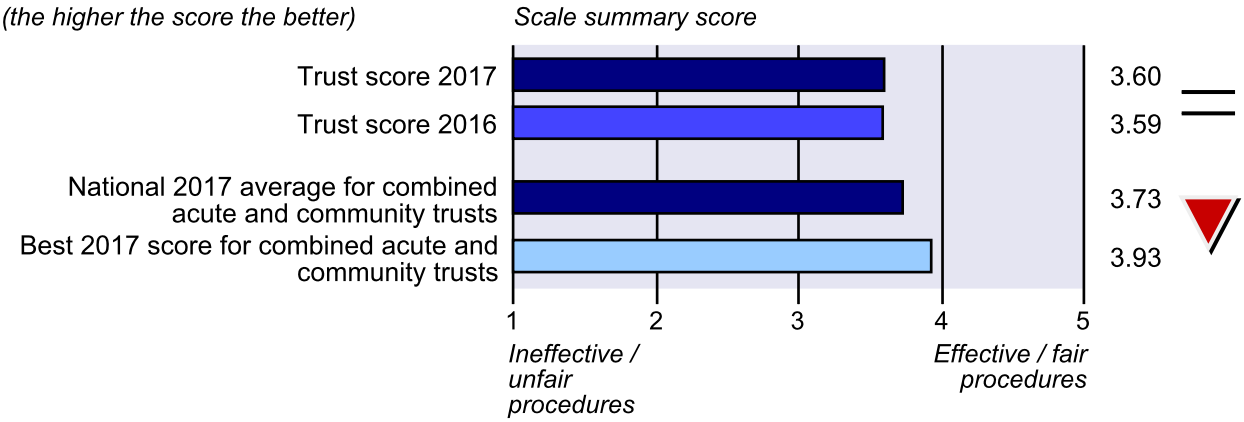
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



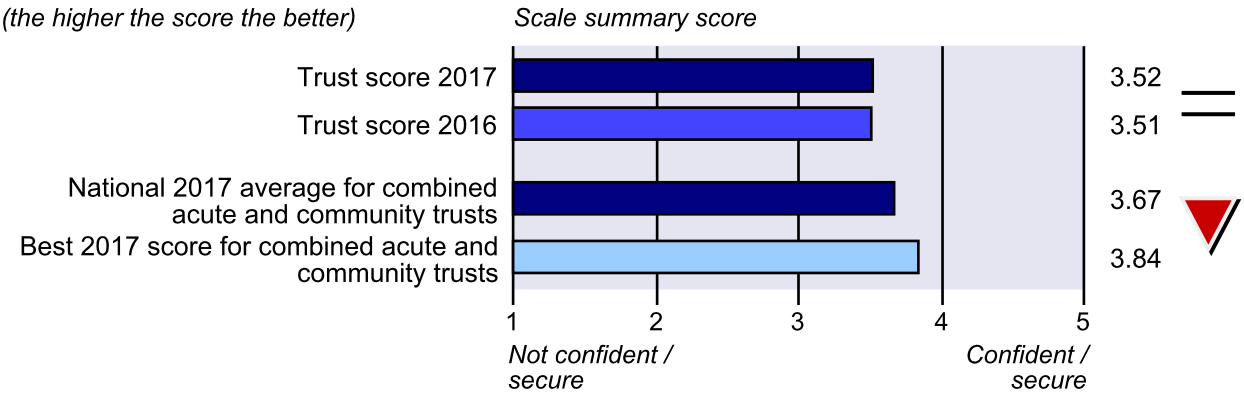
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

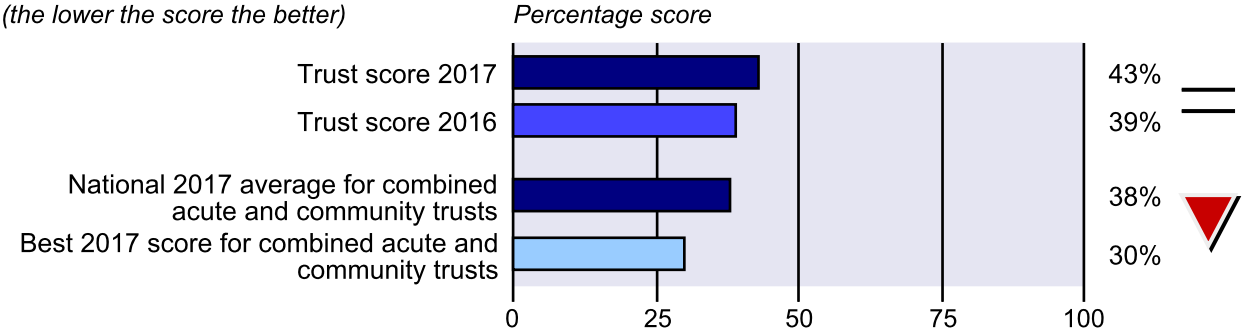
(the higher the score the better)



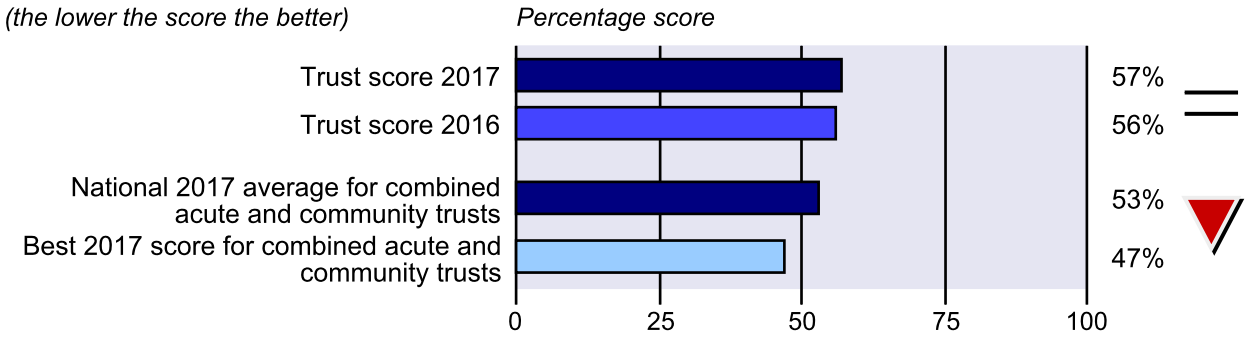
Health and wellbeing

KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

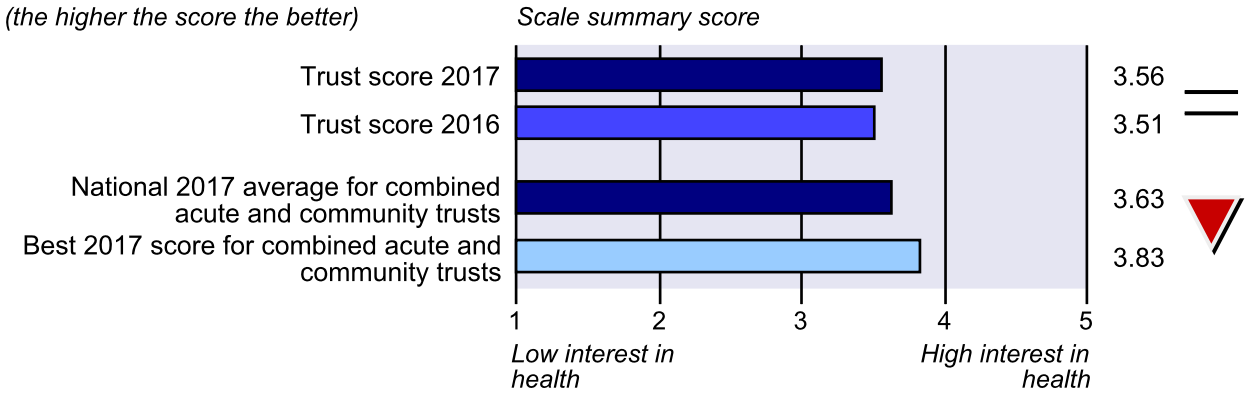
(the lower the score the better)



KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

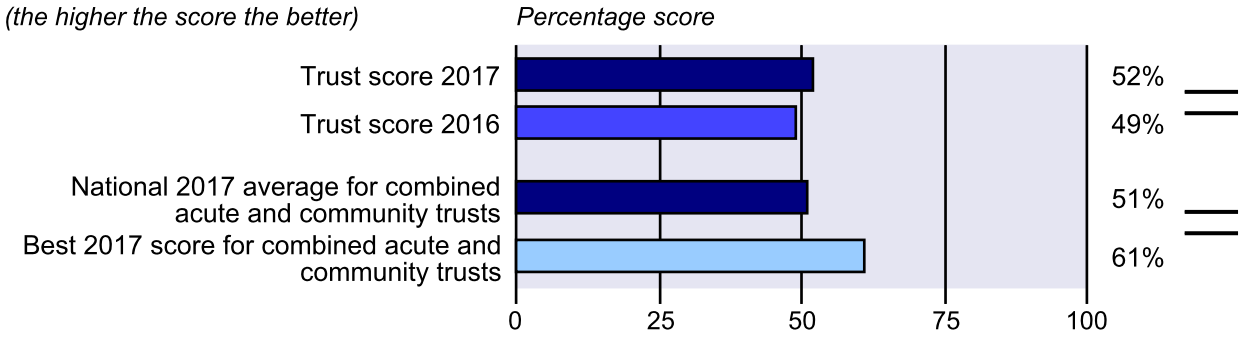


KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

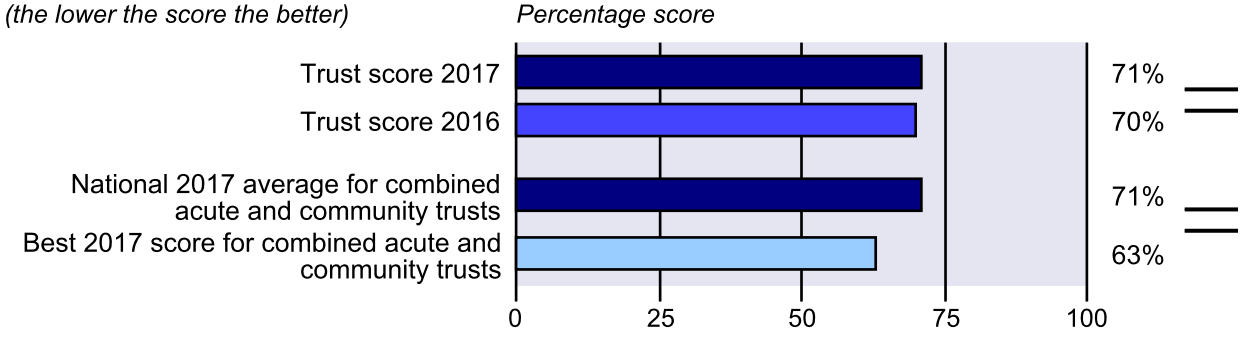


Working patterns

KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns



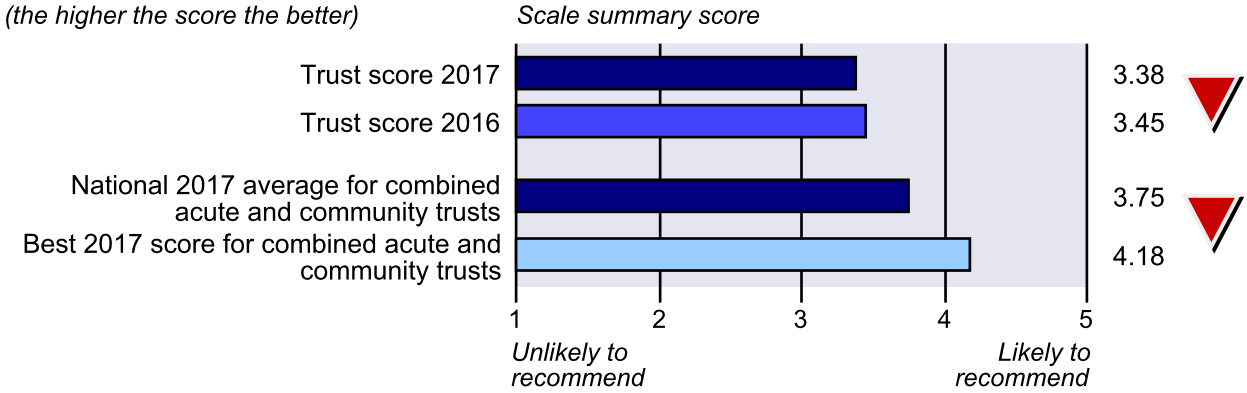
KEY FINDING 16. Percentage of staff working extra hours



Job satisfaction

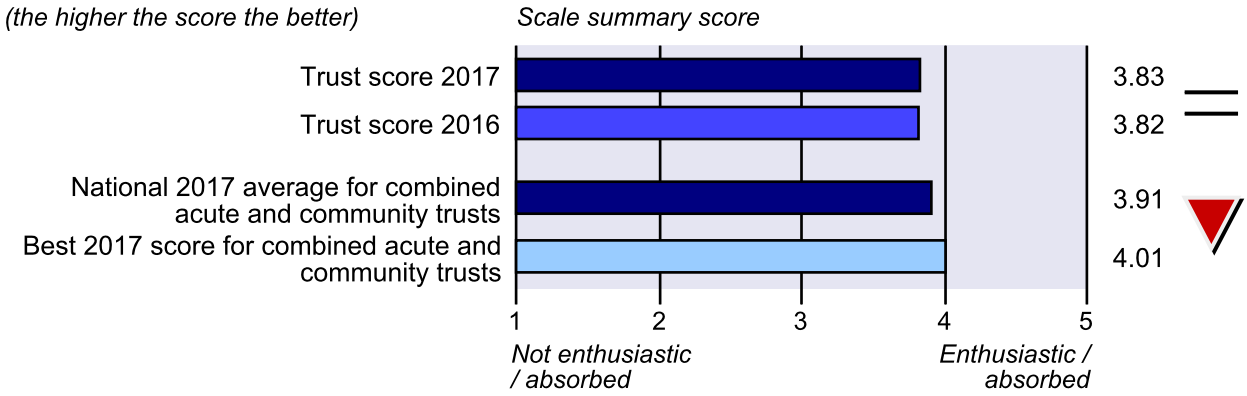
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



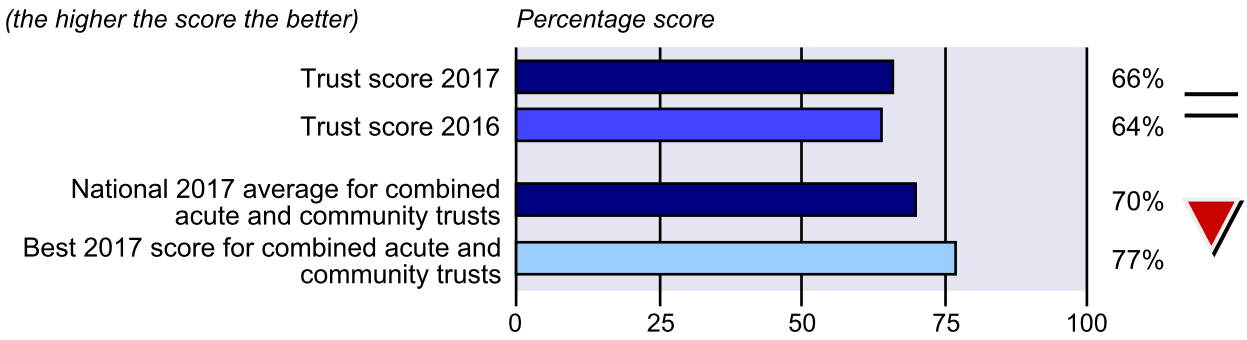
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



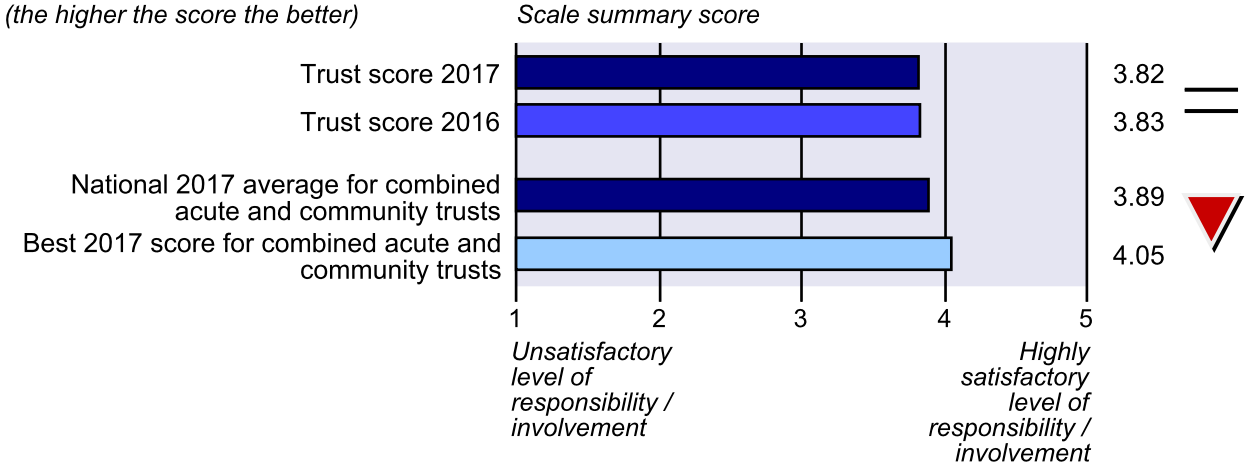
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)

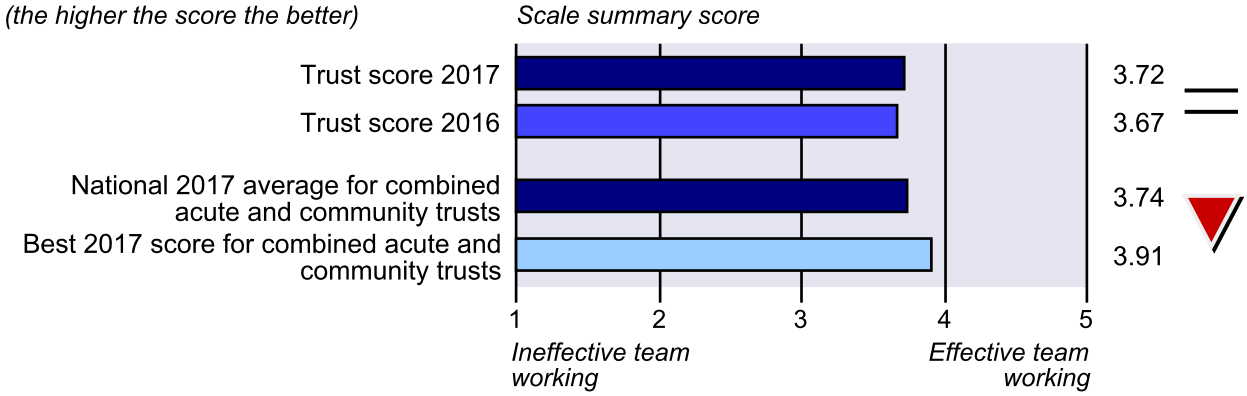


KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

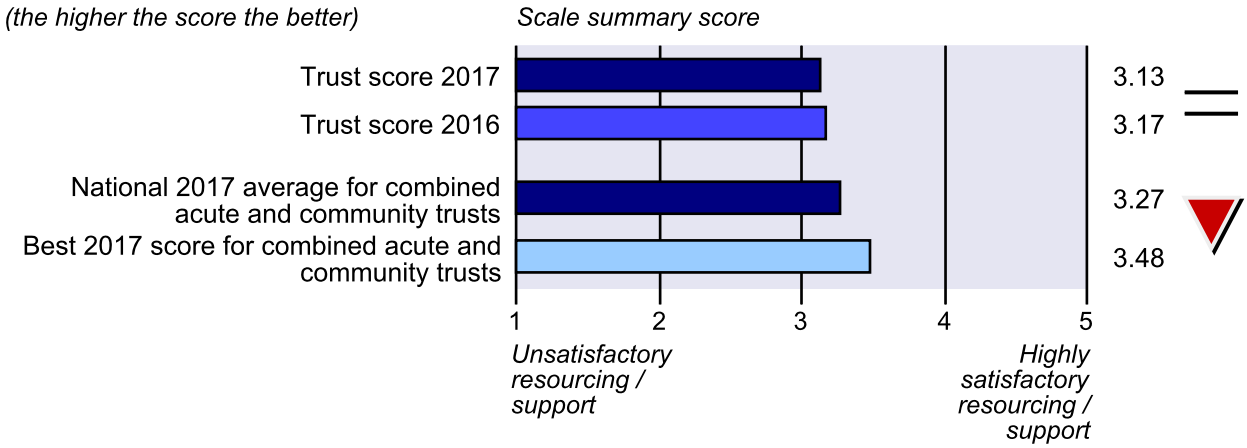
(the higher the score the better)



KEY FINDING 9. Effective team working

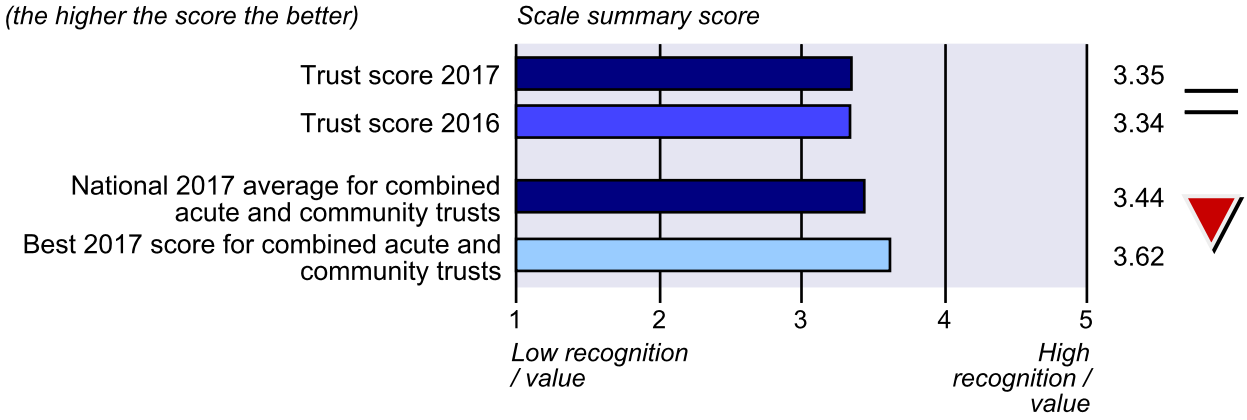


KEY FINDING 14. Staff satisfaction with resourcing and support

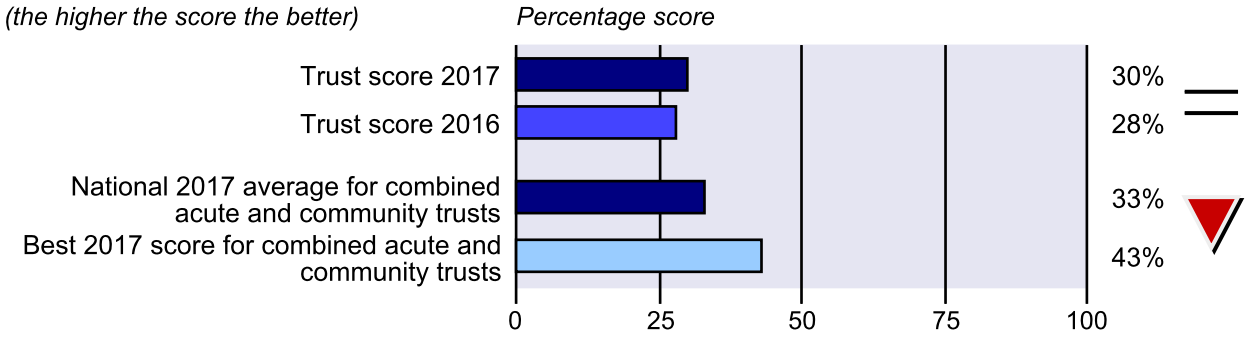


Managers

KEY FINDING 5. Recognition and value of staff by managers and the organisation

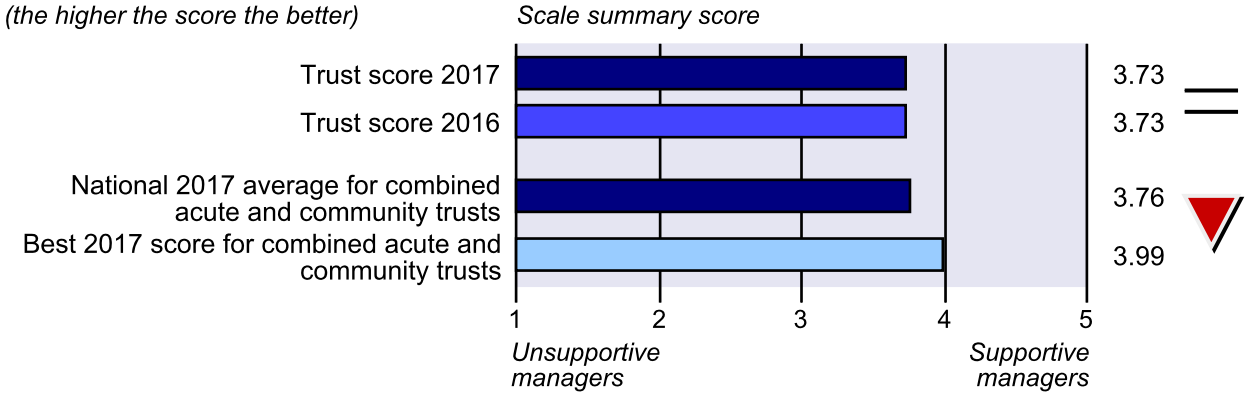


KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff



KEY FINDING 10. Support from immediate managers

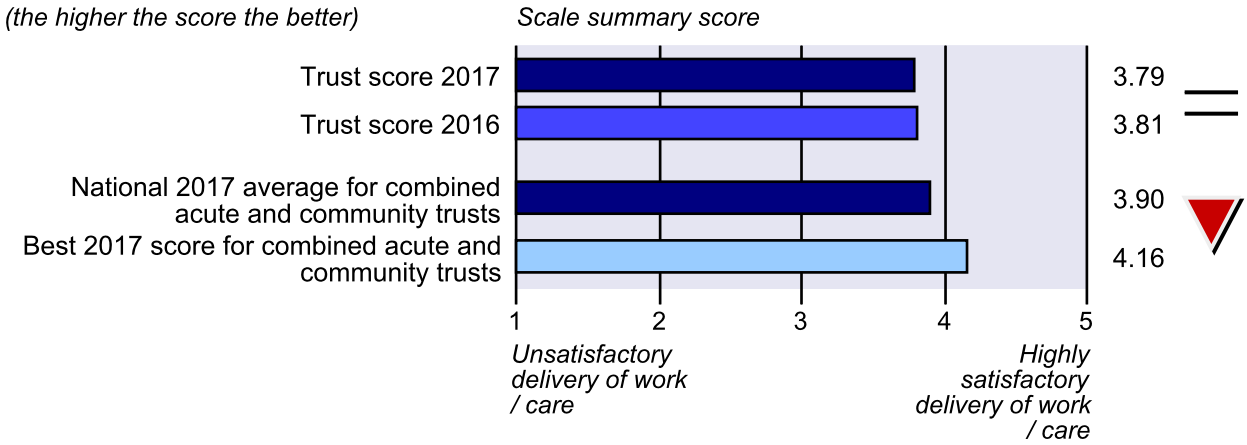
(the higher the score the better)



Patient care & experience

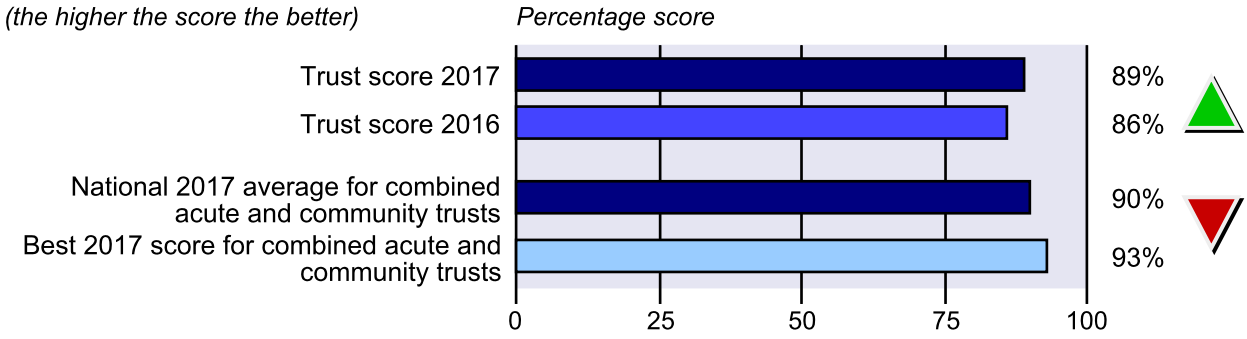
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



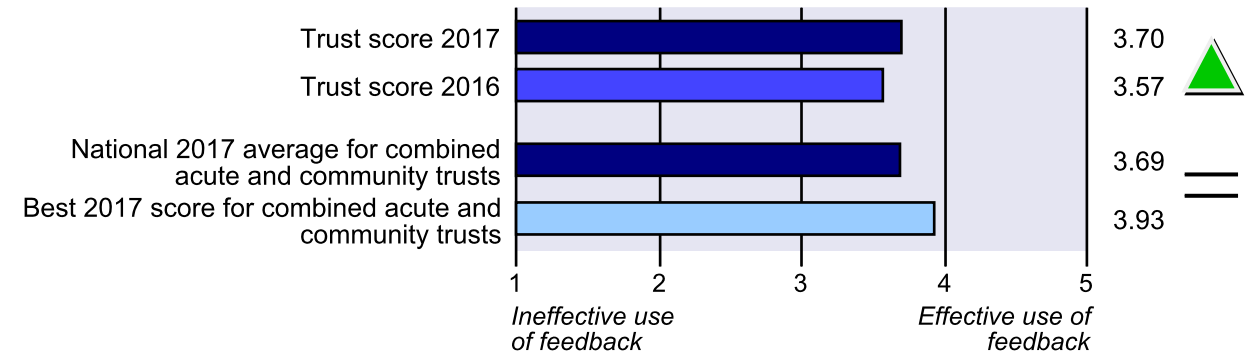
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



KEY FINDING 32. Effective use of patient / service user feedback

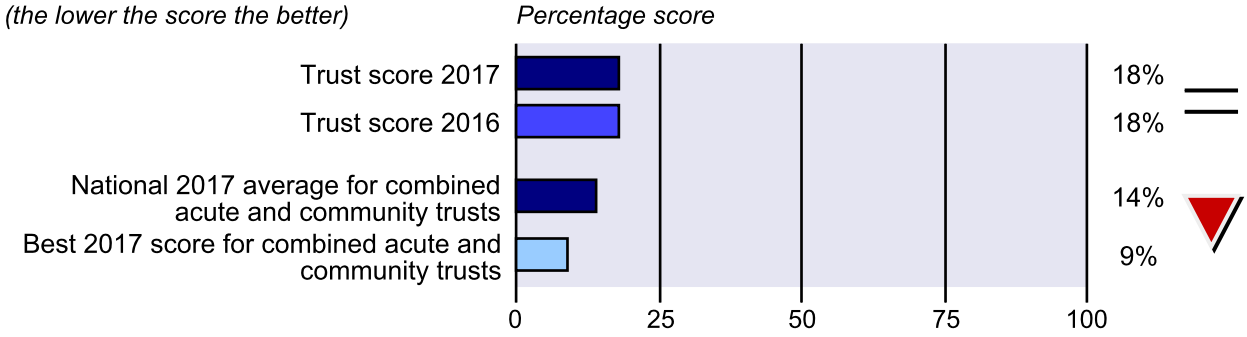
(the higher the score the better)



Violence, harassment & bullying

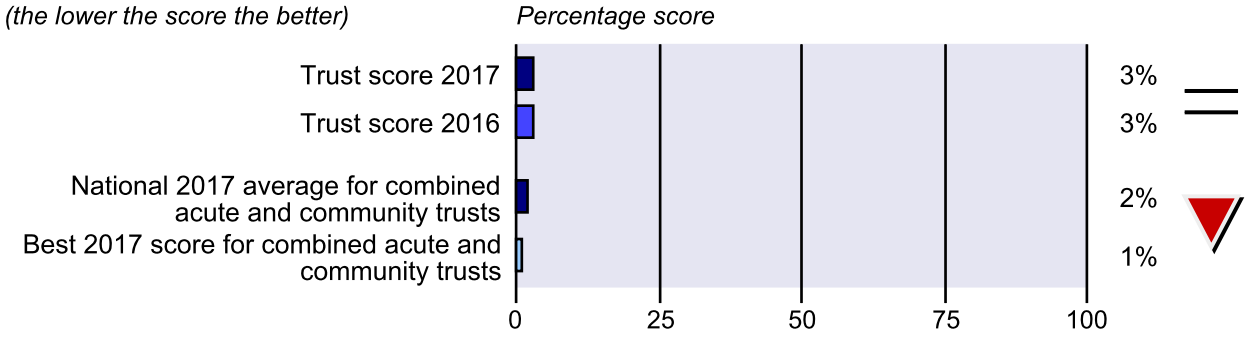
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



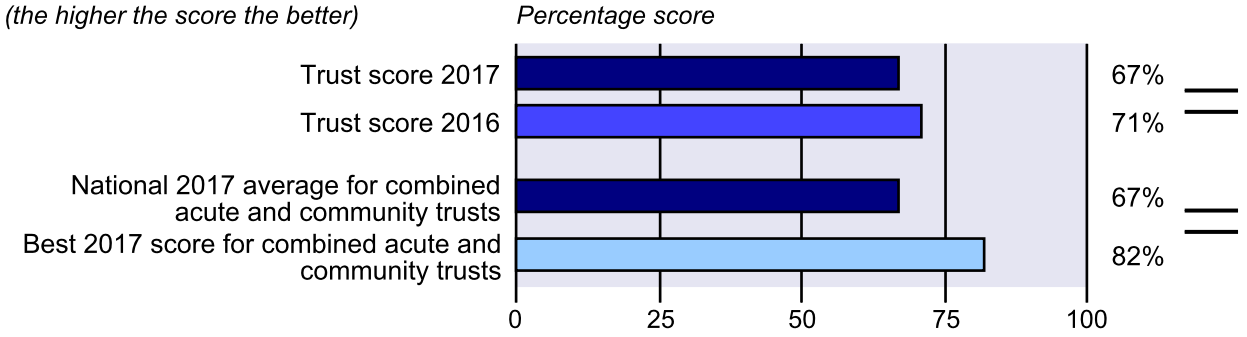
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



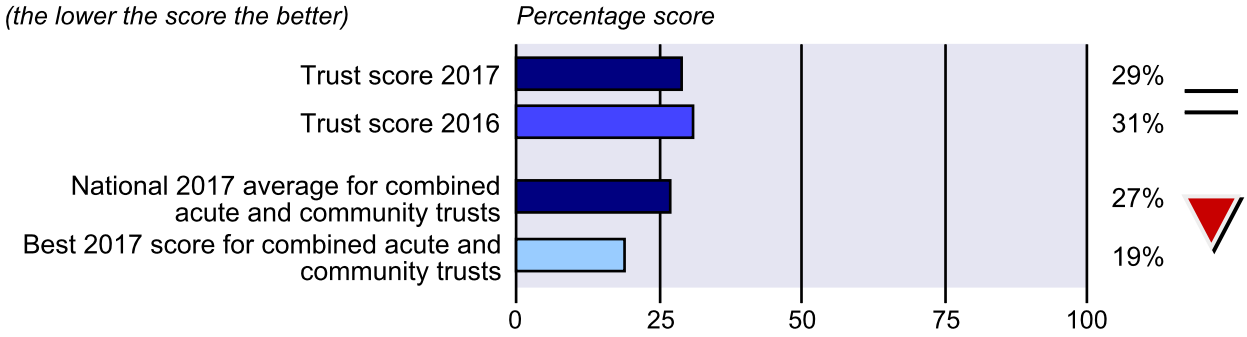
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



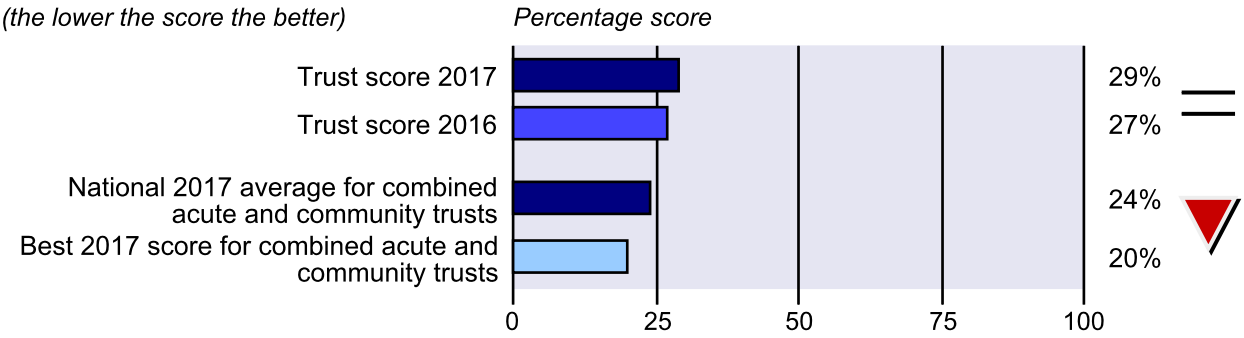
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



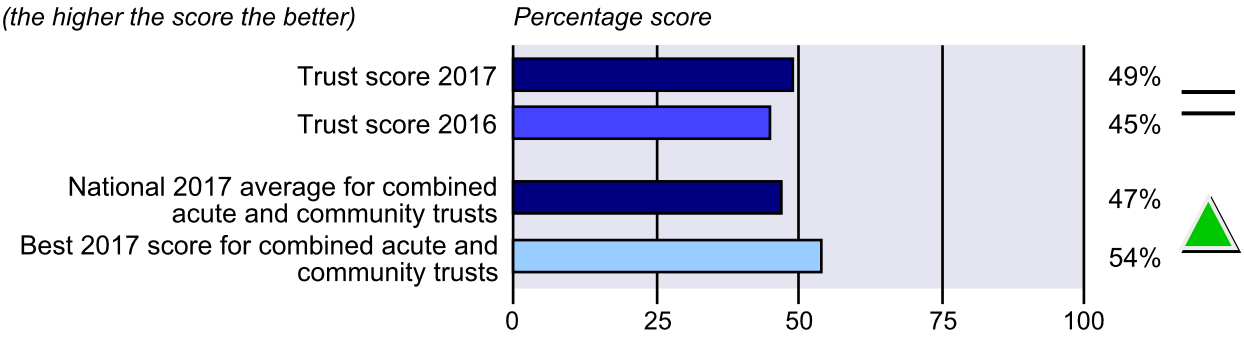
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



5. Workforce Race Equality Standard (WRES)

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	28%	26%	30%
		BME	28%	27%	31%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	27%	23%	26%
		BME	31%	29%	28%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	84%	88%	85%
		BME	68%	73%	71%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	7%	6%	6%
		BME	15%	15%	12%

6. Key Findings by work group characteristics

Tables 6.1 to 6.4 show the Key Findings at Walsall Healthcare NHS Trust broken down by work group characteristics: occupational groups, directorates, staff groups and full time/part time staff.

Technical notes:

- As in previous years, there are two types of Key Finding:
    - percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
    - scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5
- For most of the Key Findings presented in tables 6.1 to 6.4, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.
- Care should be taken not to over interpret the findings if scores differ slightly. For example, if for 'KF11. % appraised in the last 12 months' staff in Group A score 45%, and staff in Group B score 40%, it may appear that a higher proportion of staff in Group A have had appraisals than staff in Group B. However, because of small numbers in these sub-groups, it is probably not statistically significant. A more sensible interpretation would be that, on average, similar proportions of staff in Group A and B have had appraisals.
- Please note that, unlike the overall trust scores, data in this section are not weighted.
- Please also note that all percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.
- In order to preserve anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

Table 6.1: Key Findings for different occupational groups

	Adult / General Nurses	Other Registered Nurses	Nursing / Healthcare Assistants	Medical / Dental	Occupational Therapy	Physiotherapy	Radiography	Other Allied Health Professionals	General Management	Other Scientific & Technical	Admin & Clerical	Central Functions / Corporate Services	Maintenance / Ancillary
Appraisals & support for development													
KF11. % appraised in last 12 mths	89	91	83	94	96	79	79	93	79	89	84	85	84
KF12. Quality of appraisals	3.23	3.32	3.35	3.22	3.07	3.11	3.47	3.34	3.04	2.68	2.95	2.91	2.66
KF13. Quality of non-mandatory training, learning or development	4.19	4.26	4.07	4.04	3.98	4.01	4.33	4.00	4.03	3.80	3.64	3.89	3.72
Equality & diversity													
* *KF20. % experiencing discrimination at work in last 12 mths*	21	13	17	18	4	17	7	9	15	22	10	10	7
KF21. % believing the organisation provides equal opportunities for career progression / promotion	84	89	88	84	88	86	85	87	63	66	71	80	73
Errors & incidents													
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	44	33	34	66	21	23	46	26	23	63	15	11	19
KF29. % reporting errors, near misses or incidents witnessed in last mth	95	96	80	96	-	100	100	97	-	98	81	92	71
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.66	3.89	3.70	3.49	3.60	3.52	4.01	3.69	3.52	3.42	3.49	3.53	3.38
KF31. Staff confidence and security in reporting unsafe clinical practice	3.59	3.78	3.57	3.39	3.79	3.59	3.98	3.53	3.34	3.30	3.38	3.33	3.42
Health and wellbeing													
* *KF17. % feeling unwell due to work related stress in last 12 mths*	52	40	47	27	54	32	21	46	58	63	39	25	30
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	59	62	67	46	54	51	59	55	66	73	55	51	54
KF19. Org and mgmt interest in and action on health and wellbeing	3.55	3.73	3.54	3.42	3.71	3.59	3.67	3.71	3.38	3.25	3.62	3.80	3.41
Working patterns													
KF15. % satisfied with the opportunities for flexible working patterns	60	64	55	29	81	66	52	59	67	40	47	66	36
* *KF16. % working extra hours*	82	84	65	83	57	62	71	60	81	81	54	74	63
Number of respondents	228	160	103	74	28	47	28	137	39	76	276	114	90

Due to low numbers of respondents, no scores are shown for the following occupational groups: Mental Health Nurses, Social Care Staff, Public Health / Health Improvement and Emergency Care Assistant.

Table 6.1: Key Findings for different occupational groups (cont)

	Adult / General Nurses	Other Registered Nurses	Nursing / Healthcare Assistants	Medical / Dental	Occupational Therapy	Physiotherapy	Radiography	Other Allied Health Professionals	General Management	Other Scientific & Technical	Admin & Clerical	Central Functions / Corporate Services	Maintenance / Ancillary
Job satisfaction													
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.44	3.63	3.43	3.53	3.20	3.17	3.46	3.49	3.04	3.04	3.32	3.19	3.40
KF4. Staff motivation at work	3.95	4.08	3.74	4.19	3.93	3.72	4.06	3.86	3.72	3.53	3.67	3.62	3.57
KF7. % able to contribute towards improvements at work	70	77	58	64	82	72	75	76	72	61	59	77	42
KF8. Staff satisfaction with level of responsibility and involvement	3.99	4.00	3.78	3.90	3.89	3.73	4.07	4.01	3.53	3.46	3.72	3.76	3.63
KF9. Effective team working	3.94	3.98	3.59	3.80	3.93	3.84	3.96	3.88	3.68	3.48	3.57	3.81	3.06
KF14. Staff satisfaction with resourcing and support	3.23	3.21	3.15	3.07	3.12	3.03	3.24	3.17	3.01	2.63	3.16	3.18	3.13
Managers													
KF5. Recognition and value of staff by managers and the organisation	3.45	3.57	3.31	3.35	3.29	3.26	3.40	3.58	3.15	3.00	3.32	3.35	3.13
KF6. % reporting good communication between senior management and staff	32	46	39	27	29	21	46	36	33	19	24	27	14
KF10. Support from immediate managers	3.91	4.05	3.73	3.53	3.86	3.67	3.65	3.98	3.51	3.40	3.72	3.90	3.30
Patient care & experience													
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.81	3.84	3.94	3.87	3.63	3.54	4.07	3.78	3.34	3.45	3.77	3.74	3.84
KF3. % agreeing that their role makes a difference to patients / service users	93	97	93	92	93	98	100	90	82	86	79	79	79
KF32. Effective use of patient / service user feedback	3.74	3.92	3.58	3.70	3.37	3.61	3.73	3.70	3.38	3.52	3.70	3.76	3.67
Violence, harassment & bullying													
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	39	12	49	23	11	13	29	18	0	7	3	3	7
* *KF23. % experiencing physical violence from staff in last 12 mths*	5	2	3	0	0	2	0	1	0	7	1	4	4
KF24. % reporting most recent experience of violence	75	59	66	58	-	-	-	65	-	-	-	-	-
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	50	25	45	34	26	23	36	24	8	22	25	7	14
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	34	26	29	32	29	32	11	16	51	53	25	21	22
KF27. % reporting most recent experience of harassment, bullying or abuse	62	51	56	33	-	53	-	31	40	47	42	52	64
Overall staff engagement	3.71	3.85	3.55	3.75	3.68	3.53	3.84	3.70	3.53	3.31	3.48	3.53	3.35
Number of respondents	228	160	103	74	28	47	28	137	39	76	276	114	90

Due to low numbers of respondents, no scores are shown for the following occupational groups: Mental Health Nurses, Social Care Staff, Public Health / Health Improvement and Emergency Care Assistant.

Table 6.2: Key Findings for different directorates

	Corporate	Estates and Facilities	Medicine & Long-Term Conditions	Surgery	Womens, Childrens & Clinical Support Services
Appraisals & support for development					
KF11. % appraised in last 12 mths	83	83	88	84	89
KF12. Quality of appraisals	3.10	2.80	3.35	2.93	3.07
KF13. Quality of non-mandatory training, learning or development	3.97	3.86	4.09	4.07	3.99
Equality & diversity					
* *KF20. % experiencing discrimination at work in last 12 mths*	11	9	20	15	12
KF21. % believing the organisation provides equal opportunities for career progression / promotion	75	74	89	77	79
Errors & incidents					
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	19	18	35	38	34
KF29. % reporting errors, near misses or incidents witnessed in last mth	91	73	93	87	96
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.58	3.46	3.65	3.43	3.72
KF31. Staff confidence and security in reporting unsafe clinical practice	3.48	3.40	3.63	3.34	3.58
Health and wellbeing					
* *KF17. % feeling unwell due to work related stress in last 12 mths*	37	32	45	49	43
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	56	46	60	63	57
KF19. Org and mgmt interest in and action on health and wellbeing	3.74	3.40	3.66	3.42	3.55
Working patterns					
KF15. % satisfied with the opportunities for flexible working patterns	59	40	56	45	57
* *KF16. % working extra hours*	71	65	75	68	67
Number of respondents	312	150	343	244	487

Please note that the directorates classification was provided by Walsall Healthcare NHS Trust

Table 6.2: Key Findings for different directorates (cont)

	Corporate	Estates and Facilities	Medicine & Long-Term Conditions	Surgery	Womens, Childrens & Clinical Support Services
Job satisfaction					
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.34	3.39	3.54	3.22	3.36
KF4. Staff motivation at work	3.78	3.60	3.97	3.73	3.82
KF7. % able to contribute towards improvements at work	73	48	70	55	71
KF8. Staff satisfaction with level of responsibility and involvement	3.83	3.65	3.96	3.74	3.80
KF9. Effective team working	3.87	3.16	3.84	3.56	3.78
KF14. Staff satisfaction with resourcing and support	3.20	3.16	3.20	3.07	3.11
Managers					
KF5. Recognition and value of staff by managers and the organisation	3.43	3.17	3.52	3.22	3.31
KF6. % reporting good communication between senior management and staff	36	17	38	15	33
KF10. Support from immediate managers	3.88	3.25	3.96	3.57	3.74
Patient care & experience					
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.82	3.83	3.86	3.78	3.74
KF3. % agreeing that their role makes a difference to patients / service users	85	79	94	83	92
KF32. Effective use of patient / service user feedback	3.73	3.63	3.79	3.41	3.74
Violence, harassment & bullying					
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	5	7	39	21	10
* *KF23. % experiencing physical violence from staff in last 12 mths*	2	3	5	3	2
KF24. % reporting most recent experience of violence	71	-	70	66	59
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	14	14	45	37	24
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	27	22	24	39	28
KF27. % reporting most recent experience of harassment, bullying or abuse	48	67	54	43	47
Overall staff engagement	3.63	3.39	3.74	3.45	3.62
Number of respondents	312	150	343	244	487

Please note that the directorates classification was provided by Walsall Healthcare NHS Trust

Table 6.3: Key Findings for different staff groups

	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Appraisals & support for development								
KF11. % appraised in last 12 mths	96	88	82	90	79	90	94	89
KF12. Quality of appraisals	2.89	3.14	2.93	3.34	2.85	2.79	3.27	3.27
KF13. Quality of non-mandatory training, learning or development	4.02	3.98	3.78	4.11	3.88	3.78	4.04	4.23
Equality & diversity								
* *KF20. % experiencing discrimination at work in last 12 mths*	16	18	11	7	6	15	17	18
KF21. % believing the organisation provides equal opportunities for career progression / promotion	78	83	72	91	76	81	84	84
Errors & incidents								
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	61	34	16	29	17	37	64	39
KF29. % reporting errors, near misses or incidents witnessed in last mth	100	83	84	97	73	100	98	97
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.46	3.66	3.48	3.69	3.59	3.51	3.50	3.74
KF31. Staff confidence and security in reporting unsafe clinical practice	3.38	3.55	3.38	3.71	3.56	3.37	3.39	3.66
Health and wellbeing								
* *KF17. % feeling unwell due to work related stress in last 12 mths*	53	47	38	39	30	61	27	49
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	68	66	55	50	45	71	48	60
KF19. Org and mgmt interest in and action on health and wellbeing	3.44	3.51	3.64	3.76	3.40	3.46	3.43	3.59
Working patterns								
KF15. % satisfied with the opportunities for flexible working patterns	55	49	52	72	41	47	28	62
* *KF16. % working extra hours*	82	57	62	69	66	63	83	84
Number of respondents	57	217	496	131	133	44	75	383

Please note that the staff groups classification was provided by Walsall Healthcare NHS Trust

Table 6.3: Key Findings for different staff groups (cont)

	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Job satisfaction								
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.24	3.41	3.26	3.35	3.49	3.27	3.54	3.48
KF4. Staff motivation at work	3.78	3.71	3.68	3.93	3.62	3.69	4.18	4.00
KF7. % able to contribute towards improvements at work	70	62	65	81	44	70	64	73
KF8. Staff satisfaction with level of responsibility and involvement	3.78	3.73	3.71	4.01	3.66	3.72	3.90	4.00
KF9. Effective team working	3.61	3.60	3.65	4.06	3.11	3.66	3.79	3.96
KF14. Staff satisfaction with resourcing and support	2.80	3.17	3.17	3.09	3.22	2.80	3.09	3.20
Managers								
KF5. Recognition and value of staff by managers and the organisation	3.29	3.30	3.32	3.49	3.19	3.17	3.36	3.47
KF6. % reporting good communication between senior management and staff	21	35	27	36	19	27	27	37
KF10. Support from immediate managers	3.72	3.72	3.75	3.94	3.17	3.48	3.53	3.95
Patient care & experience								
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.49	3.99	3.72	3.60	3.98	3.55	3.88	3.82
KF3. % agreeing that their role makes a difference to patients / service users	91	91	79	97	82	88	92	95
KF32. Effective use of patient / service user feedback	3.61	3.57	3.65	3.70	3.61	3.64	3.69	3.81
Violence, harassment & bullying								
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	7	40	2	12	8	7	21	29
* *KF23. % experiencing physical violence from staff in last 12 mths*	5	5	2	1	4	5	0	4
KF24. % reporting most recent experience of violence	-	62	79	50	-	-	58	73
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	25	37	18	27	13	10	36	41
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	50	31	26	18	18	27	32	32
KF27. % reporting most recent experience of harassment, bullying or abuse	37	51	43	50	64	27	35	58
Overall staff engagement	3.58	3.53	3.50	3.74	3.42	3.55	3.75	3.77
Number of respondents	57	217	496	131	133	44	75	383

Please note that the staff groups classification was provided by Walsall Healthcare NHS Trust

Table 6.4: Key Findings for different work groups

	Full time / part time[a]	
	Full time	Part time
Appraisals & support for development		
KF11. % appraised in last 12 mths	86	86
KF12. Quality of appraisals	3.08	3.04
KF13. Quality of non-mandatory training, learning or development	4.02	4.03
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	14	12
KF21. % believing the organisation provides equal opportunities for career progression / promotion	79	85
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	33	20
KF29. % reporting errors, near misses or incidents witnessed in last mth	93	85
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.59	3.67
KF31. Staff confidence and security in reporting unsafe clinical practice	3.52	3.47
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	43	37
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	59	53
KF19. Org and mgmt interest in and action on health and wellbeing	3.60	3.51
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	53	58
* *KF16. % working extra hours*	72	58
Number of respondents	1144	309

[a] Full time is defined as staff contracted to work 30 hours or more a week

Table 6.4: Key Findings for different work groups (cont)

	Full time / part time[a]	
	Full time	Part time
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.35	3.45
KF4. Staff motivation at work	3.81	3.79
KF7. % able to contribute towards improvements at work	67	63
KF8. Staff satisfaction with level of responsibility and involvement	3.83	3.81
KF9. Effective team working	3.77	3.57
KF14. Staff satisfaction with resourcing and support	3.15	3.15
Managers		
KF5. Recognition and value of staff by managers and the organisation	3.35	3.37
KF6. % reporting good communication between senior management and staff	31	27
KF10. Support from immediate managers	3.78	3.66
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.81	3.77
KF3. % agreeing that their role makes a difference to patients / service users	88	90
KF32. Effective use of patient / service user feedback	3.71	3.63
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	19	9
* *KF23. % experiencing physical violence from staff in last 12 mths*	3	3
KF24. % reporting most recent experience of violence	66	75
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	29	25
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	29	23
KF27. % reporting most recent experience of harassment, bullying or abuse	48	46
Overall staff engagement	3.61	3.58
Number of respondents	1144	309

[a] Full time is defined as staff contracted to work 30 hours or more a week

7. Key Findings by demographic groups

Tables 7.1 and 7.2 show the Key Findings at Walsall Healthcare NHS Trust broken down by different demographic groups: age group, gender, disability and ethnic background.

Technical notes:

- As in previous years, there are two types of Key Finding:
    - percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
    - scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5
- For most of the Key Findings presented in tables 7.1 and 7.2, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.
- Care should be taken not to over interpret the findings if scores differ slightly. For example, if for 'KF11. % appraised in the last 12 months' staff in Group A score 45%, and staff in Group B score 40%, it may appear that a higher proportion of staff in Group A have had appraisals than staff in Group B. However, because of small numbers in these sub-groups, it is probably not statistically significant. A more sensible interpretation would be that, on average, similar proportions of staff in Group A and B have had appraisals.
- Please note that, unlike the overall trust scores, data in this section are not weighted.
- Please also note that all percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.
- In order to preserve anonymity of individual staff, a score is replaced with a dash if the demographic group in question contributed fewer than 11 responses to that score.

Table 7.1: Key Findings for different age groups

	Age group			
	Age 16-30	Age 31-40	Age 41-50	Age 51+
Appraisals & support for development				
KF11. % appraised in last 12 mths	83	87	88	87
KF12. Quality of appraisals	3.16	3.18	3.10	3.02
KF13. Quality of non-mandatory training, learning or development	4.10	4.09	4.00	3.94
Equality & diversity				
* *KF20. % experiencing discrimination at work in last 12 mths*	16	14	14	11
KF21. % believing the organisation provides equal opportunities for career progression / promotion	86	83	77	79
Errors & incidents				
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	33	31	31	29
KF29. % reporting errors, near misses or incidents witnessed in last mth	90	92	92	92
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.70	3.67	3.57	3.57
KF31. Staff confidence and security in reporting unsafe clinical practice	3.53	3.57	3.51	3.51
Health and wellbeing				
* *KF17. % feeling unwell due to work related stress in last 12 mths*	44	39	41	44
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	57	63	56	55
KF19. Org and mgmt interest in and action on health and wellbeing	3.65	3.66	3.53	3.55
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	51	64	56	49
* *KF16. % working extra hours*	63	70	72	71
Number of respondents	267	288	422	514

Table 7.1: Key Findings for different age groups (cont)

	Age group			
	Age 16-30	Age 31-40	Age 41-50	Age 51+
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.37	3.39	3.35	3.41
KF4. Staff motivation at work	3.61	3.80	3.85	3.90
KF7. % able to contribute towards improvements at work	67	68	71	63
KF8. Staff satisfaction with level of responsibility and involvement	3.80	3.80	3.83	3.84
KF9. Effective team working	3.64	3.81	3.77	3.68
KF14. Staff satisfaction with resourcing and support	3.22	3.17	3.13	3.11
Managers				
KF5. Recognition and value of staff by managers and the organisation	3.33	3.40	3.40	3.35
KF6. % reporting good communication between senior management and staff	30	36	32	26
KF10. Support from immediate managers	3.80	3.92	3.69	3.69
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.84	3.67	3.85	3.78
KF3. % agreeing that their role makes a difference to patients / service users	93	89	87	87
KF32. Effective use of patient / service user feedback	3.56	3.69	3.76	3.75
Violence, harassment & bullying				
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	28	14	16	13
* *KF23. % experiencing physical violence from staff in last 12 mths*	3	3	4	2
KF24. % reporting most recent experience of violence	54	68	80	67
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	31	26	28	27
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	21	27	30	31
KF27. % reporting most recent experience of harassment, bullying or abuse	50	46	48	53
Overall staff engagement	3.52	3.62	3.63	3.63
Number of respondents	267	288	422	514

Table 7.2: Key Findings for other demographic groups

	Gender				Disability		Ethnic background	
	Men	Women	Prefer to self-describe	Prefer not to say	Disabled	Not disabled	White	Black and minority ethnic
Appraisals & support for development								
KF11. % appraised in last 12 mths	90	86	-	71	88	86	87	84
KF12. Quality of appraisals	3.15	3.09	-	2.38	2.94	3.13	3.02	3.41
KF13. Quality of non-mandatory training, learning or development	3.96	4.04	-	3.53	3.98	4.03	3.99	4.11
Equality & diversity								
* *KF20. % experiencing discrimination at work in last 12 mths*	17	12	-	28	20	12	10	25
KF21. % believing the organisation provides equal opportunities for career progression / promotion	82	81	-	36	73	82	84	68
Errors & incidents								
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	37	29	-	42	40	28	30	34
KF29. % reporting errors, near misses or incidents witnessed in last mth	92	92	-	-	93	91	91	94
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.51	3.65	-	2.88	3.51	3.64	3.61	3.61
KF31. Staff confidence and security in reporting unsafe clinical practice	3.46	3.55	-	2.82	3.40	3.55	3.55	3.44
Health and wellbeing								
* *KF17. % feeling unwell due to work related stress in last 12 mths*	33	43	-	63	61	39	44	35
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	49	59	-	80	72	55	60	48
KF19. Org and mgmt interest in and action on health and wellbeing	3.59	3.60	-	2.80	3.52	3.60	3.59	3.61
Working patterns								
KF15. % satisfied with the opportunities for flexible working patterns	50	55	-	28	45	56	54	55
* *KF16. % working extra hours*	69	70	-	84	71	70	69	73
Number of respondents	254	1218	4	25	226	1248	1178	306

Table 7.2: Key Findings for other demographic groups (cont)

	Gender				Disability		Ethnic background	
	Men	Women	Prefer to self-describe	Prefer not to say	Disabled	Not disabled	White	Black and minority ethnic
Job satisfaction								
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.32	3.41	-	2.45	3.28	3.40	3.36	3.43
KF4. Staff motivation at work	3.77	3.84	-	3.27	3.74	3.83	3.78	3.97
KF7. % able to contribute towards improvements at work	67	68	-	20	60	68	67	65
KF8. Staff satisfaction with level of responsibility and involvement	3.81	3.84	-	3.08	3.77	3.84	3.83	3.81
KF9. Effective team working	3.77	3.73	-	2.81	3.63	3.75	3.73	3.73
KF14. Staff satisfaction with resourcing and support	3.14	3.16	-	2.79	3.01	3.18	3.13	3.23
Managers								
KF5. Recognition and value of staff by managers and the organisation	3.34	3.39	-	2.57	3.28	3.39	3.38	3.35
KF6. % reporting good communication between senior management and staff	32	31	-	0	26	32	30	33
KF10. Support from immediate managers	3.75	3.76	-	3.08	3.73	3.76	3.79	3.64
Patient care & experience								
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.71	3.81	-	3.37	3.69	3.81	3.75	3.94
KF3. % agreeing that their role makes a difference to patients / service users	87	89	-	78	88	89	88	93
KF32. Effective use of patient / service user feedback	3.72	3.71	-	2.81	3.58	3.73	3.68	3.80
Violence, harassment & bullying								
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	14	17	-	12	16	17	16	18
* *KF23. % experiencing physical violence from staff in last 12 mths*	5	3	-	0	5	3	2	5
KF24. % reporting most recent experience of violence	59	68	-	-	67	66	64	72
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	23	29	-	32	36	27	28	28
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	30	27	-	68	34	27	27	31
KF27. % reporting most recent experience of harassment, bullying or abuse	49	51	-	19	47	50	49	50
Overall staff engagement	3.57	3.63	-	2.81	3.50	3.63	3.59	3.66
Number of respondents	254	1218	4	25	226	1248	1178	306

8. Work and demographic profile of the survey respondents

The occupational group of the staff survey respondents is shown in table 8.1, other work characteristics are shown in table 8.2, and demographic characteristics are shown in table 8.3.

Table 8.1: Occupational group of respondents

Occupational group	Number questionnaires returned	Percentage of survey respondents
Allied Health Professionals		
Occupational Therapy	28	2%
Physiotherapy	47	3%
Radiography	28	2%
Clinical Psychology	2	0%
Psychotherapy	1	0%
Other qualified Allied Health Professionals	61	4%
Support to Allied Health Professionals	73	5%
Scientific and Technical / Healthcare Scientists		
Pharmacy	36	2%
Other qualified Scientific and Technical / Healthcare Scientists	29	2%
Support to Scientific and Technical / Healthcare Scientists	11	1%
Medical and Dental		
Medical / Dental - Consultant	45	3%
Medical / Dental - In Training	19	1%
Medical / Dental - Other	10	1%
Operational ambulance staff		
Emergency care assistant	1	0%
Nurses, Midwives and Nursing Assistants		
Registered Nurses - Adult / General	228	16%
Registered Nurses - Mental Health	2	0%
Registered Nurses - Learning Disabilities	1	0%
Registered Nurses - Children	22	1%
Midwives	35	2%
Health Visitors	21	1%
Registered Nurses - District / Community	56	4%
Other Registered Nurses	25	2%
Nursing auxiliary / Nursing assistant / Healthcare assistant	103	7%
Social Care Staff		
Social care support staff	3	0%
Other groups		
Public Health / Health Improvement	6	0%
Admin and Clerical	276	19%
Central Functions / Corporate Services	114	8%
Maintenance / Ancillary	90	6%
General Management	39	3%
Other	57	4%
Did not specify	67	

Table 8.2: Work characteristics of respondents

	Number questionnaires returned	Percentage of survey respondents
Full time / part time		
Full time	1144	79%
Part time	309	21%
Did not specify	83	
Length of time in organisation		
Less than a year	94	6%
Between 1 to 2 years	177	12%
Between 3 to 5 years	246	17%
Between 6 to 10 years	290	20%
Between 11 to 15 years	201	14%
Over 15 years	443	31%
Did not specify	85	

Sums of percentages may add up to more than 100% due to rounding, and do not include 'did not specify' responses

Table 8.3: Demographic characteristics of respondents

	Number questionnaires returned	Percentage of survey respondents
Age group		
Between 16 and 30	267	18%
Between 31 and 40	288	19%
Between 41 and 50	422	28%
51 and over	514	34%
Did not specify	45	
Gender		
Male	254	17%
Female	1218	81%
Prefer to self-describe	4	0%
Prefer not to say	25	2%
Did not specify	35	
Ethnic background		
White	1178	79%
Black and minority ethnic	306	21%
Did not specify	52	
Disability		
Disabled	226	15%
Not disabled	1248	85%
Did not specify	62	

Sums of percentages may add up to more than 100% due to rounding, and do not include 'did not specify' responses

Appendix 1

Key Findings for Walsall Healthcare NHS Trust benchmarked against other combined acute and community trusts

Technical notes:

- The first column in table A1 shows the trust's scores for each of the Key Findings. The same data are displayed in section 3 and 4 of this report.

- The second column in table A1 shows the 95% confidence intervals around the trust's scores for each of the Key Findings.

- The third column in table A1 shows the average (median) score for each of the Key Findings for combined acute and community trusts. The same data are displayed in section 3 and 4 of this report.

- The fourth and fifth columns in table A1 show the thresholds for below and above average scores for each of the Key Findings for combined acute and community trusts. The data are used to describe comparisons with other trusts as displayed in section 3 and 4 of this report.

- The sixth column in table A1 shows the lowest score attained for each of the Key Findings by an combined acute and community trust.

- The seventh column in table A1 shows the highest score attained for each of the Key Findings by an combined acute and community trust.

- For most of the Key Findings presented in table A1, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative score. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.

- Please note that the data presented in table A1 are rounded to the nearest whole number for percentage scores and to two decimal places for scale summary scores.

Table A1: Key Findings for Walsall Healthcare NHS Trust benchmarked against other combined acute and community trusts

	Your trust		National scores for combined acute and community trusts				
	Trust score	95% Confidence Interval	Median score	Threshold for below average	Threshold for above average	Lowest score attained	Highest score attained
Response rate	36	-	43	40	48	27	54
Appraisals & support for development							
KF11. % appraised in last 12 mths	87	[85, 89]	86	84	89	74	95
KF12. Quality of appraisals	3.10	[3.03, 3.17]	3.11	3.05	3.14	2.87	3.46
KF13. Quality of non-mandatory training, learning or development	4.02	[3.98, 4.07]	4.06	4.03	4.09	3.95	4.17
Equality & diversity							
* *KF20. % experiencing discrimination at work in last 12 mths*	14	[12, 16]	10	9	12	7	22
KF21. % believing the organisation provides equal opportunities for career progression / promotion	80	[77, 83]	85	82	88	71	93
Errors & incidents							
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	33	[31, 36]	29	28	30	22	35
KF29. % reporting errors, near misses or incidents witnessed in last mth	92	[90, 95]	91	90	91	80	94
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.60	[3.56, 3.64]	3.73	3.70	3.76	3.50	3.93
KF31. Staff confidence and security in reporting unsafe clinical practice	3.52	[3.47, 3.56]	3.67	3.61	3.71	3.44	3.84
Health and wellbeing							
* *KF17. % feeling unwell due to work related stress in last 12 mths*	43	[40, 45]	38	36	40	30	45
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	57	[55, 60]	53	52	54	47	60
KF19. Org and mgmt interest in and action on health and wellbeing	3.56	[3.51, 3.61]	3.63	3.58	3.67	3.41	3.83
Working patterns							
KF15. % satisfied with the opportunities for flexible working patterns	52	[50, 55]	51	50	52	41	61
* *KF16. % working extra hours*	71	[69, 73]	71	69	73	63	77

Table A1: Key Findings for Walsall Healthcare NHS Trust benchmarked against other combined acute and community trusts (cont)

	Your trust		National scores for combined acute and community trusts				
	Trust score	95% Confidence Interval	Median score	Threshold for below average	Threshold for above average	Lowest score attained	Highest score attained
Job satisfaction							
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.38	[3.33, 3.43]	3.75	3.64	3.79	3.38	4.18
KF4. Staff motivation at work	3.83	[3.79, 3.87]	3.91	3.88	3.93	3.80	4.01
KF7. % able to contribute towards improvements at work	66	[64, 68]	70	68	71	60	77
KF8. Staff satisfaction with level of responsibility and involvement	3.82	[3.78, 3.85]	3.89	3.88	3.93	3.81	4.05
KF9. Effective team working	3.72	[3.68, 3.76]	3.74	3.72	3.78	3.54	3.91
KF14. Staff satisfaction with resourcing and support	3.13	[3.09, 3.17]	3.27	3.25	3.34	3.13	3.48
Managers							
KF5. Recognition and value of staff by managers and the organisation	3.35	[3.30, 3.40]	3.44	3.41	3.51	3.27	3.62
KF6. % reporting good communication between senior management and staff	30	[28, 33]	33	32	35	22	43
KF10. Support from immediate managers	3.73	[3.68, 3.78]	3.76	3.73	3.78	3.57	3.99
Patient care & experience							
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.79	[3.74, 3.84]	3.90	3.86	3.96	3.73	4.16
KF3. % agreeing that their role makes a difference to patients / service users	89	[88, 91]	90	89	91	86	93
KF32. Effective use of patient / service user feedback	3.70	[3.64, 3.76]	3.69	3.64	3.73	3.43	3.93
Violence, harassment & bullying							
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	18	[16, 20]	14	13	15	9	19
* *KF23. % experiencing physical violence from staff in last 12 mths*	3	[2, 4]	2	2	2	1	4
KF24. % reporting most recent experience of violence	67	[61, 74]	67	65	70	59	82
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	29	[26, 31]	27	25	28	19	33
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	29	[27, 32]	24	23	25	20	32
KF27. % reporting most recent experience of harassment, bullying or abuse	49	[45, 53]	47	46	48	41	54

Appendix 2

Changes to the Key Findings since the 2015 and 2016 staff surveys

Technical notes:

- For most of the Key Findings presented in tables A2.1 and A2.2, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.

- It is likely that we would see some small change simply due to sample differences between the two years. The final column of the tables shows whether the change in your trust is statistically significant or not. If a change is not significant, then there is no evidence of a real change in the trust score.

- Please note that the trust scores and change scores presented in tables A2.1 and A2.2 are rounded to the nearest whole number for percentage scores and to two decimal places for scale summary scores.

- All percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.

- In certain cases a dash (-) appears in Table A2.2. This is either because the Key Finding was not calculated in previous years, or there have been changes in how the Key Finding has been calculated this year.

To enable comparison between years, scores from 2016 and 2015 have been re-calculated and re-weighted using the 2017 formulae, so may appear slightly different from figures in previous feedback reports. More details about these changes can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

Table A2.1: Changes in the Key Findings for Walsall Healthcare NHS Trust since 2016 survey

	Walsall Healthcare NHS Trust			
	2017 score	**2016 score**	**Change**	**Statistically significant?**
Response rate	36	42	-6	N/A
Appraisals & support for development				
KF11. % appraised in last 12 mths	87	87	0	No
KF12. Quality of appraisals	3.10	3.03	0.07	No
KF13. Quality of non-mandatory training, learning or development	4.02	3.99	0.03	No
Equality & diversity				
* *KF20. % experiencing discrimination at work in last 12 mths*	14	13	1	No
KF21. % believing the organisation provides equal opportunities for career progression / promotion	80	82	-2	No
Errors & incidents				
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	33	34	0	No
KF29. % reporting errors, near misses or incidents witnessed in last mth	92	87	5	Yes
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.60	3.59	0.02	No
KF31. Staff confidence and security in reporting unsafe clinical practice	3.52	3.51	0.01	No
Health and wellbeing				
* *KF17. % feeling unwell due to work related stress in last 12 mths*	43	39	3	No
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	57	56	2	No
KF19. Org and mgmt interest in and action on health and wellbeing	3.56	3.51	0.05	No
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	52	49	3	No
* *KF16. % working extra hours*	71	70	1	No

Table A2.1: Changes in the Key Findings for Walsall Healthcare NHS Trust since 2016 survey (cont)

	Walsall Healthcare NHS Trust			
	2017 score	**2016 score**	**Change**	**Statistically significant?**
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.38	3.45	-0.06	Yes
KF4. Staff motivation at work	3.83	3.82	0.00	No
KF7. % able to contribute towards improvements at work	66	64	2	No
KF8. Staff satisfaction with level of responsibility and involvement	3.82	3.83	-0.02	No
KF9. Effective team working	3.72	3.67	0.05	No
KF14. Staff satisfaction with resourcing and support	3.13	3.17	-0.03	No
Managers				
KF5. Recognition and value of staff by managers and the organisation	3.35	3.34	0.01	No
KF6. % reporting good communication between senior management and staff	30	28	2	No
KF10. Support from immediate managers	3.73	3.73	0.00	No
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.79	3.81	-0.02	No
KF3. % agreeing that their role makes a difference to patients / service users	89	86	3	Yes
KF32. Effective use of patient / service user feedback	3.70	3.57	0.13	Yes
Violence, harassment & bullying				
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	18	18	0	No
* *KF23. % experiencing physical violence from staff in last 12 mths*	3	3	0	No
KF24. % reporting most recent experience of violence	67	71	-4	No
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	29	31	-2	No
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	29	27	2	No
KF27. % reporting most recent experience of harassment, bullying or abuse	49	45	4	No

Table A2.2: Changes in the Key Findings for Walsall Healthcare NHS Trust since 2015 survey

	Walsall Healthcare NHS Trust			
	2017 score	**2015 score**	**Change**	**Statistically significant?**
Response rate	36	36	0	-
Appraisals & support for development				
KF11. % appraised in last 12 mths	87	90	-3	Yes
KF12. Quality of appraisals	3.10	3.02	0.08	No
KF13. Quality of non-mandatory training, learning or development	4.02	3.97	0.06	No
Equality & diversity				
* *KF20. % experiencing discrimination at work in last 12 mths*	14	13	1	No
KF21. % believing the organisation provides equal opportunities for career progression / promotion	80	84	-4	Yes
Errors & incidents				
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	33	37	-3	No
KF29. % reporting errors, near misses or incidents witnessed in last mth	92	90	2	No
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.60	3.58	0.03	No
KF31. Staff confidence and security in reporting unsafe clinical practice	3.52	3.43	0.08	Yes
Health and wellbeing				
* *KF17. % feeling unwell due to work related stress in last 12 mths*	43	42	1	No
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	57	55	2	No
KF19. Org and mgmt interest in and action on health and wellbeing	3.56	3.50	0.06	No
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	52	49	4	Yes
* *KF16. % working extra hours*	71	72	-1	No

Table A2.2: Changes in the Key Findings for Walsall Healthcare NHS Trust since 2015 survey (cont)

	Walsall Healthcare NHS Trust			
	2017 score	**2015 score**	**Change**	**Statistically significant?**
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.38	3.47	-0.08	Yes
KF4. Staff motivation at work	3.83	3.85	-0.02	No
KF7. % able to contribute towards improvements at work	66	68	-2	No
KF8. Staff satisfaction with level of responsibility and involvement	3.82	3.84	-0.02	No
KF9. Effective team working	3.72	3.69	0.02	No
KF14. Staff satisfaction with resourcing and support	3.13	3.12	0.01	No
Managers				
KF5. Recognition and value of staff by managers and the organisation	3.35	3.33	0.02	No
KF6. % reporting good communication between senior management and staff	30	25	5	Yes
KF10. Support from immediate managers	3.73	3.69	0.04	No
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.79	3.81	-0.02	No
KF3. % agreeing that their role makes a difference to patients / service users	89	88	1	No
KF32. Effective use of patient / service user feedback	3.70	3.60	0.10	Yes
Violence, harassment & bullying				
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	18	19	-2	No
* *KF23. % experiencing physical violence from staff in last 12 mths*	3	3	0	No
KF24. % reporting most recent experience of violence	67	72	-4	No
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	29	33	-4	Yes
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	29	27	2	No
KF27. % reporting most recent experience of harassment, bullying or abuse	49	49	0	No

Appendix 3

Data tables: 2017 Key Findings and the responses to all survey questions

For each of the 32 Key Findings (Table A3.1) and each individual survey question in the core version of the questionnaire (Table A3.2), this appendix presents your trust's 2017 survey response, the average (median) 2017 response for combined acute and community trusts, and your trust's 2016 survey response (where applicable).

In Table A3.1, the question numbers used to calculate the 32 Key Findings are also listed in the first column.

In Table A3.2, the responses to the survey questions are presented in the order that they appear within the core version of the 2017 questionnaire.

Technical notes:

- In certain cases a dash (-) appears in Tables A3.1 or A3.2. This is in order to preserve anonymity of individual staff, where there were fewer than 11 responses to a survey question or Key Finding.

- Please note that the figures reported in tables A3.1 and A3.2 are un-weighted, and, as a consequence there may be some slight differences between these figures and the figures reported in sections 3 and 4 and Appendix 2 of this report, which are weighted according to the occupational group profile of a typical combined acute and community trust.

- The question data within this section excludes any non-specific responses ('Don't know'/'Can't remember').

- More details about the calculation of Key Findings and the weighting of data can be found in the document ***Making sense of your staff survey data***, which can be downloaded from: www.nhsstaffsurveys.com

Table A3.1: Key Findings for Walsall Healthcare NHS Trust benchmarked against other combined acute and community trusts

	Question number(s)	Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
Appraisals & support for development				
KF11. % appraised in last 12 mths	Q20a	86	86	87
KF12. Quality of appraisals	Q20b-d	3.09	3.10	3.03
KF13. Quality of non-mandatory training, learning or development	Q18b-d	4.02	4.07	3.99
Equality & diversity				
* *KF20. % experiencing discrimination at work in last 12 mths*	Q17a-b	14	10	12
KF21. % believing the organisation provides equal opportunities for career progression / promotion	Q16	80	85	82
Errors & incidents				
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	Q11a-b	30	29	33
KF29. % reporting errors, near misses or incidents witnessed in last mth	Q11c	92	91	87
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	Q12a-d	3.61	3.73	3.58
KF31. Staff confidence and security in reporting unsafe clinical practice	Q13b-c	3.52	3.66	3.51
Health and wellbeing				
* *KF17. % feeling unwell due to work related stress in last 12 mths*	Q9c	42	37	39
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	Q9d-g	57	53	56
KF19. Org and mgmt interest in and action on health and wellbeing	Q7f, 9a	3.58	3.62	3.52
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	Q5h	54	51	50
* *KF16. % working extra hours*	Q10b-c	70	70	69

Table A3.1: Key Findings for Walsall Healthcare NHS Trust benchmarked against other combined acute and community trusts (cont)

	Question number(s)	Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	Q21a, 21c-d	3.38	3.75	3.44
KF4. Staff motivation at work	Q2a-c	3.81	3.90	3.82
KF7. % able to contribute towards improvements at work	Q4a-b, 4d	66	70	64
KF8. Staff satisfaction with level of responsibility and involvement	Q3a-b, 4c, 5d-e	3.82	3.89	3.83
KF9. Effective team working	Q4h-j	3.72	3.73	3.67
KF14. Staff satisfaction with resourcing and support	Q4e-g, 5c	3.15	3.28	3.16
Managers				
KF5. Recognition and value of staff by managers and the organisation	Q5a, 5f, 7g	3.36	3.44	3.34
KF6. % reporting good communication between senior management and staff	Q8a-d	30	33	28
KF10. Support from immediate managers	Q5b, 7a-e	3.75	3.77	3.73
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	Q3c, 6a, 6c	3.79	3.91	3.81
KF3. % agreeing that their role makes a difference to patients / service users	Q6b	89	90	86
KF32. Effective use of patient / service user feedback	Q21b, 22b-c	3.70	3.69	3.57
Violence, harassment & bullying				
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	Q14a	17	14	17
* *KF23. % experiencing physical violence from staff in last 12 mths*	Q14b-c	3	2	3
KF24. % reporting most recent experience of violence	Q14d	67	68	71
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	Q15a	28	27	31
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	Q15b-c	28	24	26
KF27. % reporting most recent experience of harassment, bullying or abuse	Q15d	49	47	46

Table A3.2: Survey questions benchmarked against other combined acute and community trusts

		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
	Contact with patients			
Q1	% saying they have face-to-face contact with patients / service users as part of their job	84	83	86
	Staff motivation at work			
	% saying often or always to the following statements:			
Q2a	"I look forward to going to work"	51	57	52
Q2b	"I am enthusiastic about my job"	69	73	68
Q2c	"Time passes quickly when I am working"	74	77	74
	Job design			
	% agreeing / strongly agreeing with the following statements:			
Q3a	"I always know what my work responsibilities are"	84	87	86
Q3b	"I am trusted to do my job"	90	92	92
Q3c	"I am able to do my job to a standard I am personally pleased with"	74	79	73
	Opportunities to develop potential at work			
	% agreeing / strongly agreeing with the following statements:			
Q4a	"There are frequent opportunities for me to show initiative in my role"	69	73	68
Q4b	"I am able to make suggestions to improve the work of my team / department"	71	75	70
Q4c	"I am involved in deciding on changes introduced that affect my work area / team / department"	52	52	47
Q4d	"I am able to make improvements happen in my area of work"	53	56	51
Q4e	"I am able to meet all the conflicting demands on my time at work"	41	45	41
Q4f	"I have adequate materials, supplies and equipment to do my work"	45	52	44
Q4g	"There are enough staff at this organisation for me to do my job properly"	25	30	23
Q4h	"The team I work in has a set of shared objectives"	69	73	68
Q4i	"The team I work in often meets to discuss the team's effectiveness"	64	61	60
Q4j	"Team members have to communicate closely with each other to achieve the team's objectives"	76	78	74
	Staff job satisfaction			
	% satisfied or very satisfied with the following aspects of their job:			
Q5a	"The recognition I get for good work"	49	52	46
Q5b	"The support I get from my immediate manager"	68	68	66
Q5c	"The support I get from my work colleagues"	77	81	77
Q5d	"The amount of responsibility I am given"	71	74	71
Q5e	"The opportunities I have to use my skills"	67	71	68
Q5f	"The extent to which my organisation values my work"	38	43	36
Q5g	"My level of pay"	33	33	37
Q5h	"The opportunities for flexible working patterns"	54	51	50

		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
	Contribution to patient care			
	% agreeing / strongly agreeing with the following statements:			
Q6a	"I am satisfied with the quality of care I give to patients / service users"	77	81	78
Q6b	"I feel that my role makes a difference to patients / service users"	89	90	86
Q6c	"I am able to deliver the patient care I aspire to"	63	67	63
	Your managers			
	% agreeing / strongly agreeing with the following statements:			
Q7a	"My immediate manager encourages those who work for her/him to work as a team"	73	74	72
Q7b	"My immediate manager can be counted on to help me with a difficult task at work"	70	71	71
Q7c	"My immediate manager gives me clear feedback on my work"	62	61	60
Q7d	"My immediate manager asks for my opinion before making decisions that affect my work"	55	55	53
Q7e	"My immediate manager is supportive in a personal crisis"	75	75	75
Q7f	"My immediate manager takes a positive interest in my health and well-being"	68	68	67
Q7g	"My immediate manager values my work"	71	72	68
Q8a	"I know who the senior managers are here"	81	83	79
Q8b	"Communication between senior management and staff is effective"	36	41	32
Q8c	"Senior managers here try to involve staff in important decisions"	31	33	29
Q8d	"Senior managers act on staff feedback"	29	32	28
	Health and well-being			
Q9a	% saying their organisation definitely takes positive action on health and well-being	28	32	23
Q9b	% saying they have have experienced musculoskeletal problems (MSK) in the last 12 months as a result of work activities	26	25	27
Q9c	% saying they have have felt unwell in the last 12 months as a result of work related stress	42	37	39
Q9d	% saying in the last three months they had gone to work despite not feeling well enough to perform their duties	62	57	61
	If attended work despite not feeling well enough (YES to Q9d), % saying they...			
Q9e	...had felt pressure from their manager to come to work	22	25	26
Q9f	...had felt pressure from their colleagues to come to work	20	20	20
Q9g	...had put themselves under pressure to come to work	91	92	91
	Working hours			
Q10a	% working part time (up to 29 hours a week)	21	21	24
Q10b	% working additional PAID hours	29	32	32
Q10c	% working additional UNPAID hours	58	57	56
	Witnessing and reporting errors, near misses and incidents			
Q11a	% witnessing errors, near misses or incidents in the last month that could have hurt staff	18	16	19

		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
Q11b	% witnessing errors, near misses or incidents in the last month that could have hurt patients / service users	26	24	28
Q11c	If they witnessed an error, near miss or incident that could have hurt staff or patients / service users (YES to Q11a or YES to Q11b), % saying the last time this happened, either they or a colleague had reported it	96	95	93
	Fairness and effectiveness of procedures for reporting errors, near misses or incidents			
	% agreeing / strongly agreeing with the following statements:			
Q12a	"My organisation treats staff who are involved in an error, near miss or incident fairly"	51	55	44
Q12b	"My organisation encourages us to report errors, near misses or incidents"	87	88	85
Q12c	"When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again"	59	69	56
Q12d	"We are given feedback about changes made in response to reported errors, near misses and incidents"	50	57	45
	Raising concerns about unsafe clinical practice			
Q13a	% saying if they were concerned about unsafe clinical practice they would know how to report it	94	95	95
	% agreeing / strongly agreeing with the following statements:			
Q13b	"I would feel secure raising concerns about unsafe clinical practice"	66	70	62
Q13c	"I am confident that the organisation would address my concern"	50	58	48
	Experiencing and reporting physical violence at work			
	% experiencing physical violence at work from patients / service users, their relatives or other members of the public in last 12 months...			
Q14a	Never	83	86	83
Q14a	1 to 2 times	9	9	9
Q14a	3 to 5 times	4	3	4
Q14a	6 to 10 times	2	1	1
Q14a	More than 10 times	2	1	3
	% experiencing physical violence at work from managers in last 12 months...			
Q14b	Never	99	99	99
Q14b	1 to 2 times	1	0	1
Q14b	3 to 5 times	0	0	0
Q14b	6 to 10 times	0	0	0
Q14b	More than 10 times	0	0	0
	% experiencing physical violence at work from other colleagues in last 12 months...			
Q14c	Never	97	98	98
Q14c	1 to 2 times	2	1	2
Q14c	3 to 5 times	0	0	1
Q14c	6 to 10 times	0	0	0
Q14c	More than 10 times	0	0	0
Q14d	(If YES to Q14a, Q14b or Q14c) % saying the last time they experienced an incident of physical violence, either they or a colleague had reported it	68	68	71

		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
	Experiencing and reporting harassment, bullying and abuse at work			
	% experiencing harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public in last 12 months...			
Q15a	Never	72	73	69
Q15a	1 to 2 times	15	16	18
Q15a	3 to 5 times	6	6	7
Q15a	6 to 10 times	2	2	2
Q15a	More than 10 times	5	3	4
	% experiencing harassment, bullying or abuse at work from managers in last 12 months...			
Q15b	Never	84	88	85
Q15b	1 to 2 times	11	8	10
Q15b	3 to 5 times	3	2	3
Q15b	6 to 10 times	1	1	1
Q15b	More than 10 times	1	1	1
	% experiencing harassment, bullying or abuse at work from other colleagues in last 12 months...			
Q15c	Never	80	82	81
Q15c	1 to 2 times	14	13	13
Q15c	3 to 5 times	4	3	4
Q15c	6 to 10 times	1	1	1
Q15c	More than 10 times	2	1	1
Q15d	(If YES to Q15a, Q15b or Q15c) % saying the last time they experienced an incident of harassment, bullying or abuse, either they or a colleague had reported it	50	47	46
	Equal opportunities			
Q16	% saying the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	80	85	82
	Discrimination			
Q17a	% saying they had experienced discrimination from patients / service users, their relatives or other members of the public in the last 12 months	7	5	7
Q17b	% saying they had experienced discrimination from their manager / team leader or other colleagues in the last 12 months	9	7	7
	% saying they had experienced discrimination on the grounds of:			
Q17c	Ethnic background	40	33	46
Q17c	Gender	21	20	19
Q17c	Religion	10	6	8
Q17c	Sexual orientation	7	4	5
Q17c	Disability	8	9	4
Q17c	Age	23	20	15
Q17c	Other reason(s)	28	36	32
	Job-relevant training, learning and development			
Q18a	% having received non-mandatory training, learning or development in the last 12 months	66	72	70

		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
	% who had received training, learning and development in the last 12 months (YES to Q18a) agreeing / strongly agreeing with the following statements:			
Q18b	"It has helped me to do my job more effectively"	84	84	80
Q18c	"It has helped me stay up-to-date with professional requirements"	86	88	85
Q18d	"It has helped me to deliver a better patient / service user experience"	83	83	79
Q19	% who had received mandatory training in the last 12 months	94	97	96
	Appraisals			
Q20a	% saying they had received an appraisal or performance development review in the last 12 months	86	86	87
	If (YES to Q20a) had received an appraisal or performance development review in the last 12 months:			
Q20b	% saying their appraisal or development review definitely helped them to improve how they do their job	21	21	19
Q20c	% saying their appraisal or development review definitely helped them agree clear objectives for their work	34	34	32
Q20d	% saying their appraisal or development review definitely made them feel their work was valued by the organisation	28	30	26
Q20e	% saying the values of their organisation were definitely discussed as part of the appraisal	32	32	29
Q20f	% saying their appraisal or development review had identified training, learning or development needs	63	66	64
	If (YES to Q20a) had received an appraisal or performance development review AND (YES to Q20f) training, learning or development needs identified as part of their appraisal or development review:			
Q20g	% saying their manager definitely supported them to receive training, learning or development	50	51	48
	Your organisation			
	% agreeing / strongly agreeing with the following statements:			
Q21a	"Care of patients / service users is my organisation's top priority"	66	75	65
Q21b	"My organisation acts on concerns raised by patients / service users"	65	73	65
Q21c	"I would recommend my organisation as a place to work"	47	59	47
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	48	69	48
	Patient / service user experience measures			
	% saying 'Yes'			
Q22a	"Is patient / service user experience feedback collected within your directorate / department?"	86	90	90
	If patient / service user feedback collected (YES to Q22a), % agreeing or strongly agreeing with the following statements:			
Q22b	"I receive regular updates on patient / service user experience feedback in my directorate / department"	66	61	58
Q22c	"Feedback from patients / service users is used to make informed decisions within my directorate / department"	60	56	51
	BACKGROUND DETAILS			
	Gender			
Q23a	Male	17	19	17
Q23a	Female	81	79	83
Q23a	Prefer to self-describe	0	0	0
Q23a	Prefer not to say	2	2	0

		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
	Age group			
Q23b	Between 16 and 30	18	15	19
Q23b	Between 31 and 40	19	21	18
Q23b	Between 41 and 50	28	28	26
Q23b	51 and over	34	36	36
	Ethnic background			
Q24	White	79	91	79
Q24	Mixed	1	1	2
Q24	Asian / Asian British	14	5	15
Q24	Black / Black British	5	2	4
Q24	Chinese	0	0	0
Q24	Other	1	1	1
	Sexuality			
Q25	Heterosexual (straight)	92	91	92
Q25	Gay Man	1	1	1
Q25	Gay Woman (lesbian)	1	1	0
Q25	Bisexual	1	1	1
Q25	Other	0	0	1
Q25	Preferred not to say	5	6	5
	Religion			
Q26	No religion	27	32	26
Q26	Christian	54	55	57
Q26	Buddhist	0	0	0
Q26	Hindu	3	1	3
Q26	Jewish	0	0	0
Q26	Muslim	5	2	5
Q26	Sikh	4	0	4
Q26	Other	1	1	1
Q26	Preferred not to say	6	5	4
	Disability			
Q27a	% saying they have a long-standing illness, health problem or disability	15	18	17
Q27b	If long-standing disability (YES to Q27a and if adjustments felt necessary), % saying their employer has made adequate adjustment(s) to enable them to carry out their work	71	73	70
	Length of time at the organisation (or its predecessors)			
Q28	Less than 1 year	6	8	8
Q28	1 to 2 years	12	13	13
Q28	3 to 5 years	17	17	15
Q28	6 to 10 years	20	18	19
Q28	11 to 15 years	14	14	15
Q28	More than 15 years	31	29	30

		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
	Occupational group			
Q29	Registered Nurses and Midwives	27	29	27
Q29	Nursing or Healthcare Assistants	7	8	7
Q29	Medical and Dental	5	8	7
Q29	Allied Health Professionals	16	15	17
Q29	Scientific and Technical / Healthcare Scientists	5	7	6
Q29	Social Care staff	0	0	0
Q29	Emergency Care Practitioner	0	0	0
Q29	Paramedic	0	0	0
Q29	Emergency Care Assistant	0	0	0
Q29	Ambulance Technician	0	0	0
Q29	Ambulance Control Staff	0	0	0
Q29	Patient Transport Service	0	0	0
Q29	Public Health / Health Improvement	0	0	1
Q29	Commissioning staff	0	0	0
Q29	Admin and Clerical	19	17	19
Q29	Central Functions / Corporate Services	8	6	6
Q29	Maintenance / Ancillary	6	3	6
Q29	General Management	3	2	3
Q29	Other	4	3	3
	Team working			
Q30a	% working in a team	96	96	96
	(If YES to Q30a): Number of core members in their team			
Q30b	2-5	24	21	25
Q30b	6-9	25	21	23
Q30b	10-15	20	19	21
Q30b	More than 15	31	39	31

Appendix 4

Other NHS staff survey 2017 documentation

This report is one of several ways in which we present the results of the 2017 national NHS staff survey:

1) A separate summary report of the main 2017 survey results for Walsall Healthcare NHS Trust can be downloaded from: www.nhsstaffsurveys.com. The summary report is a shorter version of this feedback report, which may be useful for wider circulation within the trust.

2) A national briefing document, describing the national Key Findings from the 2017 survey and making comparisons with previous years, will be available from www.nhsstaffsurveys.com in March 2018.

3) The document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com. This includes details about the calculation of Key Findings and the data weighting method used.

4) A series of detailed spreadsheets will be made available after publication via www.nhsstaffsurveys.com. In these detailed spreadsheets you will be able to find:
    - responses of staff in your trust to every core survey question
    - responses in every trust in England
    - the average responses for each major trust type (e.g. all acute trusts, all ambulance trusts)
    - the average responses for each major occupational and demographic group within the major trust types

2017 National NHS staff survey

Brief summary of results from Walsall Healthcare NHS Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2017 national NHS staff survey conducted in Walsall Healthcare NHS Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2017 survey results for Walsall Healthcare NHS Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

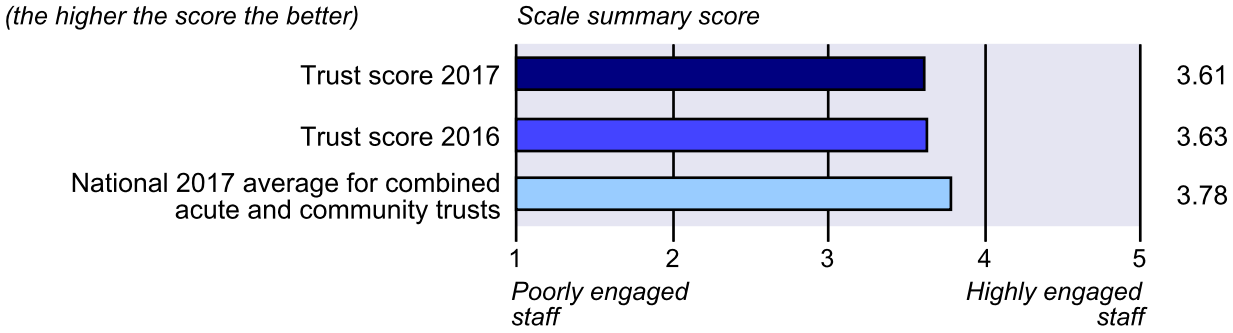
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	66%	75%	65%
Q21b	"My organisation acts on concerns raised by patients / service users"	65%	73%	65%
Q21c	"I would recommend my organisation as a place to work"	47%	59%	47%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	48%	69%	48%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.38	3.75	3.44

2. Overall indicator of staff engagement for Walsall Healthcare NHS Trust

The figure below shows how Walsall Healthcare NHS Trust compares with other combined acute and community trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.61 was below (worse than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how Walsall Healthcare NHS Trust compares with other combined acute and community trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Change since 2016 survey	Ranking, compared with all combined acute and community trusts
OVERALL STAFF ENGAGEMENT	• No change	! Below (worse than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	! Decrease (worse than 16)	! Below (worse than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	! Below (worse than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	! Below (worse than) average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

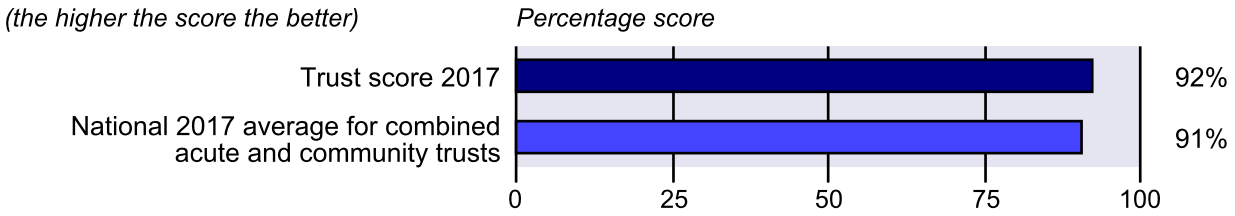
3. Summary of 2017 Key Findings for Walsall Healthcare NHS Trust

3.1 Top and Bottom Ranking Scores

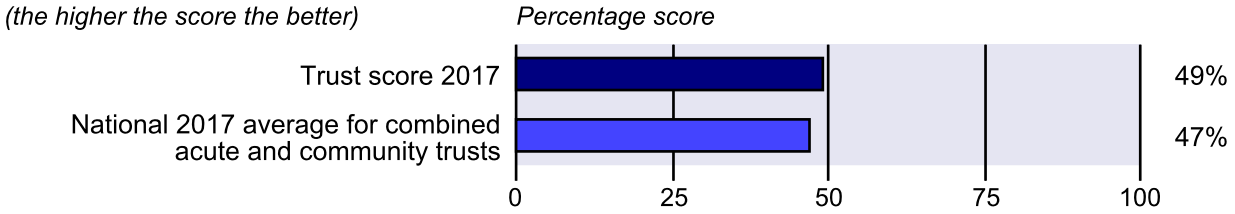
This page highlights the five Key Findings for which Walsall Healthcare NHS Trust compares most favourably with other combined acute and community trusts in England.

TOP FIVE RANKING SCORES

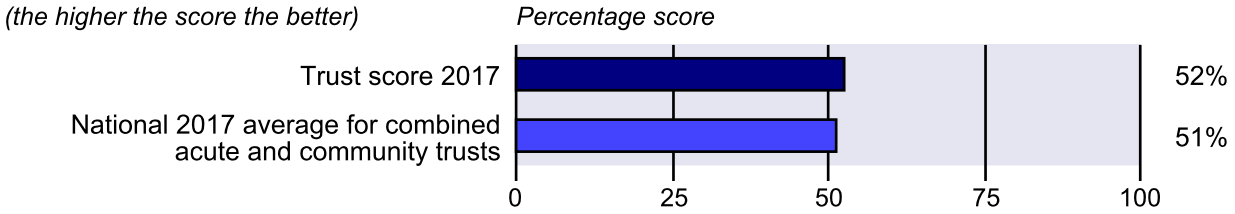
✓KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



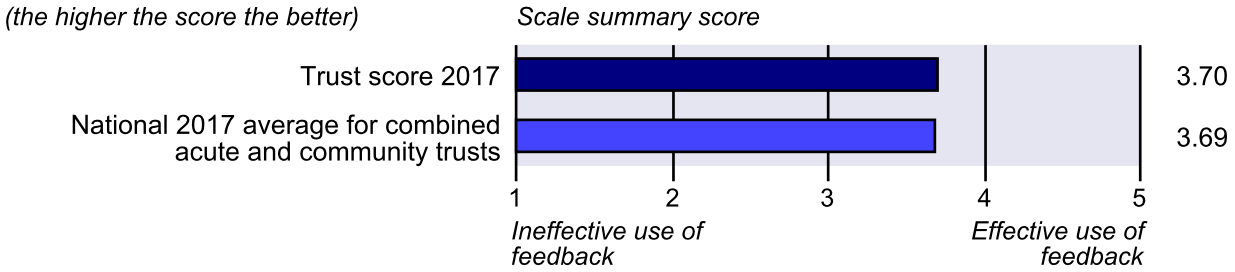
✓KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



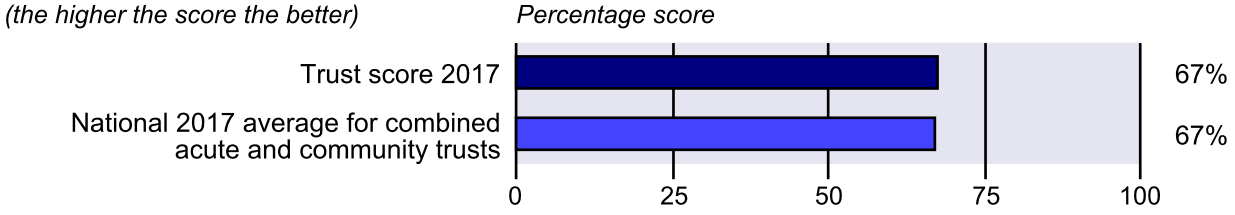
✓KF15. Percentage of staff satisfied with the opportunities for flexible working patterns



✓KF32. Effective use of patient / service user feedback



✓KF24. Percentage of staff / colleagues reporting most recent experience of violence



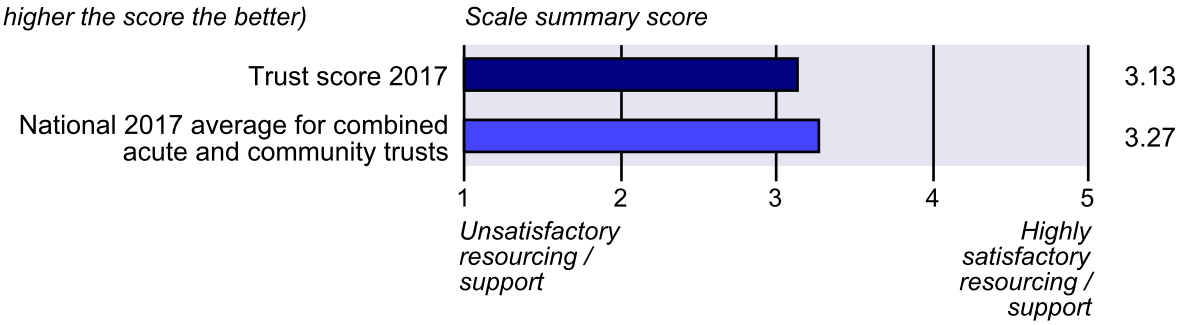
For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 43 (the bottom ranking score). Walsall Healthcare NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which Walsall Healthcare NHS Trust compares least favourably with other combined acute and community trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

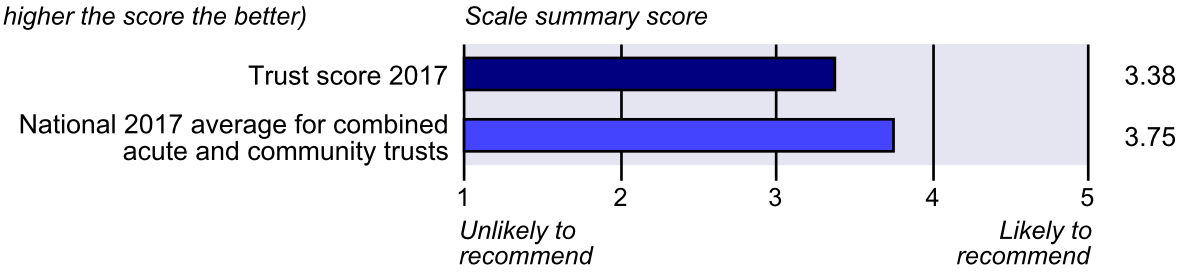
! KF14. Staff satisfaction with resourcing and support

(the higher the score the better)



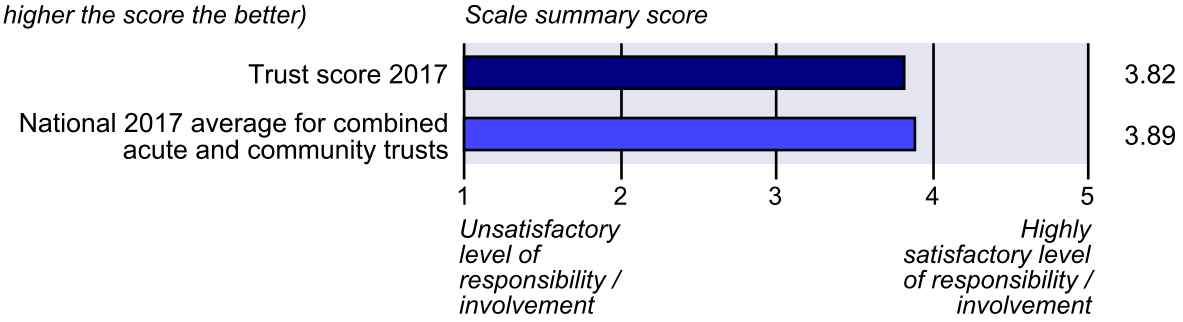
! KF1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



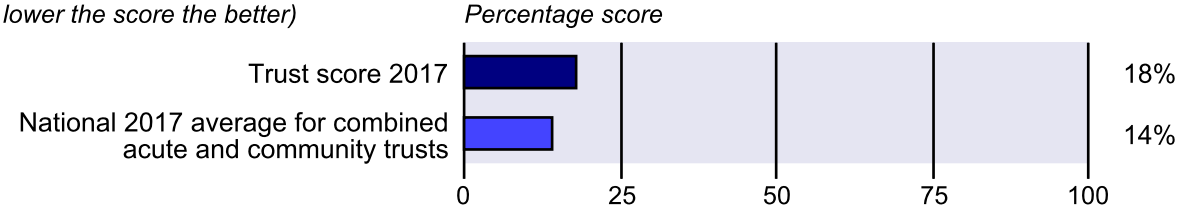
! KF8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



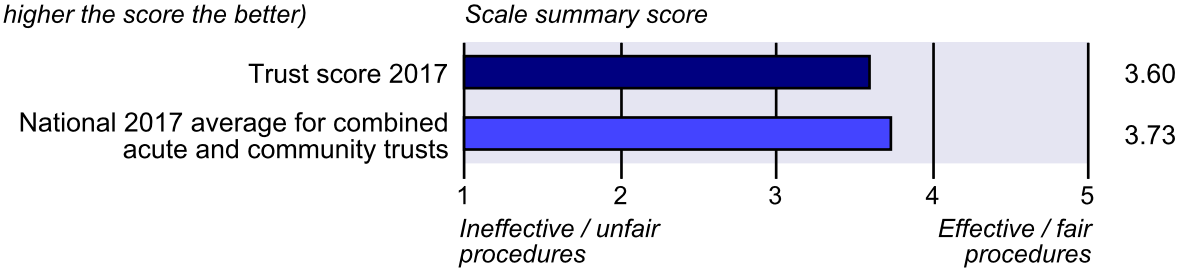
! KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



! KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



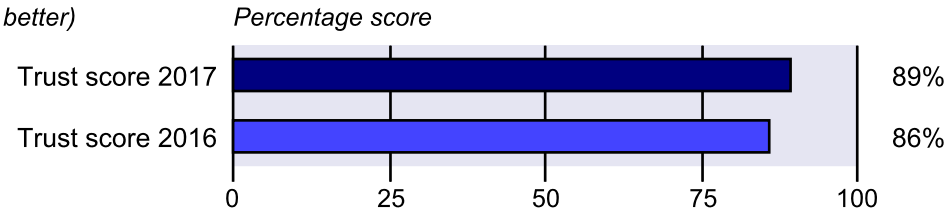
3.2 Largest Local Changes since the 2016 Survey

This page highlights the three Key Findings where staff experiences have improved at Walsall Healthcare NHS Trust since the 2016 survey. (This is a positive local result. However, please note that, as shown in section 3.3, when compared with other combined acute and community trusts in England, the score for Key finding KF3 is worse than average).

WHERE STAFF EXPERIENCE HAS IMPROVED

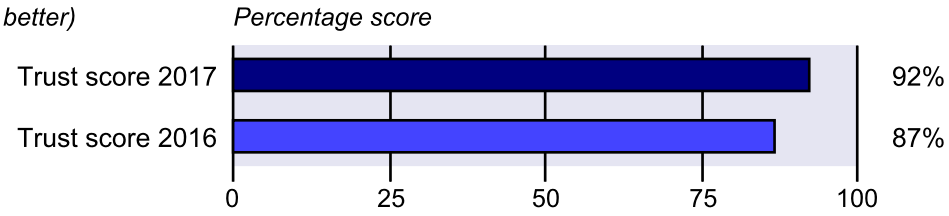
✓KF3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



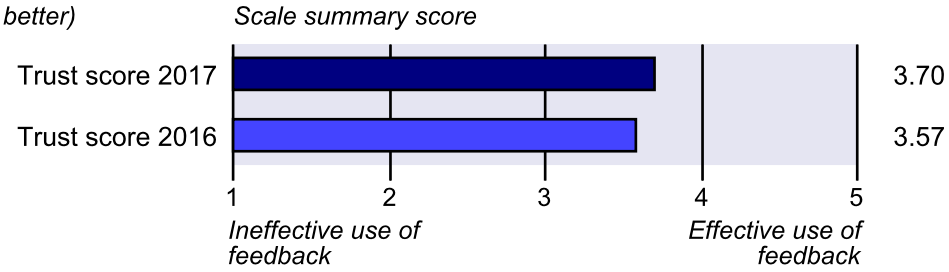
✓KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



✓KF32. Effective use of patient / service user feedback

(the higher the score the better)



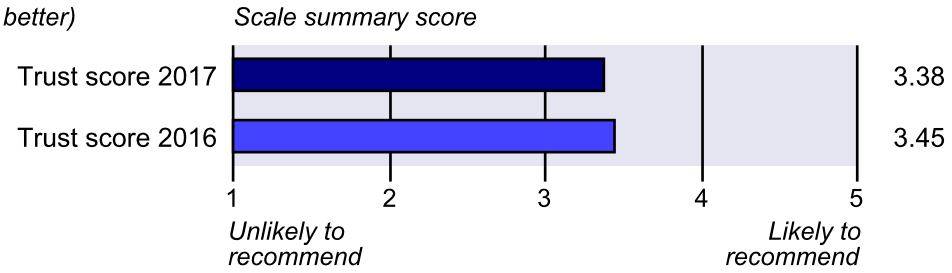
Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have improved the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the Key Finding that has deteriorated at Walsall Healthcare NHS Trust since the 2016 survey. It is suggested that this might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

! KF1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have deteriorated the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.3. Summary of all Key Findings for Walsall Healthcare NHS Trust

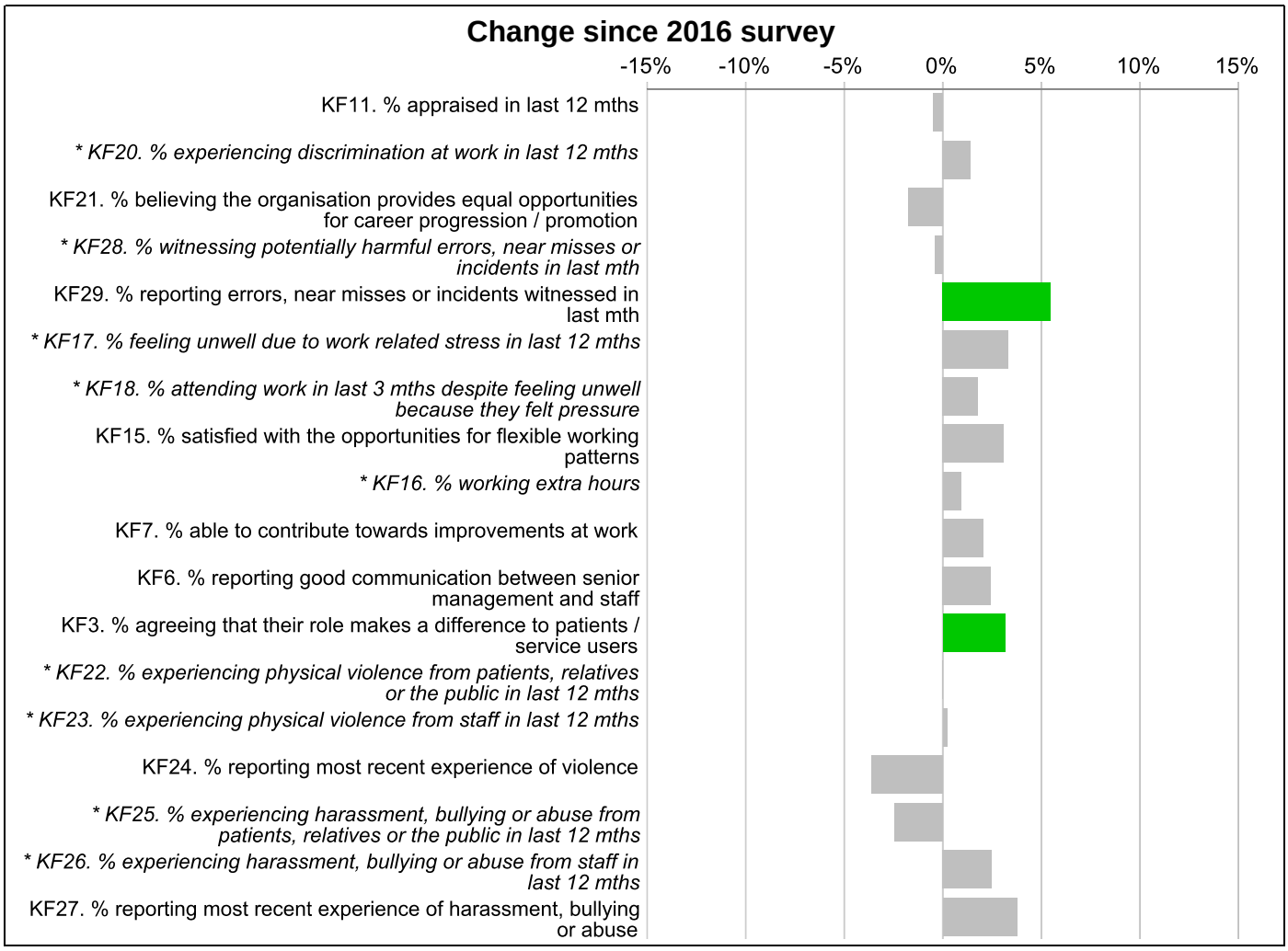
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Walsall Healthcare NHS Trust

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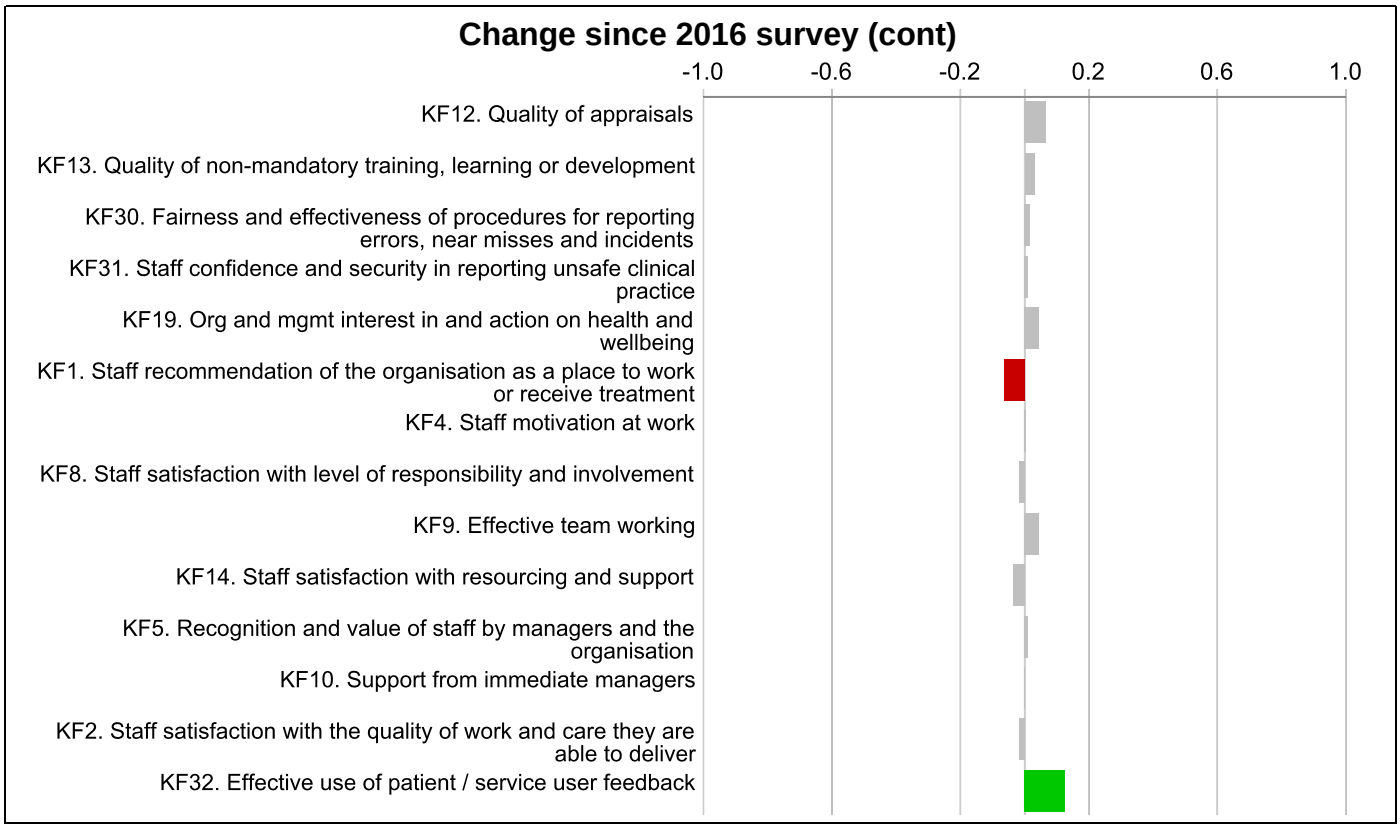
Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Walsall Healthcare NHS Trust

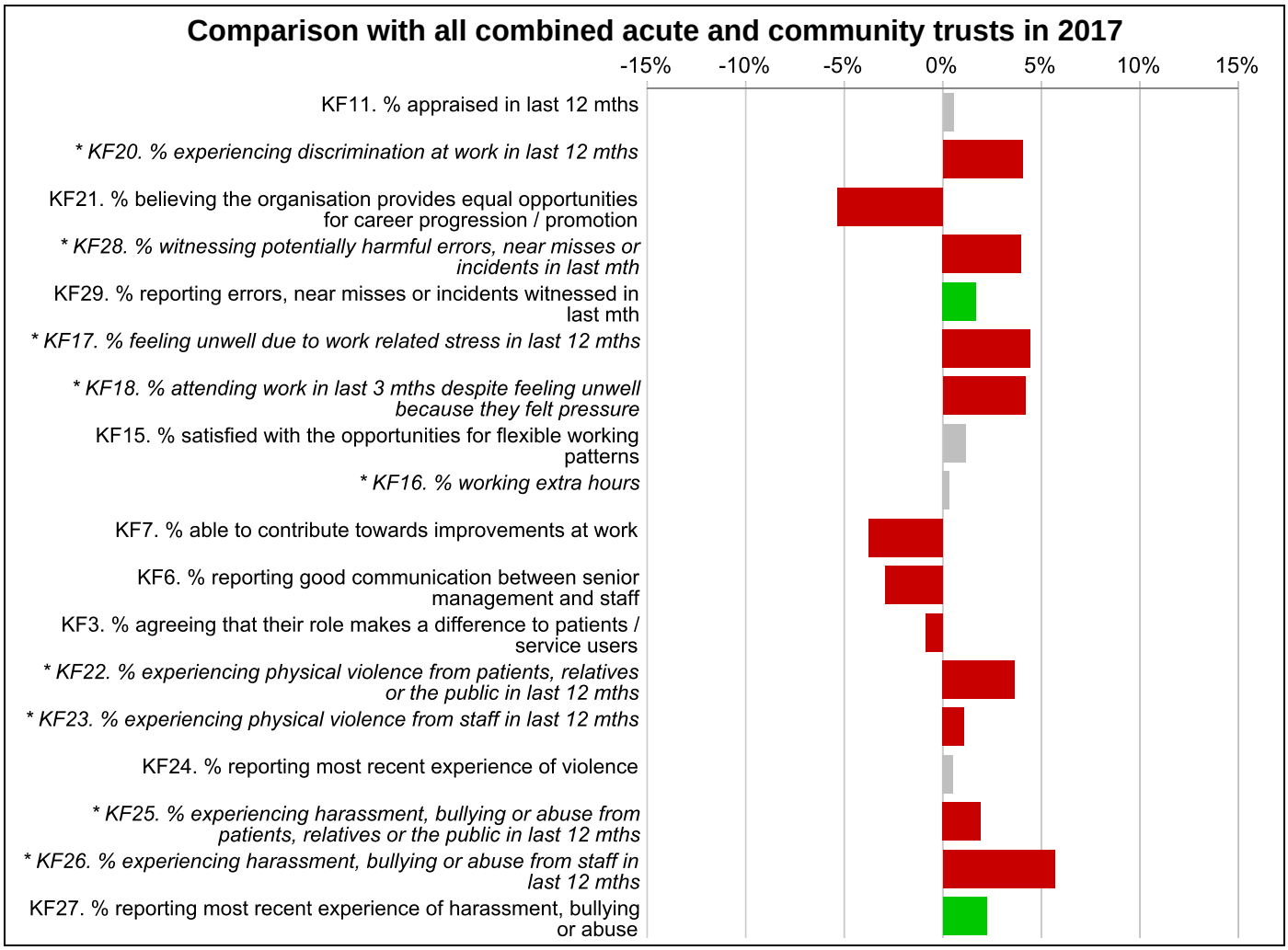
KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Walsall Healthcare NHS Trust

KEY

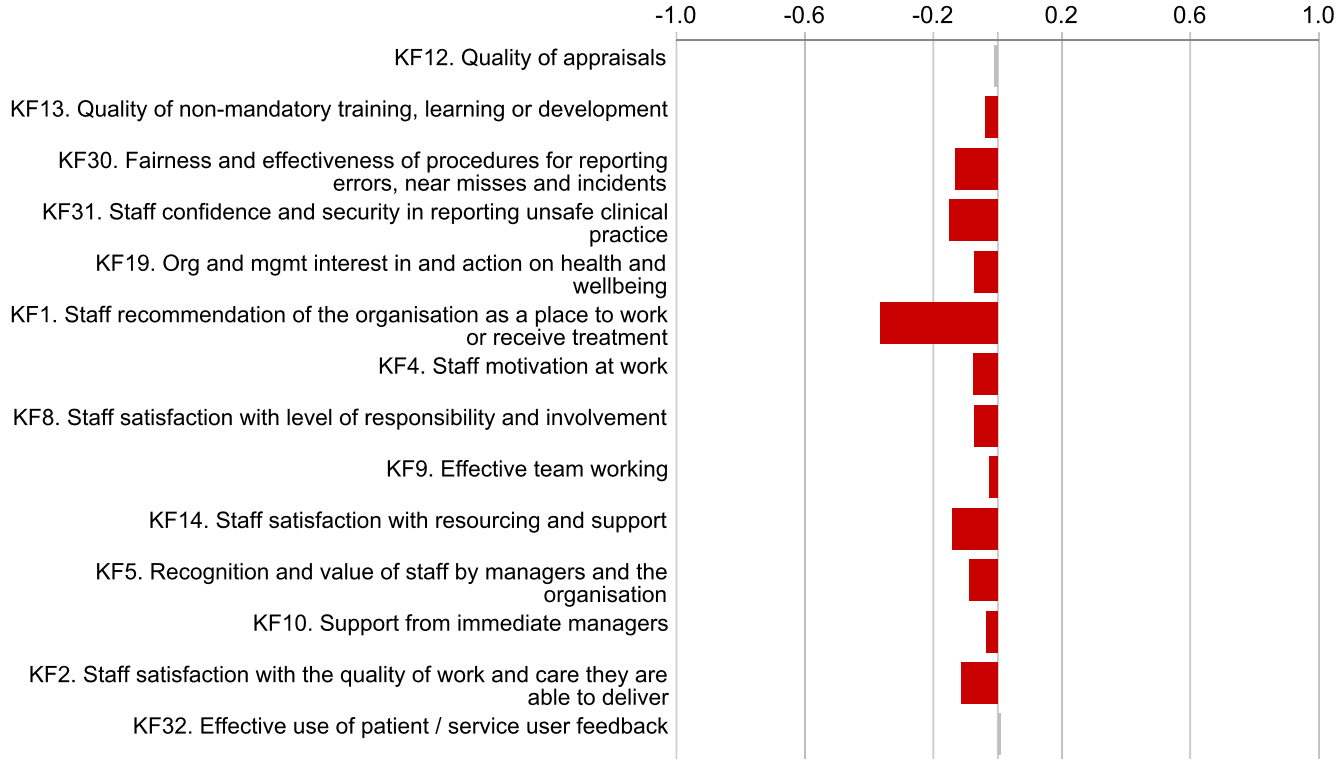
Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all combined acute and community trusts in 2017 (cont)



3.4. Summary of all Key Findings for Walsall Healthcare NHS Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2016.

! Red = Negative finding, e.g. worse than average, worse than 2016.

'Change since 2016 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2016 survey.

-- No comparison to the 2016 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2016 survey	Ranking, compared with all combined acute and community trusts in 2017
Appraisals & support for development		
KF11. % appraised in last 12 mths	• No change	• Average
KF12. Quality of appraisals	• No change	• Average
KF13. Quality of non-mandatory training, learning or development	• No change	! Below (worse than) average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	! Above (worse than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	! Below (worse than) average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	! Above (worse than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	✓ Increase (better than 16)	✓ Above (better than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	! Below (worse than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	! Below (worse than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	! Above (worse than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	! Above (worse than) average
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	! Below (worse than) average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	• Average
* *KF16. % working extra hours*	• No change	• Average

3.4. Summary of all Key Findings for Walsall Healthcare NHS Trust (cont)

	Change since 2016 survey	Ranking, compared with all combined acute and community trusts in 2017
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	! Decrease (worse than 16)	! Below (worse than) average
KF4. Staff motivation at work	• No change	! Below (worse than) average
KF7. % able to contribute towards improvements at work	• No change	! Below (worse than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	! Below (worse than) average
KF9. Effective team working	• No change	! Below (worse than) average
KF14. Staff satisfaction with resourcing and support	• No change	! Below (worse than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	! Below (worse than) average
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF10. Support from immediate managers	• No change	! Below (worse than) average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	! Below (worse than) average
KF3. % agreeing that their role makes a difference to patients / service users	✓ Increase (better than 16)	! Below (worse than) average
KF32. Effective use of patient / service user feedback	✓ Increase (better than 16)	• Average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	! Above (worse than) average
KF24. % reporting most recent experience of violence	• No change	• Average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Above (worse than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	✓ Above (better than) average

4. Key Findings for Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust had 1536 staff take part in this survey. This is a response rate of 36%[1] which is below average for combined acute and community trusts in England (43%), and compares with a response rate of 42% in this trust in the 2016 survey.

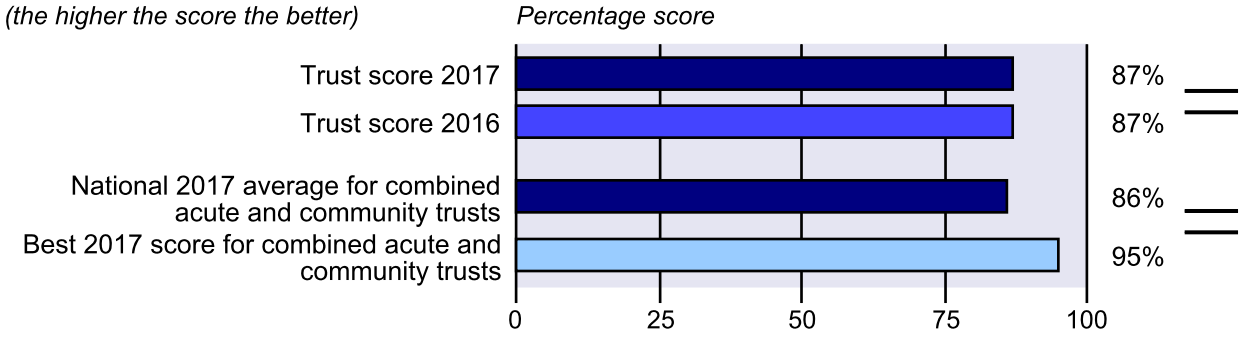
This section presents each of the 32 Key Findings, using data from the trust's 2017 survey, and compares these to other combined acute and community trusts in England and to the trust's performance in the 2016 survey. The findings are arranged under nine themes: appraisals and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience , and violence, harassment and bullying.

Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2016). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2016). An equals sign indicates that there has been no change.

Appraisals & support for development

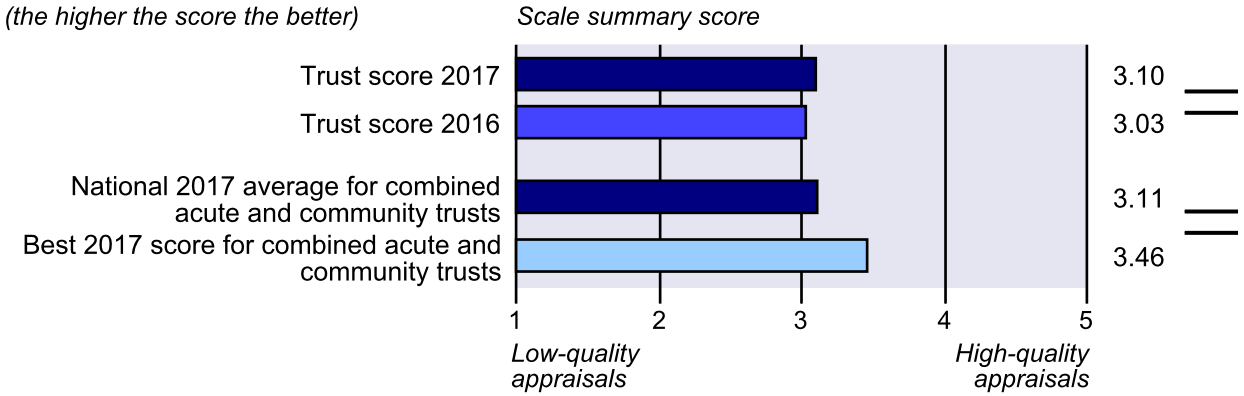
KEY FINDING 11. Percentage of staff appraised in last 12 months

(the higher the score the better)



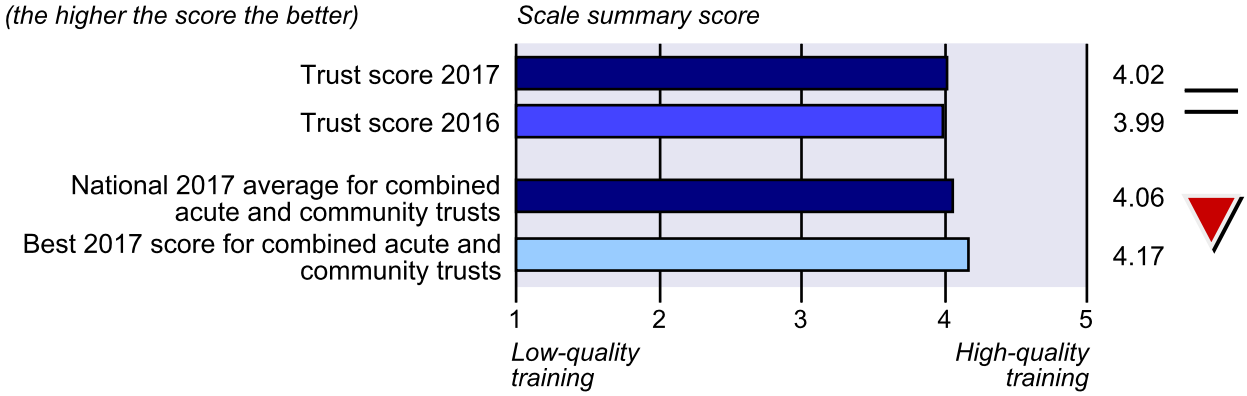
KEY FINDING 12. Quality of appraisals

(the higher the score the better)



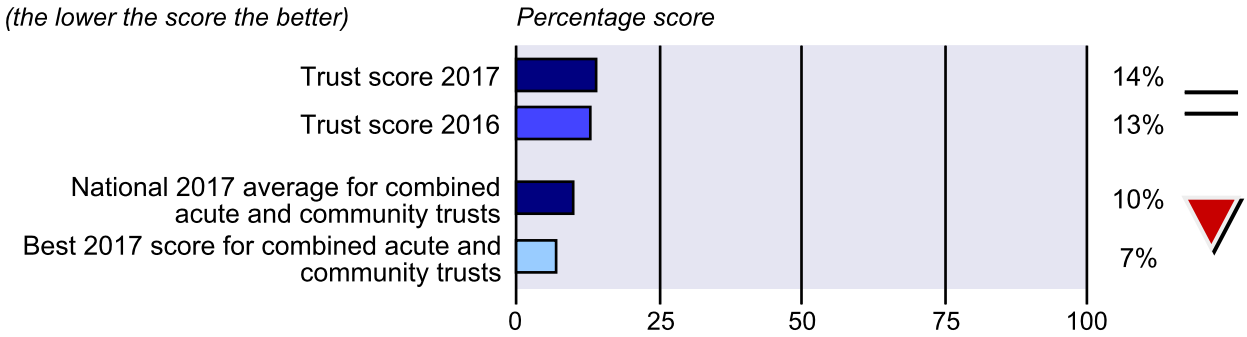
[1]Questionnaires were sent to all 4262 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

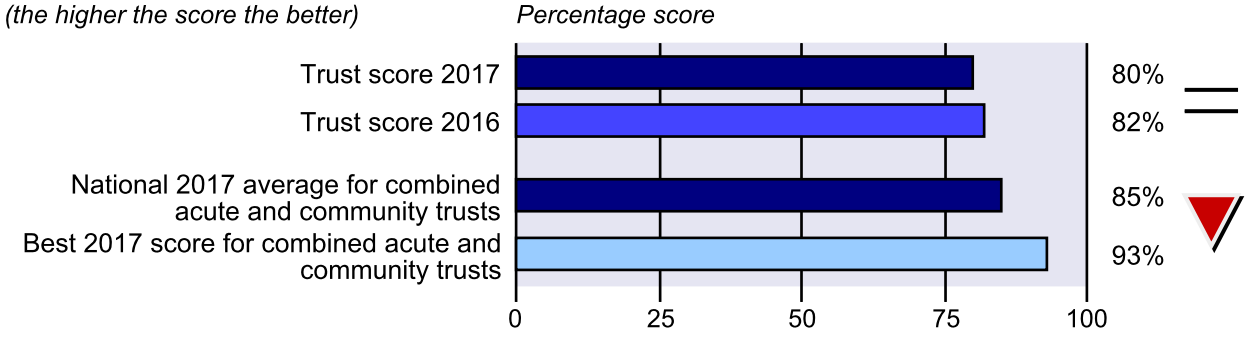


Equality & diversity

KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

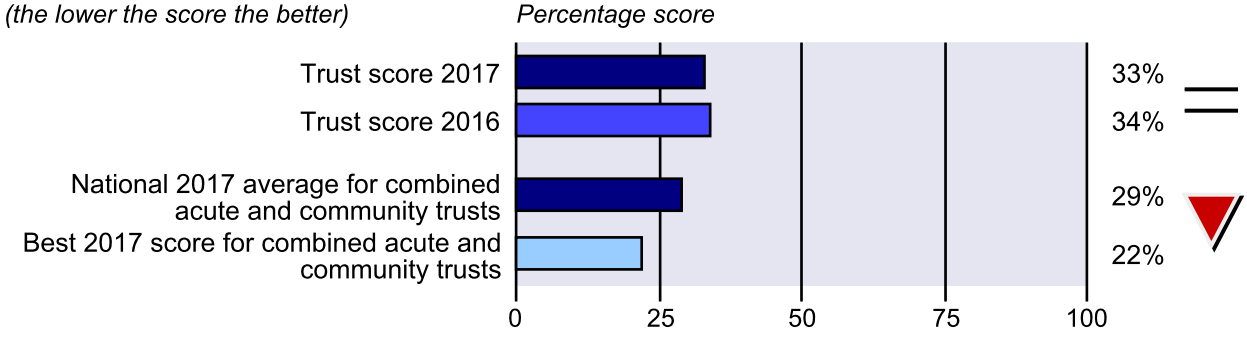


KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



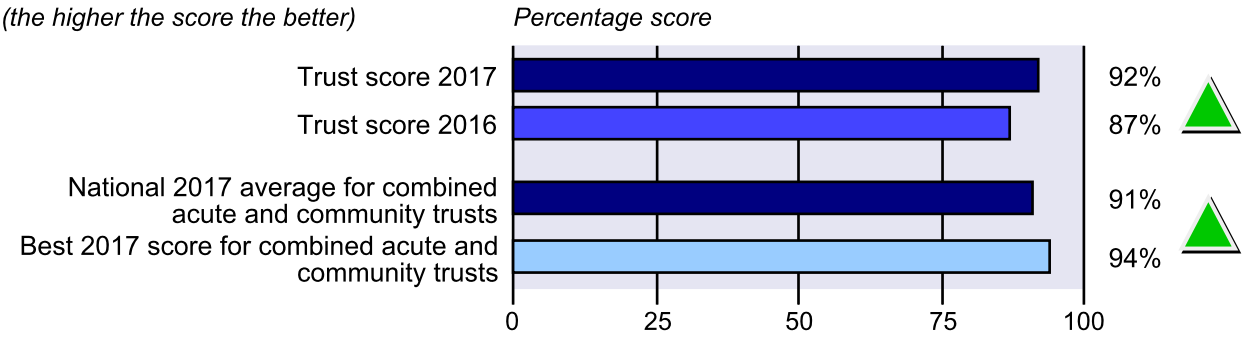
Errors & incidents

KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month



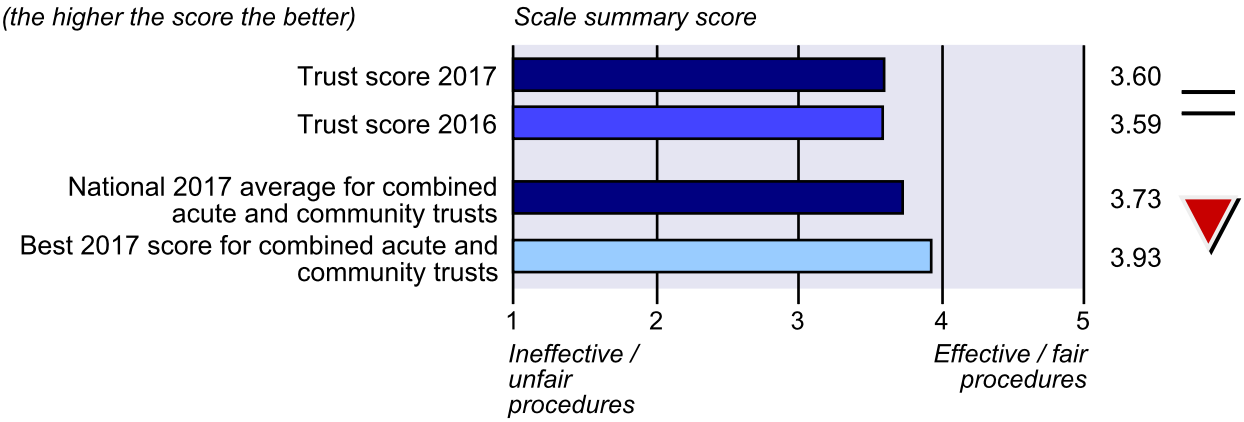
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



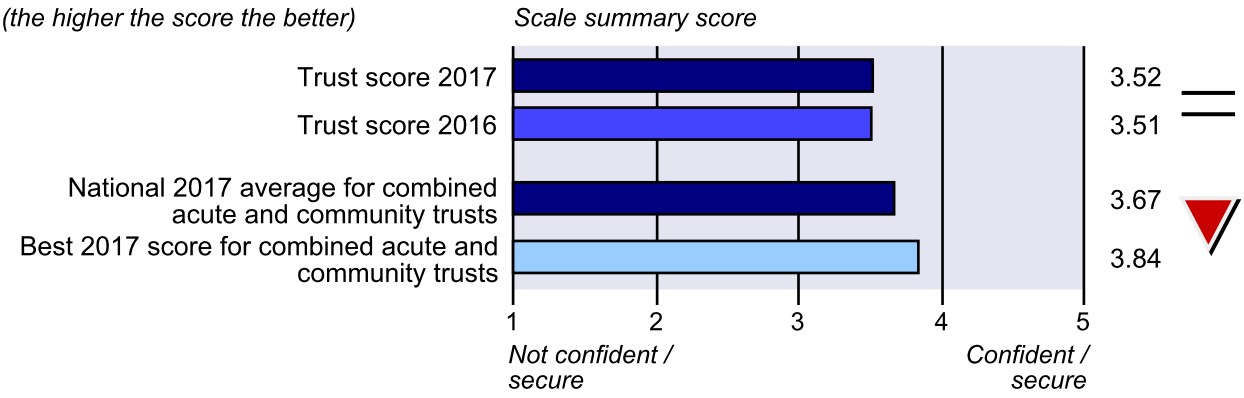
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

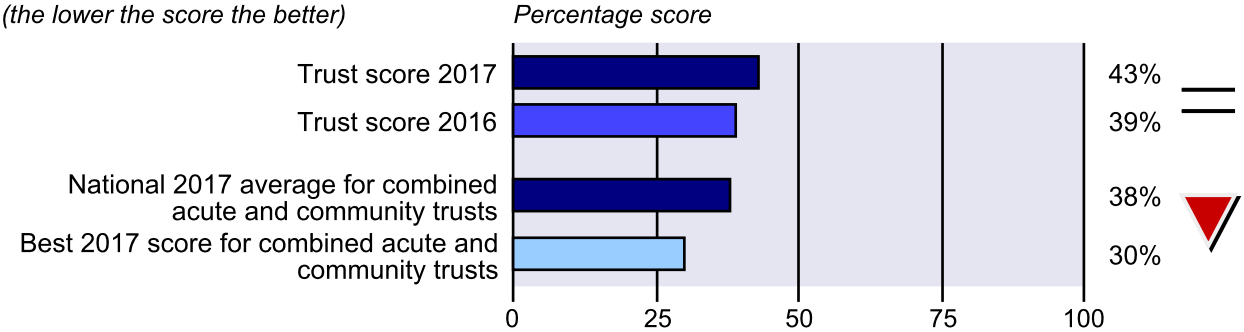
(the higher the score the better)



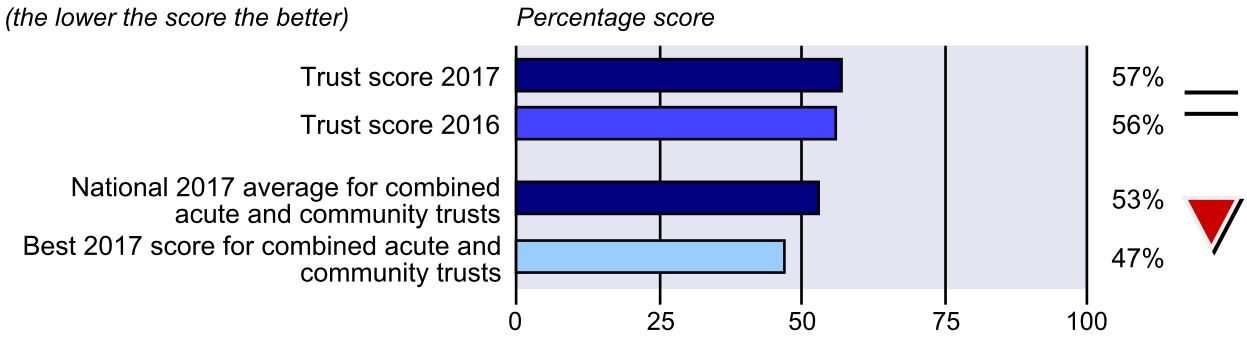
Health and wellbeing

KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

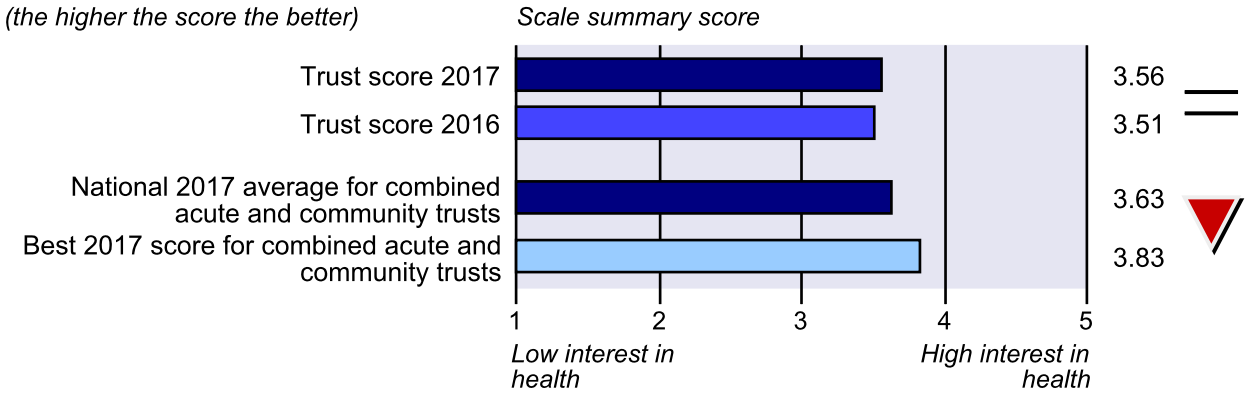
(the lower the score the better)



KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

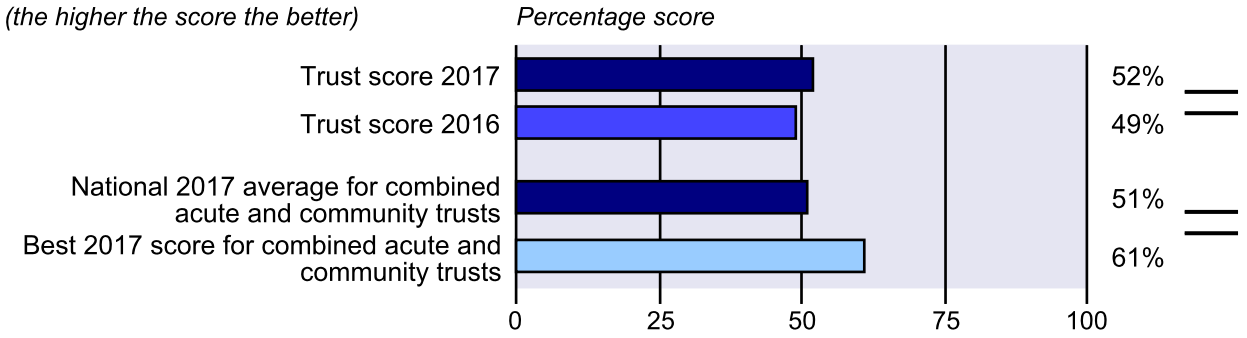


KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

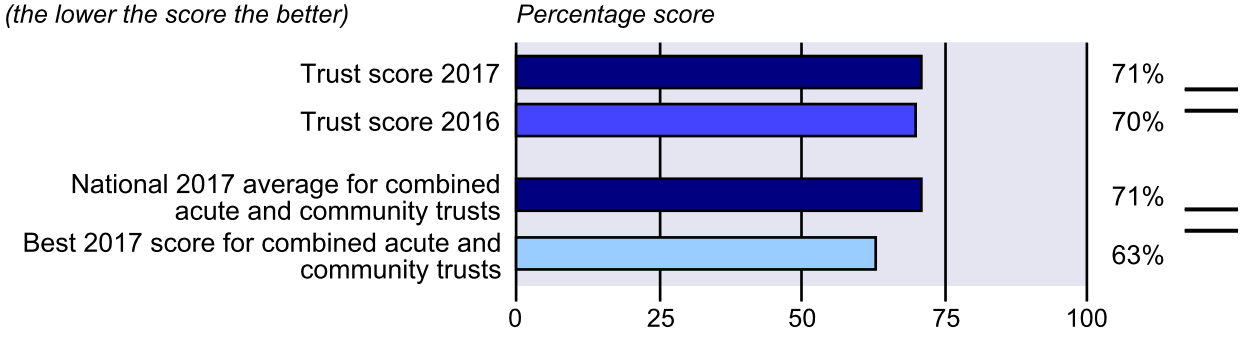


Working patterns

KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns



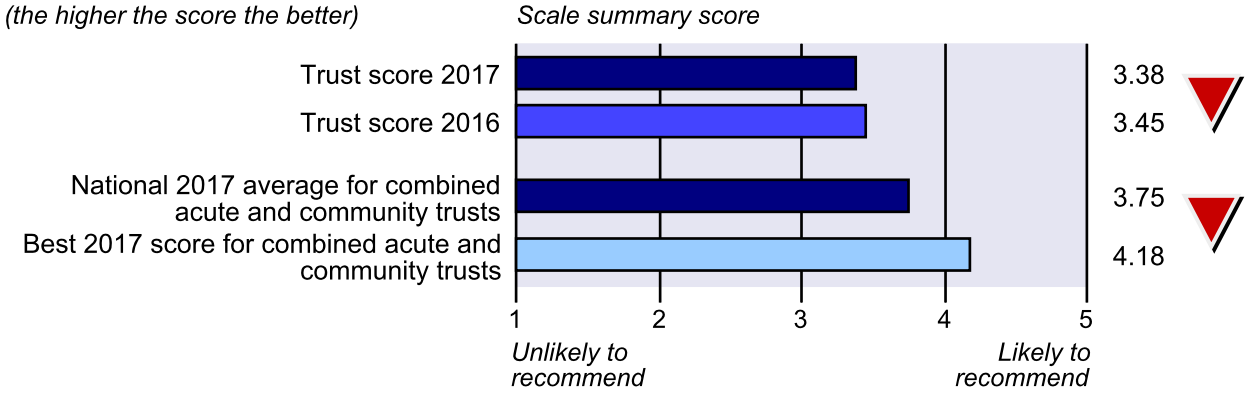
KEY FINDING 16. Percentage of staff working extra hours



Job satisfaction

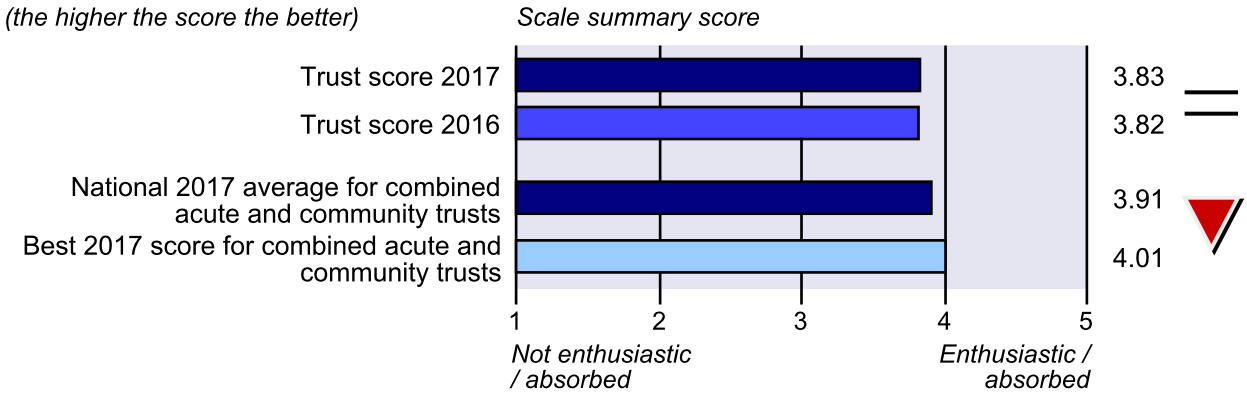
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



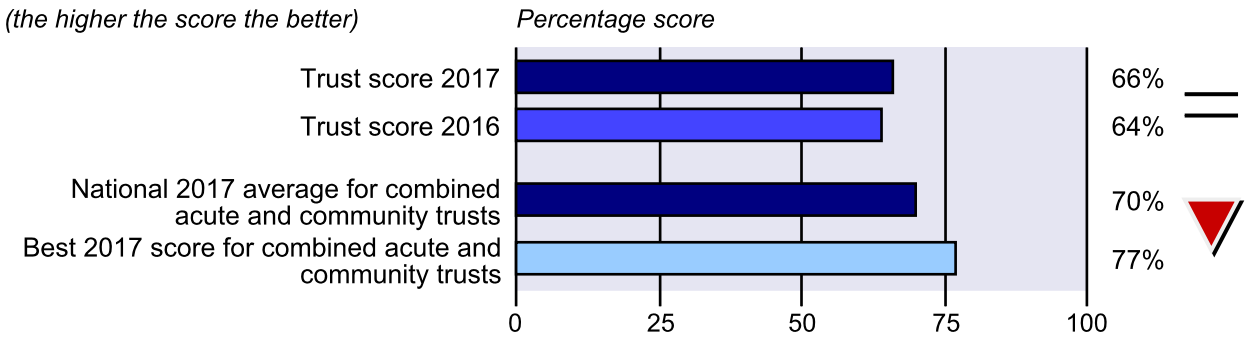
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



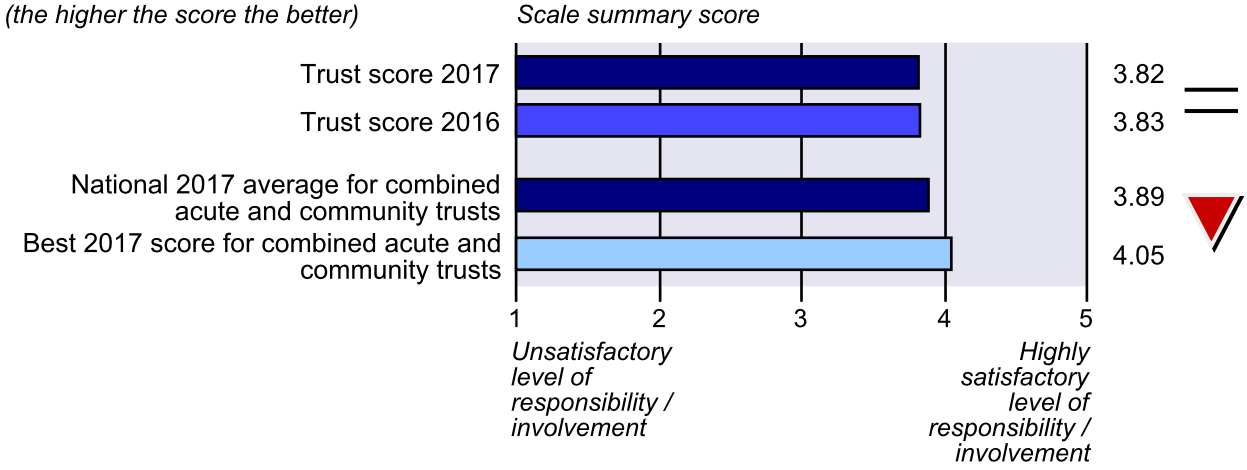
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)

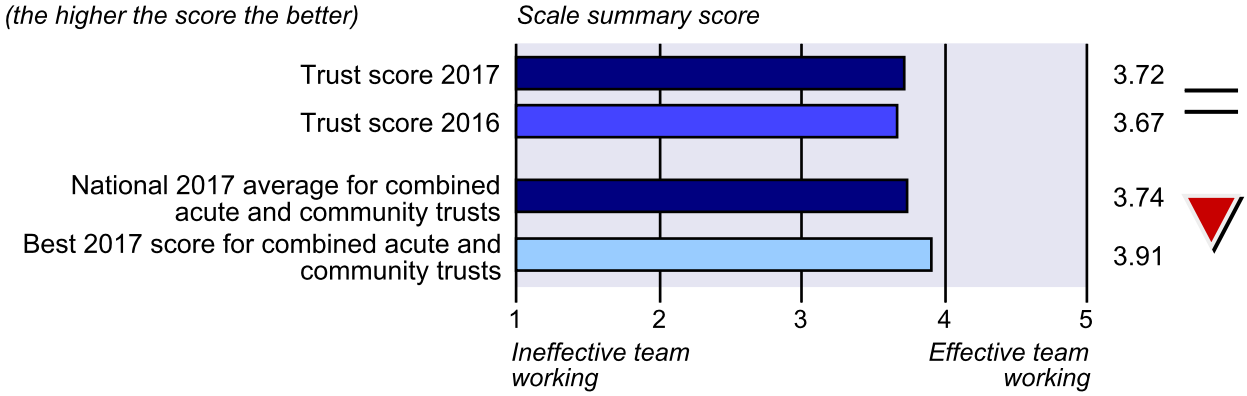


KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

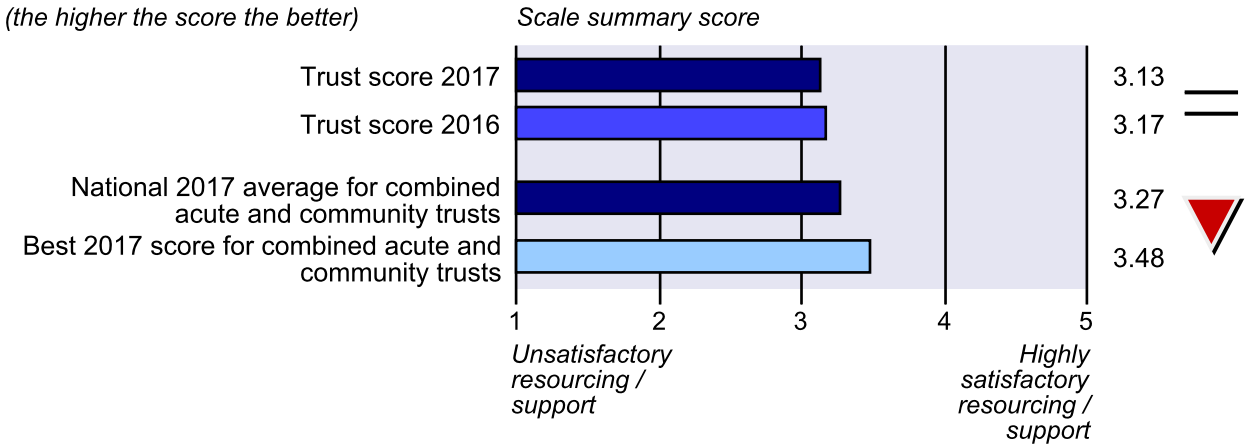
(the higher the score the better)



KEY FINDING 9. Effective team working

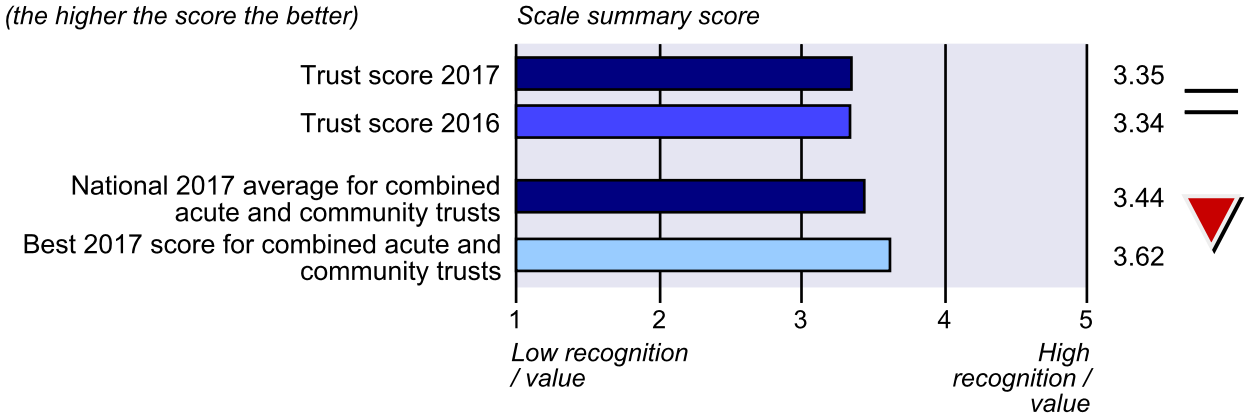


KEY FINDING 14. Staff satisfaction with resourcing and support

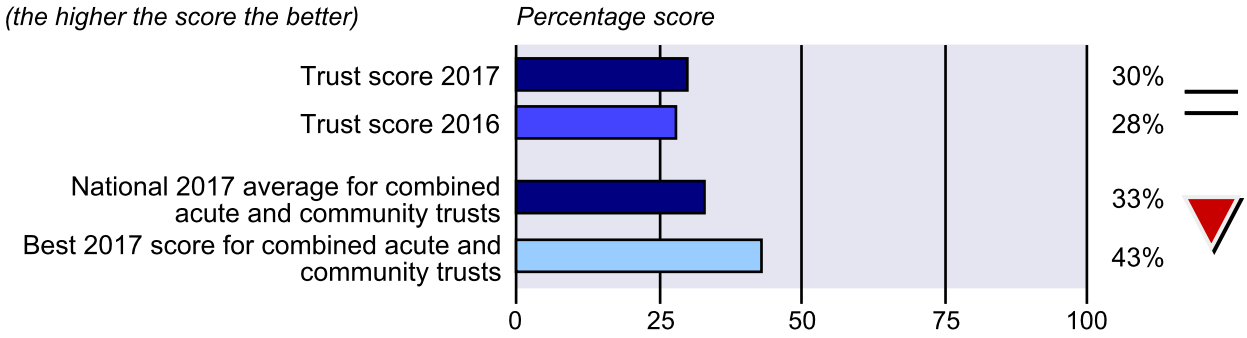


Managers

KEY FINDING 5. Recognition and value of staff by managers and the organisation

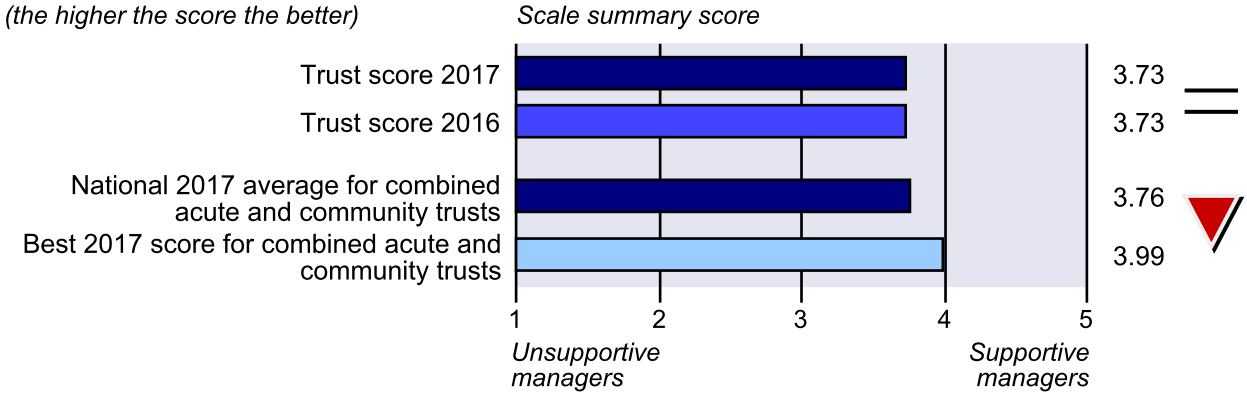


KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff



KEY FINDING 10. Support from immediate managers

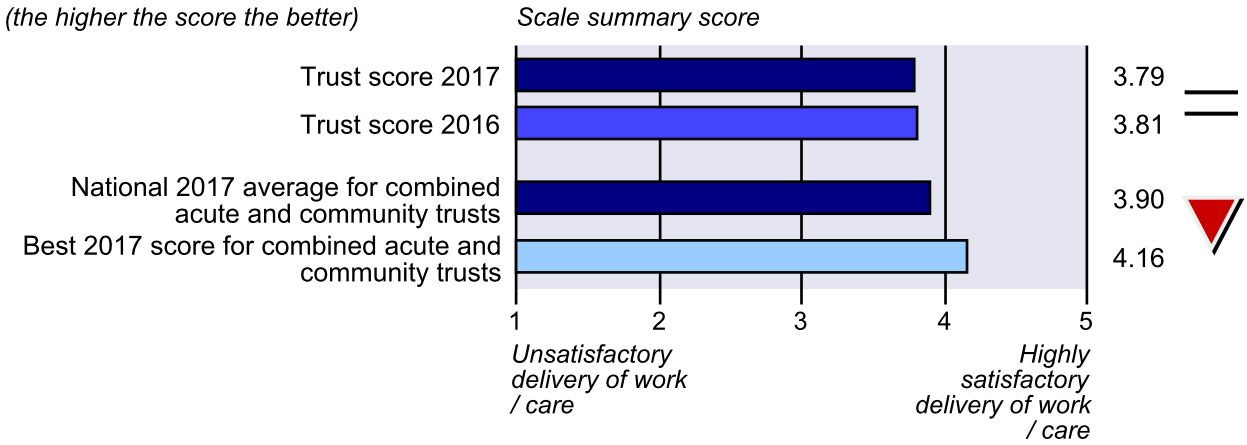
(the higher the score the better)



Patient care & experience

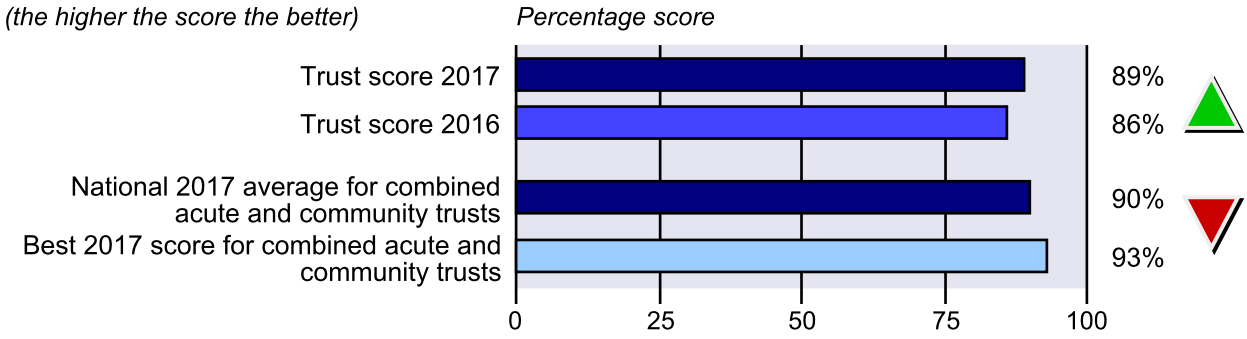
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



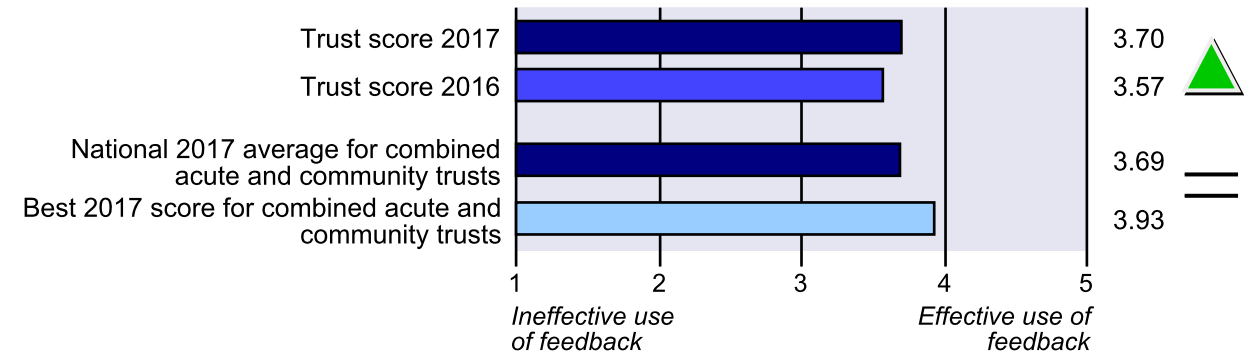
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



KEY FINDING 32. Effective use of patient / service user feedback

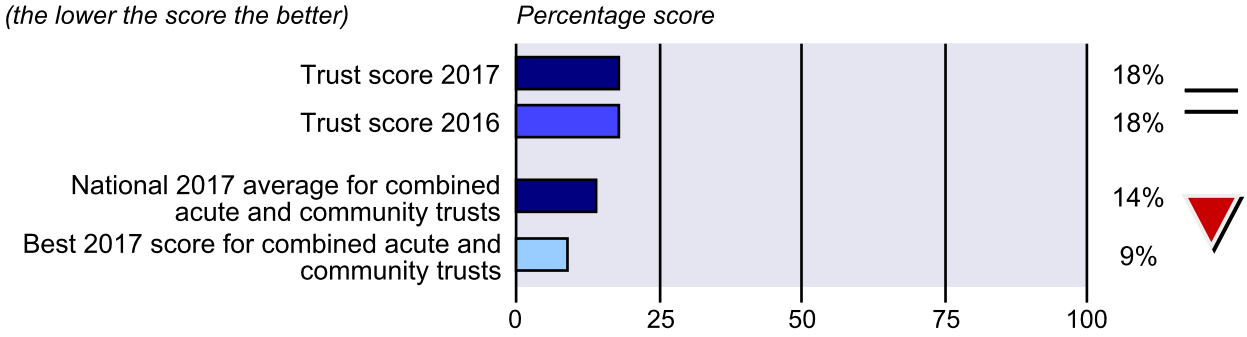
(the higher the score the better)



Violence, harassment & bullying

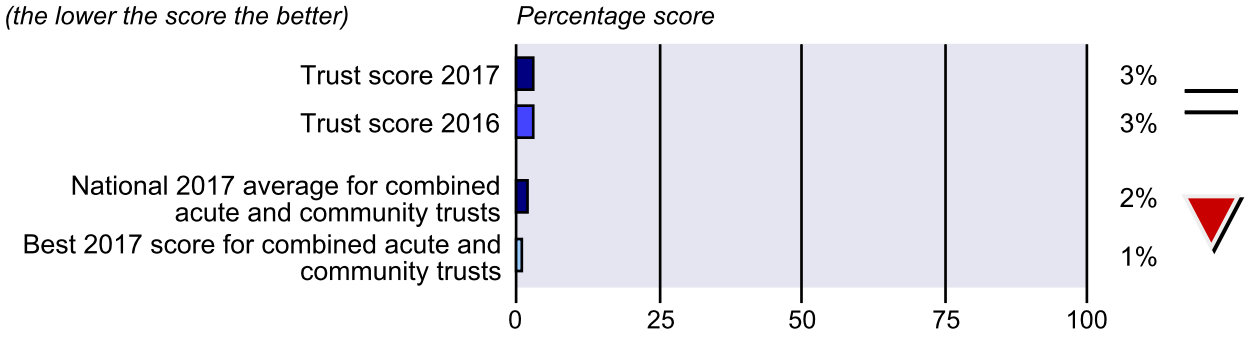
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



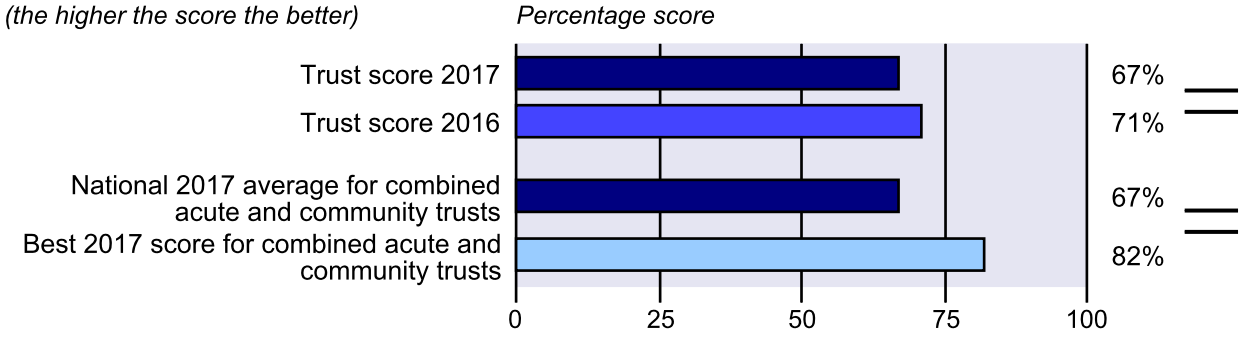
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



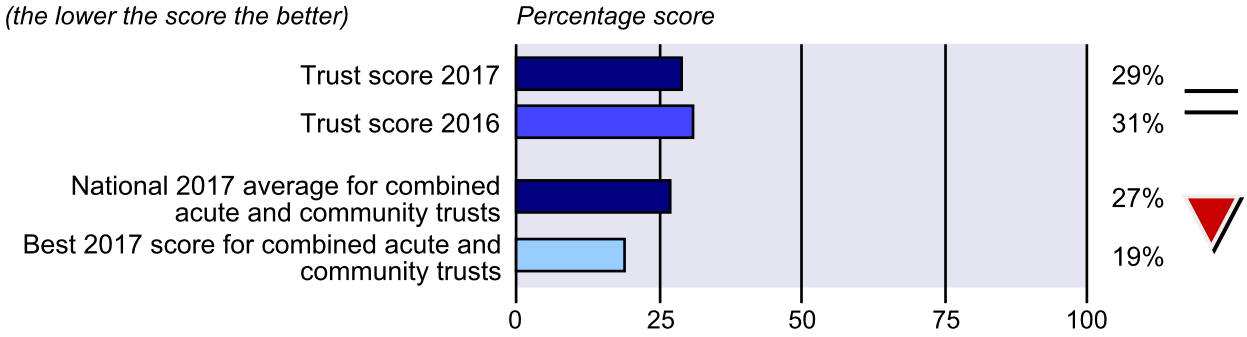
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



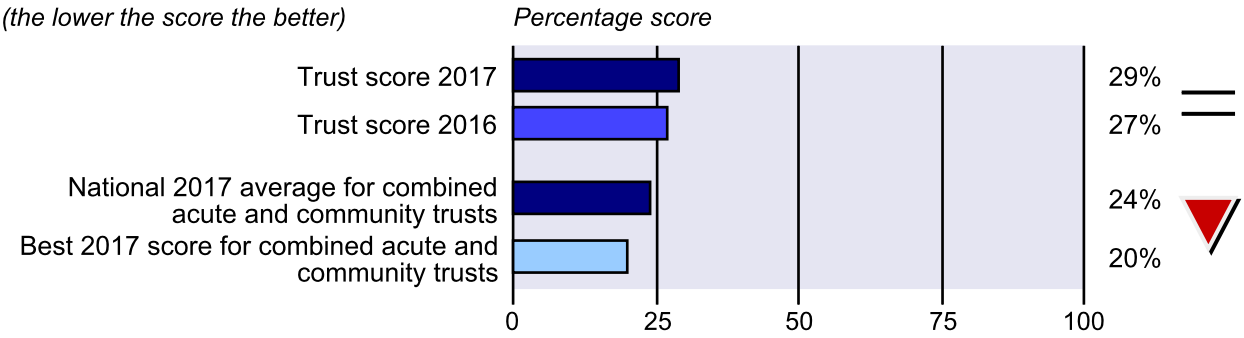
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



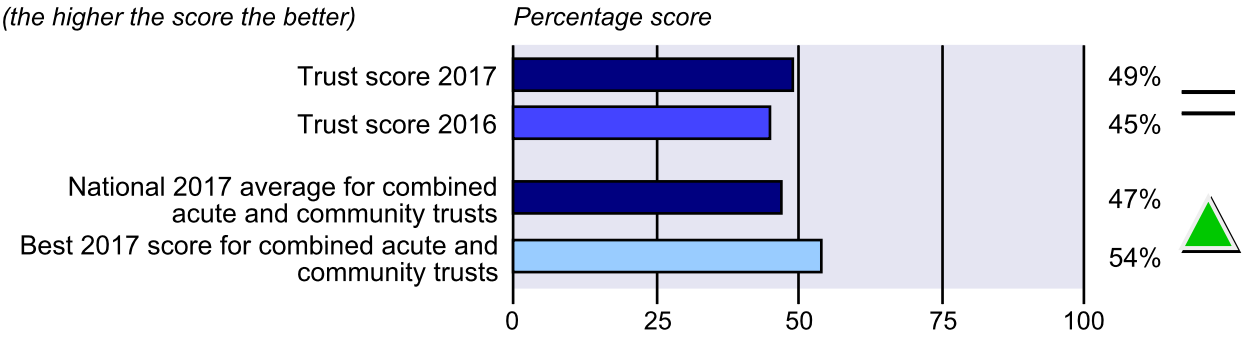
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



Dudley and Walsall NHS
Mental Health Partnership NHS Trust

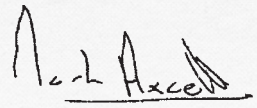
Our Board promises to...

"...value and support our staff by being excellent role models of the values designed by them.

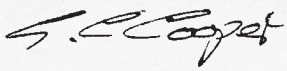
WE WILL NOT TOLERATE BULLYING.

We will take action when this occurs and will encourage and support staff to speak out through a culture where it is safe to challenge. This will ensure that staff are empowered to deliver the best possible care to our service users. We will evidence this through staff and service user surveys, listening and acting on feedback and living and reviewing our Trust values with all our staff."

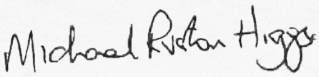
DANIELLE OUM



MARK AXCELL

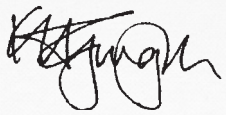


GILL COOPER



MICHAEL HIGGS

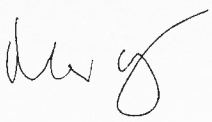
DAVID MATTHEWS



KATE GINGELL

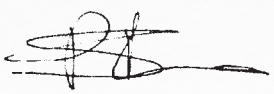
MARK WEAVER

WENDY PUGH



MARSHA INGRAM

DR SIMON MURPHY



PAWITER RANA

OLIVIA CLYMER

RUPERT DAVIES

better together

Walsall Healthcare NHS
NHS Trust

2017/18 Finance Report
February 2018 (Month 11)

Becoming your partners for first class integrated care

2017/18 Finance Report: April 2017 to February 2018 (Month 11)	Page
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Key Messages

Financial Month 11 plan.	• The total financial position for the Trust at M11 is a deficit of £23.3m against the planned deficit of £19m, resulting in an unfavorable variance of £4.2m (£3.6m January) • The Trust had targeted delivery of a £20.5m deficit for the year, this is now revised to £23.0m deficit supported by agreed recovery plans. There remains risk to the delivery of the £23.0m deficit. • 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 (£7.8m delivered to date against a target of £9.9m) and 26.9% 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 £1.7m (Nursing high based on historic trends).
Financial Risks	• Ability to deliver revised financial forecast given spending on temporary workforce and income risk • CIP achievement 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 £7.8m delivered YTD of which £2.1m is achieved non-recurrently.
Bank, Agency and Locum spend	• Temporary staffing costs reduced in February 18 by £163k to £1.69m (£1.86m in January 18). • Agency costs reduced by £149k to £0.64m in February 18 (£0.79m in January 18). • Bank Staffing costs increased by £39k to £0.61m in February 18 (£0.57m in January 18). • Locum staffing costs reduced by £53k in February 18 to £0.45m (£0.50m in January 18).

Summary Financial Performance to February 2018 (Month 11)

Financial Performance - Period ended 28th February 2018					
Description	**Annual Budget**	**Budget to Date**	**Actual to Date**		**Variance**
	£'000	£'000	£'000		£'000
Income					
NHS Activity Revenue	226,673	207,697	203,722		(3,975)
Non NHS Clinical Revenue (RTA Etc)	1,013	943	990		47
Education and Training Income	8,986	7,783	7,850		66
Other Operating Income (Incl Non Rec)	8,791	8,200	11,134		2,935
Total Income	**245,462**	**224,623**	**223,696**		**(927)**
Expenditure					
Employee Benefits Expense	(171,912)	(156,977)	(159,501)		(2,524)
Drug Expense	(17,868)	(17,421)	(17,657)		(236)
Clinical Supplies	(18,461)	(16,695)	(16,856)		(161)
Non Clinical Supplies	(15,854)	(14,481)	(14,219)		262
PFI Operating Expenses	(5,019)	(4,598)	(4,551)		46
Other Operating Expense	(21,399)	(19,231)	(20,008)		(777)
Sub - Total Operating Expenses	**(250,512)**	**(229,402)**	**(232,792)**		**(3,389)**
Earnings before Interest & Depreciation	**(5,050)**	**(4,779)**	**(9,095)**		**(4,316)**
Interest expense on Working Capital	51	47	20		(27)
Interest Expense on Loans and leases	(8,611)	(7,971)	(8,299)		(328)
Depreciation and Amortisation	(6,890)	(6,316)	(5,883)		433
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(15,450)**	**(14,240)**	**(14,162)**		**78**
Total Expenses	**(265,962)**	**(243,642)**	**(246,953)**		**(3,311)**
RETAINED SURPLUS/(DEFICIT)	**(20,500)**	**(19,019)**	**(23,257)**		**(4,238)**
Impairments	0	0	0		0
ADJUSTED SURPLUS/(DEFICIT)	**(20,500)**	**(19,019)**	**(23,257)**		**(4,238)**

Division	YTD Budget £000's	YTD Actual £000's	Variance £000's	*Narrative*
MLTC	53,261	55,891	(2,631)	*MLTC is £2.6m overspent year to date as a result of nursing staffing cost overruns (Wards, capacity and specialist areas – £1.9m) and Medical agency cover for ED and Gastro.(£1.3m).*
Surgery	49,356	51,308	(1,952)	*Surgery is £1.9m overspent due to overspends mainly within Nursing £0.6m in General Surgery and medics £0.5m Anaesthetics & Critical Care/Theatres (£0.5m).*
WC & CSS	61,993	62,573	(580)	*WCCSS is overspent by £0.6m driven by medical staffing overspends (£0.4m) largely Paediatrics.*
Estates & Facilities	13,899	14,093	(194)	*The Division remains slightly off plan through costs associated with servicing additional capacity areas.*

Financial Performance

- The total financial position for the Trust at M11 is a deficit of £23,257k. The YTD deficit plan is £19,019k, which results in an unfavourable YTD variance of £4,238k (£3,622k in M10 – January).
- The contracted income position is down against plan (£3,975k), a further deterioration of £1.5m in month, this underperformance largely a consequence of reduced Obstetric activity, outpatients and elective utilisation. Other income is over-performing largely as a consequence of winter one off allocations and Diabetes (£800k).
- Expenditure is overspent £3.4m YTD (£3.9m in M10), an element of this improvement following the allocation of winter monies and review and transfer of expenditure meeting the capital definition. The main area of overspending is pay (£2,524k) and is largely as a consequence of nursing expenditure on wards,(temporary nurse staffing costs of £0.93m in month) and overspends within medical budgets.
- The YTD CIP delivery is £2,119k behind plan, the YTD plan representing 90% of the targeted £11.0m delivery.
- The Trust is forecasting a £23m deficit outturn following accounting for disposal of land and buildings in year,noting there are risks to delivery.

CIP 2017/18 Delivery

- The Trust's Annual Cost Improvement Programme requirement is £11m.
- The CIP plan for M11 is £9,945k (90.4% of the target) and actual delivery is £7,826k (70% of target), which is an under achievement of £2,119k YTD. In addition, of this total £2,115k is delivered non-recurrently. However, the productivity improvements within Theatres and Outpatients will deliver recurrent benefits in the future.

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding is £1.12m.
- The Trust's agreed borrowing for 2017/18 is £20.5m, reflecting the deficit plan. The Trust has had to request additional borrowing because of overspending against plan to ensure continued payment of goods and services. The interest payable on the increased borrowing adds to the future savings requirement.

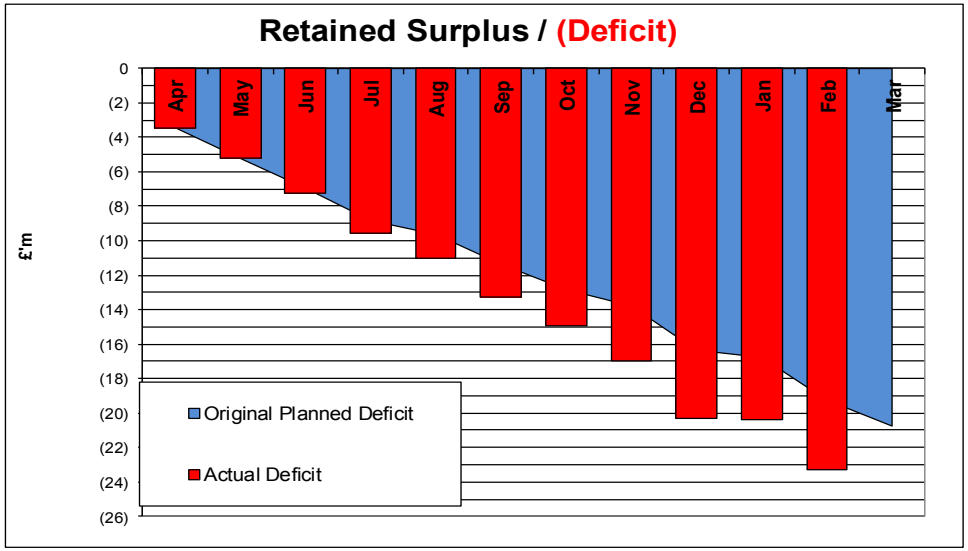
Capital

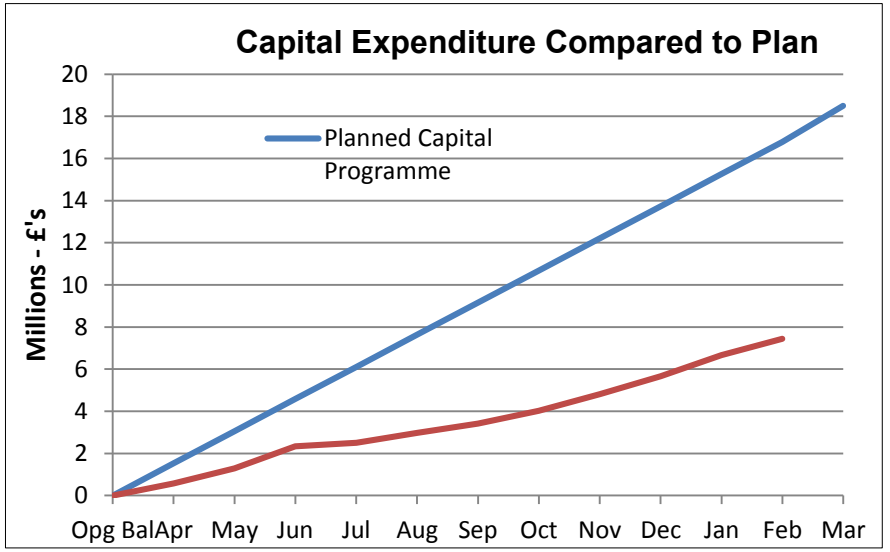
- The year to date capital expenditure is £7.4m, with the main spends relating to ICCU (£4.6m), Estates Lifecycle (£1.1m), Medical Equipment (£0.7m) and Community Mobile technology (£0.6m).

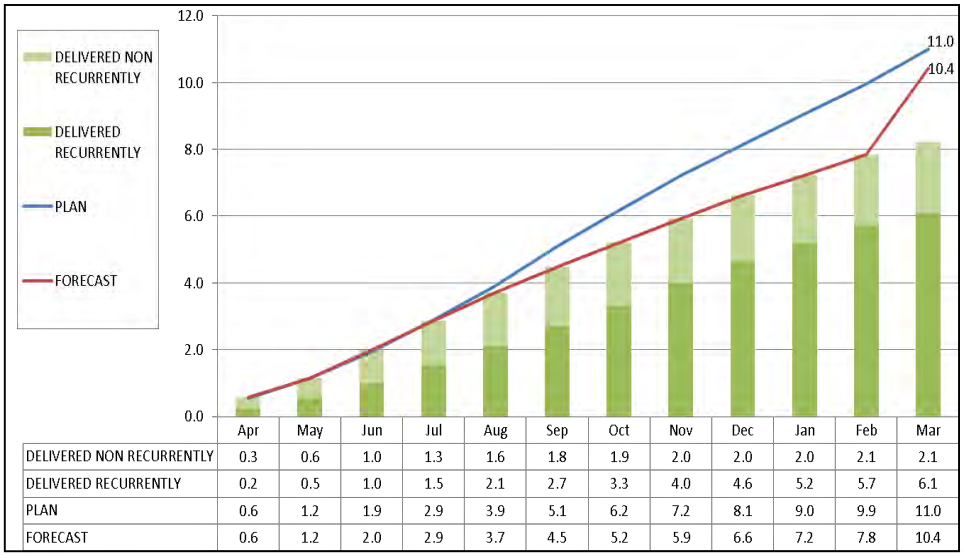
Temporary Workforce

- £1.697m February 2018 (£1.860m January 2018) a £163k reduction in month. However, Nursing costs remain high.

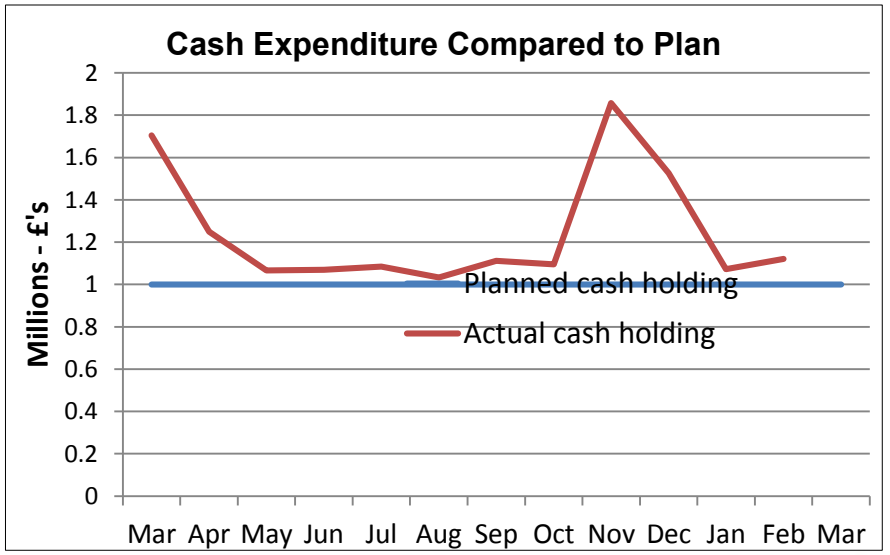
Overall Summary and RAG Assessment continued







	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	5.7	6.1
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	7.8	10.4



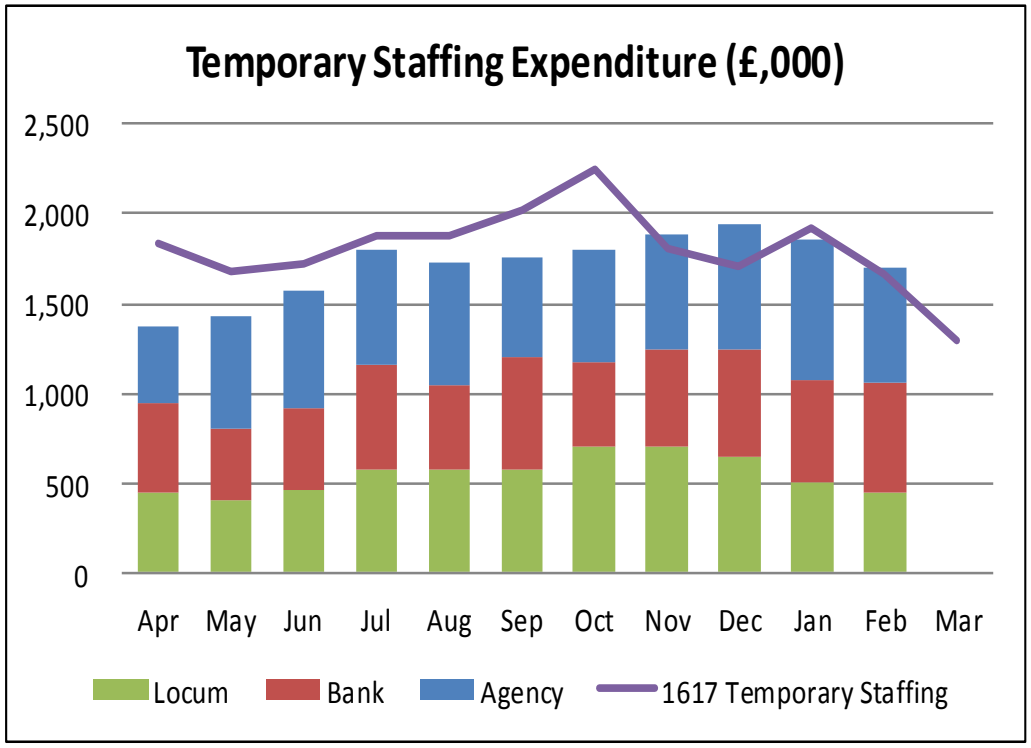
Divisional Income & Expenditure positions: April 2017 to February 2018 (Month 11)

DIVISIONAL POSITIONS	Healthcare Income				Expenditure Less Other Income				Net Divisional Position			
	Annual Budget	Year to Date Budget	Year to Date Actual	Variance Over (-) / Under	Annual Budget	Year to Date Budget	Year to Date Actual	Variance Over (-) / Under	Annual Budget	Year to Date Budget	Year to Date Actual	Variance Over (-) / Under
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Divisions												
Medical & Long Term Conditions	79,961	72,214	76,797	4,582	(57,333)	(53,261)	(55,891)	(2,631)	22,628	18,954	20,905	1,951
Surgical	53,953	49,257	48,006	(1,251)	(53,262)	(49,356)	(51,308)	(1,952)	691	(99)	(3,302)	(3,203)
Women, Childrens & Diagnostics	67,426	61,578	56,193	(5,384)	(67,631)	(61,993)	(62,573)	(580)	(204)	(415)	(6,379)	(5,964)
Total Clinical Divisions	**201,341**	**183,049**	**180,996**	**(2,053)**	**(178,226)**	**(164,609)**	**(169,772)**	**(5,163)**	**23,115**	**18,440**	**11,224**	**(7,216)**
Estates & Facilities				0	(15,316)	(13,899)	(14,093)	(194)	(15,316)	(13,899)	(14,093)	(194)
Total Operational Services	**201,341**	**183,049**	**180,996**	**(2,053)**	**(193,542)**	**(178,508)**	**(183,864)**	**(5,356)**	**7,799**	**4,541**	**(2,868)**	**(7,409)**
Corporate Services												
Management Executive					(1,776)	(1,640)	(1,726)	(86)	(1,776)	(1,640)	(1,726)	(86)
Nurse Director					(5,661)	(5,175)	(4,968)	207	(5,661)	(5,175)	(4,968)	207
Chief Operating Officer					(264)	(258)	(251)	6	(264)	(258)	(251)	6
Medical					(1,412)	(1,336)	(1,435)	(99)	(1,412)	(1,336)	(1,435)	(99)
Finance					(1,552)	(1,413)	(1,038)	375	(1,552)	(1,413)	(1,038)	375
Informatics					(4,557)	(4,146)	(3,450)	695	(4,557)	(4,146)	(3,450)	695
Strategy & Partnership					(919)	(778)	(756)	22	(919)	(778)	(756)	22
Corporate Affairs					(538)	(516)	(560)	(44)	(538)	(516)	(560)	(44)
Human Resources					138	63	55	(8)	138	63	55	(8)
Medical Negligence / Emp Liability					(13,152)	(12,056)	(12,070)	(14)	(13,152)	(12,056)	(12,070)	(14)
PFI Charges					(4,889)	(4,482)	(4,530)	(49)	(4,889)	(4,482)	(4,530)	(49)
Total Corporate Services	**0**	**0**	**0**	**0**	**(34,583)**	**(31,735)**	**(30,729)**	**1,007**	**(34,583)**	**(31,735)**	**(30,729)**	**1,007**
TOTAL ALLOCATED BUDGETS	**201,341**	**183,049**	**180,996**	**(2,053)**	**(228,124)**	**(210,244)**	**(214,593)**	**(4,350)**	**(26,784)**	**(27,194)**	**(33,597)**	**(6,403)**
Profit/Loss on Disposal of Assets					0	0	0	0	0	0	0	0
Depreciation - Owned & Donated Assets					(6,790)	(6,224)	(5,619)	605	(6,790)	(6,224)	(5,619)	605
Depreciation - Impairments					**0**	0	0	0	**0**	0	0	0
Total Depreciation					**(6,790)**	**(6,224)**	**(5,619)**	**605**	**(6,790)**	**(6,224)**	**(5,619)**	**605**
Unitary Payment Interest					(7,687)	(7,046)	(7,127)	(81)	(7,687)	(7,046)	(7,127)	(81)
Interest Receivable					(873)	(878)	(1,148)	(270)	(873)	(878)	(1,148)	(270)
Reserves & Provisions					(3,532)	(2,244)	0	2,244	(3,532)	(2,244)	0	2,244
Health Care Income: Block Contracts	26,166	25,482	25,149	(333)	(1,000)	(914)	(914)	(0)	25,166	24,567	24,235	(333)
Total Reserves & Block Income	**26,166**	**25,482**	**25,149**	**(333)**	**(4,532)**	**(3,158)**	**(914)**	**2,244**	**21,634**	**22,323**	**24,235**	**1,911**
RETAINED SURPLUS/(DEFICIT)	**227,506**	**208,531**	**206,145**	**(2,386)**	**(248,006)**	**(227,550)**	**(229,402)**	**(1,852)**	**(20,500)**	**(19,019)**	**(23,257)**	**(4,238)**

Commentary

- The Trusts deficit is £23.3m year to date.
- MLTC is £2.6m overspent year to date as a result of nursing staffing cost overruns (Wards, capacity and specialist areas – £1.9m) and Medical agency cover for ED and Gastro.(£1.3m).
- Surgery is £1.9m overspent due to overspends mainly within Nursing £0.6m (Gen Surg) and medics £0.5m (Anaesthetics) and Critical Care/Theatres (£0.5m).
- WCCSS is overspent by £0.6m driven by medical staffing overspends (£0.4m) mainly Paediatrics and non delivery of CIP .
- Corporate divisions overall are underspent by £1m. The underspend mainly coming from Informatics is as a result of staff vacancies.
- Central Reserves shows a favourable variance. It should be noted that in arriving at the YTD position, £1.5m of RTT reserves is utilised leaving a balance of £0.1m 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 February 2018 (Month 11)

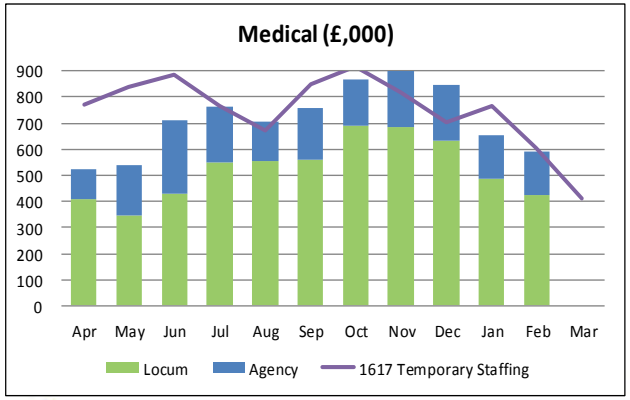


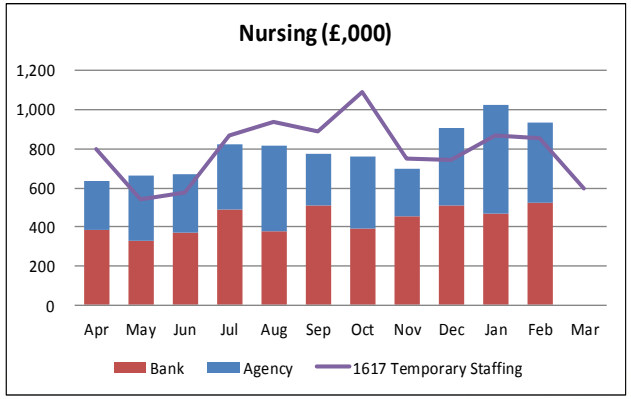
Commentary

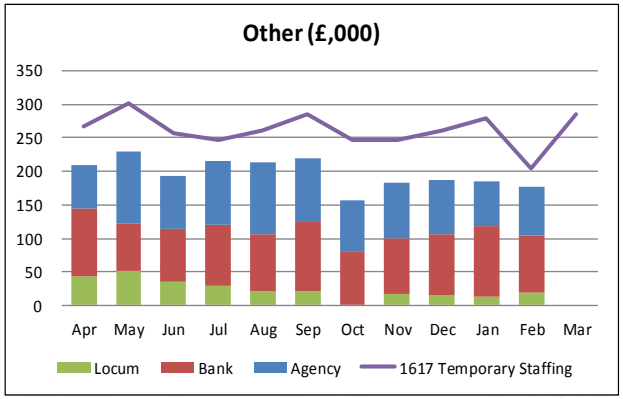
- Temporary staff costs totalled £1.697m in February 2018 (£1.663m February 2017), of which agency is £0.641m.
- The NHS Improvement target for the Trust is to spend no more than £7.0m on agency in 2017/18. The Trust originally planned for agency spend to total £8.2m.
- The Table below shows an annual forecast for temporary workforce spending. Although the table shows a reduction in agency costs the overall level of expenditure is similar to 2016/17:-

Description	2017/18		*2016/17*
	Feb YTD £000's	Annual £000's	*Annual £000's*
Temporary worker	18,824	21,596	*21,649*
Agency	6,976	7,610	*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)







Temporary Staffing Expenditure: April 2017 to February 2018 (Month 11)

Agency	16/17			17/18											
	Feb	Mar	Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	269	156	4,852	114	189	280	213	153	194	174	317	215	169	163	2,180
PTB	13	21	345	6	18	21	19	23	11	15	-6	1	14	14	136
Nursing & Midwifery	420	220	4,284	247	330	301	332	432	264	367	244	392	555	404	3,869
Other Staff Groups	83	152	1,452	59	87	59	77	84	83	62	89	78	53	60	791
Agency Total This Year	**784**	**548**	**10,932**	**426**	**625**	**660**	**641**	**692**	**553**	**618**	**644**	**686**	**791**	**641**	**6,976**
Monthly Movement	(98)	(236)		(123)	199	35	(19)	51	(139)	65	26	42	105	(150)	

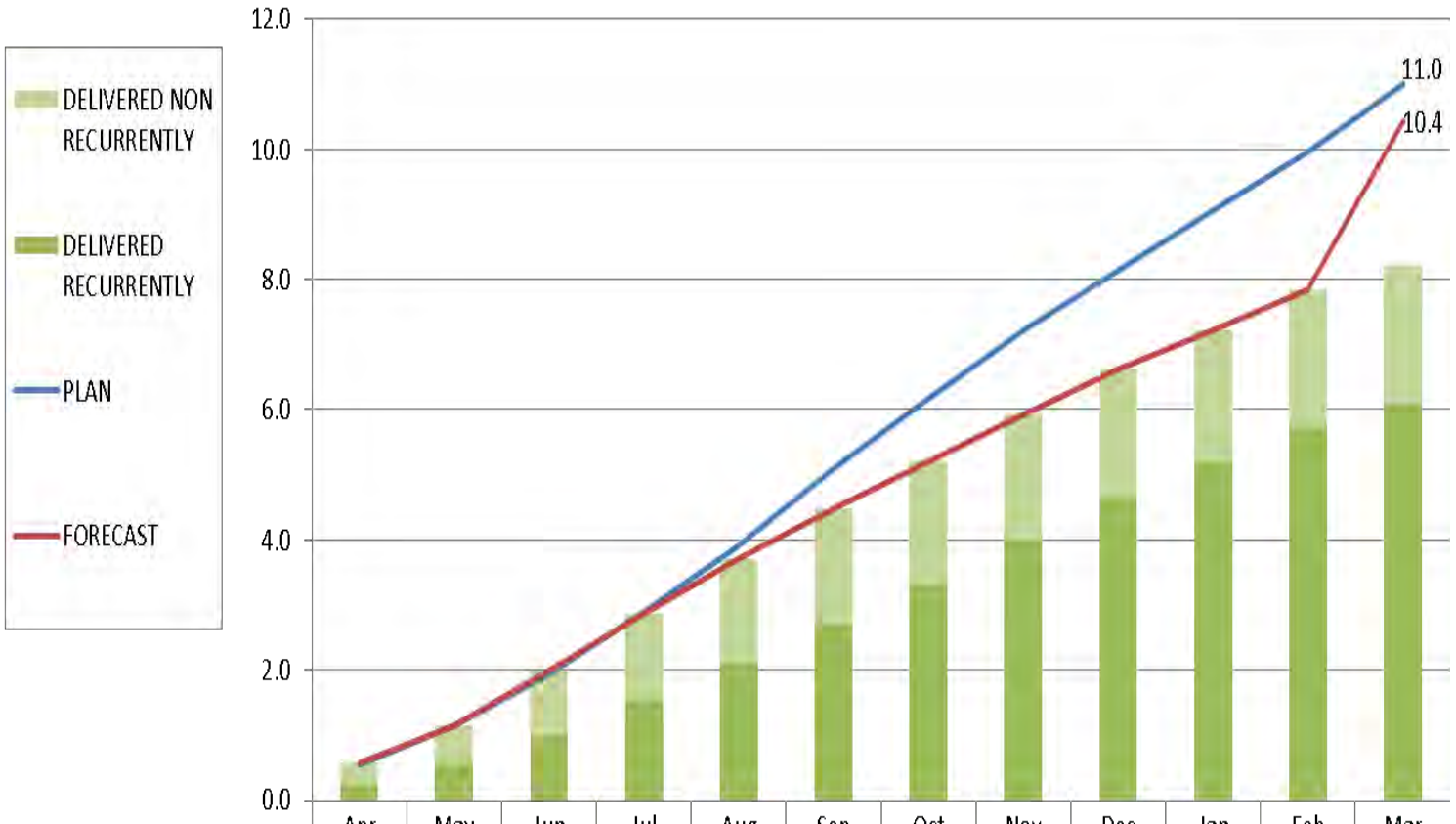
Bank	16/17			17/18											
	Feb	Mar	Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PTB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nursing & Midwifery	435	377	5,230	386	330	370	489	382	511	393	454	512	467	526	4,820
Other Staff Groups	71	80	970	101	72	79	91	85	104	79	83	93	105	84	976
Bank Total This Year	**506**	**458**	**6,200**	**487**	**402**	**449**	**580**	**466**	**616**	**473**	**537**	**605**	**571**	**610**	**5,796**
Monthly Movement	5	(48)		29	(85)	46	131	(114)	149	(143)	64	68	(34)	39	

Locum	16/17			17/18											
	Feb	Mar	Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	334	252	4,138	411	348	430	551	553	561	691	683	630	486	425	5,769
PTB	38	31	376	43	51	35	30	22	21	16	17	14	13	20	281
Nursing & Midwifery	0	0	0	0	0	0	0	0	0	0		0			0
Other Staff Groups	0	1	3	0	0	0	0	0	0	0		0			1
Locum Total This Year	**372**	**285**	**4,517**	**454**	**399**	**465**	**581**	**575**	**582**	**707**	**700**	**644**	**499**	**445**	**6,052**
Monthly Movement	(159)	(88)		169	(55)	66	116	(6)	7	125	(7)	(56)	(145)	(54)	

Grand Total	**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**	**1,696**	**18,824**
Total Monthly Movement	(253)	(372)		76	60	147	228	(69)	17	47	83	54	(74)	(165)	

Becoming your partners for first class integrated care

Cost Improvement Target Achievement: April 2017 to February 2018 (Month 11)



	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	5.7	6.1
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	7.8	10.4

Headlines & Commentary

Cost Improvement Programme Target for 2017/18 is £11m.

YTD Delivery

- Year to Date delivery at month 11 totalled £7.8m against a plan of £9.9m, giving an under-delivery of £2.1m
- Of the total savings achieved £2.1m is delivered non-recurrently

Full Year Plan

- The full year delivery forecast totals £10.4m with a number of schemes still remaining as medium to high risk.
- Work continues with the programme to support the delivery of schemes.
- £8.2m has been delivered full year for 2017/18 of which £6.1m 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	1,225	781
Integrated Critical Care Unit	7,800	4,566	3,234
Maternity	5,200	93	5,107
Accident & Emergency	2,000	170	1,830
Pharmacy Retail Development	0	0	0
Treatment Rooms	0	0	0
Medical Equipment Replacement	800	257	543
Gamma Camera	300	416	(116)
Information Management & Technology			
Hardware & Software	400	158	242
Total Mobile	0	553	(553)
Contribution to SLR	0	0	0
Total Cost of Capital Schemes	**18,506**	**7,438**	**11,068**

Commentary

- The Trust's capital expenditure totals £7.4m as at the 28th February 2018. This is below plan mainly due to the delay in the commencement of the ICCU, Maternity schemes and approval of the A&E redevelopment.
- The Gamma Camera is part funded through a League of Friends donation and the Trust's own Charitable Funds.
- The Outline Business Case for the A&E development has been submitted to NHS Improvement for review.
- A review of the capital programme will be completed to confirm the required level of capital resource with NHS Improvement.

Statement of Financial Position

Statement of Financial Position	as at 31/03/17	as at 28/02/18	Movement
	£000	£000	£000
Non-Current Assets			
Property, plant & Equipment	133,168	134,929	1,761
Intangible Fixed Assets	1,010	1,068	58
Total Non-Current Assets	**134,178**	**135,997**	**1,819**
Current Assets			
Receivables less than one Year	14,603	18,275	3,672
Cash (Citi and Other)	1,705	1,121	(584)
Inventories	2,107	2,384	277
Total Current Assets	**18,415**	**21,780**	**3,365**
Current Liabilities			
NHS Payables less than one year	(6,561)	(3,896)	2,665
Payables less than one year	(22,896)	(27,169)	(4,273)
Borrowings less than one year	(31,183)	(59,231)	(28,048)
Provisions less than one year	(420)	(420)	-
Total Current Liabilities	**(61,060)**	**(90,716)**	**(29,656)**
Net Current Assets less Liabilities	**(42,645)**	**(68,936)**	**(26,291)**
Non-current Assets			
Receivables greater than one year	1,119	1,106	(13)
Non-current liabilities			
Borrowings greater than one year	(131,346)	(128,118)	3,228
Total Assets less Total Liabilities	**(38,694)**	**(59,951)**	**(21,257)**
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	(23,257)	(23,257)
Total TAXPAYERS' EQUITY	**(38,694)**	**(59,951)**	**(21,257)**

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 £3.67m since 31st March 2017. Invoiced debtors has increased by £12.6m net in month and primarily reflects the advance invoicing of Walsall March mandate and the monthly SLAs with the Trust's main commissioner, invoicing for M10 drugs and M10 non contracted activity (NCA).
- 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 £1.6m net, and primarily reflects the delays in cash settlement of creditor invoices due to cumulative effect of continued overspending. The Trust has taken deficit loan and capital loan support totalling £28.0m in year at the end of February.

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 £23,257k 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)	(14,982)
Depreciation and Amortisation	5,883
Donated Assets Received credited to revenue but non-cash	(264)
Fixed Asset Impairments	0
(Increase)/Decrease in Trade and Other Receivables	(3,661)
Increase/(Decrease) in Trade and Other Payables	2,228
Increase/(Decrease) in Stock	(277)
Increase/(Decrease) in Provisions	0
Interest Paid	(8,295)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	(19,368)
Cash Flows from Investing Activities	
Interest received	20
(Payments) for Property, Plant and Equipment	(8,089)
Receipt from sale of Property	0
Net Cash Inflow/(Outflow)from Investing Activities	(8,069)
Net Cash Inflow/(Outflow) before Financing	(27,437)
Cash Flows from Financing Activities	26,853
Net Increase/(Decrease) in Cash	(584)
Cash at the Beginning of the Year 2016/17	1,705
Cash at the End of the Month	1,121

Commentary

Cash Flow

- The Trust made an adjusted operating deficit of £14,982k at the end of February and received cash of £5,883k 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 £8,089k in relation to payments for outstanding capital projects from 2016/17 and current 2017/18 projects.
- The Trust has received a total of £28.0m against the temporary borrowing loan facility by the end of February to support working capital payments, and £2.0m in returned PDC.

BOARD/COMMITTEE REPORT

Meeting	Trust Board	**Date:** 05/04/18
Report Title	Month 11 Finance Report	**Agenda Item:15** **Enclosure No.:13**
Lead Director to Present Report	Mr R Caldicott, Director of Finance & Performance	
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 £23.3m deficit compared to the planned deficit of £19.0m at month 11, giving an unfavourable variance of £4.3m for the period ended 28th February 2018. 2. The Trust had targeted delivery of a £20.5m deficit for the year, this is now revised (with recovery plans) to deliver a £23.0m deficit. There remains risk to delivery of the forecasted £23m outturn. 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. The Trust has underperformed on contracted income by £3.9m YTD (largely non-elective and outpatients). 4. 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. 5. The Divisional financial performance was: - • Clinical Divisions expenditure overall is £5.2m adverse to plan mainly due to temporary staffing costs and CIP underperformance • CIP delivery YTD is £7.8m. The annual target is £11m • Temporary staffing expenditure in February 2018 remains high at £1.7m (in particular the Nursing expenditure) 6. The Trust's full year targeted savings for 2017/18 are £11m. As at month 11 the Trust has delivered £7.8m against a phased plan of £9.9m. 7. 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 February 2018 is £1.1m. The Trust has additional borrowing due to the revised forecast deficit and is incurring higher interest charges as a result.	

<table>
<tr><td></td><td colspan="4"></td></tr>
<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 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>
</table>

BOARD/COMMITTEE REPORT

Meeting	**Trust Board**	**Date:** 5th April 2018
Report Title	Performance and Quality Report for February 2018	**Agenda Item: 16** **Enclosure No.: 14**
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 improved to 82.81% compared to 82.68% in January and remained below the trajectory of 89%. 2. **Ambulance Handover:** The number of delayed ambulance handovers totalled 129 which was a significant reduction compared to 296 in January. Of these the number delayed by more than 1 hour reduced to 21 from 37. 3. **Cancer** – All 8 cancer metrics achieved in January. 4. **18 Weeks Referral to Treatment Incomplete: Target 92%:** February's performance improved to 83.69%, there were no patients waiting more than 52 weeks at the end of February on an incomplete pathway. 5. **Diagnostic waits:** This achieved the 99% target (99.54%). 6. **HSMR (HED) & SHMI** - December HSMR rate was 128.00. November SHMI changed to 100.88 from 101.3 in October. There were 112 deaths in February. 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 December was 0.18. January and February are pending RCA outcomes. 9. **Falls** - The rate of falls per 1000 bed days improved to 5.10 from 5.11 in January and was within the target of 6.63. There were no falls resulting in serious injury. 10. **Open Contract Performance Notices** – Six remain open in February. 11. **CQUINS** – Work continues on schemes for 2017-19. A forecast summary is included.	

Purpose	**Approval**	**Decision**	**Discussion**	**Note for Information**
	☒	☐	☒	☐

Recommendation	The Committee is asked to NOTE the content of the paper and DISCUSS any areas of concern.

<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>
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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">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 – 20/03/2018
Performance, Finance & Investment Committee – 28/03/2018
Quality and Safety Committee – 29/03/2018</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

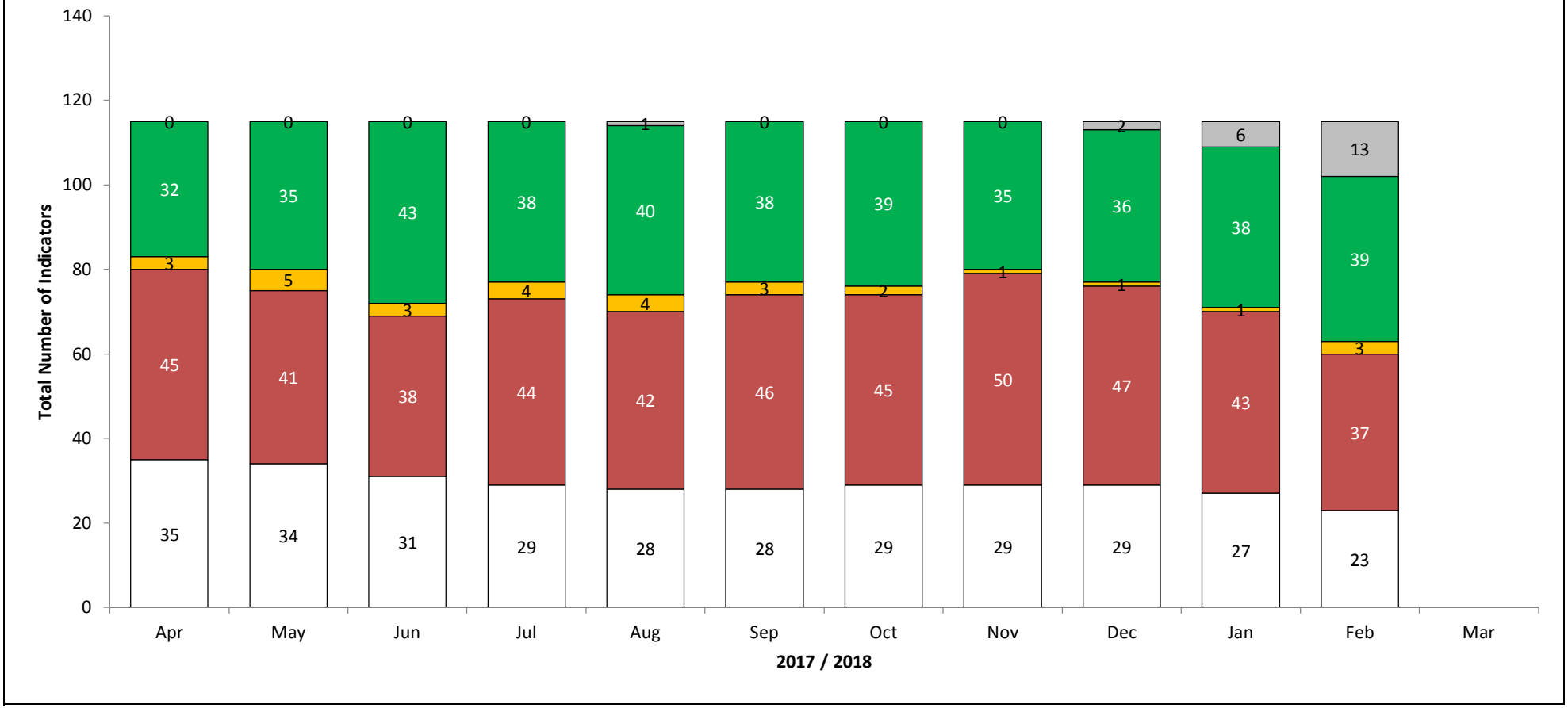
March 2018
(February 2018 Results)

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

Contents

TRUST PERFORMANCE FRAMEWORK



Indicators with No Targets

Failing to meet Target or Major Variance from Plan

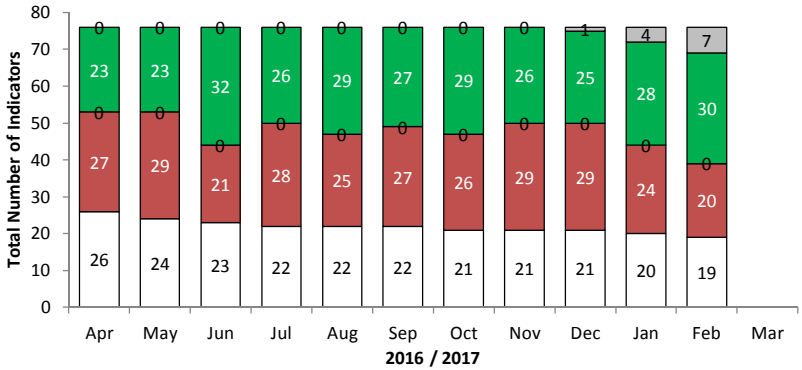
Minor Variance from Plan

Achieving Target or On Plan

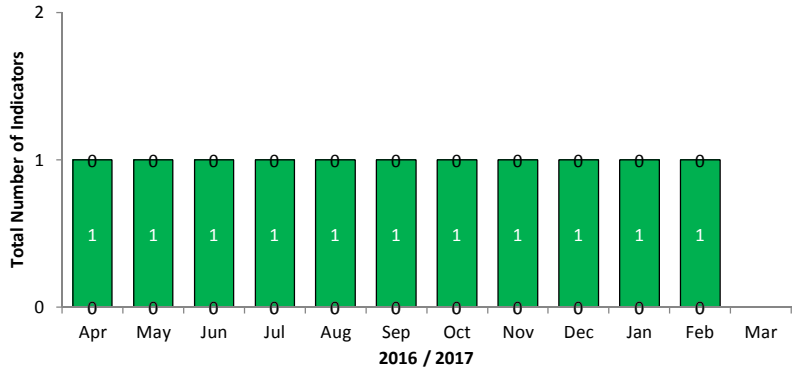
Indicators reported in Arrears or not yet available in Month

TRUST STRATEGIC VALUES FRAMEWORK

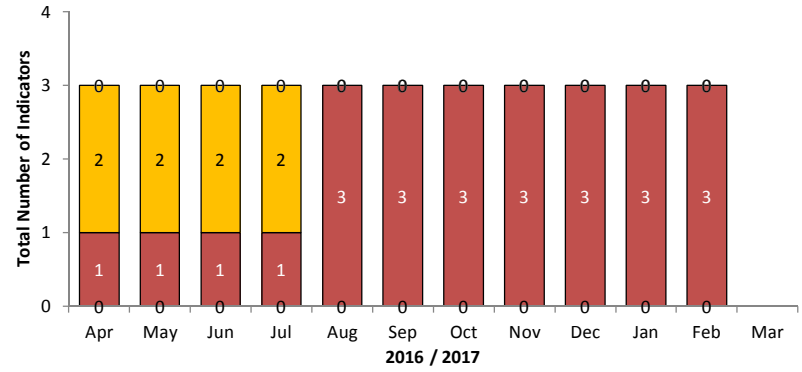
Provide Safe, High Quality Care Across All Our Services



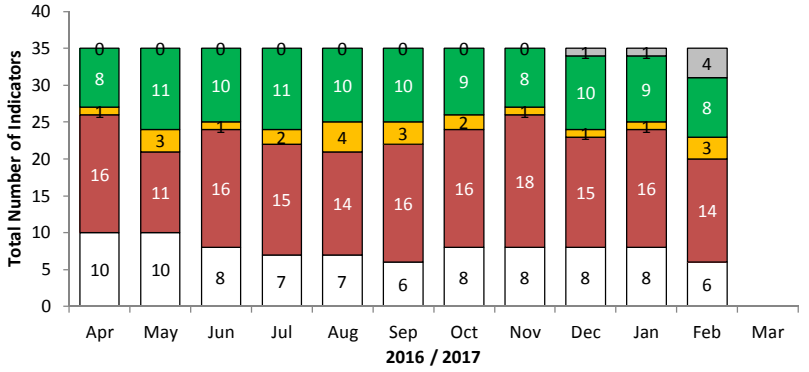
Care For Patients at Home Whenever We Can



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 falls resulting in severe harm in February. The number of serious incidents (Community acquired) reduced to 4 in February compared to 8 in January and this achieves the monthly trajectory of 4. Inpatient FFT achieved their target for the first time in 5 months.

PERFORMANCE NOT ACHIEVED: There was a reduction in the number of mixed sex accommodation breaches in February from 3 to 2 and this was within the monthly trajectory of 10. HSMR declined to 128.00 in December compared to 88.09 in November. There were 3 avoidable category 3 and 4 pressure ulcers reported for December. January and February figures are provisional. VTE improved to 93.18% in February compared to 91.30% in January. There were 13 serious incidents (Acute) reported in February which exceeds the monthly trajectory of 7. One to one care in established labour narrowly failed to achieve the 100% target with performance of 99.43%. Emergency Readmissions within 30 days did not achieve in January with performance of 10.44%. EDS compliance failed to achieve in February however improved to 91.84%. Dementia screening declined slightly to 79.55%, against a target of 90%, however methodology to determine performance of this metric is still under review. 3 FFT areas failed to achieve in February.

TO NOTE:
The number of deaths reduced from 139 in January to 112 in February. This is the second month that Compliance with MCA stage 2 tracking is reported and shows performance of 77% in February. A target is to be agreed from April 2018. The percentage of medication incidents resulting in harm will be re-instated from next month.

NONE APPLICABLE

NONE APPLICABLE

PERFORMANCE NOT ACHIEVED – OF NOTE: The number of births remains stable at approximately 9 per day average however the year to date total remains below the expected number.

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE
2017-2018

		SEP	OCT	NOV	DEC	JAN	FEB	YTD Actual	17/18 Target	16/17 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no	Sleeping Accommodation Breaches	4	7	6	9	3	2	**58**	0	**105**	N
no..	HSMR (HED)	81.42	84.46	88.09	128.00			**97.06**	100.00		N
no..	SHMI (HED)	94.05	101.03	100.88					100.00		BP
no	Number of Deaths in Hospital	63	86	80	137	139	112	**1053**		**1123**	BP
%..	% of patients who achieve their chosen place of death	58.82%	66.00%	73.81%	46.30%	63.04%		**55.85%**			
no	MRSA - No. of Cases	0	0	0	0	0	0	**0**	0	**0**	N
no	Clostridium Difficile - No. of cases	2	1	0	4	0	0	**11**	18	**21**	N
%..	Percentage of patients screened for Sepsis (CQUIN audit - quarterly)	93.48%	92.75%	92.19%	95.00%			**93.59%**	90.00%		
no..	Pressure Ulcers - (category 2, 3 & 4's) - Avoidable per 1000 beddays	0.35	0.61	0.66	0.18	0.41	0.12				BP
no	Pressure Ulcers - No. of Avoidable (category 2, 3 & 4's) - Trust	5	10	10	3	7	2		0	**19**	BP
no	Pressure Ulcers - (category 2, 3 & 4's) - Hospital	5	14	12	11	15	21			**167**	
no	Pressure Ulcers - (category 2, 3 & 4's) - Community	12	16	15	9	17	16			**143**	
no	Falls - Total reported	98	96	83	95	88	83	**931**		**932**	BP
no..	Falls - Rate per 1000 Beddays	6.80	6.46	5.50	5.79	5.11	5.10		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	1	0	2	1	1	0	**8**	0	**22**	BP
%..	VTE Risk Assessment	90.75%	90.45%	89.95%	93.45%	91.30%	93.18%	**87.87%**	95.00%	**90.90%**	N
no	National Never Events	0	0	1	0	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	7	16	9	9	13	**111**	102	**102**	L
no	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	5	4	5	4	8	4	**72**	50	**49**	L
no	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	18	22	31	28	22	24	**244**		**218**	L
no	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	4	10	4	2	16	4	**81**		**55**	L
%..	% of incidents resulting in moderate, severe harm or death as a % of total incidents	2.29%	3.06%	3.27%	3.09%	3.31%	2.89%	**2.83%**		**2.41%**	L
%..	Deteriorating patients: Percentage of observations rechecked within time	89.80%	91.30%	90.16%	88.19%	88.72%	90.27%	**90.06%**	85.00%		
%..	Medication Storage Compliance	95.00%	95.00%	95.00%	93.00%	89.00%		**95.00%**			
%..	Controlled Drug Compliance (quarterly audit)	80.50%			78.00%						
%..	% of Pharmacy Interventions made based on charts reviewed		20.15%	20.00%	26.56%			**22.61%**			
no..	Midwife to Birth Ratio	1:28.1	1:25.7	1:25.4	1:25.4	1:24.8	1:22.4		1:28	**1:30.6**	N
%..	One to One Care in Established Labour	95.50%	99.07%	98.96%	98.91%	98.98%	99.43%		100.00%	**100.00%**	N
%..	C-Section Rates	26.84%	25.77%	28.62%	32.86%	27.14%	26.61%		30.00%		

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE

2017-2018

		SEP	OCT	NOV	DEC	JAN	FEB	YTD Actual	17/18 Target	16/17 Outturn	Key
%..	Instrumental Delivery	12.83%	11.95%	11.47%	8.93%	14.36%	9.09%				
%..	Induction of Labour	33.89%	35.74%	33.33%	33.45%	32.01%	31.85%				
%..	NHS Safety Thermometer - Maternity - Women's Perception of Safety	100.00%	96.20%	64.30%	91.30%	82.60%	100.00%				
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (month in arrears)	11.43%	10.75%	10.35%	11.44%	10.44%		**10.51%**	10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	87.35%	88.30%	85.38%	89.73%	91.63%	91.84%	**89.32%**	100.00%	**88.40%**	N/L
%..	Dementia Screening 75+ (Hospital) (Internal audit Dec17 onwards)	49.07%	60.52%	44.47%	80.79%	79.55%		**58.79%**	90.00%	**87.24%**	N
%..	Compliance with MCA 2 stage tracking					71.00%	77.00%				
no	Complaints - Total Received	23	22	15	13	24	23	**258**		**327**	BP
%..	Complaints - Percentage responded to within the agreed timescales	96.30%	100.00%	92.00%	100.00%	100.00%	100.00%	**84.59%**	70.00%	**47.75%**	BP
no	Clinical Claims (New claims received by Organisation)	8	13	9	10	10	14	**123**		**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	10.94%	9.74%	8.85%	9.78%	9.96%		**9.20%**			
%..	Friends and Family Test - Inpatient (% Recommended)	94.00%	95.00%	92.00%	91.00%	93.00%	97.00%	**97.00%**	96.00%		N
%..	Friends and Family Test - Outpatient (% Recommended)	91.00%	91.00%	90.00%	91.00%	91.00%	91.00%	**91.00%**	96.00%		N
%..	Friends and Family Test - ED (% Recommended)	75.00%	73.00%	76.00%	77.00%	75.00%	79.00%	**79.00%**	85.00%		N
%..	Friends and Family Test - Community (% Recommended)	97.00%	97.00%	99.00%	99.00%	97.00%	99.00%	**99.00%**	97.00%		N
%..	Friends and Family Test - Maternity - Antenatal (% Recommended)	88.00%	73.00%	82.00%	80.00%	97.00%	0.00%	**0.00%**	95.00%		N
%..	Friends and Family Test - Maternity - Birth (% Recommended)	88.00%	89.00%	94.00%	83.00%	100.00%	100.00%	**100.00%**	96.00%		N
%..	Friends and Family Test - Maternity - Postnatal (% Recommended)	92.00%	100.00%	79.00%	85.00%	97.00%	100.00%	**100.00%**	92.00%		N
%..	Friends and Family Test - Maternity - Postnatal Community (% Recommended)	100.00%	87.00%	100.00%	100.00%	99.00%	100.00%	**100.00%**	97.00%		N
	RESOURCES										
no	Total Births	304	293	279	280	280	253	**3314**	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 cancer measures (8) achieved in January. There were no patients reported as waiting more than 52 weeks at the end of February, the first time since July 2017.

PERFORMANCE NOT ACHIEVED: The ED 4 hour performance very slightly improved to 82.81%. ED median waiting time reduced slightly in February. The number of delayed ambulance handovers significantly reduced in February to 129 compared to 296 in January, of these the number delayed by more than 1 hour also reduced to 21 from 37. Incomplete 18 weeks RTT for February improved to 83.69%. The percentage of stroke patients who spent 90% or more of their stay on a stroke unit failed to achieve for the fifth 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 January 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 February with performance of 11.27% however did not achieve the monthly trajectory of 9.00% . Average length of stay failed to achieve the 7.01 target reporting 7.59 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 February was 63.60%, a target is to be agreed for inclusion next month.

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

2017-2018

		SEP	OCT	NOV	DEC	JAN	FEB	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)	81.82%	82.75%	82.03%	83.38%	82.68%	82.81%	**82.84%**	95.00%	**84.10%**	N
no	Total time spent in ED - No. of Trolley waits over 12 hours	1	0	0	0	0	0	**3**	0	**2**	N
no	Median Waiting Time in ED Metric (average in mins)	179	177	171	179	181	178		120		
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	69.33%	62.19%	70.04%	58.42%	59.73%	71.31%	**65.36%**	100.00%	**65.44%**	BP
no	Ambulance Handover - No. of Handovers completed between 30-60mins	110	193	122	246	259	108	**1692**	0	**1765**	N
no	Ambulance Handover - No. of Handovers completed over 60mins	4	35	8	35	37	21	**227**	0	**249**	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	94.49%	97.13%	95.88%	97.42%	95.16%	96.87%	**95.20%**	93.00%	**96.12%**	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	94.92%	97.14%	96.88%	100.00%	94.12%	98.31%	**96.27%**	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%	**98.73%**	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	100.00%	100.00%	100.00%	100.00%	98.82%	100.00%	**99.33%**	96.00%	**99.16%**	N
%..	Cancer - 62 day referral to treatment from screening	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**97.74%**	90.00%	**96.20%**	N
%..	Cancer - 62 day referral to treatment of all cancers	86.05%	87.65%	85.51%	90.12%	87.36%	85.71%	**88.09%**	85.00%	**87.10%**	N
%..	Cancer - 62 day referral to treatment from consultant upgrade	85.53%	82.89%	87.84%	85.71%	90.91%	78.33%	**86.24%**	85.00%	**92.03%**	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	85.06%	84.75%	83.57%	80.99%	82.48%	83.69%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	1	2	1	1	1	0	**13**	0	**97**	N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Admitted	3	1	1	0	1	0	**9**	0	46	N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Not Admitted	2	0	1	0	0	1	**9**	0	165	N
%..	Diagnostic Waits - % waiting under 6 weeks	99.05%	99.64%	99.53%	99.15%	99.54%	99.66%	**99.18%**	99.00%	**99.24%**	N
%..	Elective Cancellations - No. of last minute cancellations on day of operation or after patient admission	0.44%	0.73%	0.58%	0.51%	0.19%	0.35%	**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	80.65%	77.27%	78.95%	74.29%	68.97%	70.97%	**80.39%**	80.00%	**89.42%**	BP/SS
no	Rapid Response Team - Avoidable admissions (month in arrears)	176	206	237	248	326		**2052**			
no..	FES Avoided Admissions Metric (New metric under development)										
%..	Number of RN staffing Vacancies Metric	10.94%	9.74%	8.85%	9.78%	9.96%	9.20%	**9.20%**			
no	No. of Open Contract Performance Notices	9	6	6	6	6	6	**6**	0	**6**	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	6.98%	6.89%	6.50%	7.00%	6.71%	6.18%	**6.74%**	7.00%	**7.03%**	BP
	RESOURCES										
%..	Clinic Utilisation Rate	87.07%	92.27%	92.15%	91.14%	90.13%	90.41%	**89.63%**	90.00%	**87.27%**	L
%..	Outpatient DNA Rate (Acute and Community)	11.98%	11.99%	11.77%	14.36%	12.11%	11.27%	**12.28%**			
no..	New to follow up ratio - WHT	1.83	1.94	1.93	2.03	2.04	2.01	**1.99**	2.14	**1.95**	BP
%..	Theatre Utilisation - Overall In Session Utilisation (%)	89.13%	87.58%	75.44%					85.00%	**81.91%**	BP
%..	Theatre Utilisation - Touch Time Utilisation (%)	64.64%	65.08%	61.11%	66.31%	58.16%	63.60%				

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

2017-2018

Safe, high quality care | Care at home | Partners | Value colleagues | Resources

		SEP	OCT	NOV	DEC	JAN	FEB	YTD Actual	17/18 Target	16/17 Outturn	Key
no..	Length of Stay	6.80	6.46	7.06	7.51	7.50	7.59	7.18	7.01	7.32	BP
%..	Delayed transfers of care	1.58%	3.16%	3.27%	2.16%	3.11%		2.35%	2.50%	2.35%	L
no	Hospital beds open at month end	435	468	468	483	532	514			470	L
%..	Day case rates	87.42%	88.41%	90.32%	88.82%	90.32%	88.44%	88.26%		87.98%	BP
%..	Bank & Locum expenditure as % of Paybill	8.26%	8.11%	8.48%	8.53%	7.29%	7.42%	7.43%	6.30%	6.22%	L
%..	Agency expenditure as % of Paybill	3.81%	4.25%	4.41%	4.69%	5.39%	4.51%	4.37%	2.75%	6.35%	L
£	Surplus or Deficit (year to date) (000's)	-£11,361	-£14,923	-16976	-£20,342	-£20,395	-£23,257	-£23,257		-£21,392	L
£	Variance from plan (year to date) (000's)	-£1,872	-£2,088	-3093	-£3,991	-£3,622	-£4,238	-£4,238		-£15,192	L
£	CIP (£) (000's)	£4,476	£5,180	£5,924	£6,620	£7,213	£7,826	£7,826	£560	£6,600	L
%..	CIP % delivered (year to date)	61.00%	64.00%	68.00%	71.00%	72.30%	74.80%	74.80%	100.00%	71.00%	L
£	Income variance from plan (year to date) (000's)	-£877	£456	£653	£464	£640	-£927	-£927	£0	-£5,423	L
£	Expenditure - Variance from Plan (year to date) (000's)	-£941	£1,500	£2,245	£4,271	£3,991	-£3,389	-£3,389	£0	-£9,537	L
£	Cash Against Plan (variance) (000's)	£111	£94	£858	£526	£73	£121	£121		£700	L
£	Capital spend YTD (000's)	£3,415	£4,031	£4,818	£5,663	£6,674	£7,438	£7,438		£4,660	L
no	Monitor Risk Rating (Actual YTD)	1	1	1	1	1	1	1	3	1	BP
no	Total Referrals (Contracted) (month in arrears)	7887	8449	7699	6419	8730		80699		89125	BP
no	Total Elective Activity (Contracted)	299	290	275	218	250	250	3398		3422	L
no	Total Non Elective Activity (Contracted)	27	34	53	138	61	62	571		689	L
no	Total Outpatient attendances (Contracted)	19189	20653	20830	15371	15932	18388	210519		248452	L
no	Total Day Case Activity (Contracted)	1893	1957	2147	1500	2089	1812	20407		21515	L
no	Total Emergencies Activity (Contracted)	2649	2845	2747	2689	2815	2551	29238		30275	L
no	Total ED Attendances Type 1 Pbr (Excl Badger) (Contracted)	6232	6637	6417	6577	6551	5984	67398		64686	L
no	Total AHP Activity (Contracted)	1736	1846	2145	1337	1811	1866	19818		24338	L
no	Total Critical Care Days (Contracted)	904	994	863	1232	990	895	10516		10760	L
no	Total Unbundled Chemo Delivery Activity (Contracted)	350	359	359	241	323	318	3593		3425	L
no	Total Maternity Pathway	1046	1083	894	720	881	766	10816		12382	L
no	Total Community Contacts (Contracted)	18184	21720	20614	13823	23589		294014	379962	344377	L
no	Total Births	304	293	279	280	280	253	3314	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 improved significantly from 6.23% in January to 5.00% in February, this is the lowest rate reported since September. PDR's improved in February to 79.47% 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

		SEP	OCT	NOV	DEC	JAN	FEB	YTD Actual	17/18 Target	16/17 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Number of RN staffing Vacancies Metric	10.94%	9.74%	8.85%	9.78%	9.96%	9.20%	**9.20%**			
	VALUE COLLEAGUES										
%..	Sickness Absence	4.73%	5.76%	5.55%	5.81%	6.23%	5.00%	**5.26%**	4.00%	**4.59%**	L
%..	PDRs	74.43%	75.19%	76.25%	75.90%	78.24%	79.47%	**79.47%**	90.00%	**84.66%**	L
%..	Mandatory Training Compliance	79.50%	79.71%	78.69%	79.65%	78.14%	77.61%	**77.61%**	90.00%	**80.71%**	L
	RESOURCES										
%..	Bank & Locum expenditure as % of Paybill	8.26%	8.11%	8.48%	8.53%	7.29%	7.42%	**7.43%**	6.30%	**6.22%**	L
%..	Agency expenditure as % of Paybill	3.81%	4.25%	4.41%	4.69%	5.39%	4.51%	**4.37%**	2.75%	**6.35%**	L
no	Staff in post (Budgeted Establishment FTE)	4097	4094	4073	4100	4100	4116	**4116**		**4201**	L
%..	Turnover	8.58%	8.79%	8.89%	8.93%	8.77%	8.89%	**8.89%**	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	Feb-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%	89.00%	82.81%	82.83%	▲	

What is driving the reported underperformance?

Performance results:

Performance in February was 82.81% which is a slight improvement compared to 82.68% in January but below the agreed monthly trajectory of 89%.

Based on Calender Month	Dec-17	Jan-18	Feb-18
Type 1 attenders	6639	6416	6576
Type 3 attenders	3617	3324	3547
WiC attenders	-	3659	3723
Breaches	2293	2416	2420
Admissions from ED	2253	2224	1953
% of Patients Admitted	33.94%	34.66%	29.70%
Ambulances to ED	2989	2848	2545
All Discharges	5435	6334	5631
Trolley Waits over 12 hours	0	0	0
ED Median Waits (mins)	179	181	178

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 03 for 25 days compared to 27 days in January.

- Average attendances per day were 235 compared to 207 (Jan)
- Average breaches per day were 75 compared to 78 (Jan)
- Admissions per day were 70 compared to 72 (Jan)
- Discharges per day were 201 compared to 204 (Jan)

There were significant daily variations in performance, at its lowest it was 77.12% and at its highest 88.73%.

Benchmarking:

For February, our position was 86th out of 133 and 6th out of 14 regionally compared to the previous month's respective ranks of 90th and 8th.

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 February equate to £91,320.

What actions have we taken to improve performance?

New Actions:

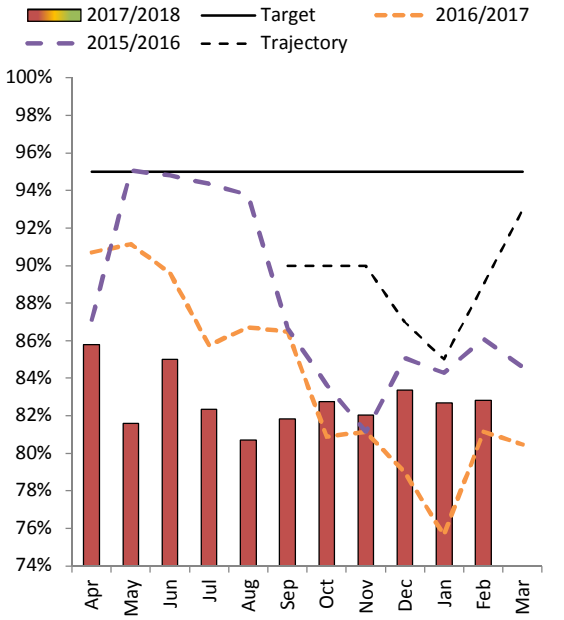
- AMU have implemetented a Boarding Protocol to support ED in times of increased pressures, this aligns with the MLTC protocol when the Full Hospital Protocol is activated.
- ECIST have spent time in the ED Department reviewing the ambulance handover processes. A session has been arranged with the Nurse Team on w/c 26th March to discuss possible changes and recommendations to reduce any handover delays.
- New handover processes have been trialled and ongoing changes made within the Acute Team to reduce delays in transfers.
- The 3 day Length of Stay review was completed during February. Actions have been taken from the review and are being taken forward into areas such as Therapies with recommendations that were provided by ECIST.

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.
- Transformation Managers continue to support the Patient Flow Meeting which is in place weekly.

Contractual Financial Penalties (LCA)

YTD £ £1,063,680



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	

Walsall Healthcare NHS Trust

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	Feb-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		108	1692	▲	
	0		21	227	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties (LCA)	YTD £	£565,400

Performance results:

The number recorded between 30 to 60 mins and over 60 mins were 108 and 21. This is a significant improvement compared to 259 and 37 respectively recorded in January. Handover performance (excluding ambulances where no time was recorded) was 71.31% compared to 59.73% in January

	Jan-18		Feb-18	
<15mins	1679	57.84%	1814	69.66%
15-30	836	28.80%	601	23.08%
30-60	259	8.92%	108	4.15%
>60	37	1.27%	21	0.81%
No Time	92	3.17%	60	2.30%
Total	2903		2604	

*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 93, compared to 94 in January.
- There were over 90 ambulance arrivals to the department on 18 days during the month and 7 days where the Trust saw over a 100 ambulances to ED which is the same as January.

Benchmarking:

The Trust is ranked 2nd regionally out of 14 Trusts for February which is an improvement when compared to the previous month ranking of 3rd.

Contractual Status:

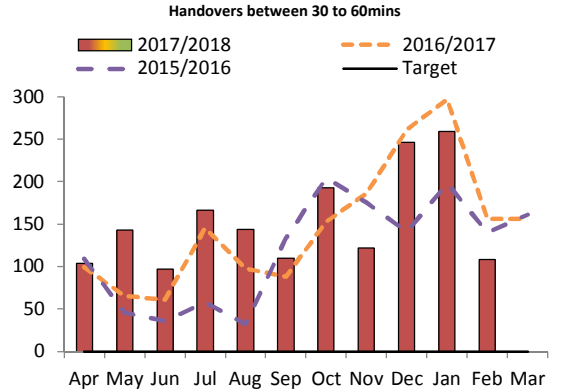
As stipulated in the national contract, £200 will be applied for every handover recorded between 30 and 60 minutes and £1,000 will be applied for any handover over 60 minutes. For February a fine of £42,600 will be incurred.

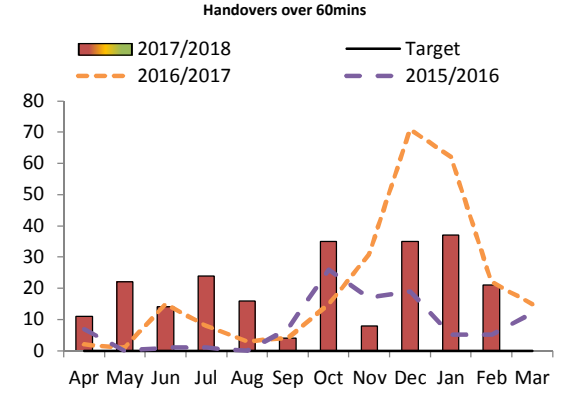
New Actions:

- ECIST have provided specialist support to the ED Team to review and provide recommendations for improvement specifically for ambulance handover times.
- A session has been arranged w/c 26th March for all Team Leaders and Nurse In Charge Team from ED to hold an LIA specifically to change the handover process which is supported by ECIST.
- New IT equipment has been requested by the ED Team so that portable handover tablets can be used at point of ambulance entry to take PINs directly from WMAS.

Continuing Actions:

- Two additional Registered Nurses (an additional Triage Nurse and an additional Ambulance Handover Nurse) continue to be booked daily to support ED flow from point of arrival and decrease delays.
- 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.
- 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.





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 Trust

18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
	92.00%	87.00%	82.48%		▲	

What is driving the reported underperformance?

Performance results (Validated January 2018)

The Trust failed to achieve the national standard with performance of 82.48%, an improvement compared to 80.99% in December.
The number of patients waiting over 18 weeks has reduced by 364 compared to December.
At the end of January there was 1 patient breaching 52 weeks within General Surgery, this patient had been offered earlier appointments. The confirmed appointment date in February was unable to proceed as the patient was unfit (unrelated illness)

		Nov-17	Dec-17	Jan-18
PTL Size		15931	15632	14889
No. over 18 Weeks		2617	2972	2608
No. over 52 Weeks		1	1	1
Clock Stops	Total	6854	4851	6757
	Admitted	995	673	915
	Not Admitted	5859	4178	5842
Specialties achieving 92%		12	7	8

Performance of Divisions (target 92%):
- MLTC achieved 83.45% compared to 79.72% in December.
- Surgery achieved 79.45% compared to 78.72% in December.
- WCCSS achieved 93.98% compared to 95.01% in December.

Benchmarking:

For January, the Trust ranked 114th out of 127 Acute Trusts nationally who submitted information and 11th out of 14 Trusts regionally. 73 Acute Trusts reported breaches of over 52 week waits in January.

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:

- Robotic software in place and project initiated in January with a view to completing lettering by end of March for follow up backlog pre 2017. Validators continue to work on validation of duplicate and 'attended' status access plans. Numbers reduced to below 13,897.
- 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. Issues with non completion of forms is the focus for the outpatient improvement project. Close down procedures for clinics have been strengthened with the objective of all forms being completed before the clinics finish.

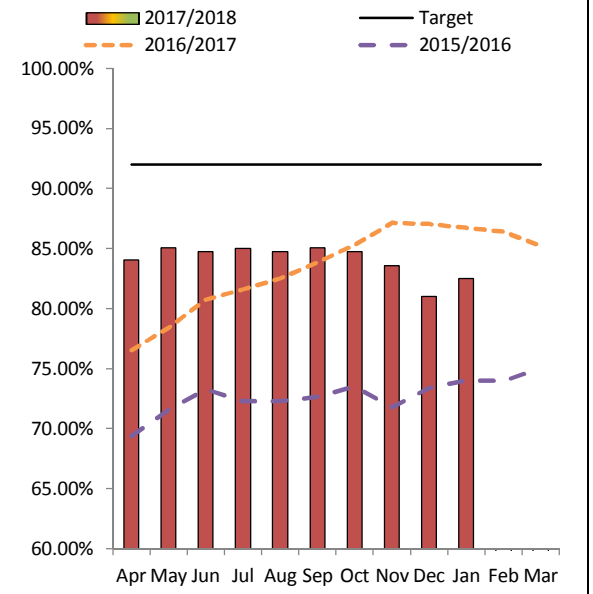
Capacity Improvements:

- WLI clinics in place to support cancer delivery and long waiters in RTT.
- Work is on going with KPMG. Daily ops meetings in place to review bookings and replace cancellations for theatres and outpatients. Figures for outpatients has shown an increase in forward booking for service areas and improved booking utilisation. Focus is to maximise booking opportunities and KPIs are in place for the three Divisions. On the day cancellations remain between 3 to 5%. Daily review of DNAs has shown improvement during February

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 £ £4,455,800



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	Feb-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%		70.97%	80.39%	▲	

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 February with performance of 70.97%. This is the firth consecutive month this measure has not achieved however is a slight improvement compared to 68.97% reported in January.

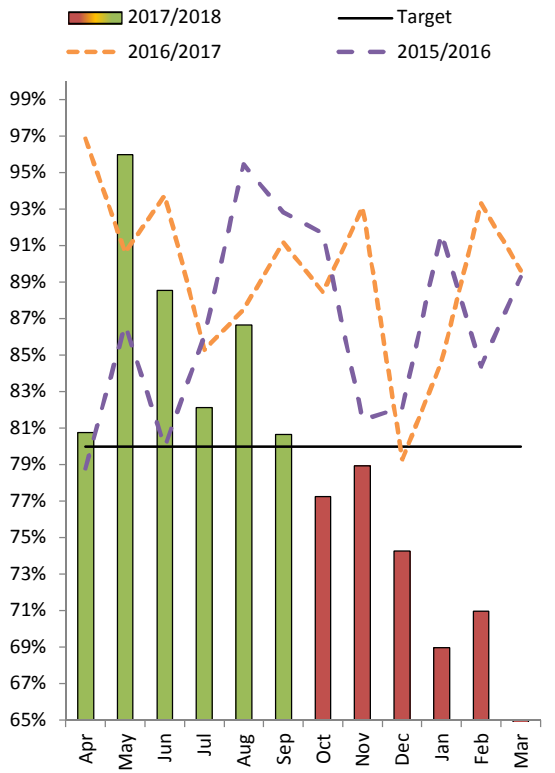
This measure was not achieved due in part to limited availability of beds on the stroke ward as there were general capacity pressures across the Trust which led to General Medical patients being placed there. In addition, the number of patients who were medically fit for discharge also increased.

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.



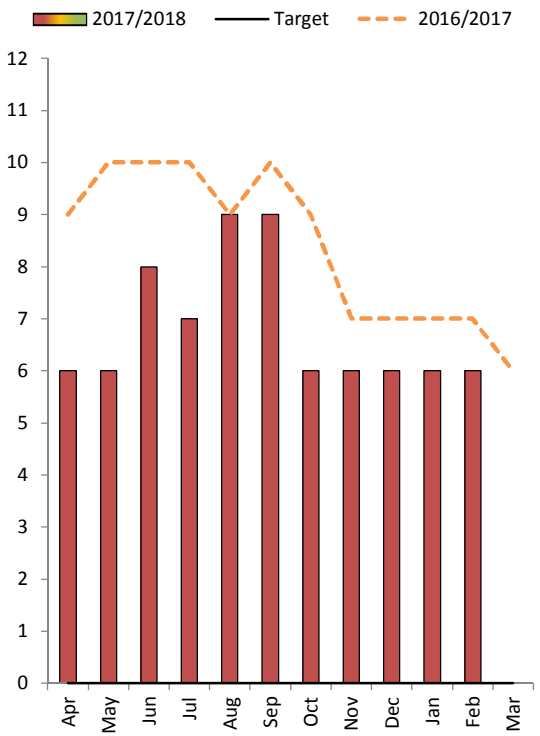
Expected date to meet standard	To be agreed
Lead Director	Chief Operating Officer

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	Feb-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 28th February 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	Feb-18	YTD	Change on last month	Year End Forecast
		9.00%	11.27%	12.28%	▲	

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 11.27% in February has improved by 0.84% compared to January (12.11%) but does not achieve the agreed monthly improvement trajectory of 9.00%.

Divisional Performance
- MLTC = 11.44% (compared to 12.72% in January)
- SURG = 10.28% (compared to 11.34% in January)
- WCCSS = 12.23% (compared to 12.49% in January)
.

New Actions:-

- Trust to switch on voice reminder system (IVM) for four key specialties in March (Dermatology, General Surgery, ENT and Diabetes). This is to remind patients for whom we do not have a mobile number (circa 600 patients per week). Roll out to all specialities planned following review of go live.

- A project has been initiated to support the roll out of a 'partial booking' process for all review appointments. This will allow patients an opportunity to agree suitable appointment dates. This will commence in April.

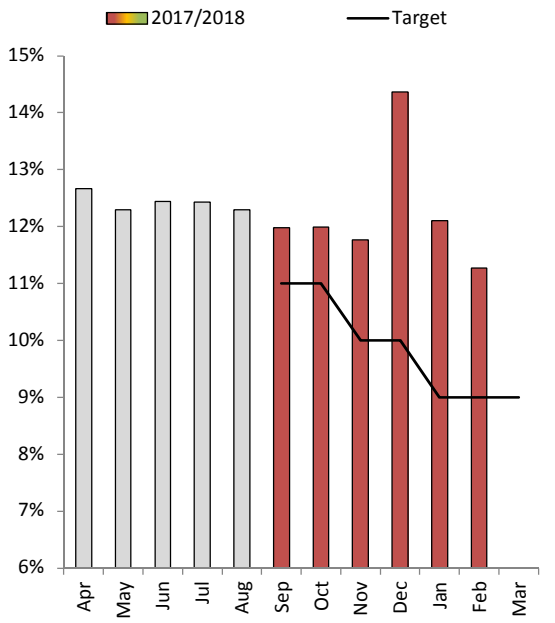
- Analysis of services with high DNA rates commenced in March. A standard report is to be developed to enable Care Groups to interrogate DNA rates, drilling down to booking methods and previous cancellations. This will support specialty specific action plans to reduce DNA rates.

- Roll out plan for direct booking via ERS is in place for all new patients, in line with the National Paper Free Project. New software for call centre planned for April. This will allow the team to analyse the call patterns and abandonment rates and will enable review of call centre staff rotas to ensure resources are available to reduce abandoned calls as initial indications suggest that high call abandonment levels and the number of DNA's each day are related.

- Care Groups are validating patients to reduce DNAs and act as a further caller reminder.

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	Feb-18	YTD	Change on last month	Year End Forecast
	7.01		7.59	7.18	▼	

What is driving the reported underperformance?

Performance results:
Overall performance for LoS in February was 7.59 days. This is very similar to the 7.56 days reported in January. 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 Jan	Ave LoS Feb	% LoS <72hr	% LoS of "0"
MLTC	8.93	9.34	51.08%	23.48%
SURG	6.03	5.29	64.81%	20.66%
WCCSS	2.92	2.80	93.40%	67.53%

The average LoS for Medicine and Long Term Conditions declined during February compared to January however Division of Surgery and Women's, Children's and Clinical Support Services saw an improvement in February compared to January.

The following specialties saw the highest increases in the month:

- Diabetic Medicine - 11.10 days in February compared to 8.89 days in January.
- Nephrology - 9.88 days in Febuary compared to 7.95 days in January.

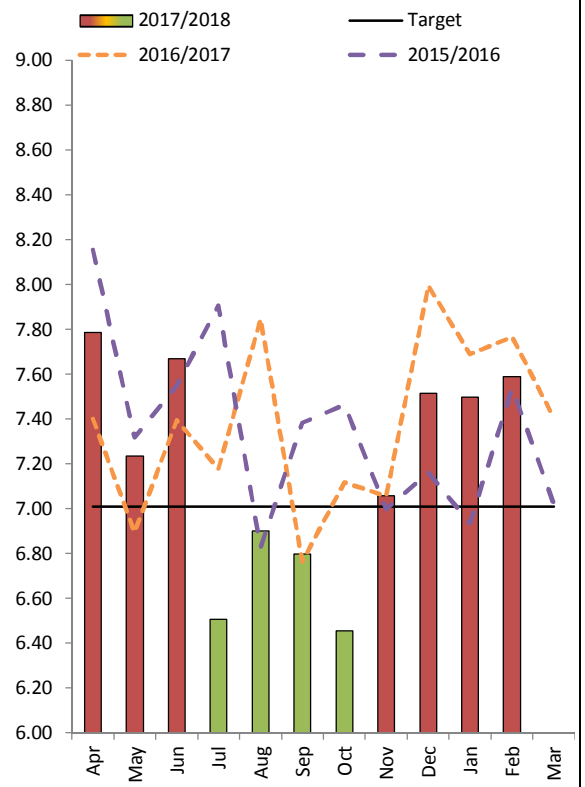
Benchmarking:
No formal national reports.

Contractual status:
No contractual requirements apply.

What actions have we taken to improve performance?

Continuing Actions:
The Emergency Care Improvement Team is working with the Trust on a range of areas; focusing on LOS reduction
- 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

Delayed Transfers of Care	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
The number of beds days relating to patients who were classified as a delayed discharge taken as a snapshot on the last Thursday of the month	2.50%		3.11%	2.35%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance results: Reported one month in arrears
The target of 2.50% or below attributable to delays as a total of available bed days was not achieved in January with performance of 3.11%. This is a decline in performance compared to 2.16% reported in December.

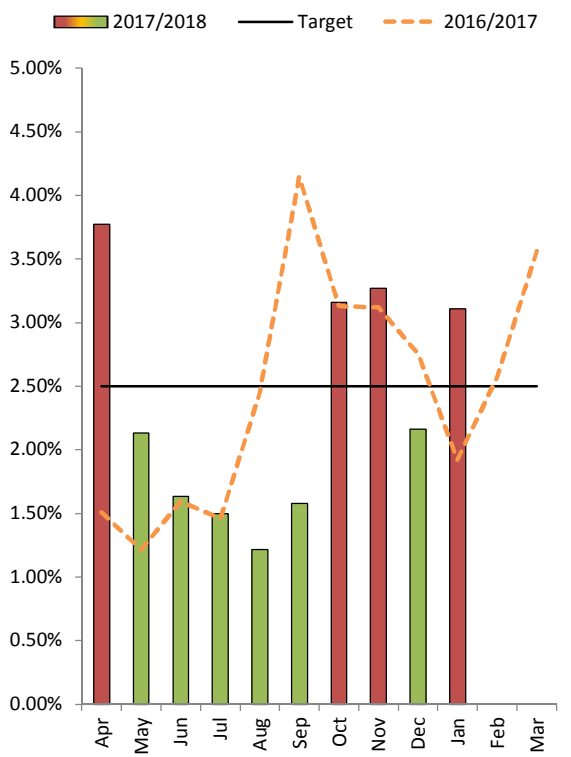
The DTOC reporting changed from 1st October 2017. Now every medically fit patient is reviewed daily and any DTOC patients are recorded. Previously this was only done once a week. This has had an impact on the reported delays at the end of the month and increase in the numbers. DTOC is therefore more accurately reported.

Benchmarking:
Benchmarking for this measure is based on the number of bed days impacted from delayed transfers every month.

Latest benchmarking shows, 415 bed days were impacted in January 2018 from delayed transfers taken at the snapshot position. This ranks the Trust 44th out of 133 Trusts nationally and 2nd out of 14 Trusts regionally.

Contractual status:
There is no financial penalty against the Trust for this metric.

Actions being taken to reduce the DTOC are:
- CHC assessments (DSTs) completion in the community will accelerate beyond the few voluntary cases we have previously completed. This will increase significantly following the management of change consultation period Feb / March involving the discharge liaison nurses.
- ICS model is developing training and guidance for the acute wards on discharge planning.
- ECIP team are in the hospital to work with teams to improve Trust performance.
- ICS model are developing patient information and patient choice policy with the Trust
- DTOC audit has commenced to check accuracy.
- ICS team have developed community therapy pathways in order to facilitate discharges sooner and conduct therapy assessments in the community.



Expected date to meet standard	To be agreed
Lead Director	Chief Operating Officer

g underta	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Sleeping Accommodation Breaches	Year Standard	Monthly Trajectory	Feb-18	YTD	Change on last month	Year End Forecast
	0	10	2	58	▲	

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 2 patient breaches reported within the Trust during February. This is an improvement in performance compared to 3 reported in January and is within the monthly trajectory of 10.

For the 2 patient breaches reported in February the length of breach incurred for each patient was one day. Both patients breached on the 3rd February and were from NHS South East Staffs and Seisdo and Peninsular CCG.

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 12 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 February shows that 47 out of 137 Acute Trusts reported sleeping accommodation breaches.

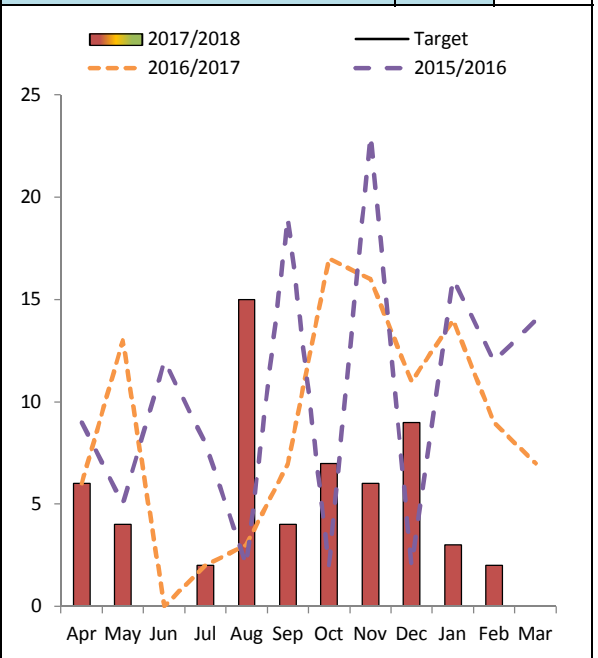
Contractual status:

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.

Continuing 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.
- 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 business case for the new Intensive Critical Care Unit was approved by NHSI in March 2017, 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	Dec-17	YTD	Change on last month	Year End Forecast
	100		128.00	97.06	▼	
	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 128.00 for December 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 19 less deaths than expected.

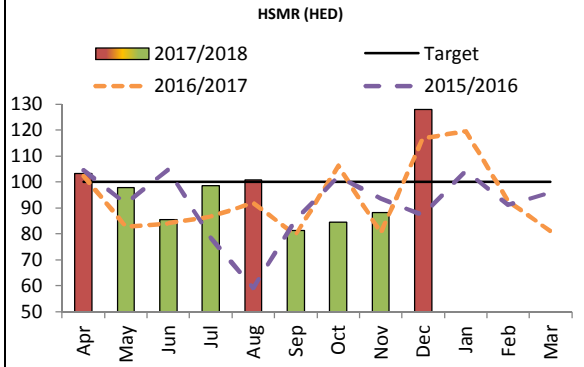
SHMI is a measure of mortality which includes all in hospital deaths and all deaths within 30 days of an inpatient episode. SHMI is published in 2 ways, as a monthly metric by HED and as a rolling 12 month metric published quarterly by NHS Digital. HED monthly SHMI for November was 100.88.

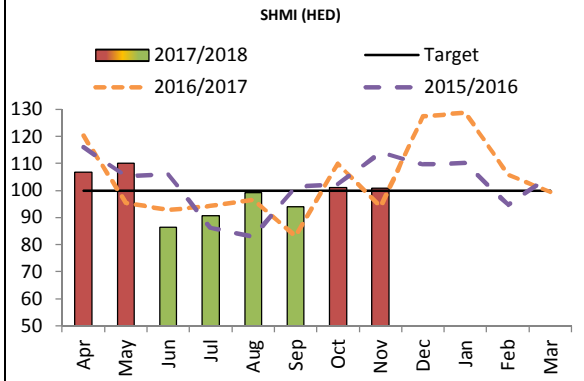
SHMI Benchmarking Based on NHS Digital Data:
SHMI published by the NHS Digital has been released for the period from April 2016 to March 2017 which shows a SHMI rate of 1.06. This ranks the Trust 92nd nationally and 8th regionally.

Contractual status:
No contractual requirements apply.

New actions:
- The review of deaths reported in December & January will be expanded to include place of residence in line with collaborative work with WCCG to review deaths of patients from care homes.
- Paediatrics continue to follow national protocols for reviewing paediatric & neonatal deaths and participating in regional & national forums and quality reviews.
- Reviews will be undertaken, as per national guidelines, for all Oncology patients who die within 30 days of receiving chemotherapy.

Continuing actions:
- Escalate poor performance in reviewing deaths to DDs & CDs
- Align the actions to address poor documentation to the CQC PCIP work.
- 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 the 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	By end of Q4 2017/18
Lead Director	Medical Director

National Contract		Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Infection Control	Year Standard	Monthly Trajectory	Feb-18	YTD	Change on last month	Year End Forecast
CDiff - Total number of cases of Clostridium Difficile recorded in the Trust	18	1	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 February 2018.

There were no cases of MRSA bacteraemia attributed to Walsall Healthcare NHS Trust during February 2018.

Benchmarking:
CDiff:
Data published one month in arrears by Health Protection England confirms that for January 2018, there were 0 cases of hospital attributable C.Difficile toxin at Walsall Healthcare. This compares to 5 cases at Dudley and 3 cases at Wolverhampton.

MRSA:
Data published one month in arrears shows there were no cases of MRSA recorded regionally for January 2018.

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?

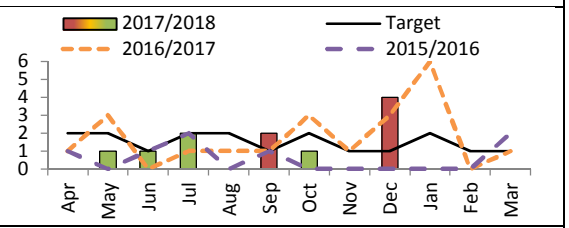
New actions:
CDiff: - As there were no C.Difficile cases reported in February 2018 there are no specific new actions currently being taken.

MRSA: - As there were no MRSA cases reported in February 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 £**

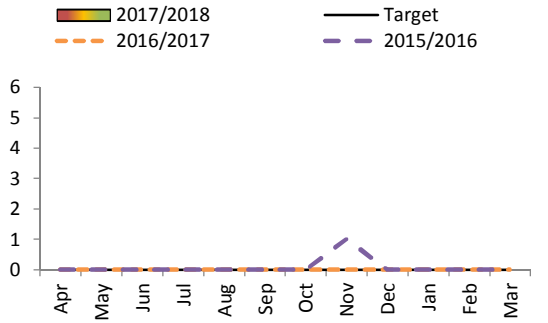
CDIFF



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	March 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	Dec-17	YTD	Change on last month	Year End Forecast
Figures based on all avoidable pressure ulcers acquired within the Trust			0.18		▲	

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)***
Dec-17	Cat 2	10 **(2)**	7 **(0)**
	Cat 3	1 **(1)**	0 **(0)**
	Cat 4	0 **(0)**	0 **(0)**
	Unstage	0 **(0)**	2 **(0)**
*Jan-18	Cat 2	9 **(3)**	9 **(0)**
	Cat 3	1 **(0)**	1 **(0)**
	Cat 4	0 **(0)**	0 **(0)**
	Unstage	5 **(1)**	7 **(3)**
*Feb-18	Cat 2	14 **(2)**	11 **(0)**
	Cat 3	1 **(0)**	1 **(0)**
	Cat 4	0 **(0)**	0 **(0)**
	Unstage	6 **(0)**	4 **(0)**

Rate per 1000 Beddays					
Dec-17	0.18	*Jan-18	0.41	*Feb-18	0.12

*Figures for these months are still being validated - please note there are 4 Unstageable PU's for December still awaiting final validation but initial discussions have already taken place with the wards involved.
There were 20 PU related incidents reported in December.
The highest reported area of prevalence continues to be on patients heels. There have been 8 incidents confirmed as avoidable in December. The themes identified were:
Hospital - Lack of patient information and delay in air mattress

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:

Inform ward staff re waterlow assessment tool and reinforce the new process for mattresses. New document will include patient information readlily available to issue

Education

Short education sessions are being provided to ward staff in response to action plans following investigations. A&E & AMU have received sessions. Theatres have requested and planned sessions. Other core sessions are planned for the rest of the year. The pressure ulcer prevention session on 20th March was cancelled due to only 4 booked attendees.
Competencies have now been agreed and Tissue Viability are progressing with assessment of community wound care link nurses

Equipment

The new process for ordering air mattresses started mid February. There was a delay in ability to adhere to the new process as there was a shortage of base foam mattresses. TV are monitoring the new process. Representatives from Invacare and Drive Devilbiss will be supporting nursing staff to embed the process. A question and answer session has been set up for 12th April at nursing forum.

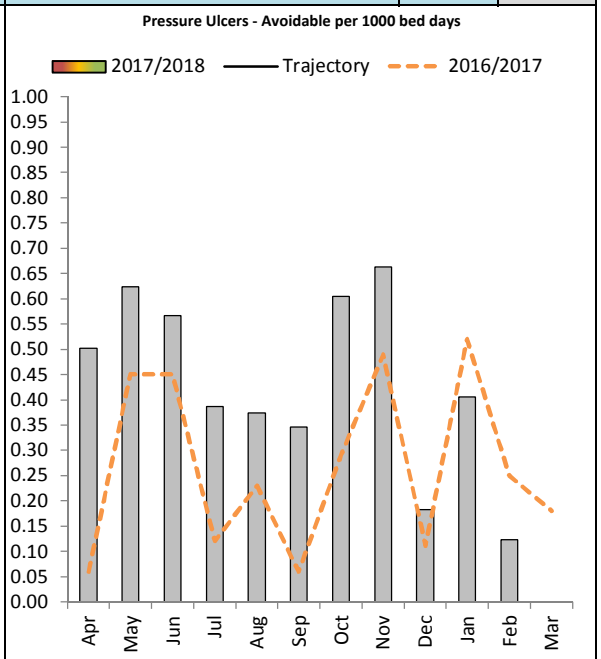
Documentation

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.

Wound Care Formulary Group

The wound care formulary group continue to 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.
TV have started work to review the wound care guidelines.

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	Feb-18	YTD	Change on last month	Year End Forecast
			83	931	▲	
	6.63		5.10		▲	

What is driving the reported underperformance?

Performance results:

There were 83 falls reported during February 2018, equating to a rate of 5.10 falls per 1000 beddays for the month which is comparable to 5.11 in January and achieves the Trust target of 6.63.

Based on Calendar Month		Dec-17	Jan-18	Feb-18
Count of Falls	Total	95	88	83
	MLTC	67	64	66
	Surgery	24	23	16
	WCCSS	1	0	1
	Comm / Corporate	2	1	0
	Other	1	0	0
Rate per 1000 beddays - All Falls		5.79	5.11	5.10
Rate per 1000 beddays - Moderate & Severe Falls		0.18	0.12	0.06

There were 10 reported incidents of patients falling more than once in February which is less than in January. In total these patients had 21 falls. The highest no.of falls were reported on Ward 11 (10 falls), Ward 01 (9 falls) & Ward 15 (7 falls).

There was one fall resulting in moderate harm with the patient suffering multiple injuries.

NHS Safety Thermometer results for February show performance of 0.72% of Falls resulting in harm (this is based on the number of falls reported on a one day audit completed each month).

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:

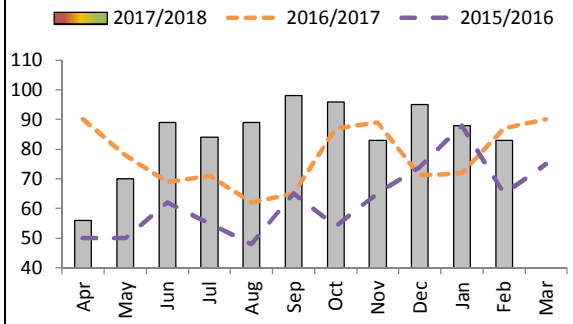
- Falls steering group continues with good representation across both community and acute trust. Terms of reference agreed
- An audit is planned following the rollout of new risk assessment and care plans
- New training programme agreed to include use of bedrails
- The Trust has been accepted and is working collaboratively with NHSI regarding enhanced care

Continuing actions:

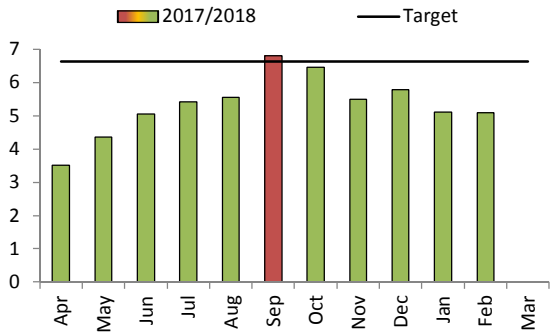
- Monthly falls audits continue
- Falls dashboard is shared with all wards and is monitored via the ward review process.
- All incidents relating to falls are recorded within the Safeguard system.
- Safety huddles on wards continue.
– Moving and handling training includes Falls scenarios and includes 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.

No Contractual Financial Penalties | **YTD £**

Number of Falls reported



Rate per 1000 Bed Days



Expected date to meet standard	Achieved in February 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	Feb-18	YTD	Change on last month	Year End Forecast
Number of patients who have had a VTE risk assessment	95.00%	95.00%	93.18%	87.87%	▲	

What is driving the reported underperformance?

Performance Results (Validated February 2018):
VTE initial Risk Assessment did not achieve in February 2018 with performance of 93.18% against a 95% target. This is an improvemer compared to January's performance of 91.30% but does not achieve the trajectory of 93.50%.

During February, 4589 patients who were admitted to the Organisation were eligible for VTE Risk Assessment and of those, 4276 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 February 2018 was as follows:-
- Surgery: 95.97% (93.94% in January)
- MLTC: 84.51% (82.11% in January)
- WCCSS: 98.60% (96.84% in January)

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.

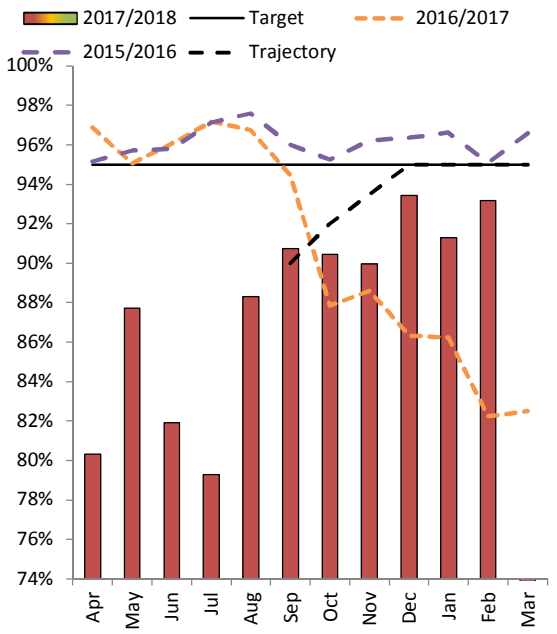
Contractual Status:
A contract performance notice relating to non achievement of this target was received from WCCG in August. A full response was made in September. Further contractual action has been instigated in March 2018.

What actions have we taken to improve performance?

New Actions:-
• Clinical input to FY1 & FY2 teaching sessions every 6 weeks to reinforce VTE assessment and prophylaxis guidelines and use of VitalPac
• Increased clinical input to doctor changeover. IT VitalPac training sessions to incorporate assessment and prophylaxis guidelines
• Undertake bi annual audits to assure appropriate prophylaxis is prescribed and administered

Continuing Actions:-
- As part of the contract notice action plan sent to WCCG, 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
• Standing agenda item for MAC for action by CD's and DD's to address performance
• Included VTE performance in the divisional quarterly reviews as pa of the Divisional Accountability Framework

No Contractual Financial Penalties	YTD £	



Proposed Trajectories					
Apr	May	Jun	Jul	Aug	Sept
Oct	Nov	Dec	Jan	Feb 93.50%	Mar 94.00%
Expected date to meet standard	End of Quarter One 18/19				
Lead Director	Medical Director				

	X	Local Contract	X	Best Practice		CQUIN	

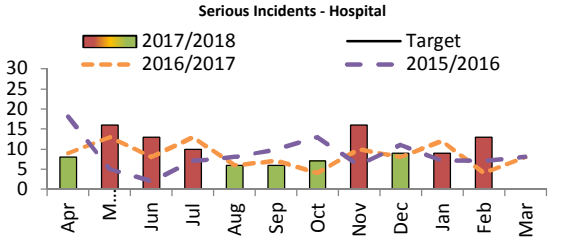
Serious Incidents (inc cat 3&4 pressure ulcers, HCAI's & Falls)

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	Feb-18	YTD	Change on last month	Year End Forecast
	102	7	13	113	▼	
	50	4	4	72	▲	

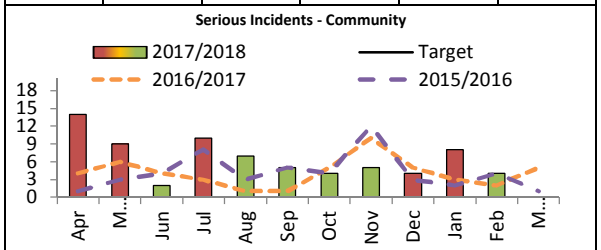
What is driving the reported underperformance?	What actions have we taken to improve performance?
There were 17 Serious Incidents reported to WCCG in February 2018, which is comparable to the 17 Serious Incidents reported in January 2018. Breakdown of Serious Incidents:- • 4 x non-pressure ulcer related incidents • 4 x unstageable pressure ulcers – community acquired • 2 x category 3 pressure ulcer – hospital acquired • 7 x unstageable pressure ulcers – hospital acquired Non-pressure ulcer Serious Incidents include: • 3 x diagnostic issues • 1 x adverse media coverage or public concern about the organisation.	Please see monthly Serious Incident Report New trajectories will be considered for the year 2018/19.

Contractual Financial Penalties — YTD £



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



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	Jan-18	YTD	Change on last month	Year End Forecast
	10.00%		10.44%		▲	

What is driving the reported underperformance?

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 January is 10.44% which is an improvement compared to 11.44% in December 2017.

There were 593 emergency readmissions in January, of which, 56 were related to GAU cohort.

Of the patients who were re-admitted in January:-
- Approximately 27% of the readmissions were aged under 30 (an increase compared to 19% in December).
- Approximately 31% of the readmissions were aged over 70 (a decrease compared to 37% in December).

The average number of days between the original admission and the re-admission is 9 compared to 10 days in December.

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 the same as in December.

Benchmarking:
There are no formal national reports published for this metric.

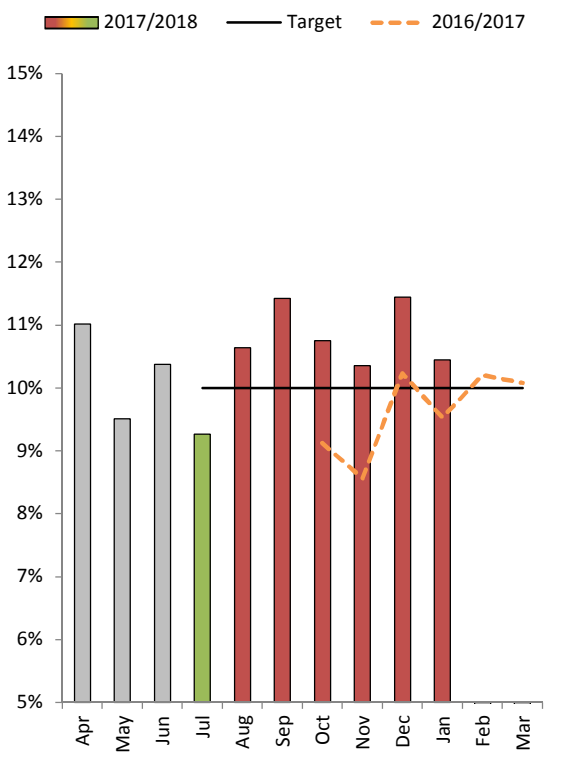
Contractual status:
No contractual target, however performance is reported monthly to commissioners.

What actions have we taken to improve performance?

New Actions:
- Further discussions are taking place within the Division to establish whether the GAU cohort can be excluded from the metric.
- Analysis is to be undertaken to review the readmissions reported in December & January to establish trends and identify patients who have high number of admissions during the winter periods.

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.

No Contractual Financial Penalties | **YTD £**



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	Feb-18	YTD	Change on last month	Year End Forecast
Number of EDS completed within 48 hrs of the point of patient discharge	100.00%		91.84%	89.32%	▲	

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 in February to 91.84% compared to 91.63% in January however this does remain below the locally agreed target of 95%.

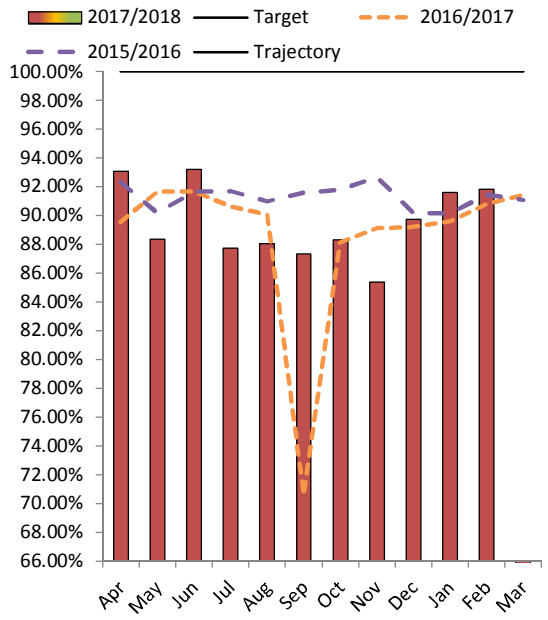
Divisional performance for February 2018 was as follows:-
- Surgery: 91.87% (91.78% in January)
- MLTC: 93.11% (91.19% in January)
- WCCSS: 89.82% (92.08% in January)

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:
- Performance against this measure was discussed with Commissioners at the Clinical Quality Review. A further meeting is to be arranged with GP's, WCCG & the Trust to discuss this topic further.

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 a significant improvement compared to the reported result in November 2017 (44.47%) but this attributable to the change in methodology explained below.

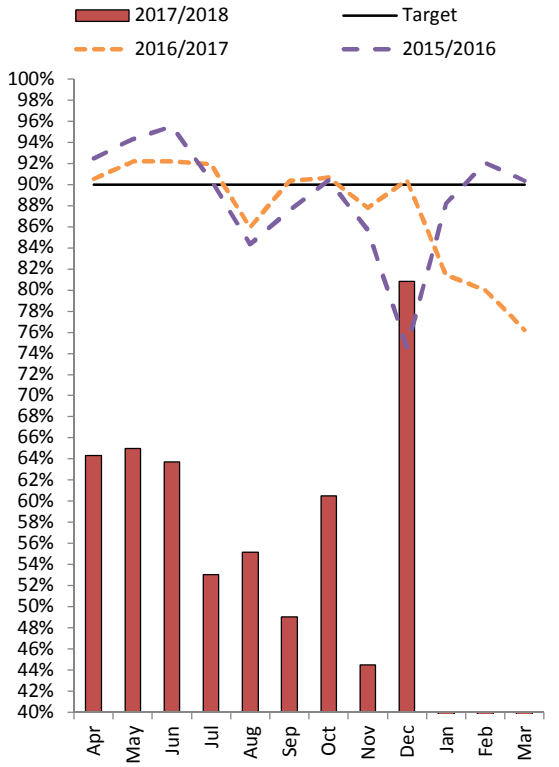
In agreement with WCCG and the Trusts executive lead, the reporting methodology has changed to utlising an audit approach rather than against the full cohort as it was not possible to capture the assessments for all applicable patients due to electronic system limitations. As a result the performance 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. As a national submission has not been made since November pending the discussions regarding methodology, no more recent bench marking is available.

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, although they acknowledged the difficulties in collating all of the data electronically. A briefing paper was drafted for the Director of Nursing to discuss this issue with fellow Execs. Following the outcome of this discussion reporting of this metric will need to be raised with Walsall CCG at the Clinical Quality Review Meeting.

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	Feb-18	YTD	Change on last month	Year End Forecast
	85.00%		79.00%		▲	
	96.00%		97.00%		▲	

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	Jan	Feb
Inpatient	96%	93%	97%
Outpatient	96%	91%	91%
ED	85%	75%	79%
Community	97%	97%	99%
Maternity-Antenatal	95%	97%	0%*
Maternity-Birth	96%	100%	100%
Maternity-Postnatal Ward	92%	97%	100%
Maternity-Postnatal Community	97%	99%	100%

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.

*iPads unavailable for collection of data.

Benchmarking:

For ED, the latest benchmarking (January) ranks the Trust 128th out of 131.

For Inpatients, the latest benchmarking (January) ranks the Trust 115th out of 133.

Contractual status:

NHS standard contract applies but no contractual financial penalties.

Inpatients:

- No change to status of MLTC, Surgery and WCCSS's efforts to secure funding for FFT ipads for their areas. Ipads would make FFT more inclusive, help improve response rates and be cost effective.
- The 'Quiet Protocol' to promote rest and sleep for patients at night has been agreed to be implemented by the Patient Experience Group (PEG). It has been co-produced with Staff and Service Users.
- The national award-winning Walsall Healthcare Paediatric app is now used for gathering FFT feedback.
- AMU chosen to be the first pilot area for rollout of the Always Event® programme in collaboration with the Patient Experience team.

ED:

- Volunteer numbers in ED are increasing to support improving patient area experience.

Outpatients:

- Team leaders promoting FFT to patients and discussing results within their teams. Focus on improving the patient registration information quality.

Maternity:

- IT team has started returning re-configured Ipads/tablets to the maternity wards which now have the facility to do FFT. All devices are expected to be returned by end of the month.

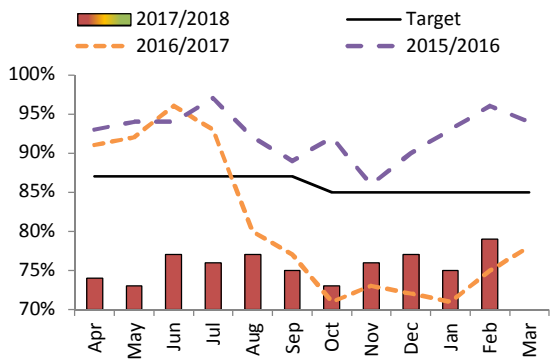
Community:

- Maintaining current level of support with Community Teams.

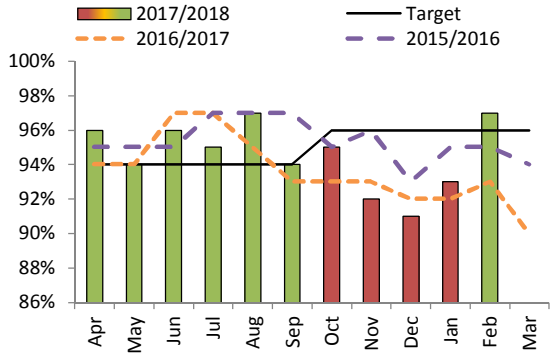
Continuing actions:

- 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.

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	Feb-18	YTD	Change on last month	Year End Forecast
	4.00%		5.00%	5.26%	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £

Performance status:
Sickness levels improved in February with performance of 5.00% compared to 6.23% in January 2018 but did not achieve the target of 4.00%. This represents a rise of 0.28% compared to same period 2016/17.

Monthly short-term sickness during February 2018 totalled an estimated cost of £154k and long-term sickness totalled an estimated cost of £267k.

There were 172 long-term episodes of sickness during February 2018 and 12 LTS cases extend to 6 months or more.
The largest cause of absence during February 2018 was Anxiety/stress/depression/other psychiatric illnesses - 1243 FTE Days across 86 episode(s) including 49 long-term.
The second largest cause of short-term absence was Other musculoskeletal problems - 799 FTE Days across 51 episode(s) including 35 long-term.
The sickness absence during the past 12 months stands at 5.19%, 1.80% above the Trust target.

Benchmarking:
No national or regional benchmarking available for this measure.

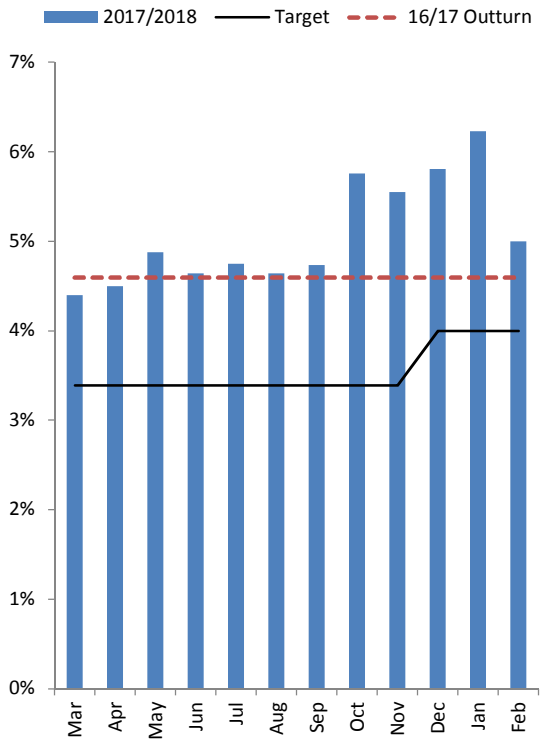
Contractual status:
No contractual requirements apply.

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 3 half day 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 healthy 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	Feb-18	YTD	Change on last month	Year End Forecast
	90.00%		79.47%	79.47%	▲	

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 February 2018 was 79.47%, an increase on January's 78.24%. This represents a rise of 1.23% month on month.

Compliance amongst Very Senior Management colleagues was 44%, while 123 Band 7 & above colleagues required an annual appraisal at the end of February 2018, resulting in a 78% compliance rate for this group.

The majority of divisions experienced a rise in compliance levels over the past month, of between 1% and 4%.

The Women's, Children's & Clinical Support Services division has th highest level of compliance at 88.25%.

Benchmarking:
No national or regional benchmarking available for this measure.

Contractual status:
No contractual requirements apply.

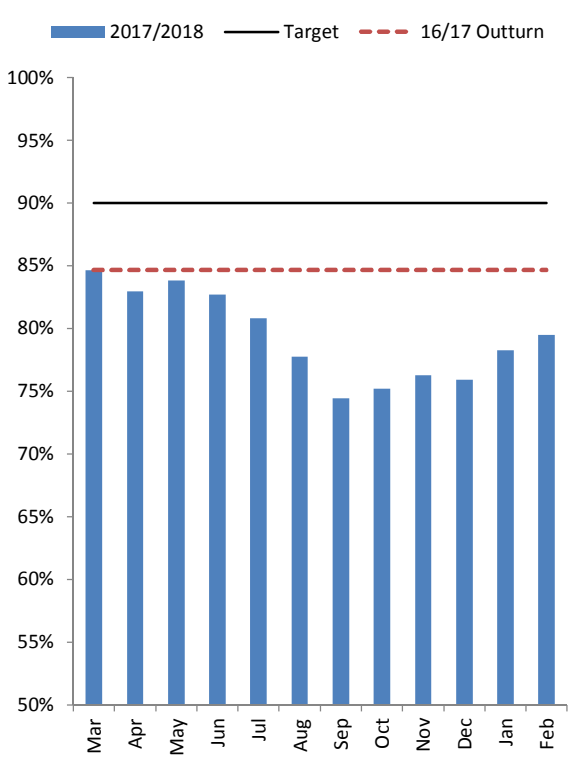
Continuing Actions:
- HR KPI reports have been developed based upon line management, rather than organisational, hierarchy lines.

- 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	Feb-18	YTD	Change on last month	Year End Forecast
	90.00%		77.61%	77.61%	▼	

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 February have declined to 77.61% compared to 78.14% reported in January. A fall of 0.53% month on month. This represents a fall of 2.04% since the end of Q3 17/18 and a fall of 2.99% compared to the same period last year.

2 of the 8 core mandatory competences saw compliance increase by up to 1% month on month.

The largest improvement owed to Information Governance, whereby compliance rose by 0.94% month on month.
All divisions have experienced a fall in compliance levels over the past month, of between 1% and 10%.

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.

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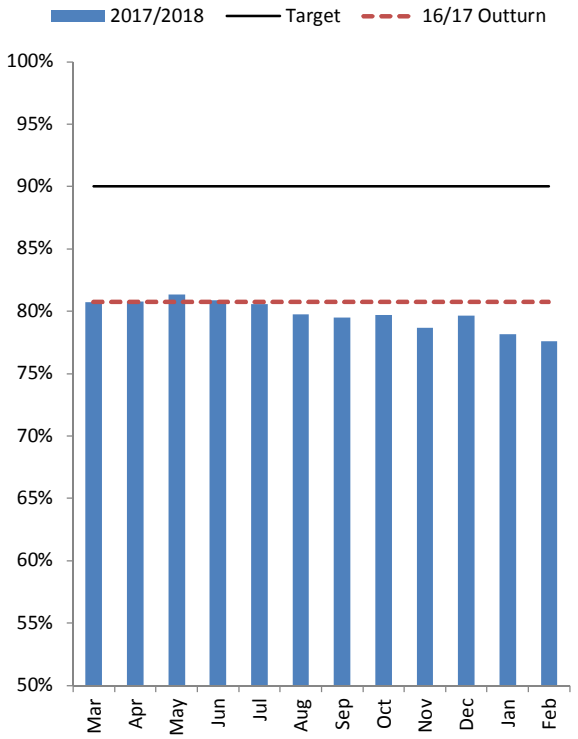

Expected date to meet standard	August 2018
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

CQUINs

	Total year 1	Q1 - Confirmed	Q2 - Confirmed	Q3 - (Expected)	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**: Results = 28% resulting in no payment (based on less than 3% improvement), however does show an improvement on previous year. WCCG have been contacted to request them to consider a payment to reflect the improvement. Local proposal to be considered for year 2
						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:** Results = 74% a decline resulting in no payment (no improvement), however there has been an improvement on the previous year, WCCG have been contacted to request them to consider a payment to reflect the improvement. Local proposal to be considered for year 2.
						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:** Results = 58% a decline resulting in no payment (no improvement). Local proposal to be considered for year 2.
					£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) . **Status: Achieved**
					£19,173	b.) The banning of advertisements on NHS premises of HFSS; **Status: Achieved**
					£19,173	c.) The banning of HFSS from checkouts; **Status: Achieved**
					£19,173	d.) Ensuring that healthy options are available at any point including for those staff working night shifts. **Status**: Letters issued between the Trust and food providers committing to keep the changes, a paper is being prepared to go to board summarising progress made to date.
					£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). **Status**: Audit conducted 8th March, results = 70% achieved 2018/19 - target increases to 80%.
					£25,564	b.) 60% of confectionery and sweets do not exceed 250 kcal. **Status**: Audit conducted 8th March, results = 64% achieved. 2018/19 - target 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 **Status**: Audit conducted 8th March, results = 67% achieved. 2018/19 increases to 75%.
					£153,384	**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:** Results = 70.7% Achieved. 2018/19 - target 75% by February 2019.
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: year 2 : Q2 Achieve the nationally set target
						year 2 : Q4 Achieve the nationally set target
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% (Sen. 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
						75% > of identified cohort have evidence of care and support planning conversations as recorded by provider = 100% of CQUIN value (50-75% = 50% payment)
						50% > of identified cohort demonstrate an improvement in their patient activation assessment = 100% of proportion of CQUIN value (25-50% = 50% payment)
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
- OH – Occupational Health
- ORMIS – Operating Room Management Information System

P

- PE – Patient Experience
- PEG – Patient Experience Group
- PFIC – Performance, Finance & Investment Committee
- PICO – Problem, Intervention, Comparative Treatment, Outcome
- PTL – Patient Tracking List
- PU – Pressure Ulcers

R

- RAP – Remedial Action Plan
- RATT – Rapid Assessment Treatment Team
- RCA – Root Cause Analysis
- RCN – Royal College of Nursing
- RCP – Royal College of Physicians
- RMC – Risk Management Committee
- RTT – Referral to Treatment
- RWT – The Royal Wolverhampton NHS Trust

S

- SAFER – Senior review - All patients will have an expected discharge date - Flow of patients - Early discharge – Review
- SAU – Surgical Assessment Unit
- SDS – Swift Discharge Suite
- SHMI – Summary Hospital Mortality Indicator
- SINAP – Stroke Improvement National Audit Programme
- SNAG – Senior Nurse Advisory Group
- SRG – Strategic Resilience Group
- 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:** 5 April 2018
Report Title	Performance Finance and Investment Committee Highlight Report and Minutes			**Agenda Item:17** **Enclosure No.: 15**
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			
Executive Summary	The report provides a highlight of the key issues discussed at the most recent Finance Performance and Investment Committee Meeting held on 28th March 2018 together with the confirmed minutes of the meeting held on 21st February 2018 and Extraordinary Meeting on 8th March. The meeting on the 8th March 2018 was quorate and Chaired by Mr John Dunn, Non-Executive Director and Chair of the Committee. The meeting on 28th March 2018 was not quorate and a general discussion about key issues and the committee's process's were discussed. A rescheduled full meeting is being arranged.			
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 and 8th March 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 8th March together with the approved minutes of the meeting held on the 28th February 2018 and 8th March..

2. KEY ISSUES FROM MEETINGS HELD ON 8th March 2018

2.1 The meeting was quorate and Chaired by Mr Dunn, Non-executive Director and Committee Chair.

2.2 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.

The likely outturn was stated as being £23m deficit.

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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.