Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 3 MAY 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. 6838 or jackie.white@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.	Patient Story (TBC)	Learning	Acting Director of Nursing	Verbal	**10.00**
CHAIR'S BUSINESS					
2.	Apologies for Absence	Information	Chair	Verbal	**10.30**
3.	Declarations of Interest	Information	Chair	ENC 1	**10.35**
4.	Minutes of the Board Meeting Held on 5 April 2018	Approval	Chair	ENC 2	**10.40**
5.	Matters Arising and Action Sheet	Review	Chair	ENC 3	**10.45**
6.	Chair's Report	Information	Chair	ENC 4	**10.50**
7.	Chief Executive's Report	Information	Chief Executive	ENC 5	**10.55**
QUALITY IMPROVEMENT					
8.	Serious Incident Report	Discussion	Acting Director of Nursing	ENC 6	**11.00**
9.	Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Acting Director of Nursing	ENC 7	**11.10**
10.	Update on NHS Improvement Review of Internal Nursing Temporary Workforce Arrangements	Information	Acting Director of Nursing	ENC 8	**11.20**
11.	Quality and Safety Committee Highlight Report and Minutes	Information	Acting Director of Nursing	ENC 9	**11.30**

STAFF ENGAGEMENT AND DEVELOPMENT OF A CLINICALLY LED ORGANISATION

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
12.	People and Organisational Development Committee Highlight Report and Minutes	Information	Interim Director of OD & HR	ENC 10	**11.40**
13.	DRAFT terms of reference and proposal to establish a Trust Management Board	Approval	Chief Executive / Interim Trust Secretary	ENC 11	**11.50**
BREAK – TEA/COFFEE PROVIDED					**12.00**
FINANCIAL IMPROVEMENT					
14.	Financial Performance Month 12	Discussion	Director of Finance & Performance	ENC 12	**12.10**
15.	Performance and Quality Report Month 12	Discussion	Director of Finance & Performance	ENC 13	**12.20**
16.	Performance, Finance & Investment Committee Highlight Report & Minutes	Information	Director of Finance & Performance	Verbal	**12.30**
DEVELOPING OUR CLINICAL SERVICES STRATEGY					
17.	Partnership Update	Information	Director of Strategy & Improvement	ENC 14	**12.40**
18.	Annual Plan update	Approval	Director of Strategy & Improvement	ENC 15	**12.50**
GOVERNANCE AND COMPLIANCE					
19.	Audit Committee Highlight Report and Minutes	Information	Director of Finance & Performance	ENC 16	**13.00**
20.	Use of the Trust Seal	Information	Interim Company Secretary	ENC 17	**13.10**
21.	2017/18 Data Security Protection Requirements - Summary of Compliance - April 2018	Approval	Director of Strategy & Improvement	ENC 18	**13.15**

22. **QUESTIONS FROM THE PUBLIC**

23. **DATE OF NEXT MEETING**
Public meeting on **Thursday 7 June 2018** at 10.00 a.m. at the Manor Learning and Conference Centre, Manor Hospital

23. **Exclusion to the Public** – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date:** 3rd May 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 5TH APRIL 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 A Khan	Medical Director

In Attendance:

Mr D Fradgley	Director of Strategy & Improvement
Ms L Ludgrove	Interim Director of Organisational Development and Human Resources
Mr M Dodd	Director of Operations, Medicine and Long Term Conditions
Miss J Wells	Senior Executive PA (Minutes)

Members of the Public 0
Members of Staff 3
Members of the Press / Media 0
Observers 1

001/18 Staff Story

Mr Hesham Abdalla, Consultant Paediatric Respiratory Consultant attended the meeting with Mr Kuldeep Singh, Patient Experience Manager, Ms Louise Mabley – Lead for Volunteers, Patient Experience and Self-Management, with Samantha Deane, Fiona Mullner and Caroline Whyte from the Peadiatric Team and Ms Louise Blunt, Head of Operations of the Patient Experience Network (PEN) who would present the team with their Innovation award for the development of an app.

Ms Blunt advised that PEN were a not for profit organisation who

created a patient experience network to identify, celebrate, share and embed staff experience. National awards were established to bring teams together and showcase their work.
The app that the team had created and launched had won the Overall winners award.

Mr Abdalla gave a presentation and showed a video detailing the functions of the app and how it benefitted patients visiting ward 21 at Walsall Healthcare.

Questions and Comments

Ms Oum thanked the team for the fantastic work they had undertaken to create the app which was a wonderful tool for both staff and patients. Thought had been given to the requirements of staff who could refer to guidelines quickly and easily and enabling patients to gain an understanding of how procedures were done in order to prepare children prior to visiting the hospital.

Mr Khan congratulated the team on their award. Mr Khan highlighted that the team had kept staff and patients at the heart of their work and challenged other departments follow suit as the basics were in place to develop the app further with no need for extra finances.
Mr Abdalla responded that the team were keen to work with other departments to get involved as the platform could easily be tailored. The Women's and Children's division had shown interest in developing the app for their area. A workshop had been arranged to showcase the app to staff at the end of the month.

Mrs Harris advised that the development of the app was fantastic, especially for patients, though it was every department's responsibility to develop the app for their areas.
Mrs Harris queried how easy the app was to replicate in other Trusts and whether it could be marketed.
Mr Abdalla responded that a roadshow to present to other Trusts had been planned, keeping the recognition that Walsall had started, sharing good practice.
Ms Blunt advised that the patient experience network had invited the team to a roadshow to showcase their work to others.

Mr Gayle stated that he attended the patient experience group meeting when the app was initially introduced and commended their achievement. Mr Gayle asked whether consideration had been given to cultural appropriateness.
Mr Abdalla replied that capacity had been limited but consideration was being given moving forward with development. Patients and children feedback had been taken on board and included during development. The app was currently only available in English.
Mr Singh agreed that add-ons could be later incorporated.

Ms Oum thanked the team for presenting to the Board, who were supportive and proud of the team's efforts and award.

002/18 Apologies for Absence

Apologies were noted from;

- Mr P Thomas-Hands, Chief Operating Officer. Mr M Dodd, Director of Operations, Medicine and Long Term Conditions deputised.
- Mrs B Beal, Interim Director of Nursing.
- Mrs P Furnival, Associate Non-Executive Director – Adult Community Care.

003/18 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.

004/18 Minutes of the Board Meeting Held in Public 8th March 2018

Mr Beeken requested that page 3 was amended to read patients within their few months or weeks of life rather than palliative care patients.

Clarification was given on page 8 to reflect that the redevelopment of the Emergency Department had been approved by the Board.

The minutes of the meeting held on the 8th March 2018 were agreed as a correct record with the above amendments.

Resolution

The Board approved the minutes of the meeting held on the 8th March 2018 as an accurate record with the above amendments.

005/18 Matters Arising and Action Sheet

The Board received the action sheet and the following updates were provided;

150/17 07/09/2017 – Mr Khan advised that the Trauma Unit standards would be reviewed at the next Quality and Safety Committee and would provide feedback to the Board.

160/17 07/09/2017 – Mrs Ludgrove advised that the Workforce Impact Assessment would be reviewed at the People and Organisational Development Committee later in the month.

195/17 02/11/2017 – Mr Khan updated that training had been undertaken by staff in relation to the timely treatment of sepsis and

there were signs of improvement, though work was ongoing. Monthly reports were reviewed at the Quality and safety Committee.

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

006/18 Chair's Report
Ms Oum presented the report which was taken as read but added that she had also met with the Black Country Chairs of collaboration and partnership. Future reports would be presented under the four Trust priority headlines.

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

007/18 Chief Executive's Report
Mr Beeken presented the report which was taken as read. The main focus of the report was the four Trust priorities.

Mr Beeken acknowledged that difficulties had been experienced by patients and relatives of patients over the last two weeks following an outbreak of the norovirus. Mr Beeken gave thanks to the efforts of operational colleagues during the challenging period. There were no excessive waits for admissions reported given that a number of wards or part thereof were closed to admissions at one point.

Ms Oum expressed appreciation and thanks to staff on behalf of the board during the challenges, particularly during the recent bank holidays.

Questions and Comments

Mr Heer advised that it would be useful for the board to view the detailed plans, timings and outcomes that lay beneath the four priorities.
Mr Beeken replied that the Annual Plan 2018-2019 would be scrutinised along with outlined specifics and trajectories and would include personal assessment, commitment and actions following the 100 days.
Work with the Trust Secretary would continue regarding the policy change of NHS Providers and governance. An Interim Trust Secretary was due to start at the Trust on Monday 9th April 2018.

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

008/18 Serious Incident Report
Mr Khan presented the Serious Incident report on behalf of Mrs Beal. The Quality and Safety Committee had reviewed the report. The following key points were highlighted;

- A total of 1100 incidents were reported, the majority of which were low harm.
- 3 serious incidents relating to diagnostics were reported.

- 13 pressure ulcers were reported, 4 community acquired and 9 hospital acquired.

Mr Khan thanked the public of Walsall in assisting to contain the spread of norovirus, though there were inconveniences, the public had been very understanding of the situation.

Mr Khan updated the Board regarding the occurrence of a never event in relation to surgery. Processes had been put in place to ensure that the incident was not repeated and would be reviewed at the Quality and Safety Committee.

Questions and Comments

Mr Beeken informed that there was clear instruction nationally that any breach of cancer standards needed to be reported through the Quality and Safety Committee at Public Trust Board. All breaches required investigation under a root cause analysis approach. Mr Beeken queried how the Trust addressed them.
Mr Khan responded that there was a clinical incident process in place where they would be documented within the serious incident report and performance dashboards. The incidents were reviewed by the Clinical Harm Group followed by the Quality and Safety Committee.
Mr Beeken asked to ensure that even if the breaches resulted in no harm, they should be articulated.

Mr Dunn advised that though never events were bought to the attention of Board members during the meeting, information prior to Public Trust Board detailing actions put in place would be welcomed.
Ms Oum confirmed that this practice had recently been put into place.

Ms Oum noted that three serious incidents had been reported in relation to diagnostics, adding that there was a spate of incidents some years previously where actions had been put in place and the issues resolved. Ms Oum was concerned that they didn't become a trend and would like to know what the Trust were doing to do to understand the reasoning behind them.
Mr Khan replied that the incidents were not solely related with diagnostics but included failures to diagnose at the right time. Action plans were being drafted for review at the Quality and Safety Committee.

Ms Oum noted the increase of the number of pressure ulcers reported, advising that assurance had previously been given that the initial rise was due to the change of reporting and would decrease over a period of months. Ms Oum wanted to understand what actions were in place to mitigate.
Mr Khan responded that a review would take place at the Quality and Safety Committee which would provide feedback to the Board.
Mr Gayle reiterated that the same questions regarding pressure ulcers remained without assurance as there appeared to be a steady increase which raised concerns regarding patient safety.
Professor Beale confirmed that actions being taken were under

review at the Quality and Safety Committee.
Ms Oum expressed concern that it appeared that there was a recurrent theme of basic assurance in practice and basic procedure wasn't being followed and asked the Quality and Safety Committee to check that actions were taking place and being embedded.

Mr Heer advised that the language of the report was difficult to interpret whether changes in practice had been made.

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

009/18 Mortality Report
Mr Khan presented the Mortality Report which had been reviewed at the Quality and Safety Committee and highlighted the following key points:

- HSMR and SHMI year to date were below 100.
- Spikes were seen over the winter period and into February.
- Following review, there were no specific triggers of conditions and focus remained on providing the right care for patients in the right place.

Questions and Comments

Mr Beeken queried Mr Khan's view of Consultant's medical engagement in mortality reviews as the percentage of reviews completed in a timely fashion by speciality was not encouraging.
Mr Khan replied that a discussion had taken place at the Medical Advisory Committee earlier in the week regarding a Medical Examiner role which had been introduced at other Trusts who would be able to provide support to relatives and liaise with the coroner. A further discussion was scheduled to take place at the Quality and Safety Committee.

Ms Oum observed that the report identified levels of HSMR and SHMI in comparison to other Trusts but did not get the same sense of comparable with the number of patient deaths. Ms Oum queried whether the number of deaths were in line with the severity of the winter and whether more could have been done.
Mr Khan responded that a review of common themes had been undertaken and the Trust was not an outlier. A number of deaths were seen in patients with a 0-1 day length of stay, adding that many were repeat admissions which should have been known to the Trust, prompting further work with community teams.

Mr Dunn advised that the mortality report and winter plan should be reviewed together as integration was key and the Trust should take learning from both.
Mr Beeken agreed, adding that the winter plan would be reviewed by the A&E Delivery Board and findings reported to the Trust Board.

Mr Heer stated that data should be used more intelligently and suggested setting benchmarking against previous years.

Ms Oum agreed and asked for consideration to be given at the Quality and Safety Committee.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Consideration of a Medical Examiner and benchmarking process to be discussed at the Quality and Safety Committee.** **Q&S**

010/18 Quality and Safety Committee Highlight Report and Minutes

Professor Beale presented the highlight report from the most recent meeting held on 29th March 2018, together with the approved minutes of the meeting held on 22nd February 2018. The following key points were highlighted:

- VTE was 95%. Work had been underway to identify problematic areas and solutions sought.
- The committee gave thanks to clinical teams, nursing staff, housekeeping and infection control during the recent outbreak of norovirus within the Trust.

Questions and Comments

Mr Caldicott praised that VTE compliance had attained 95.4%, which may further improve following validation.

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

011/18 Improvement Academy Approach

Mr Fradgley presented the progress and overview report for the Quality Improvement (QI) Academy, highlighting the following key points;

- Focus was on making small scale changes and upskilling a core set of individuals that would grow year upon year to deliver organisational objectives.
- The Academy had been established as part of a requirement through regulators and the CQC Well-Led framework.
- Mr Hesham Abdalla was the Clinical Lead and driving force for the academy, building upon LiA work and engaging staff.
- The academy could provide tools and mentors to deliver tangible outcomes leading to better experience for patients, staff and finance.

Questions and Comments

Ms Oum advised that she had attended the launch of the academy in February which was well engaged and had displayed a great level of enthusiasm.

Mr Dunn agreed that the establishment of the QI academy was beneficial for the Trust but cautioned to ensure that senior leaders

created the time for staff to participate as there was clear reward and recognition.
Mr Hesham Abdalla attended the meeting for the update and advised that the academy was accredited and agreed that staff needed to be released in order to contribute.
Mr Khan stated that it was important to equip people to take ownership and make changes themselves. Help to make changes and support should be given.

Mr Heer reiterated the need to embed within culture but challenged how it would be formalised. The pace was very slow and queried why only 20 delegates formed cohort 1.
Mr Beeken replied that there was an opportunity at Board Development the following week to discuss what emerging integrated improvement looked like, what defined quality effectiveness, efficiency and linear measures.
Mr Beeken added that the QI approaches needed to drive projects and work to achieve outcomes.

Professor Beale stated that the establishment of the QI Academy may help to improve upon core business by offering an improved incentive. Professor Beale suggested sourcing funding availability.

Mr Fradgley advised that the cohorts had to start small due to limited resource and allocation available. The governance structure was owned by the People and Organisational Development Committee and would be a standing agenda item with Trust Board oversight.
In terms of financing, discussion had taken place regarding the availability of monies from special measures. Resources and capacity were big issues. Mr Fradgley advised that thoughts and feedback would be discussed at the People and Organisational Development Committee and finances would be reviewed at the Performance, Finance and Investment Committee.

Ms Oum thanked Mr Fradgley for the update and agreed that the Board Development session would be a good platform for further discussion. The Board supported the approach and accepted the rationale for wanting to equip people with the skills to make changes. Consideration should be given to driving improvement changes through the PMO and how it would benefit big ticket items.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Noted that further discussion would be held at the Board Development meeting on 9th April 2018.**

012/18 Partnership Update

Mr Fradgley presented the update and highlighted the following key points;

- The MDT report was attached and to be taken as read. Teams were progressing well and working on a single referral process.

- Concerns of progress had been raised previously in relation to GP led. Progress was being made through pilots which were outlined within the report. One pilot site had been lost which had proved the complexities and problems involved but lessons had been learnt.
- There was no estate available that would allow co-location of the teams and there would be financial pressures of staff moves.
- Participation of 161 GPs across 60 practices was a significant number.
- The next steps of the programme and work plan for the Case for Change was underway. A proposal had been received from a support partner which was being considered by KPMG.
- A review of sustainability of services undertaken in house was underway. This entailed reviewing data with the intention of taking the best and the most challenged services and presenting to the STP what the future looked like.
- The Acute Response Service issues needed to be worked through in partnership with other partners within the STP in order to resolve. Feedback would be provided to the Performance, Finance and Investment Committee followed by a review of programme plans at Trust Board.

Questions and Comments

Ms Oum thanked Mr Fradgley for the update and the three simultaneous pieces of work that were progressing.

Mrs Harris queried whether the size of the teams had been scoped originally and whether any locations had been identified.
Mr Fradgley replied that mapping of teams had taken place from day one. Venues had been identified however they were either occupied or were deemed not to be cost effective. There was little progress to date in terms of a resolution which would likely only to be reached if there was a fundamental shift in use of estate and financial plans.
Mr Dodd advised that consideration was being given to centralising community based teams which would limit costs.

Mr Heer asked whether there was assurance health and safety wasn't currently having an impact upon services.
Mr Beeken replied that no assurance could be given at this point other than through interrogation of quality, safety and workforce challenges.

Mr Heer stated that the reports were displayed in isolation making it difficult to see how it all linked together and not focusing on a comprehensive picture.
Mr Beeken responded that the criteria of each of the services were 3-dimensional covering finance, workforce and quality.

Mr Dunn expressed concern regarding resources and engagement and asked when a proposal would be available outlining the placement of professionals.

Mr Fradgley replied that barriers were faced in terms of estates but the level of urgency was paramount. Plans would be discussed at through governance cycles within the month. A proposal for external support was being drafted. The governing body had assessed the suitability of the paper at the end of March.

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

013/18 General Data Protection Regulation

Mr Fradgley presented the update for information. The new General Data Protection Regulations were being implemented on 25th May 2018. There had been a thorough overview of preparedness and review at Audit Committee. A detailed action plan and information governance toolkit had been put in place. The Trust policy which referenced data protection would be updated in April.

Questions and Comments

Ms Oum queried how regular reviews would take place.
Mr Fradgley answered that reviews would be conducted by the Information Governance Group and feedback provided to the Quality and Safety Committee.

Mrs Harris asked whether the Trust were ready for the change.
Mr Fradgley advised that steps had been put in place in readiness. Sharon Thomas, Medical Records Manager was taking over from Kirstie Macmillan following her departure in Information Governance and would be the Trust lead.

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

014/18 Staff Survey 2017 & Staff Engagement Action Plan

Mr Simon Johnson, Staff Engagement Lead attended the meeting to provide the Board with an update regarding the staff survey and engagement plan.

Mr Johnson advised that there were 32 key findings from the staff survey. The number of staff who completed the survey was reported at 36% against a national average of 40.4%. It was noted that the timing of the issue of the survey may have been ill timed with the rise in car parking charges.

Ms Oum queried the timeline of the Friends and Family Test results. Mr Johnson replied that it ran through February to March 2018 and was therefore quite current.

Mr Johnson stated that the overall picture for Walsall Healthcare had improved from 37th to 35th against other Trusts. The next stage was to meet with HR Managers who had links with divisions in order to complete action plans of focus areas and take ownership.

Mr Heer challenged that some key areas still didn't appear to have made improvement. Staff engagement needed to be built in line with

the four Trust priorities. The Trust needed to understand what was trying to be achieved and how it fitted with strategy before embarking upon further action plans.
The survey results were concerning. Pace and ambition was required.

Ms Oum cautioned that the staff survey took place during September and that staff engagement had not fully commenced at that point.

Mr Gayle advised that more time was needed for engagement to be embedded as it took time for staff to see significant changes. There was much work ahead and the upcoming Pulse Check may provide further insight.
Mr Gayle queried whether the responses related to certain areas.
Mr Johnson replied that the responses were not related to specific areas. The Trust was now being more transparent than previously but culture change takes time, though there were signs of improvement.

Mrs Ludgrove stated that the key issue was actual change but had seen elements of positivity following providing good feedback and addressing behaviours of senior managers within the organisation which had been progressed at a good rate.

Ms Oum advised that the People and Organisational Development Committee would review feedback, led by Mrs Ludgrove.

Mr Fradgley observed that the positives should be picked out from the reports and driven forward. While the report outlined a number of negative views which caused alarm, equally there was change and the organisation felt better than it did the previous year, noting there had been a positive CQC report since the staff survey was issued.

Mr Beeken agreed that buy in from colleagues was required in order to make change. Mr Beeken had previously met with Mr Johnson to review the results, which in isolation looked grim but there had been notable changes in some areas, though there was a long way to go. Staff engagement was captured within the Trust four priorities as a discrete and separate priority. There is no substitution for good staff engagement with effective staff management and leadership, allowing a two way communication within teams. Mr Beeken added that there needed to be a quality improvement culture where people sought forgiveness not permission.
Listening into Action had been a hugely important tool and needed to form part of a wider set to improve the quality effectiveness and efficiency of the Trust.

Mr Dunn expressed disappointment of only 36% of staff participation in the staff survey. Progress needed to be measurable. Mr Dunn added that he would like to see clear goals that the Board could sign up to as a critical change needed to be seen.
Ms Oum suggested that Mr Johnson and the Executive Directors reviewed and created a realistic target.

Mrs Harris reiterated the timelines, outlining that Mr Johnson joined the Trust in July and had only been in post for two months prior to the launch of the staff survey. Much engagement had taken place since then and time was needed to see changes. Mrs Harris encouraged Board members to attend engagement groups.

Mr Johnson advised that the signs were similar to other Trusts where a very slight improvement had been seen in year one followed by a marked improvement the following year.

Mr Khan stated that staff needed to want to be good at what they do and have the freedom to do it. The processes needed to be right to allow people to do things in order to change.
Ms Oum agreed that passion was important.

Ms Oum confirmed that the Board were all agreed that engagement was a clear Trust priority and asked to ensure that it formed part of the improvement plan. There was a feeling of change but focus was to remain.

Mr Johnson summarised the action plan and the five key areas included within. A new set of values had been established by staff and would be launched at the Leadership Conference, in turn providing a behavioural framework.
Mr Johnson highlighted that appraisals required further focus.

Mr Johnson had circulated a poster as an example for a Trust pledge with a view to launching in July, asking for feedback and comments.
Mr Dunn advised that the pledge should be supporting the values.
Professor Beale replied that he was not convinced a pledge would make any impact.
Mr Beeken agreed with Mr Dunn's comment of tying in to values and behaviours which are developed by staff for staff.

Ms Oum thanked Mr Johnson for the important piece of work which the Board supported.

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

015/18 Financial Performance Month 11

The Financial Performance for month 11 was reviewed and the following key points were highlighted;

- The Trust had attained a £23.3m deficit at month 11, giving a £4m adverse variance.
- Clinical divisions were adverse to plan mainly due to temporary staffing costs and CIP underperformance.
- A forecasted outturn of £23m had been submitted to NHSI.
- There were significant cash impacts. Tre Trust was funded for a deficit of £20.5m therefore had requested increased cash resource.

Questions and Comments

Mr Gayle queried whether there was confidence that £23.3m would be achieved.
Mr Caldicott replied that he was relatively confident that it would be achieved. Risks centred upon clinical challenge with healthcare commissioners.

Ms Oum advised that the Board had previously been given assurance that the outturn was achievable.
Mr Caldicott added that they had met with the regulators prior to the reforecast and they were supportive of the Trust stance.

Mr Heer expressed disappointment and concern at the figures outlined in the Cost Improvement Plan, noting that there was uncertainty in terms of the CIP and recommended that slippages should be examined.
Mr Caldicott agreed, advising that slippages were due to elective work for emergency care which was a national issue. Concern however did remain in the practice of use of temporary workforce. There could not be any cost over runs that remained unmitigated into the new financial year.

Mr Dunn stated that outturn had been reviewed in depth at the Performance, Finance and Investment Committee. There was an intention to have a much clearer focus with weekly monitoring in place with more key ownership and detailed plans resourced properly. There were critical learning points to be noted. Mr Dunn also expressed disappointment that there was a £4m unfavourable variance which could not happen again.

Ms Oum summarised that there was a clear message that Board members were disappointed that the financial target had not been achieved that had been felt was deliverable. Leaning needed to include a robust review of what went wrong and where.

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

016/18 Performance and Quality Report Month 11

Mr Caldicott presented the Performance and Quality Report for month 11 and highlighted the following key points:

- A&E Performance within 4 hours was reported at 83% which was below trajectory.
- RTT performance was 84% and had shown an improvement on the previous months.
- 6 week diagnostics had delivered.
- VTE was adverse to pan but had moved to 95% at end of March 2018.

Mr Dodd advised that winter pressures continued into February which was longer than anticipated. Performance had stabilised during March.

Cancer targets had stabilised which had been prioritised.
Improvements had been made in elective access, improving efficiency in certain areas to hold the 18 week target had been seen during February and carried through into March.

Questions and Comments

Mr Heer explained that he tried to look at the positives but scrutiny was needed. Under performance could not be continuously justified with half term and weather.
Mr Beeken replied that there had been a vivid description previously from the Chief Operating Officer regarding the unacceptability of urgent care because of its impact upon patients. Under-performance was not being accepted and the reports did not reflect relaunch and adjustments to plans. The winter period had been one of the worst seen in some time due to the sustained period of it and far beyond the robust plans that were in place. There had been a significant increase in the number of elderly patient admissions. Plans would be adjusted accordingly which may form a new baseline.

Ms Oum requested a timely look at the way information was presented which set the tone of the papers.

Mr Dodd agreed that there was a danger of reports being viewed as complacent which was the wrong impression. Focus should be drawn back to staff and patient experience within A&E.
This year there were 95 extra beds available than the previous year, starting from a better baseline and handover with ambulances had dropped from the previous year regardless of the pressures within the department. ECIP had been providing helpful feedback.

Professor Beale questioned when the winter plan for next year would be available.
Mr Beeken responded that it was a national requirement to be produced by 30th April 2018.

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

017/18 Performance, Finance & Investment Committee Highlight Report and Minutes

Mr Dunn presented the highlight report from the Performance, Finance and Investment Committee held on 28th March 2018 and the Extraordinary Committee held on 8th March 2018, with the confirmed minutes from the meeting held on 21st February 2018.

Mr Dunn advised that changes were being seen in relation to becoming a learning organisation, discussing issues and making changes to governance and approach.

Mr Dunn added that the meeting scheduled for 28th March 2018 was not quorate therefore could not proceed, however a positive debate took place regarding a clearer focus moving forward per quarter.

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

018/18 Audit Committee Highlight Report and Minutes

Mr Heer provided a verbal update due to the meeting being held one day prior to Trust Board and highlighted the following key points;

- The meetings on 12th March 2018 and 3rd April 2018 focused on year end and internal audit recommendations.
- Internal Audit and Executive Directors were in agreement of actions still outstanding which should not slip from the previous year.
- External Audit would submit the annual report at the end of April and the Quality Account in June 2018.
- There was concern that the audit report and timetable was not progressing as it should have which was due to audit support, planning and continuity issues. Mr Caldicott and Mr Heer were seeking a meeting with audit partners to table concerns and to gain assurance that the timetable was achievable.

Questions and Comments

Ms Oum confirmed that it was vital that timetables were achieved and stated that it needed to be made clear that Board members were not happy with the progress of audit.

Mr Beeken advised that colleagues were committed to produce updated actions by a certain date which had passed. A further update would be required by the end of the week.

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

019/18 Questions from the Public

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

Mr Cliff Lemord, Union Representative raised the following points;

- There may be some culture changes but unions only saw a snapshot and didn't feel like there was much change within the organisation. Leaders needed to show that culture change and it didn't necessarily happen consistently.
- A recent Daily Dose communication was issued detailing staff being rude to volunteers. Reports were still being made of staff being rude to other staff.
- Staff had reported that communications were up and down, informing staff of changes rather than involving them.
- Concerns raised would be discussed with Mrs Ludgrove at their monthly meeting.

Mr Beeken reiterated earlier discussion that there had been elements of culture change in some areas and that it would take time

to embed.
Unacceptable behaviours would be addressed by adopting a set of values and holding contra-behaviours of individuals to account.

Mr Lemord added that appraisal targets were not being achieved. People needed to be held to account but was unsure of how that could be managed.
Ms Oum agreed that appraisals were of importance and required a review of how to measure success.

020/18 Date of Next Meeting

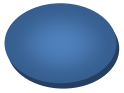
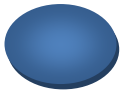
The next meeting of the Trust Board held in public would be on Thursday 3rd May 2018 at 10:00a.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

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
NHS Trust

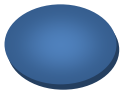
PUBLIC TRUST BOARD ACTION SHEET

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	**Complete** Update included in the Quality & Safety Committee Highlight report	
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** Completed. Report submitted to PoD and accepted at meeting on 16.04.18	
195/17 02/11/2017 Performance & Quality Report Month 6	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 Committee.	Chief Executive	~~01/02/2018~~ ~~21/02/2018~~ 07/06/2018	**Update** CEO is discussing and agreeing format of exception reports to Board with each individual Executive Director. This must be delivered in the context of the emerging IIP and how portfolio holders report to Board will change.	

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
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 & Improvement	08/03/2018	**Update** Strategy group met 18/04/18 – Verbal update to be provided during Board	
226/17 02/02/2018 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~~ 07/06/2018	**Update** Further work being done following board development session. Report to be provided in June.	
009/18 05/04/2018 Mortality Report	Consideration of a Medical Examiner and benchmarking process to be discussed at the Quality and Safety Committee.	Medical Director	03/05/2018	**Update** Being progressed through the Mortality Surveillence Group	

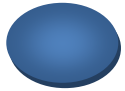
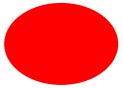
ENC 2

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**		**Date: 03/05/18**
Report Title	**CHAIR'S UPDATE**		**Agenda Item: 6** **Enclosure No.: 4**
Lead Director to Present Report	Danielle Oum, Chair		
Report Author(s)	Danielle Oum, Chair		
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. In keeping with the Trust's refocusing on core fundamentals, this report has been restructured to fit with the organisational priority objectives for the coming year. With regard to the priorities 3 and 4, I have embarked on a programme of engagement with colleagues and stakeholders to communicate our organisational focus as well as gather perspectives and triangulate information to contribute to Board assurance.		
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	1. NOTE the Chair's update The Board are asked to note this report.			

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Walsall Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD
5th APRIL 2018

CHAIR'S UPDATE

PRIORITY OBJECTIVES FOR 2018/19

1. **Quality improvement**
   Chairing the Maternity Taskforce in place of Richard – I was gratified to note the acknowledgement from key stakeholders of the progress being made in the Maternity Service.

2. **Financial improvement**
   I was greatly heartened by spending time with many innovative and committed colleagues this month but was disappointed to see that some Trust systems are inhibiting the drive to improve efficiency and best use of resources.

3. **Improving staff engagement and development of a clinically led organisation**
   I was pleased to attend a presentation on the use of Human Factors as an intervention to drive cultural change in the Maternity Service. Having participated in one of the workshops on "teams" I am convinced of the potential as a tool in delivering improvement across the organisation.

   I have continued to visit services and shadow colleagues. I am impressed by the passion for improvement, the sense of energy and drive is palpable – I welcome more invitations to visit services.

4. **Developing our Clinical Services Strategy through organisational collaboration**
   I have had discussions with chairs at all the Black Country acute Trusts, to emphasise the Trust's commitment to collaboration as a means of achieving sustainable acute services across the STP footprint.

Meetings attended / services visited
Fair Oaks Day Hospice
Lung Cancer Outpatients
Older People's Mental Health Liaison Service
Community Midwifery Service
Pharmacy
Maternity Services Taskforce Meeting
Human Factors presentation
I have met with Katrina Boffey from NHSI and Simon Johnson, Staff Engagement Lead and Jog Hundle from Mills & Reeve.
I opened the Vaisakhi celebrations in the main entrance on 23rd April

One to one meetings with the Black Country Chair

The Board is recommended to:

1. NOTE the Chair's report.

Danielle Oum
3 May 2018

BOARD/COMMITTEE REPORT

Meeting	**TRUST BOARD**		**Date: 3rd May 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 actions and interactions on key pieces of work, set against the organisational priority objectives for the financial year 2018/19.		
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.			

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Walsall Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD
3rd MAY 2018

CHIEF EXECUTIVE'S REPORT

PRIORITY OBJECTIVES FOR 2018/19

1. **Improving Quality**
   Since the last Board meeting a few developments have occurred with regard to our first priority as an organisation for 2018/19.

   With regard to our forthcoming CQC inspection, the Trust has still not received our Provider Information Request (PIR) which is the signal for the start of an inspection process. Therefore, it is clear that our inspection will not be until at least mid-summer this year.

   On this basis, we need to start our preparations for this process. With our Interim Director of Nursing, Barbara Beal, stepping down at the beginning of May, it is crucial that we secure excellent Deputy Director of Nursing support for Kara Blackwell, who will be acting up as Director of Nursing until our substantive appointment is made to the post. Sue Holden, Improvement Director, and I are in discussions with an experienced former Director of Nursing and Improvement Director, whose services we hope to secure to provide the following roles:

   - Deputy Director of Nursing and Quality
   - CQC inspection preparation lead – with a particular focus on leading the wards and departments of the Trust in sustaining the improvements in the fundamentals of care which we delivered as an organisation before the last inspection
   - Lead officer for the development of the Integrated Improvement Programme – to carry the organisation from "Requires Improvement" to "Good"

2. **Culture, staff engagement and clinical leadership**
   The recruitment process for our crucial executive roles of Director of Nursing and Executive Medical Director began on Monday 16th April.

   At my next Chief Executive staff briefing, the staff engagement lead, Simon Johnson and I, will lead an interactive session which will seek to explore the drivers behind our three key organisation-wide development areas coming out of the results of the NHS Staff Opinion Survey. The output of these discussions will lead to a further iteration of the Trust-wide action plan on staff engagement. We will also ensure that our

Divisional Performance Review framework, as we now shift to monthly review as opposed to quarterly, will focus our Divisions on the specific actions which are pertinent to their detailed results.

3. **Financial Improvement**
   In the next two weeks, I will be meeting all the executive sponsors and senior responsible officers for the key work streams of the financial improvement programme, to agree objectives, trajectories and resources for each. Joining me at these sessions will be the PMO Director and the Finance Director. The sessions will be informed by the useful discussion the Chair and I had with our Board Committee chairs recently, setting out their expectations with regard to accountability for delivery of the key elements of our financial plan.

4. **Clinical strategy**
   The Black Country STP has been under considerable scrutiny from NHSE and NHSI in the last few weeks. This scrutiny was driven by concern that the NHS clinical strategy for acute service sustainability and strategic commissioning development/CCG consolidation, was unclear and not moving quickly enough. As a result of this scrutiny and following extensive discussions, the following has been agreed:
   - Helen Hibbs, AO for Wolverhampton CCG, has been supported to take over from Andy Williams as SRO for the STP
   - I have been supported to become the notional Deputy SRO for the STP, with a particular focus on acute hospital service integration and sustainability plans
   - Mark Axcell, CEO of DWMHPT, has been supported to become the mental health lead, with a particular focus on integration of mental health services in the Black Country
   - The STP clinical strategy, which will more clearly define the development of "place based" service change in each Borough, together with the finer detail of proposed acute service and mental health service change, will be developed during the first quarter of 2018/19. The Board can expect to receive and review this strategy for the STP, when it is completed

   In relation to the above, the Trust continues to work with partner organisations on the Walsall place based agenda. The Walsall Together Provider Board, will shortly sign off the clinical and managerial leadership structure, which will take the partnership through its first year, adhering to the timelines committed to in the Case for Change, which the Board agreed two months ago. On acute service development, the Medical Director and Strategy & Improvement Director, will lead an important half day session with our clinical Divisions at the beginning of May, which will refine our Sustainability Review outputs, into a final form, before the Board receives these for consideration in the next two months.

The Board is recommended to:

1. NOTE the Chief Executive's report.

Richard Beeken
3rd May 2018

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board (Public)			**Date: 03/05/2018**
Report Title	Serious Incident Report			**Agenda Item: 8** **Enclosure No.: 6**
Lead Director to Present Report	Kara Blackwell – Acting Director of Nursing			
Report Author(s)	Chris Rawlings – Head of Clinical Governance			
Executive Summary	1. There were 17 new Serious Incidents reported in March 2018 ○ 8 Pressure Ulcers (5 Community acquired and 3 Hospital Acquired) ○ 3 Infection Control incidents ○ 2 Diagnostic issues ○ 2 Surgical invasive procedures (including 1 Never Event). ○ 1 Information Governance issues ○ 1 Treatment delay 2. Three Serious Incidents relating to Infection Control were reported and included ward closures due to Norovirus and an outbreak of influenza. 3. Pressure ulcer reporting has decreased and was exclusively associated with unstageable pressure ulcers across both the acute site and community settings. (8 incidents reported in March 2018 compared to 13 incidents in February 2018). 4. A Never Event was reported 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 be undertaken to address learning and prevent recurrence.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	The Board is recommended to NOTE THE REPORT FOR INFORMATION.			

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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 – March 2018

Executive Summary

1. Introduction

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

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

Serious Incidents in the NHS are defined as:

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

Never Events are defined as:

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

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

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

2. Total Incidents

There were a total of 1113 incidents reported in March 2018
The breakdown of harm is shown below:-

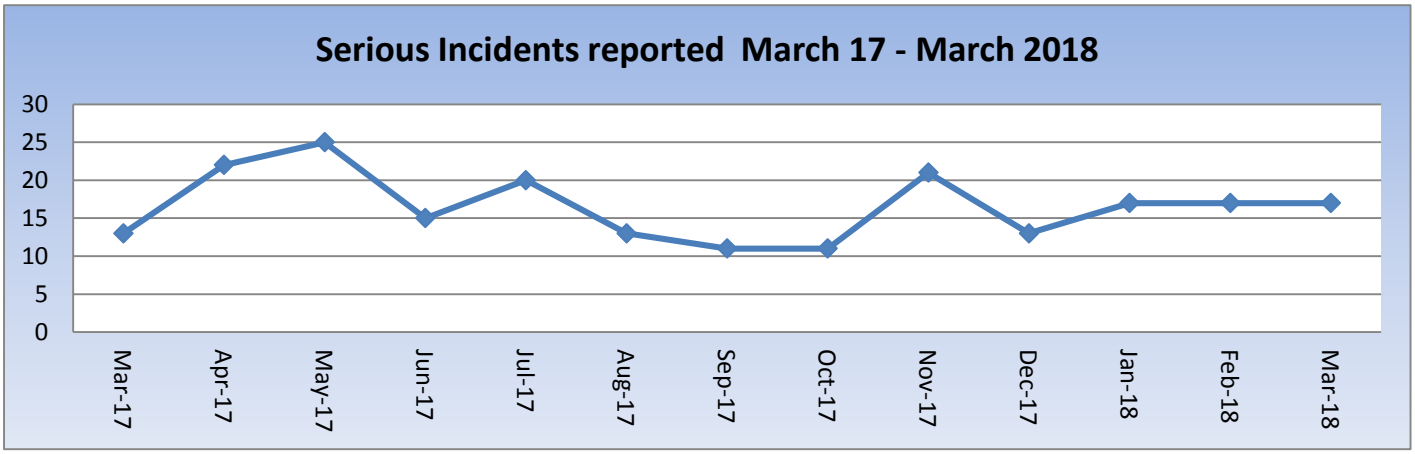
Actual Impact	**Incidents reported**
Near Miss	18 (1.6%)
No Harm/Low Harm	1072 (96.3%)
Moderate Harm	21 (1.9%)
Severe Harm	2 (0.2%)
Catastrophic Harm (Death)	0 (0.0%)
TOTAL	**1113**

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

[1] NHSE Serious Incident Framework 2015

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 March 2018 and the previous 12 months**



4. **Key Trends/Themes in new Serious Incidents**
   - Three incidents relating to Infection Control were reported and required ward closures due to outbreaks of Norovirus and Influenza.
   - The development of unstageable pressure ulcers acquired across the Hospital and Community sites continue has shown a notable decrease.

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5. **New Incidents**

There were 17 new Serious Incidents reported in March 2018
   - 8 Pressure Ulcers (5 Community acquired and 3 Hospital Acquired)
   - 3 Infection Control incidents
   - 2 Diagnostic issues
   - 2 Surgical invasive procedures (including 1 Never Event).
   - 1 Information Governance issues
   - 1 Treatment delay

6. **Closed Incidents – Lessons Learned**

	2017/3764		**Diagnostic incident**
	Patient was referred by Consultant for radiological investigations and subsequent surgical exploration with no further treatment required. The patient was discharged back to GP for management. The patient underwent further CT scanning six months later following a period of illness, which identified a lesion requiring urgent surgical intervention. A review of the patient's historical imaging confirmed that there was a missed diagnosis during the previous episode of care. The patient was discharged home with follow-up arrangements in place.		
Lessons Learned	• Where individuals and services are unable to deliver care in accordance with their job plan and National best practice due to time and capacity pressures; this should be considered as a part of their individual job plan and in their IPDR to support them in a healthy and holistic work life balance and support in the delivery of safe, high quality care.		
Key Changes to Practice	• Workforce plan and the implementation of new working practices where appropriate. • Audit completed and any identified concerns with workstation calibration or workplace suitability actioned accordingly. • Support individual with appropriate time required to deliver care safely. • Improved reliability and sustainability of service by having additional Radiologists carrying out CT Colon reporting and double reporting.		

	• Radiology workforce review with requirements for additional staff set out on risk register and recruitment proposals being pursued

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	**Trust Board**			**Date: 3rd May 2018**
Report Title	Monthly report of Nurse and Midwifery Staffing and Quality – March 2018 data			**Enclosure No.: 7**
Lead Director to Present Report	Barbara Beal- Interim Director of Nursing			
Report Author(s)	Gaynor Farmer- Corporate Senior Nurse			
Executive Summary	• The overall RN vacancy total for Wards, ED and Community teams is 72.83 WTE in March18. This is an increase since last month. • The Interim Nurse Director has commenced a Nursing Workforce Review looking at establishments, staff utilisation and processes and controls in place. An updated Action Plan is included in the paper. • The Trust was not compliant with 90% fill rates CSW at night in the UNIFY Safe Staffing return. • There were 2 wards that had < 90% fill for RN in both day and night. Wards 24/25 and 9. • Registered Nurse Agency hours have increased by 4188 hrs during March 18. • CSW Agency hours have increased by 3963 hrs during March18. • Agency Cap breaches decreased by 19 shifts during March 18. • Off framework agency increased from 72 shifts during Feb18 to 95 during March 18. The rise was attributed to a paediatric patient needing 1:1 specialist care. • Average Care Hours per Patient Day was 7.47 during March 18. • A total of 6 overseas nurses are now working in the Trust. 1 has now gained an OSCE pass and is waiting for NMC registration. 5 are awaiting OSCE pass before working as an RN. 2 nurses are planned to arrive in May18 • There were no reported Serious Incidents related to nurse or midwifery Staffing during March 18. • The Safer Nursing Care Tool is currently in data analysis phase and is currently under review by senior nursing teams before sharing with Exec. • The Trust have requested on the advice of the Interim DON and support of CEO to undertake a review of the Trusts Safer Staffing, Modern Hospital and use of Nursing Temporary workforce. This has been agreed and commenced 17th April 18. _Verbal update as part of board paper • The Trust have agreed to stop the use of Thornbury Agency from end April 18 ensuring that the agreed plan for a 'HIT Team is in place', to offset and mitigate and potential risks to patient safety and quality of care. This will be piloted on a monthly basis over three month period			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☒
Recommendation	The Board/Committee is recommended to NOTE and DISCUSS the content of the report			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>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>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 the quality, performance experience improvements that we have begun in 2016/17</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr>
<tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☒</td></tr>
<tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">BAF Objective No. 5: Establish a substantive workforce that reduces our expenditure on agency staff.
Corporate Risk No 11 Failure to assure safe nurse staffing levels</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Resources are needed from all teams to focus on efficient scheduling of staff and the prompt action to resolve short staffing where possible. This includes resources from the departments that coordinate the temporary supply of staff.</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">This report is discussed at Senior Nurse Advisory Group, Trust Quality Executive AND Quality & Safety Committee on a monthly basis.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">This is a regular monthly report for the committee.</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>

MONTHLY STAFFING UPDATE

(March 2018 data)

INTRODUCTION

This report details the Nurse and Midwifery staffing levels across the Trust and examines the correlation to Quality for those wards reporting low staffing levels.

VACANCY POSITION-Wards/ED and Community Teams

The overall RN vacancy total for Wards,ED and Community teams is **72.83 WTE for Registered** staff and **19.89 WTE for CSW** staff. Detail is tabled below:

	MLTC	SURGERY	WCCS	COMMUNITY TEAMS	**TOTAL VACANCY WTE**
RN/RM	38.73 WTE - Wards 4.25 WTE - ED	16.43 WTE	1.0 – SN 0.61 – NNU 4.21 - PAED 2.6 - HV	5 WTE	**TOTAL RN VACANCY= RN 72.83 WTE**
CSW	16.53 WTE – Wards 1.36 WTE - ED	0 WTE	0 WTE	2 WTE	**TOTAL CSW VACANCY= 19.89 WTE**

*NB-The Vacancy numbers tabled above are representative of the **ED, Ward areas and Community teams** within Walsall healthcare NHS Trust. This data is supplied directly from Divisional Heads of Nursing. Other workforce reports may indicate a higher figure due to the wider workforce analysis which includes ANY posts within Trust that have an RN requirement and also those posts which are currently held as 'not for recruitment' in the budgets.*

On the surgical wards we have 16.43 RN vacancies of which 11 have been appointed to (combination of overseas, Newly Qualified and staff from around the region). In addition, 3 RN posts are being held to enable recruitment of the TNA's into establishments when they qualify at the end of this year.

Theatres- In addition, total vacancies for Theatre currently are 6.26wte Band 5 and 5.28wte Band 2. To provide substantive cover going forward, 7 posts have been offered to trained staff following a successful recruitment campaign. These include

overseas recruits, trainee ODP's that are due to qualify and also experienced staff. These staff will commence with the trust between April and September 2018. Presently, to enable maternity theatre shifts to be covered safely, staff from main theatres have either been seconded or pick up bank shifts to cover. The shortfalls in main theatres are covered by bank or agency staff but this should reduce as appointees commence.

Theatres- Future workforce initiatives.

Theatres have run a successful return to practice course for an ODP which concludes in April. Our Professional Development Unit are supporting the theatre team so we will be able to offer this course more widely to attract more ODP's that wish to return to practice.

We are also liaising with Staffordshire University with regard to securing places for our established band 2 ODSW's to access the Theatre Assistant Practitioner course should they wish and we are in the early stages of developing a pathway for an enhanced support worker role in theatres as well as scoping the potential for apprentices in theatre.

RN Vacancy Rates by Ward %

RN/RM Vacancy Rates by Ward are illustrated below. This data is supplied from the Finance /ESR data. Arrows indicate improvement or deterioration from last report. Evident is that 9 wards have had some staff leave since the last report.

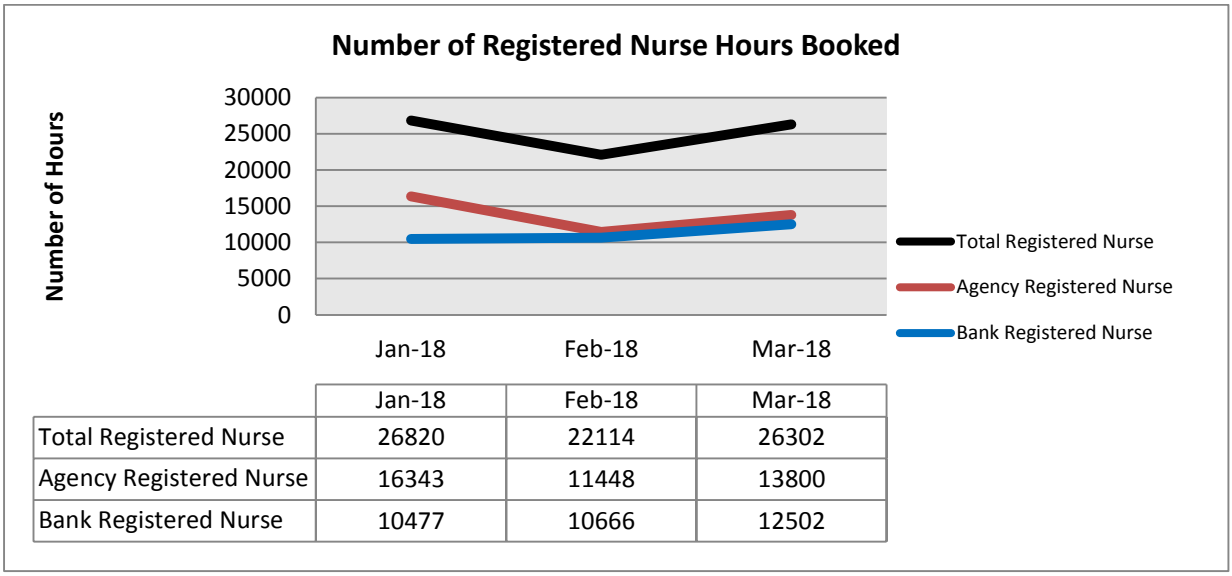
Division/Ward	RN/RM Nurse vacancy rate % as of 22.2.18	RN/RM Nurse vacancy rate % as of 5.3.18	Comparison to previous month
SURGERY	**26%**	**20%**	⇩
Ward 9	27.84%	27.84	⇔
ASU		30.14	
Ward 20a	10.13%	10.13	⇔
Ward 20bc	15.69%	16.08	⇧
HDU/ITU	-3.45%	-3.58	
Theatres	55.67%	55.67	⇔
MLTC	**16%**	**17%**	⇧
Ward 1	25.80%	30.57	⇧

Ward 15	26.17%	26.17	⟷
Ward 16	25.80%	25.80	⟷
Ward 17	36.11%	31.32	↓
Ward 2 (Swift)	-18.57%	-18.57	⟷
Ward 3	25.19%	25.19	⟷
Ward 4	25.44%	25.44	⟷
Ward 5/6 (AMU)	27.19%	24.59	↓
Ward 7	-0.67%	1.62	↑
Ward 14 (new addition)	24.50%	36.53	↑
A&E	7.50%	7.61	↑
WCCS	**10%**	**11%**	↑
Delivery Suite	11.68%	12.65	↑
Foxglove & Primrose	37.76%	36.04	↓
Neo-natal Unit	2.04%	2.04	⟷
Ward 23 & 26	-10.34%	3.09	↑
W 21/PAU	-4.32%	-3.31	

RN -BANK AND AGENCY BOOKINGS (recorded in hours)-last 3 months

The overall total Temporary Staffing **REGISTERED NURSING hours** booked within Nursing and Midwifery has increased by 4188 hours since the last month. The majority of these hours were booked with Agencies and there was an increase of Bank RN bookings of 1836 shifts.

These numbers include the bookings that have been made with Off Framework Agency, which saw an increase largely attributed to a Paediatric patient need and impact of Norovirus on filling Agency shifts.



	Jan-18	Feb-18	Mar-18
Total Registered Nurse	26820	22114	26302
Agency Registered Nurse	16343	11448	13800
Bank Registered Nurse	10477	10666	12502

Data taken directly from the E-Roster Bank Booking system.

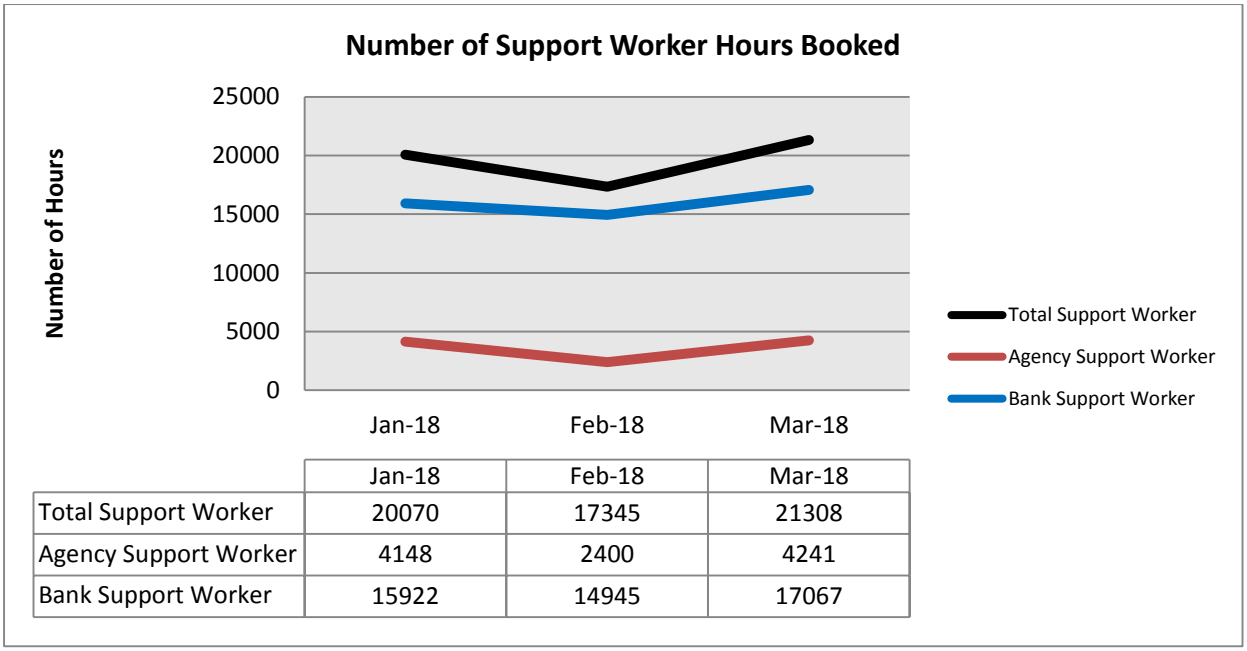
The Table below indicates the areas that used RN Agency hours during March 18. The majority of bookings were for ED, AMU, ASU and Theatre. 671 hours more Agency RN was used within the week of 19th March which correlates with the Norovirus Outbreak within the Trust.

Week Commencing	**05.03.18**	**12.03.18**	**19.03.18**	**26.03.18**
Ward/Dept.	**Agency RN**	**Agency RN**	**Agency RN**	**Agency RN**
Accident & Emergency	204.5	216.5	171.5	296.5
ASU (11 & 12)	379	380.5	410.5	408.5
Bed Bureau	34.5			
Cardiac Unit Capacity	121.5	149.5	172.5	161
Endoscopy	11.5			
Endoscopy Capacity	11.5	46	133.5	126.5
Intensive Care Unit	11.5	11.5	41	
SAU	57.5	80.5	69	69
Swift Discharge Suite			11.5	
Theatre	38	325	249	249.5
Ward 1	167		115.5	207.5

Ward 10 Capacity	172.5	204	184	
Ward 14 Capacity	175	209	287.5	203
Ward 15	86.5	103.5	151.5	133.5
Ward 16	190	184	184	149.5
Ward 17	178.5	126.5	212.5	161
Ward 20a	23			6
Ward 20b/c	109	23	81.5	80.5
Ward 20c Capacity	23	11.5	69	23
Ward 21			253	28
Ward 23 Capacity			23	
Ward 28 Neo-Natal Unit			23	
Ward 29	232	207	172.5	230
Ward 3	34.5	103.5	57.5	115
Ward 4	46.5	24	34.5	46.5
Ward 5/6 - Acute Medical Unit	258.5	282	261	257
Ward 7	11.5			74
Ward 9	174	138	122.5	147.5
Totals	**2751**	**2825.5**	**3497**	**3173**

CSW -BANK AND AGENCY BOOKINGS (recorded in hours)-last 3 months

The number of Temporary Staffing **CSW hours** increased by 3963 hours during March 18 overall with this mostly being filled with Bank staff.



	Jan-18	Feb-18	Mar-18
Total Support Worker	20070	17345	21308
Agency Support Worker	4148	2400	4241
Bank Support Worker	15922	14945	17067

Data taken directly from the E-Roster Bank Booking system.

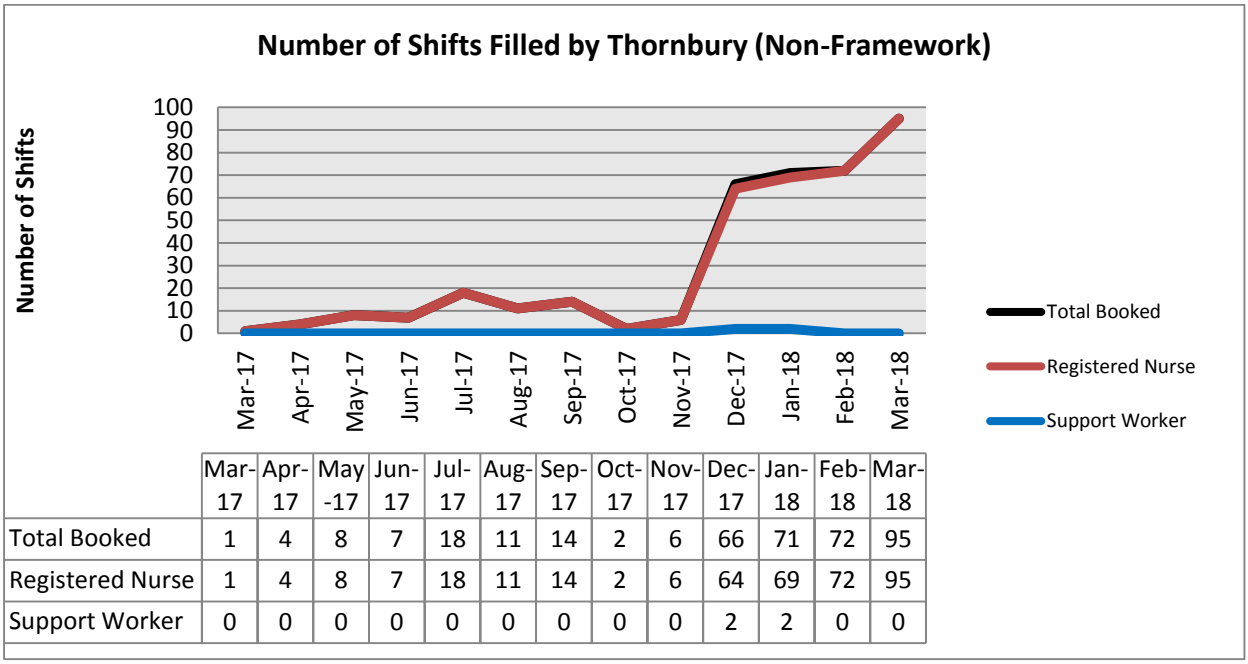
The Table below indicates the areas that used CSW Agency hours during March 18. There is an increase of CSW bookings to correlate with the Norovirus outbreak period.

Week Commencing	**05.03.18**	**12.03.18**	**19.03.18**	**26.03.18**
Ward/Dept.	**Agency CSW**	**Agency CSW**	**Agency CSW**	**Agency CSW**
Accident & Emergency	34.5	80.5	52.5	42
Arrivals Lounge		11	10.5	
ASU (11 & 12)	144.5	117.5	6	173
Bed Bureau	23			
Cardiac Unit Capacity	61	63.5	23	34
Discharge Lounge	14.5			
Endoscopy	11.5			
Endoscopy Capacity		34.5	69	91
High Dependency Unit	6			
Intensive Care Unit	11.5			
SAU	11.5	11.5	11.5	32.5
Swift Discharge Suite	12		9	23
Ward 1	45		46.5	86
Ward 10 Capacity	23	28.5	123.5	
Ward 14 Capacity	105.5	28.5	87	23
Ward 15	29	11.5	34.5	17.5
Ward 16	43	37	17	17.5
Ward 17	11.5	11.5	46	56
Ward 20a	23		23	57.5
Ward 20b/c	11.5	17.5	23	11.5
Ward 20c Capacity	11.5	11.5	80	46
Ward 23/26/GAU				11.5
Ward 23 Capacity	11.5	23	11.5	
Ward 29	23	11.5	11.5	12
Ward 3	29	93	93	58
Ward 4	70	6	29.5	57.5
Ward 5/6 - Acute Medical Unit	35	18	75.5	163.5
Ward 9	76	77	35.5	142
Totals	**877.5**	**693**	**918.5**	**1161**

OFF-Framework Bookings

The number of OFF- FRAMEWORK shifts increased during March to 95 shifts. This was an increase of 23 on the previous month. All shifts were booked for RN cover.

Due to specific patient care needs within Paediatrics there were 16 Thornbury shift bookings made for patient safety/1:1 care. Agencies were unable to cover the specific shift requirements. The Divisional Director of Nursing for Paediatrics is liaising with the CCG regarding cross charging to cover the Thornbury costs in this case.



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Total Booked	1	4	8	7	18	11	14	2	6	66	71	72	95
Registered Nurse	1	4	8	7	18	11	14	2	6	64	69	72	95
Support Worker	0	0	0	0	0	0	0	0	0	2	2	0	0

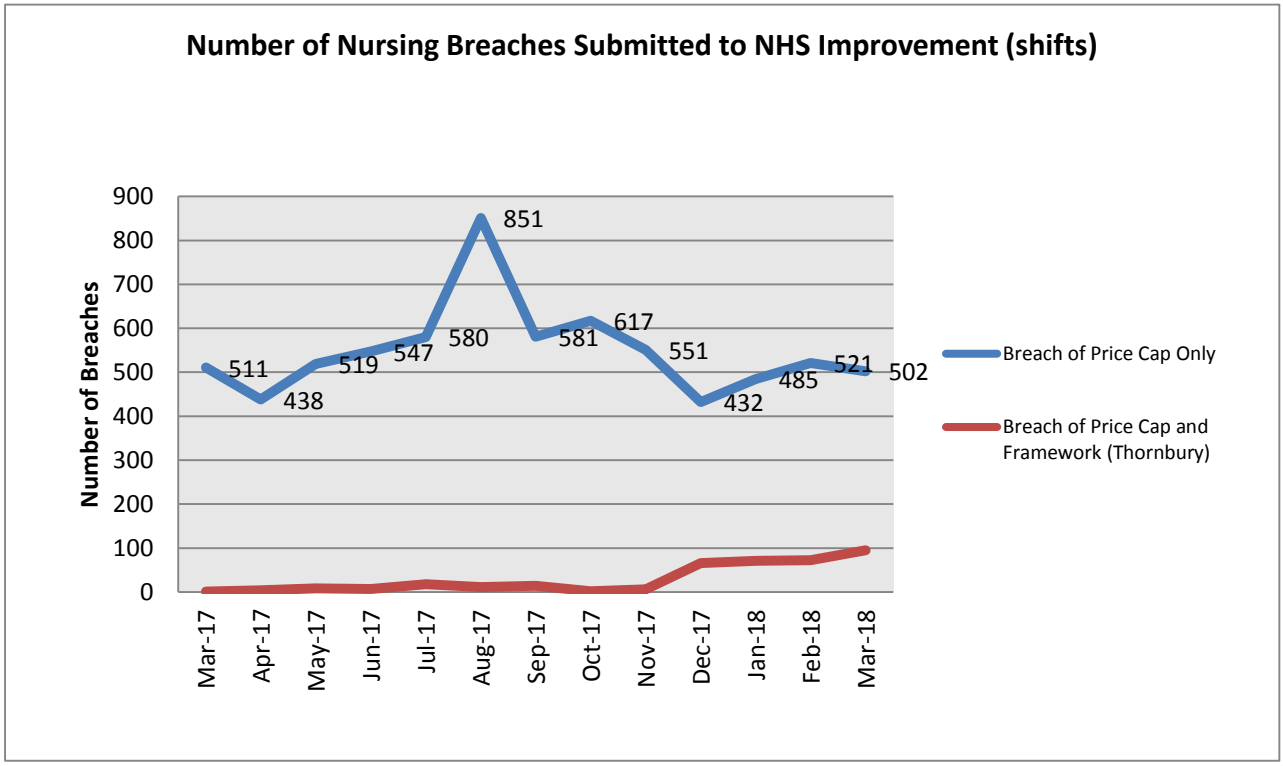
A breakdown of the number of hours of Off framework used per department is shown below:

Number of Hours Booked with Thornbury	
Accident & Emergency	284.5
ASU	94
Bed Bureau	23
Cardiac Unit Capacity	113
Endoscopy Capacity	149
Endoscopy	11.5
Intensive Care Unit	52.5
SAU	23

Ward 2	6
Ward 1	58
Ward 10 capacity	34.5
Ward 15	5
Ward 14	17
Ward 16	23
Ward 17	11.5
Ward 20c Capacity	23
Ward 21	126.5
Ward 28 - Neo-Natal Unit	34.5
Ward 29	59.5
Ward 4	17.5
Ward 5/6 - Acute Medical Unit	31.5
SAU	11.5

Agency Cap Breaches reported to NHSi

The number of Agency Cap breaches reported to NHSI (reported in shifts) has decreased during March 18 demonstrating that despite an increase in Agency use, the Nurse Bank optimised the use of cap compliant agencies.



Extra Capacity Utilisation-March 18

There was extra capacity open across the site as per tables below. This was in addition to patients who were outliers to their own speciality which adds nursing complexities to elements of their care.

There was 6 days where the Trust escalation level reached 4 indicating that there was additional pressure in the system to assist with flow.

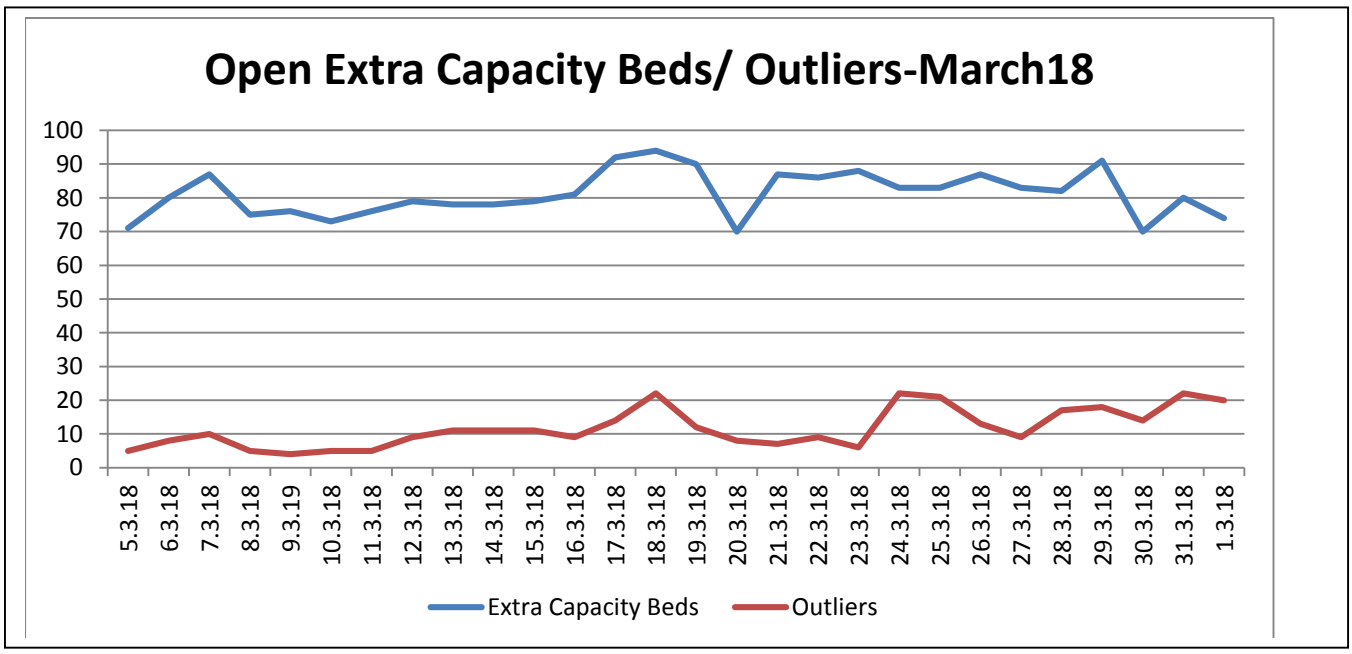
05/03/2018 - 11/03/18	MON	TUES	WED	THURS	FRI	SAT	SUN
OUTLIERS	**5**	**8**	**10**	**5**	**4**	**5**	**5**
EXTRA CAPACITY	71	80	87	75	76	73	76
ESCALATION LEVEL	3/4/4/	4/4/	3/3/	3/3/	3/3/	3/3/	3/3/

12/03/2018 - 18/03/18	MON	TUES	WED	THURS	FRI	SAT	SUN
OUTLIERS	**9**	**11**	**11**	**11**	**9**	**14**	**22**
EXTRA CAPACITY	79	78	78	79	81	92	94
ESCALATION LEVEL	3/3/	3/3/	3/3/	3/3/	3/3/	3/3/	3/3/

19/03/2018 - 25/03/18	MON	TUES	WED	THURS	FRI	SAT	SUN
OUTLIERS	**12**	**8**	**7**	**9**	**6**	**22**	**21**
EXTRA CAPACITY	90	70	87	86	88	83	83
ESCALATION LEVEL	3/3/	3/3/	3/4/	4/3/	3/3/	3/3/	3/3/

26/03/2018 - 01/04/18	MON	TUES	WED	THURS	FRI	SAT	SUN
OUTLIERS	**13**	**9**	**17**	**18**	**14**	**22**	**20**
EXTRA CAPACITY	87	83	82	91	70	80	74
ESCALATION LEVEL	3/3/4/	3/4/	3/3/	3/3/	3/3/	3/3/	3/3/

RED=Bank Holiday weekend



Bank Staff Recruitment -Last 3 months

NURSING		JAN18	FEB18	MAR18
RECRUITS	Total new RN joiners	18	13	14
RECRUITS	Total new CSW joiners	9	16	20
COMPLIANCE	Clinical Update Compliance	90.33%	88.89%	90.72%

Top 5 Booking Reasons for Bank/Agency Bookings

Booking Reasons (RN and CSW shifts combined)	Hours Booked (FEB18)	Hours Booked (MAR18)
1. Vacancy	21443	21619
2. Additional capacity	7242	10038
3. Sickness	5392	6993
4. Mat Leave	1616	2193
5. Patient Acuity (one to one or a richer skill mix)	1205	1273

The Roster Review clinics with wards are ensuring that staff are understanding how to correctly request shifts for cover in the system to ensure that this correct reasons are used.
The greatest increase was with shifts booked for additional capacity. Sickness and Maternity leave also increased significantly.

UNIFY SAFE STAFFING DATA – MAR 18

Day				Night			
RN/Midwives		**Care Staff**		**RN/Midwives**		**Care Staff**	
Total Planned Hours	Actual Hours	Total Planned Hours	Actual Hours	Total Planned Hours	Actual Hours	Total Planned Hours	Actual Hours
33453.6	30315.35	24831	21924.8	27094	25219.3	17503	18005.5
RN/Midwives		**Care Staff**		**RN/Midwives**		**Care Staff**	
%Bank	%Agency	%Bank	%Agency	%Bank	%Agency	%Bank	%Agency
9.51	7.46	17.75	4.23	12.43	20.30	31.93	3.77
Average Fill Rate - RN/Midwives (%)		**Average Fill Rate - Care Staff (%)**		**Average Fill Rate - RN/Midwives (%)**		**Average Fill Rate - Care Staff (%)**	
90.6%		88.3%		93.1%		102.9%	

TRUST OVERALL EXCEPTION DETAIL (less than 90% fill rate)
The Trust was not compliant with Night CSW fill rates during March 18.

Below is a list of wards that had elements of RN non- compliance:

Division	< 90% fill rate-RN Day	<90% fill rate- RN night
MLTC	Ward 1 Ward 4 Ward 15 Ward 16 Ward 29	
SURGERY	Ward 9 ASU	Ward 9
WCCS	Ward 24/25	Ward 24/25

STAFFING UNIFY DATA WARD BY WARD DETAIL (Exception of less than 90% fill highlighted RED)
Ward 24/25 will be subject to a review of unify data to ensure that the plan reflects the changes to the ward area in the recent months.

MARCH 2018 SAFE STAFFING UNIFY REPORT	Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Acute Surgical Unit	83.1%	90.9%	94.2%	114.5%
Paediatric Assessment Unit	100.0%	83.5%	98.4%	89.2%
Ward 1	88.4%	85.7%	95.7%	97.8%
Swift Discharge Suite	117.2%	86.7%	97.5%	97.7%
Ward 3	104.9%	96.2%	94.6%	120.4%
Ward 4	72.6%	90.7%	103.2%	98.4%
Acute Medical Unit	98.5%	97.9%	102.8%	105.9%
Ward 7	94.0%	94.0%	98.9%	73.1%
Ward 9	75.5%	67.9%	60.2%	121.5%
Ward 15	84.2%	99.5%	90.3%	130.6%
Ward 16	80.9%	85.1%	95.7%	104.8%
Ward 17	98.8%	101.1%	97.8%	108.1%
Ward 18	90.7%	91.5%	92.5%	90.3%
Ward 19	100.5%	-	97.3%	50.0%
Ward 20a	94.3%	84.0%	100.0%	100.0%
Wards 20b/20c	97.6%	93.2%	94.6%	104.3%
Ward 21	96.8%	-	97.6%	-
Ward 23	132.5%	68.9%	100.0%	98.0%
Ward 24/25	66.3%	74.7%	68.1%	81.6%
Ward 28	90.2%	29.0%	82.3%	74.2%
Ward 29	86.8%	93.8%	120.7%	129.0%

** Please note ward ASU is a merge of wards 10 and 11, this change occurred during February 18.

WARD EXCEPTION QUALITY EVALUATION (MARCH 18)

The wards that did not comply with 90% fill in both day and night RN are subject to a further evaluation looking at workforce and Quality Indicators.

Ward	Mat Leave	Vacancy % RN/RM	Annual Leave %	Sickness %	Serious Incidents	Medication Errors	Patient Falls	Pressure Ulcers (Grade 2,3,4)	Patient Complaints
Data Source	***Eroster***	***ESR***	***Eroster***	***Ward Nursing Dashboard/ESR***	***Ward Nursing Dashboard***	***Ward Nursing Dashboard***	***Ward Nursing Dashboard***	***Ward Nursing Dashboard***	***Ward Nursing Dashboard***
9	0.34	27.84	15.67	10.48	data not available	data not available	3	2	data not available
24/25	6.71	36.04	17.11	4.13	data not available	data not available	0	0	data not available

Sickness leave and vacancies is high on ward 9 causing increased pressure. Annual leave was managed closely to the target of 14%. There were incidences of patient falls and pressure ulcers. Other Nursing Dashboard data was unavailable at time of completing the report.

For Ward 24/25- though sickness is close to trust target, the maternity leave on this ward is high with an extremely high vacancy rate. There were no incidences of patient falls and pressure ulcers. Other Nursing Dashboard data was unavailable at time of completing the report.

CARE HOURS PER PATIENT DAY

CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators.

Our PEER group in the most recent Model Hospital Report (Jan18) are measuring 7.5 CHPPD with a National Average of 7.6 CHPPD

For March 18 - our median average CHPPD is 5.7 hrs so we are close to our PEER group although lower than national average.

Ward/Dept	**Registered midwives/nurses**	**Care Staff**	**Overall**
Acute Surgical Unit	2.9	2.6	5.5
Ward 1	2.6	2.3	4.8
Swift Discharge Suite	2.0	2.6	4.6
Ward 3	2.4	2.8	5.2
Ward 4	1.9	2.9	4.8
Acute Medical Unit	4.1	3.5	7.6
Ward 7	3.4	3.1	6.5
Ward 9	1.7	2.3	4.0
Ward 15	2.5	2.8	5.3
Ward 16	2.7	2.4	5.1
Ward 17	3.3	2.5	5.7
Ward 18	14.6	2.9	17.5
Ward 19	26.1	0.1	26.3
Ward 20a	3.6	2.0	5.6
Wards 20b/20c	3.5	3.0	6.5
Ward 21	6.2	0.0	6.2
Ward 23	4.4	2.2	6.6
Ward 24/25	3.9	2.1	6.0
Ward 28	9.6	1.0	10.5
Ward 29	2.7	2.4	5.1

Update on Nursing Workforce review- updated 17.4.18

The Interim Nurse Director has commenced a Nursing workforce review looking at objectives as listed below:

- To determine the current workforce baseline – i.e. review core establishments, review of ESR data, vacancies
- To establish current methods of auditing/reporting staff deployment/utilisation – i.e. internal and external reporting
- To determine existing controls for the booking/deployment of locum staff [bank and agency]
- To identify the key issues that impact on supply and demand of nursing and midwifery staff – i.e. changes in education, introduction of new roles etc.
- To review the current Recruitment and Retention strategy
- To review the Workforce Planning Strategy

Action Plan for Nursing Workforce review

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
Safer Nursing Care Tool Staffing Review, current roster skill mix profile and alignment to ward budgets has potential impact on	Limited assurance on the findings, analysis and questions about the reliability of the data meaning unable to professionally sign off the September 17 Safer Staffing Establishment Review and	Escalated formally to Executive 24th December 17 by DON, and reported to NHSI, CQC regulatory meetings and Trust Quality Executive and SNMAG December 17	31st January 2018 DON	complete	Green

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
quality and safety, as well as finances	ward budgets for 18/19	Review being undertaken by DON and Deputy DON of the SNCT data, alongside benchmark data, peer data and professional judgement alongside triangulation of quality data. Budgets for 2018/19 signed of by Divisional Nurses with finance	31st March 2018 DON/DDON	SNCT data is currently being analysed for reporting in April 2018. Also under review by NHSI at request of interim DON and CEO on behalf of Trust – commenced 17th April 18	
		Following above review, agreement with senior nurses/ward sisters of skill mix, and recommended establishments	27th April 2018 DON/Senior Nurses	Also under review by NHSI at request of interim DON and CEO on behalf of Trust – commenced 17th April 18	
		Review of budgets and budget realignment with Divisional Nurses and Finance Leads (ward budgets last realigned 2015 following investment in nursing workforce)	1st May 2018 DON/DOF	Associated with above NHSI workforce reviewer to meet with FD April 18	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
		Divisional Senior Nursing Workforce Working Arrangements under review to ensure consistent senior nurse presence in clinical areas (Divisional Nurses, Matrons, Ward Sisters/Charge Nurses submitted and under review with Executive team	31st May 2018 DON/DDON	1-1 reviews with Divisional nurses completed March 18 for review meeting w/c 23rd March 18 with DDON, Interim Director of HR and OD and COO (who is also reviewing divisional managers working arrangements	
		Review of Staffing Policies – out to divisions for consideration by divisional boards	30th April 2018 DON/HR Director	Divisional Nurses to feedback at SNMAG April 18 then launch and implementation	
		Implementation of recommendations from Internal Audit Review of Safer Staffing 2017		Updated 17th April 18 . Shared with NHSI as part of review	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
		1. Policy and procedural guidance to be developed, approved and circulated to relevant staff in respect of Safe Staffing Risk Management; to include an escalation policy to ensure that staffing establishments are met on a shift-to-shift basis and to include process for evaluating the impact of staffing on quality. 2. Reinforcement of Roster Policy rules to include rosters to be completed and signed off by Matron in accordance with Roster Policy and timescales. This will be monitored via the establishment of monthly staffing/roster management clinics	30th April 18 DON/Senior Nurse Workforce	Policy has been circulated for comments and now is being presented to DQ Boards SOP in place	
			31st January 2018 ongoing DON/Divisional DONs/Senior Nurse Workforce	In place Roster review clinics have commenced in Jan 18 and are ongoing. They will now be combined with Sign off reviews to optimise status of rosters at sign off	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
		3. Quality Crosses notice boards to be reviewed by matrons for consistency, accuracy and completeness across wards	31st May 2018 DON/Divisional DON	Subject to outcome of review by NHSI requested by Trust	
		4. Links between rostering, staffing levels, vacancies and quality to be reported at Board level on a monthly level. A comprehensive review is to be undertaken of nursing and midwifery workforce to review the capacity to deliver high quality, safe care while being cost and clinically effective	27th February 2018 – in place DON	Current TQE Staffing report details staffing and quality. The comprehensive review is underway as part of the staffing evaluation after SNCT data is available and included in external NHSI Review commenced 17th April 18	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
Nursing Workforce- Requirements to ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff to keep patients safe (identified in recent CQC report 2017 as a regulatory breach)	The Trust is currently facing persistent significant gaps in its Nursing Workforce due to high numbers of RN vacancies and operational vacancies due to sickness, maternity leave	Nursing Workforce work-stream established Oct 2017 supported by KPMG and Trust PMO in place	October 2017 DON	PMO support was delayed in October 18 and started March 2018. However some data analysis and oversight support provided by KPMG. Additional KPMG support agreed with CEO and FD supported by NHSI April 18 negotiations taking place. Lead KB	
		Nursing Workforce Review and Terms of Reference agreed by Executive and TQE, QEC December 17 to be progressed through the work-stream. Key priority for SNMAG and Divisions	30TH April 2018 DON/Senior Nurses	Work stream established and in place. Additional 40 K provided from NHSI budget to secure data analytic support to work-stream	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
				for first quarter of 2018/19 start date to be confirmed anticipated April 18. Also included in review by NHSI 17th April 17	
		Implementation on commencement of training offer letter to student nurses with necessary safeguards	31st December 2017 DON/HR Director	Completed and in place.	
		Reviewing Nursing Education and Training Needs Analysis, Commissioning intentions with HEE including New Roles, competencies including increased placements for Nursing Associates and work being progressed for Midwifery Support Workers	31st March 2018 Associate Director Nursing/HR Transformation lead	For sign off at SNMAG April 18	
		Robust strategy for recruitment and retention of registered nursing staff required	31st May 2018 DON/HR Director	DON highlighted concerns to CQC, NHSI, and secured support from	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
				NHSI for Recruitment and Retention – Ongoing through R&R task and finish group led by DDON and included in review by NHSI commenced 17th April 18. Presentation by interim DON on current state nationally, regionally and locally to Executive team 10th April 18 Draft Nursing and Midwifery Acountability Framework launched-review April 18 for approval May18	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
Leadership, Values, Behaviours and Culture	Professional concern about the leadership style, behaviours and culture of nursing staff/groups and the associated link with patient outcomes	Under review and being addressed in line with the Trust Executive staff survey findings action plan Nursing and Midwifery Code of Conduct update sessions/workshop held through SNMAG to set the standard of leadership and behaviours in line with values.	31st May 2018 DON	Band 6 leadership programme in place April 18 Interim DON/DDON/Associate DON (rep on NMC) reviewed status of all NMC cases over last 3 years and meeting regional NMC lead to build on closer engagement	
		Review of effectiveness of SNMAG , membership, TOR and core business/work programme	27th February 2018 DON/DDON	Terms of reference circulated to SNMAG group 12th Feb 18. Complete	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
		Review of interface, and team working between corporate nursing and divisions and vice versa – ongoing	31st March 2018 DON/DDON	Complete. Interim DON recommends For review on appointment of substantive DON	
		Proposed Review of the level of leadership and development support required for -Band 7 ward managers, band 6 nurses through LiA	31st March 2018 DON/DDON	Progressed :a leadership course has been launched- 'Step Up' programme- aimed at band 6 development. LIA planned May 18 now merged into wider PCIP programme through revised approach led by CEO and DDON	
		Take action where evidenced to address declining professionalism and any unacceptable tolerance of poor standards	OngoingDON/ Divisional DON/	Refer to NMC cases and review process	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
Bank and Agency Controls and Expenditure	Limited Assurance on Trust, Divisional and Care Group Bank and Agency Controls	Agreement with HR and FD to undertake a root and branch review of the Trusts internal controls and assurance on Bank and Agency. Ensuring consistency of operational, performance and financial data, analysis, cost and reporting	June 2018 DON/DOF/HRD	NHSi Agency Assurance toolkit completed internally for assurance. To be reviewed as part of NHSI process requested by interim DON and CEO Executive assurance via Daily Staffing Capture to measure temporary staffing bookings against levels of absence/vacancy. Ongoing – March 18 DON secured with CEO support of NHSI to review Trust controls,system	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
				s and processes for Nursing Temporary Workforce, Safer Staffing, Modern Hospital, NICE. Guidance 1:8. Commenced 17th April 18	
		Implemented revised Standard Operating Procedure for Bank and Agency Controls including effectiveness and responsiveness of the Nurse Bank	31st January 2018 DON/Senior Nurse Workforce, Divisional DON	SOP signed off, circulated and in use from Dec17. Completed.	
		Implemented Revised Standard Operating Procedure for Roster Controls and Processes, to include rosters developed and signed off by matron 6 weeks in advance, appropriate skill mixes, annual leave allocation, shifts out to bank 6 weeks in advance and Tier 1 agency 2 weeks in advance. To be monitored through implementation of roster management clinics	31st January 2018 DON/Senior Nurse Workforce, Divisional DON	SOP signed off, and in use from Dec17. For review by NHSI immediate recommendation to consider a move to 8 weeks sign off.	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
		As offered by NHSI support to strengthen the Trust procurement and management of agency controls	31st March 2018 DON/Senior Nurse Workforce	Reviewed- procurement of agency workers are all through the HTE framework with exception of Thornbury. To stop Thorn bury end April 18 once mitigation arrangements in place. Papers re overtime and enhanced rates for AMU AND ED declined by executive team March 18. April 18 agreed to put in place a hit team for review over a three months period and stop Thornbury end April 18 agreed at Execs 10th	Amber

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
				April 18.	
		Undertake analysis of Trust Nurse Bank against NHSI proposed shared bank arrangements	31st January 2018 DON/Senior Nurse Workforce	We are part of the collaborative bank work being undertaken across the STP and being led by New Cross Hospital. However not implemented across whole of BC alliance and not priority under STP review with NHSI	
Patient Safety Incidents Severe - Nursing	Number of significant concerns identified through the Trusts Patient Safety Alerts, Risk Management and Serious Incident Process (Include risks on opening and staffing of additional capacity	Established SI Review Group with clear TOR, actions. Need to strengthen divisional attendance, implementation and embedding of actions and learning and feedback loop to those who have reported risks.	31st January 2018 Head of Clinical Governance	In place ongoing for refresh and review with new CEO. Initial meeting held with RB 12th Apri 18 Head of Governance/	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
	wards, failure to risk assess, staffing and failure to identify, rescue and care for deteriorating patients			Risk CR to progress with KB	
		As a consequence of above prepared a draft Nursing and Midwifery Accountability and Responsibility policy	30th April 2018 DON	Out for consultation April 18. Implement May 18	
		To monitor nursing SI etc more effectively through the professional section of the SNMAG, to be standard agenda item and to include effectiveness of actions implemented	31st March 2018 DON	In place and ongoing	
		Standardised agenda item on Care group/Divisions Quarterly Reviews to include effectiveness of actions implemented and lessons learnt.	31st March 2018 DON	Under review as part of new CEO plans for monthly divisional reviews from April 18	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
		Introduce Human Factors Behaviour training to band 6 nurses and above	September 18 (link to QA approach to HF in maternity) DON/HR	For discussion at Execs and SNMAG	
Operational Capacity and demand on Performance and its subsequent Impact and Risks on Quality and Patient Safety	Inconsistent standards across Care Groups, Divisions and Trust for Flow whilst safeguarding and assuring the quality and safety of patients, and care – 'SAFER, RED TO GREEN' , 'Get up, get dressed, get moving'. Increase in Escalation levels and opening and closing of additional bed capacity to cope with demand, constant movement and transfer of patients and associated risks, boarding of patients, appropriate utilisation of discharge lounge, Mental Health Act, DoLS, IPC, Dementia, end of life care,	Review by ECIP/NHSI of how we are keeping patients safe during winter, positive and constructive feedback December 17. Input of Emergency Care Improvement Programme Team input commences 5th and 8th January 17 (Critical to support the required changes in systems, processes, efficiency and controls	3oth June 2018 COO/DON	ECIP plan in place – ongoing through COO, DDON and divisional nurses Launch of PJ 17th April 18	
		Risk review findings and actions of opening of extra capacity wards (Ward 12) and introduction of a standardised risk assessment tool	30th June 2018 DON/Divisional DON	Plans to close additional capacity April/ May 18	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
	deteriorating patient, VTE etc (significant impact of safer staffing, workforce issues, gaps, bank and agency, staff bank effectiveness, R & R etc highlighted earlier)			Commissioned WMQRS to undertake a review of the deteriorating patient. Initial scoping meeting held 12th April 17 for site review September 18. KB DDON lead for nursing	
		Twice daily review of nurse staffing through Divisional Nurses, Matrons and Deputy Director of Nursing	31st January 2018 DON/Divisional DONs	In place. Included in NHSI Review	
		Deputy DON aligned to support operational safety and performance as a % of her role from November 17	31stNovember 2017 DDON	In place. Included in NHSI Review	

Risk/Issue	Current State	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion/ Person responsible	Update	RAG Rated
		Escalation and review of issues at daily bed meetings and through Internal incident reporting systems and processes and SNMAG from November 17 ongoing	31st January 2018 DON/COO	IN place. Under review with NHSI April 18	
Quality, Patient Safety Standards and Assurance	Quality and safety data is currently collected but not fully triangulated with staffing data	Dashboards to be revised and Divisional Nursing reporting templates for quality, safety and staffing to be developed and implemented at ward through to Divisional level via development of Nursing exception reports Revision of Ward Review process to ensure corporate input as part of this process via DON/nominated rep attendance and following through with appropriate action plans	30th April 2018 DON/DDON	Review commenced April 18 as part of NHSI review Trust to secure a acuity and dependency model from Safer Care through Imperial on licence free to NHS 17th April 18 – lead GF	
			30th April 2018 DON	Ward review template is being reviewed by Divisional DON. Update to be provided at April 18 SNMAG	

WARD REVIEWS

The Ward reviews are conducted by Divisional Directors of Nursing and are reported to Senior Nurse Advisory Group on a monthly basis. The tables below indicate the most recent Ward review status of wards across the divisions.

The tool for the Ward Review is currently being revised to reflect the KPIs for Erostering and Safe Staffing and to align with the Nursing Workforce Review. The new tool will be 'tested' during February18.

WCCS AREAS	OVERALL RATING
21	silver
PAU	silver
23	silver
24/25	bronze
27 DS	
28 NNU	Silver

MLTC Ward	OVERALL RATING
1	silver
2	bronze
3	bronze
4	bronze
AMU	bronze
7	bronze
15	bronze
16	bronze
17	bronze
29	bronze
ED	bronze

Surgical Wards	OVERALL RATING
8	bronze
9	silver
10	bronze
11	bronze
HDU	bronze
ITU	bronze
20a	bronze
20bc	bronze

RECRUITMENT ACTIVITIES-NURSING

Currently the Trust has completed visits to the EU and two visits to the Philippines (last visit early February 2017) to recruit Registered Nurses. Expected timeline for Philippines arrivals is 9-12 months post visit and then they have 6 months to complete OSCE before RN registration. During this time they will be paid Band 4.

The Table below tracks status from each previous overseas trip.

Overseas round	Number of RN/RM's in shortlisting stage	Number of RN/RM's recruited/ arrived	Number of recruits still in post	Other information
EU 2016	n/a	16	2	The nurses have left for varying reasons including returning home and travelling to work in Southern Ireland where IELTS is not required. We have 2 RNs who are still outstanding the IELTS exam. They are liasing with the PDU for support. The written element has now been changed by the NMC to Occupational which should make the test easier.
Philippines 2016	35 nurses remain active	1-awaiting pin	1 Philippines RN arrived.	The candidate has successful at OSCE and is now waiting for NMC registration. 2 arrivals are planned for May18.
Philippines 2017	54 remain active in the pipeline	5-awaiting pin	5 Philippines RN arrived	1 candidate has been unsuccessful at OSCE x2 and is now waiting a 3rd attempt. Booking can be made after May18. 2 Both booked for OSCE exam, 24th April 2018

SKYPE	21 have been successful in interview			The candidates have been interviewed via SKYPE and have been successful. These are all IELTS trained Filipino nurses and arrangements are being made for their arrival- approximately 6 months lead time to arrival. No further skype interview dates are planned at this point.

The pdu team have been to a refresher day at OSCE centre to seek assurance on processes we are following as a Trust. The opinion of the Test centre is that we are currently doing far more than other Trusts to support candidates through OSCE and their support/pastoral care is good. Currently theres a 59% fail rate nationally across the 3 test centres.

Trainee Nurse Associates

The Trust Trainee Nurse Associate pilot commenced during January 2017 and 23 remain on the programme. This cohort is 2 year training at Band 3 with a commitment to appointment at Band 4 in January 2019.

A second cohort has commenced in March 2018 as an Apprenticeship scheme. This cohort has 8 candidates. The candidates will remain on their current pay scale during training. This second cohort is not guaranteed a job and therefore the Divisions need to plan to introduce these staff into the workforce ready for qualification in 2020.

Recruitment –Additional Information

NHSi have agreed to work with us to look at recruitment and retention strategies and this will fall into the Nursing workforce review.

For international recruits, the OSCE test simulation environments will be arranged on site in the MLCC and the Practice Development Team will support the staff through this process. One of the Practice Development Team has undertaken the training supplied by the national test centres to prepare staff for OSCE Exams.

REPORT CONCLUSION

The Trust is continuing to comply with its nationally mandated requirements to provide information about the staffing levels across the inpatient wards and the usage of agency workers above the nationally agreed cap.

The Safer Nursing Care Tool has been repeated during February 18 as part of the actions developed through the Nursing Workforce review and data will be available once signed off through the Senior Nurse Group. This will comply with the requirement to undertake two assessments per year.

The extra capacity areas that are open continue to add pressure into the system in respect of the Temporary staffing utilisation.

There continues to be a focus on ensuring all clinical areas are staffed appropriately with a system for mitigation and responsiveness, including using matrons to support the workforce where a deficit is identified.

Appendix 1

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Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board	**Date: 3rd May 2018**
Report Title	Update on NHS Improvement Review of Internal Nursing Temporary Workforce Arrangements	**Agenda Item: 10** **Enclosure No: 8**
Lead Director to Present Report	Barbara Beal, Interim Director of Nursing	
Report Author(s)	Kara Blackwell, Deputy Director of Nursing	
Executive Summary	In April 2018 Walsall Healthcare NHS Trust approached NHSi to request a review of the Internal Nursing Temporary Workforce Arrangements from September 2017 to March 2018. This review was commissioned following the Trust's implementation of a temporary staffing workforce programme, in response to the findings of the internal audits departments safe staffing reports and the following an increase in our temporary staffing usage over the winter period. The aim of the NHSi review is expected to provide increased oversight and objectivity which will assist the Trust by informing and providing further assurance to our Trust Board now and going forward. The key objectives outlined for the review to the NHSi included: • A review of the Trust's Policies, Internal Audit and External Reports, Controls, Systems and Processes for the management of the Nursing Temporary Workforce • A review of Safer Staffing and Acuity Tool for September 2017 and February 2018, Modern Hospital Care Hours Per Patient Day (CHPPD), NICE Guidance Safe Staffing • A review of the Budgeted Establishment as above • To inform our Trust Boards understanding, consider the professional decision made by the current interim Director of Nursing to cease the former Nurse Directors advice to the Trust Board that a Clinical Support Worker could replace a Registered Nurse if unable to fill to a short-term shift requirement within budgeted establishment. The review commenced on the 17th April 2018 lead by the Clinical Workforce lead for NHS; in addition to the above the review will also include a review of our e-roster system and the governance around nursing staffing in the Trust. The clinical workforce lead has spent time in the Trust walking the wards, speaking to ward sisters, ward nursing staff and has had a meeting with the matrons. She will also be having meetings with other key staff including the CEO, Finance Department and other senior nursing staff. It is anticipated that a report in relation to the review and findings will be provided to the Trust by the end of May 18.	

<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">The Board is recommended to discuss the content of the report and raise any questions in relation to the assurance provided.</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">Embed the quality, performance 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">Not Relevant</td></tr>
<tr><td colspan="2">Use resources well to ensure we are Sustainable</td><td colspan="2">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="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">NA</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="4">Compliance with National Safe Staffing recommendations</td></tr>
<tr><td><u>Report History</u></td><td colspan="4">A monthly Safe Staffing paper is provided to the Quality & Safety Committee and Trust Board.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="4">Continue with Trust Nursing Workforce Plan including tightening control mechanisms in place for the use of temporary staffing and implement the recommendations of the NHSi Nursing Workforce Review following recent of the report anticipated to be in late May 18.</td></tr>
</table>

Freedom of Information Status	**The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee**

BOARD/COMMITTEE REPORT

Meeting	Trust Board			**Date: 3rd May 2018**
Report Title	Quality & Safety Committee Highlight Report			**Agenda Item: 11** **Enclosure No: 9**
Lead Director to Present Report	Chair of Quality & Safety Committee, Non-Executive Director, Victoria Harris			
Report Author(s)	Kara Blackwell- Deputy Director of Nursing			
Executive Summary	The report provides a highlight of the key issues discussed at the most recent Quality & Safety Committee meeting held on 26th April 2018 together with the confirmed minutes of the meeting held on 29th March 2018 (appendix 1). Key items discussed at the meeting were: • PCIP and Trust Quality Commitment • Compliance with Trauma Unit Standards • Pressure Ulcers occurring in Specific Communities • Mortality rates The meeting held on 29th March was quorate and chaired by Professor Beale and the meeting held on 26th April was also quorate and was chaired by Victoria Harris.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Board is recommended to DISCUSS the content of the report and raise any questions in relation to the assurance provided.			

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<tr><td><u>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 – 3RD MAY 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 26th April 2018

The Committee was quorate and discussed a number of items. Minutes will be provided to the Trust Board in June. The highlights for the Trust Board to be aware of are as follows:

Performance and Quality Report

The Performance & Quality report was presented and the following updates were noted:

- VTE performance had improved, worked now needed to focus on sustaining this improvement
- There had been an increase in MSA breaches in March but these all related to HDU and ITU step down of patients
- HSMR had increased
- An external chair for the recent Never Event and the investigation had commenced.
- Emergency readmissions had increased but this was linked to changes in pathways in surgery on SAU discharging patients and bringing them back for surgery, this issue was being resolved by the Surgical Division

Patient Care Improvement Programme and Review of Trust Quality Commitment

The main points highlighted within the paper were:

- PCIP- the 'must' and 'should' dos action sheet had been developed divisionally and corporately. Work is now in progress to develop a supporting infrastructure to record the actions and track progress which enables reports to be generated from this
- Integrated Improvement Programme- The Trust plans moving forward are to develop an Integrated Performance Programme which will encompass all aspects of improvement in relation to quality, operational delivery and efficient utilisation of resources

- Review of Quality Commitment- The Quality Commitment will be reviewed and revised to capture a small number of high level aims with detailed actions to achieve these provided at Divisional and Care Group levels in their revised Quality Commitment

Compliance with Trauma Unit Standards

The Trauma Unit Standards report was presented which provided an update on the Trust's compliance against these standards. The following key points were discussed:

- The Trust is now operating a 7 day trauma list.

- There were 2 areas identified where the Trust had struggled to achieve compliance:
    - The first related to representation by all relevant specialities at the Trauma Group which had failed to be quorate on several occasions. Further actions had been taken to improve attendance at the meeting which had included rescheduling the timing of the meeting itself.

    - The second area were the Trust had struggled to achieve compliance related the named rehabilitation co-ordinator; the Trust has a lead but work was being undertaken to ensure they are released from other commitments to undertake this role.

Pressure Ulcers occurring in Specific Communities

A review has been undertaken of the ethnicity of patients reported to have a pressure ulcer in the community. This showed that 67% were coded as white-British or white other, with 12% ethnicity recorded as Black or Asian, with the remaining being not stated or left blank. This compares to the demographics of the Walsall Borough, which has seen a significant increase in the level of ethnic diversity over the last decade or more with white British remaining the highest, accounting for approx. 76%, the number of minority ethnic residents in the borough now accounts for approx 1 in 4 of residents, with Asian being the most common (approx. 23%).

Although the review did not identify whether language was a barrier to compliance in relation to patients who had developed a pressure ulcer, the information provided to patients is currently only provided in English and the Trust is now working to ensure that this information is available in the 10 most common languages relevant to our Walsall population. With regards to the coding of ethnicity this has also been escalated to the community teams to ensure that this is recorded.

The quarterly pressure ulcer report will in future also report on the ethnicity of patients who have developed a pressure ulcer in both the hospital and community.

Mortality rates

The report was presented and the following key point discussed:

- For December 2017 and January 2018 there had been a higher number of deaths reported.
- HSMR has increased during this time period but has started to reduce again.
- HSMR remains below 100 but it is concerning that there was a rise in deaths over December, January and February
- 30% of deaths usually occur in the community, but throughout December, January and February these reduced to 20% so more patients died in hospital. This has been looked at as part of a recent review
- There was an increase in the number of patients who were admitted and died within a 0-1 length of stay. An audit of these has been undertaken with contribution to the audit from the CCG, acute, community and primary care and the results of this audit will feed into the winter plan for next year which include aspects of improving anticipatory care planning, the use of AMBER care bundle, GSF which needs to be included as part of the Walsall Together Partnership.

With regards to the mortality reviews the new review process is much more detailed and a majority of these reviews relate to the medical division. The Trust is looking at options as part of the mortality review group and it has been suggested that we implement a role of medical examiner which will include mortality review.

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Walsall Healthcare NHS
NHS Trust

APPENDIX 1

MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON THURSDAY 29TH MARCH 2018 AT 9.00 A.M ROOM 10, MLCC, WALSALL MANOR HOSPITAL

Present:	Professor R Beale	Non-Executive Director (Chair)
	Mrs B Beal	Interim Director of Nursing
	Mr R Beeken	Chief Executive
	Mr R Caldicott	Director of Finance & Performance
	Mr P Gayle	Non-Executive Director
	Mrs V Harris	Non-Executive Director
	Mr A Khan	Medical Director
In Attendance:	Mr D Fradgley	Director of Strategy & Transformation
	Miss S Garner	Executive Assistant (minutes)
Apologies:	Mr P Thomas-Hands	Chief Operating Officer

230/17 Welcome and Introductions

Professor Beale welcomed everyone to the meeting.

231/17 Declarations of Interest

There were no declarations of interest.

232/17 Minutes of the Meeting Held on Thursday 22nd February 2018

Resolution
The minutes of the meeting held on 22nd February 2018 were agreed as a true and accurate record.

233/17 Action Sheet and Matters Arising

The Committee reviewed the live action sheet and the following points were noted:

197/17 – Mr Khan confirmed that work was ongoing with the divisional teams to prioritise the list of equipment for replacement and a further discussion was due to take place at the Medical Advisory Committee. It was agreed that a detailed report including risk assessments for equipment not being replaced would be presented to the Trust Quality Executive and Quality & Safety Committee in April.

Mr Beeken highlighted that the Head of EBME had raised concerns about the robustness of the current equipment replacement programme and discussions were ongoing to further strengthen the process. It was noted that teams had also been asked to identify equipment in need of replacement via their risk registers.

221/17 – The Committee were advised that the internal audit team had been asked to review current rostering processes and overpayments and it was agreed that a summary report would be provided to the committee when completed.

224/17 – Professor Beale identified that a meeting had been scheduled with the Divisional Director for Surgery and agreed to pick up the theatre workstream discussion as part of that.

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

234/17 Performance & Quality Report

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

- The number of deaths reported in February remained high and deaths continued to be reviewed with the community teams
- Although an improvement in VTE performance had been seen in February, the target of 95% had not been achieved. A separate report had been shared with the committee to update on actions being taken to address this.

Mr Gayle raised concerns that the number of deaths for February was significantly higher than the number reported in February 2017. Mr Khan confirmed that it was likely that the number had not reduced due to the adverse weather in February which had not been the case the previous year. He confirmed that this would continue to be monitored.

There was a detailed discussion about VTE performance and it was noted that the main area of concern was in relation to patients who had been clerked in the Emergency Department where there was no electronic solution for recording the VTE assessment. Options were now being considered to incorporate a paper solution for recording of assessments in the Emergency Department. Mr Gayle highlighted the importance of this was the impact on the patient when a VTE assessment had not been completed and not the achievement of the target. Mr Beeken assured that he had raised the importance of this at all of his staff

briefings recently to raise awareness of the impact of harm to patients. Mrs Beal confirmed that this had also been raised with the nursing teams and a nursing lead had been identified to support the medical teams to ensure the assessments were completed and documented.

Mr Caldicott highlighted that there had been a significant improvement to the midwife to birth ratio to 1:22 which was also well above the national target, however the Midwifery Led Unit remained closed. It was noted that the decision had been made to support the maternity team in addressing concerns raised as a result of the CQC inspection; however, this would need to be reviewed in due course.

The committee noted the number of acute serious incidents reported and were advised that no specific themes had been identified. Mrs Beal confirmed that all serious incidents were reviewed at a weekly meeting and highlighted that she and the Head of Clinical Governance would be meeting with the Chief Executive to strengthen the current process for reviewing serious incidents and agreed outcomes being reported to the Board. There had been some serious incidents reported in relation to deteriorating patient which the West Midlands Quality Review Service had agreed to review independently. The outcome of the review would be shared with the committee.

Mr Khan reported that 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 reduce the spread of infection. Portable sinks had been situated at all entrances to encourage hand washing for all staff and visitors. It was noted that there were a number of wards and bays closed which was impacting on patient flow throughout the organisation and the Trust had declared internal major incident status. Mr Gayle queried whether there had been any lessons learnt from the outbreak. Mrs Beal advised that the Trust had a nationally recognised Infection Prevention & Control team who had been very responsive; however, concerns had been raised regarding the level of compliance with hand washing audits. Targeted intervention was now being taken with support from Trust volunteers to ensure patients and staff were washing their hands when entering the building. Cleaning duties had been prioritised to focus on the clinical areas rather than corporate areas. Visiting restrictions were due to be lifted for the Easter weekend following advice from the Trust's microbiologist. 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.

Mrs Harris raised concerns in relation to the lack of compliance with dementia assessments. Mrs Beal highlighted that the criteria

for the national data set had been amended, therefore, there would need to be a change to the data currently being submitted by the Trust. This would need to be agreed with the CCG and a meeting had been scheduled to address this. Mrs Beal assured that there was evidence that the assessments were being completed; however, the data was not being submitted. She agreed to provide an update on this at the next meeting. **BB Apr 18**

Mr Gayle confirmed that he had met with the Director of Human Resources and Organisational Development to discuss the references within the report for the People & Organisational Development Committee. A further discussion was due to take place at the next committee meeting to agree how this information could be triangulated.

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

235/17 Maternity & Neonatal Task Force Update

Mrs Beal advised committee members that a decision had been made at the Trust's Oversight Group meeting with the CQC held on 30th January 2018 to conclude the work of the group and merge it into the Trust's Maternity Taskforce Committee. The report provided a summary of the discussions held at the first meeting on 16th March 2018 and it was noted that members of the CQC had been assured on progress being made within maternity services.

The committee noted the improvement in a number of performance indicators included on the maternity dashboard and there was a discussion about the ongoing risk regarding the lack of clinical leadership in obstetrics and gynaecology. It was also noted that the Listening into Action Pulse Check would be utilised in maternity services to understand whether there had been a shift in the culture. Concerns were raised that there had been little improvement with this and some issues remained regarding behaviour of individuals. Mr Gayle confirmed that he had been discussing the culture changes across the organisation with the Director of Human Resources & Organisational Development. Mrs Beal highlighted that there had been significant improvements in the midwifery leadership over the previous months and this had been recognised by the Regional Executive Director of Nursing for NHS Improvement who had recently visited the department. It was noted that the Edgcumbe work continued to support the team within maternity and a project had commenced in relation to human factors to improve the culture across the organisation. Mr Beeken advised that external recruitment would also be undertaken to fill some clinical

vacancies across the Trust.

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.

Resolution
The Committee received and noted the Maternity & Neonatal Task Force Update.

236/17 Report on Mental Health & Capacity

Mrs Beal presented the report which had been requested by the Trust Board following a discussion about the recurrent issue relating to mental health and capacity. An update was provided on performance and training with regards to Mental Capacity Assessments and Deprivation of Liberties Safeguards. It was noted that the Trust's Older People's Mental Health team provided interventional support for patients admitted to the Trust.

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.

There was a further discussion about the availability of community respite beds for the Trust. Mrs Harris advised that respite services provided by Walsall Council had been decommissioned. Mr Gayle suggested that he may be able to offer some support with this and it was agreed that a discussion would take place outside of the meeting.

Mr Beeken also raised concerns regarding the poor utilisation of the Dorothy Pattison Hospital for patients with mental health concerns and highlighted that patients were being brought to the hospital as a result of section 136 of the Mental Health Act rather than being taken to the mental health facility available in Walsall.

Mrs Harris queried whether staff were aware of their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberties Safeguards. Mrs Beal stated that this could be improved throughout the organisation, however, support was provided to the ward staff by the Mental Health team. It was noted that the team had identified an increase in cases of dementia in younger adults which there was currently no provision for. Further discussions about this were due to take place with the commissioners.

It was recognised that staff within the Trust were not currently provided with mental health first aid training. Mr Gayle agreed to pick this up at the People & Organisational Development Committee and Ms Beal agreed to discuss with the Director of Nursing at the mental health trust.

There was a further discussion about the number of adults who had been discharged before a mental capacity assessment had been completed. It was noted that this had been recognised by the team and in some cases medically fit patients were being discharged to a care home with the understanding that an assessment would be completed following discharge.

Resolution
The Committee received and noted the report on Mental Health & Capacity.

237/17 Compliance with Trauma Unit Standards

Mr Khan apologised that the report had not been made available to the committee at this point and advised that further work was being done to address some gaps that had been identified in relation to Trauma Unit standards. He would be addressing these with the Trauma lead and agreed to provide a report to the next meeting.

AK
Apr 18

Resolution
The report on Compliance with Trauma Unit Standards was received and noted by the committee.

238/17 Compliance with NatSSIP's and LocSSIP's Guidance

Mr Khan presented the 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. It was noted that a Clinical Lead had now been appointed and would be working with the Governance Lead to implement local safety standards for invasive procedures (LocSSIP's) across the organisation to improve patient safety and experience.

Resolution
The report on compliance with NatSSIP's and LocSSIP's Guidance was received and noted by the committee.

239/17 Progress Report on Compliance with VTE Processes

The Committee received the progress report on compliance with VTE processes and discussions had taken place as part of the

Performance and Quality Report item.

Resolution
The Committee received and noted the progress report on Compliance with VTE Processes.

240/17 Risk Management Committee Information & Escalation Report

Mrs Beal presented the report from the Risk Management Committee and advised that attendance at these meetings had been variable recently. She confirmed that she and the Head of Clinical Governance would be meeting with the Chief Executive to review the membership and terms of reference for this committee and a number of other sub committees.

An update was provided on the corporate risk register and it was noted that a considerable amount of work was being done on the Patient Care Improvement Programme (PCIP) supported by the Trust's Improvement Director. The committee were advised that the Trust Quality Executive had been due to receive an update on the PCIP in March; however, the meeting had been cancelled. The update would be provided in April and would then be shared with the committee. It was agreed that assurance provided to the committee on the PCIP could be strengthened.

The Committee received the final RCA report from the Never Event reported in November 2017 in relation to a retained foreign object (swab) post procedure in maternity. The Chair queried whether lessons learnt from the incident had been put into practice. Mrs Beal provided 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 on BadgerNet to support with relevant documentation. It was agreed that an update on the never event would be included in the highlight report to the Trust Board.

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

241/17 Monthly Nursing & Midwifery Quality & Staffing Report

The monthly nursing and midwifery quality and staffing report was received by the committee along with an update on the nursing workforce workstream. Ms Beale circulated an updated version of the action plan for the workstream and advised that NHS Improvement had agreed to support the Trust by undertaking a review of current systems, processes and controls

in relation to temporary nursing workforce. She agreed to provide a verbal update at the next meeting and a full written report once the review had been completed. **BB**

Mr Gayle asked for an update on the reduction in the number of vacancies and the decision to review the number of CSW posts. Mrs Beal highlighted that current data suggested that the number of vacancies for Registered Nurses was at the lowest it had been for the previous 3 years. Work was now ongoing to improve retention rates and to consider new roles to further support the position. It was noted that the first cohort of students on the Trainee Nursing Associate programme were due to qualify in January 2019 and a mapping exercise was being completed with the divisional nurses to identify where those posts would be implemented. It was agreed that it would be beneficial for the committee to receive a presentation on the role of the Trainee Nursing Associate at a future meeting and Mrs Beal agreed to organise this with the Associate Director of Nursing. Members were advised that the Trust Board had been informed that the number of CSW posts would be reduced as a result of a strengthened Registered Nursing workforce and this was being mapped out as part of the review being done by NHS Improvement. **BB**

Mr Caldicott highlighted that the fill rates had significantly increased on some wards and gaps had been identified elsewhere. It was noted that this may be as a result of incorrect recording on e-roster in relation to staff location. Mrs Beal advised that this was being picked up as part of the work to strengthen the rosters and roster clinics were being held for each ward. The level of compliance had improved slightly; however, further work was required. The committee were also advised that the executive team had been discussing the proposal to cease Thornbury agency use from April onwards with some exceptions being made for critical care.

Mr Gayle highlighted that a neighbouring Trust currently used an online system for the bank and staff were able to log on to the system and book their own shifts. Mrs Beal identified that this was something the Trust would be looking into and confirmed that the bank office was now staffed 7 days a week to ensure bookings could be made as required.

Safe Staffing Internal Audit Report

The Committee received a revised version of the Safe Staffing Internal Audit Report following discussions and discrepancies raised at the previous meeting. The actions from this had been incorporated into the action plan for the Nursing Workforce Workstream.

Resolution

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

242/17 Mortality Report

Mr Khan presented the Mortality report and identified that there had been an increase in the number of deaths for the previous three months, as previously discussed. This had resulted in an increase of HSMR reported in December. There was a theme identified in the number of patients who had died during a 0 – 1 day length of stay. The committee acknowledged that the NHS as a whole had experienced a very difficult winter and it was agreed that it would be beneficial to review the benchmarking data for the Trust.

The Chair queried what lessons had been learnt following the review of patients that had died who were known to have a learning disability. A meeting had taken place with the Lead Nurse for Learning Disabilities and it was noted that all wards had a Learning Disabilities champion. Further work was being done to explore an electronic solution for flagging patients with a learning disability. The Learning Disabilities nurses also provided support to the wards to identify patients to ensure that the appropriate care was provided. Mr Khan identified that learning points had been identified following two recent deaths in the Medicine division and a full RCA had been undertaken for both cases.

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

245/17 Presentation on Quality Improvement Academy

Mr Fradgley joined the meeting to provide a report on the Quality Improvement (QI) Academy which was being rolled out across the organisation. He provided a brief overview of the history of the development of the academy which would support Listening into Action Teams in maximising outcomes and increasing the sustainability of changes being implemented.

The committee were advised that the Quality Improvement Faculty had been established to support the academy and would meet on a bi-weekly basis with a monthly steering group chaired by the Director of Strategy and Improvement. Mr Fradgley confirmed that the governance proposal was to submit progress reports directly to the People and Organisation Development Committee on a quarterly basis. The LiA Teams progress would continue to be reported at the bi-weekly LiA Sponsor Group meetings chaired by the Chief Executive. Mr Fradgley thanked

the committee for their time and asked for any questions.

Mr Beeken highlighted that a discussion had taken place at the LiA Sponsor Group recently and members had a strong view that LiA should be integrated with the QI Academy rather than running alongside. Mr Fradgley agreed with this proposal and highlighted that this should not change the purpose of the academy.

The Chair highlighted that the development of the academy would require sponsorship from all levels of staff and necessary funding and asked how this would be provided. It was noted that some clinical time had been funded for the lead of the academy and additional funds had been secured to support with the running of workshops including administrative materials and literature. Members recognised the importance of ensuring clinicians were given the time to be involved in the academy and it was noted that there were some existing forums and meetings that could be used to cascade information and hold workshops.

Mrs Harris highlighted that the Trust's engagement lead had recently launched a new group called passionate about engagement and asked whether the work of the QI Academy would link with this. Mr Fradgley confirmed that discussions were ongoing with the executive team about the proposal of developing an integrated improvement plan to ensure all elements of improvement were interlinked e.g. financial, quality, engagement.

The Chair highlighted that the approach taken by the academy would result in ideas from staff that would need to be acted on and asked how these would be prioritised with the resources available. Mr Fradgley confirmed that all ideas would be submitted to the steering group for prioritisation and identified that some would be incorporated into existing workstreams as required. It was noted that all current ideas were resourced; however, requests for investment would be made to the People & Organisational Development Committee and the Trust Board.

Resolution

The Committee received and noted the content of the report and supported the Quality Improvement Academy initiative.

246/17 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 5th April 2018:

- 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

247/17 Any Other Business

Mrs Beal informed the committee that the CQC visited the Trust each month for an engagement meeting to discuss key lines of enquiry and any issues and complaints that had been raised during the month. The meeting was attended by the Director of Nursing, Deputy Director of Nursing and Head of Clinical Governance. Key leads were also invited to attend the meeting as required to update on specific issues. Mrs Beal suggested that an update be provided to the committee each month following the engagement meeting. An update was provided in relation to key points for discussion at this month's meeting which included:

- Assurance regarding progress with the four areas of improvement relating to the Section 29a Warning Notice
- An update was requested on the National Bowel Cancer Audit – the care group team had been invited to the next meeting.
- Actions taken as a result of recent Never Events reported in Maternity.

Mrs Beal shared an initial draft of a flash report which provided key quality performance information including pressure ulcers, falls, VTE, medication errors for escalation and discussion by the committee. It was agreed that this would be useful for the committee and would prompt high level discussion. Mrs Beal confirmed that this would be discussed further with the executive team to agree how the information could be used.

Mr Gayle raised concerns in relation to medicines management practice throughout the organisation. He confirmed that this had been raised as a concern during the 2015 CQC inspection and although intensive work had initially been undertaken, the focus on this had recently slipped. Mrs Beal agreed with this and confirmed that the Controlled Drugs audit compliance would also support this statement. It was noted that medicines management was included in the PCIP and was also being considered as one of the priorities for the Quality Account. It was agreed that an update on actions being taken to tackle this would be provided to the next meeting.

AK
Apr 18

248/17 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.

249/17 Date & Time of Next Meeting

Thursday 26th April 2018, 9:00am
Room 10, MLCC

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date: 3rd May 2018**
Report Title	People & Organisational Development Committee Highlight Report			**Agenda Item: 12** **Enclosure No.: 10**
Lead Director to Present Report	Non Executive Director and Committee Chair, Philip Gayle			
Report Author(s)	Louise Ludgrove, Interim Director of OD & HR			
Executive Summary	The report highlights the key issues discussed at the People & Organisational Development Committee meeting held on 16th April 2018.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Board is recommended to discuss the content of the Report and raise any questions in relation to the assurance provided.			

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No 7. That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff
No 8. That we are not successful in our work to establish a clinically led, engaged and empowered culture.
No. 11. That our governance remains “inadequate” as assessed under the CQC Well Led standard.</td></tr>
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<tr><td><u>Report History</u></td><td colspan="2">The Committee reports to the next Trust Board with a highlight report on the key issues raised at the most recent meeting.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The minutes from the meeting held on 16th April will be submitted to the Trust Board in June 2018.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HIGHLIGHT REPORT

The meeting was quorate and was chaired by Philip Gayle, Non Executive Director and Chair of the Committee.

Key issues discussed were:

1. It was noted that the Staff Engagement Lead had presented a comprehensive update at the last meeting of the Trust Board.
2. The Committee received a presentation on Human Factors and the current project focused on patient focused care in Maternity Services. The Committee expressed their enthusiasm and support for the work going forward and agreed that regular progress reports would be submitted to them.
3. Daren Fradgley updated the Committee on issues to be considered relating to the Quality Improvement Academy and the Committee agreed that a regular Governance Report should be presented to the Committee going forward. It was noted that a quarterly report would subsequently be presented to Trust Board, subject to synchronising dates between this Committee and Board meetings.
4. Bobbie Petford, OD Practitioner updated the Committee on the progress of an initiative launched by the Department of Health twelve months previously, branded "Collective Call to Action – tackling bullying in the NHS". It was noted that a multi disciplinary team, including representatives of Trust Staff Side, had been established within the Trust and had produced an Action Plan, which was endorsed by the Committee.
5. Marsha Belle updated the Committee on the work which had been progressed in relation to Equality, Diversity and Inclusion within the Trust. She reported that a draft strategy and action plan were currently being reviewed and would be presented to EDIC at its next meeting and that a Listening into Action event was currently being planned to engage with staff across the Trust. Louise Ludgrove updated that recruitment was to be launched shortly for a six month secondment role to lead on the internal focus around E, D & I and Phil Gayle emphasised the traction that was needed in progressing this work quickly.
6. The Committee received the KPI information and noted a significant reduction in sickness during February 2018. However it was noted that this should be received with caution, recognising the concerns around managers' input of sickness into ESR, previously identified. Discussion took place around an update on nurse recruitment and levels of agency usage, which needed to be correlated with discussions at PFIC.
7. Marsha Belle reported that the gender pay gap report had been uploaded on time to the government website and on the Trust intranet. It was noted that Trust statistics were broadly in line with other local Trusts. The Committee noted that it would hope to see an improvement in these figures when the next report was compiled in 2019 and it was confirmed that work was underway to achieve this.
8. Phil Gayle requested that Amir Khan be asked to attend future Committee meetings or to send a representative and noted that he would pursue this request.
9. Matthew Dodd presented the Workforce Impact Assessment paper relating to the closure of wards in autumn 2018 and the Committee discussed the findings. The importance of engaging with affected staff and the impact of not doing so was discussed and noted. The Chair asked that this paper also be considered at Executive Team for discussion.

10. The Committee considered the updated Consultant Vacancy Report and noted that this work will contribute to the current sustainability review. Phil Gayle asked that Amir Khan present an updated paper to the June meeting of the Committee.
11. The Library Strategy was presented to the Committee and accepted. Jacqui Watkeys was thanked for her hard work in writing the strategy and commended on the services provided by her team in the library.
12. Marsha Belle updated on progress related to the development of new roles in the Trust to enable sustainable staffing going forward. It was noted that this work supported the development and application of the first cut of a Workforce Plan scheduled for Board in August.
13. Debra Davis presented an update on the Apprenticeship Levy. The Committee noted that the Trust has significant opportunities to expand the use of Apprenticeships in the current financial year and will therefore be able to maximise funding through the levy.

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board (Public)			**Date: 3 May 2018**
Report Title	Proposal to develop a Trust Management Board and DRAFT terms of reference			**Agenda Item:13** **Enclosure No.:11**
Lead Director to Present Report	Richard Beeken, Chief Executive Jackie White, Interim Trust Secretary			
Report Author(s)	Richard Beeken, Chief Executive Jackie White, Interim Trust Secretary			
Executive Summary	This paper makes a recommendation to establish a Trust Management Board (TMB) which is designed to support the Trust in delivering its vision and objectives. The purpose of the establishing a TMB is develop a leadership culture with a shared agreement and consistent approach to decision making, performance management, compassion for culture, facilitating and rewarding learning and quality improvement and innovation and in developing team and cross team working within the Trust. The TMB will work together and build cultures where the success of patient care is everyone's priority and not just their individual area of responsibility. Attached to the report is a draft set of terms of reference which sets out the full duties of the TMB. For the time being, it is considered a separate forum for the management and delivery of the Trust's financial plan, given current risks around that programme.			
Purpose	**Approval** ☒	**Decision** ☒	**Discussion** ☐	**Note for Information** ☐
Recommendation	The Board is recommended to Approve the proposal and terms of reference			
Trust Objectives Supported by this Report	**Provide Safe High Quality Care Across all of Our Services**		**Embed the quality, performance 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		**Not Relevant**	
	Use resources well to ensure we are Sustainable		**Not Relevant**	

<table>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td>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>BAF No. 8 That we are not successful in our work to establish a clinically-led, engaged and empowered culture.</td></tr>
<tr><td><u>Resource Implications</u></td><td>None</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td>None</td></tr>
<tr><td><u>Report History</u></td><td>Executive Group</td></tr>
<tr><td><u>Next Steps</u></td><td>Further work on strengthening the governance and business processes within Divisions will be required
Implementation of monthly performance meetings with Divisions</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>
</table>

1. Purpose

This paper makes a recommendation to establish a Trust Management Board (TMB) which is designed to support the Trust in delivering one of the 2018/19 Trust objectives, namely:

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

2. Background

Delivering our vision of "Becoming Your Partners for First Class Integrated Care" requires an effective framework for accountability and decision making within the Trust. The Accountability Framework which was introduced in June 2017 supports a culture of fair accountability within the Trust alongside a quick and effective process for decision making.

Alongside the Trust's accountability framework the Trust refreshed its approach to decision making to ensure it supported our approach to accountability. This approach is, again, based on our organisational structure of clinically-led divisions and care groups seeks to provide operational autonomy to divisions consistent with the need for good governance and the operation of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Supporting this devolved accountability and decision making structure, the Trust established three Trust Executive Groups which bring together the clinical leaders and Directors from across the Trust to have oversight and delivery of quality, strategy, productivity and finance and workforce. This structure has ensured clinical leader engagement in assurance and oversight of performance but hasn't involved Divisional Leaders in the key decisions the Trust leadership team makes. Moreover, adherence to the processes in place for making key decisions is not consistently achieved.

3. Details

The purpose of the establishing a TMB is develop a leadership culture with a shared agreement and consistent approach to decision making, performance management, compassion for culture, facilitating and rewarding learning and quality improvement and innovation and in developing team and cross team working within the Trust. The TMB will work together and build cultures where the success of patient care is everyone's priority and not just their individual area of responsibility.

The TMB will support development of the Trust Strategy and ensure the delivery of corporate objectives and the mitigation of corporate risks. It will ensure that there is a focus on quality, strategy, productivity and cultural change. It will agree actions needed to define and deliver the Trust's agenda.

It will be a key forum for development and implementation of major strategies and operational plans and ultimately, the Integrated Improvement Programme.

The Trust Management Board will be accountable to the Board of Directors through the Chief Executive.

Attached to the report is a draft set of terms of reference which sets out the full duties of the TMB.

4. Conclusion

Although there are existing mechanisms in place for clinical leader engagement and decision making, these mechanisms are felt not to have produced the desired effect and therefore it is recommended that the three Executive Groups are ceased and replaced with a new Board which should ensure that there is a joint accountability and culture for decision making across the Trust.

We will use the LIA “Pulse check” method to establish whether our revised engagement approach is having the desired effect.

For the time being, it is considered a separate forum for the management and delivery of the Trust’s financial plan, given current risks around that programme.

5. Recommendation

The Board of Directors is asked to approve the recommendation to establish a Trust Management Board and approve the draft terms of reference.

The Board of Directors is asked to note that further work on strengthening governance and decision making processes will continue to be undertaken in line with the accountability framework.

Richard Beeken
Chief Executive

Jackie White
Interim Director of Governance / Trust Secretary

April 2018

BOARD/COMMITTEE REPORT

Meeting	Trust Board	**Date:** 03/05/18
Report Title	Month 12 Finance Report	**Agenda Item: 14** **Enclosure No.: 12**
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 £23.0m deficit against the original planned deficit £20.5m; this position is adjusted for movement on donated assets to give a financial performance against control total of £23.3m deficit. 2. The contracted income position is down against plan (£6,029k). The underperformance was largely a consequence of reduced Obstetric activity, outpatients and elective utilisation. Other income over-performed largely as a consequence of additional funding allocations for winter (£1.85m total) and other one off income additions such as Diabetes (£800k). 3. Expenditure is overspent as a result of increased staffing costs, the main cause being temporary workforce to cover nursing and medical vacancies and additional capacity. The expenditure position improved in latter months, an element of this improvement following the allocation of winter monies also review and transfer of expenditure meeting the capital definition. 4. The Trust's targeted efficiency savings for 2017/18 are £11m. The actual savings delivery was £10.9m, an under achievement of just £0.1m. However, of this total £4.6m is delivered non-recurrently (includes asset sales of £1.3m), placing increased pressure on future requirement to recover this shortfall	

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

Recommendation	Trust Board is recommended to: Note the report and associated risks.

<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>Not Relevant</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>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>
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</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2"></td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2"></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"></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

Financial Performance Update Month 12

Trust Board

3rd May 2018

Summary Financial Performance to March 2018 (Month 12)

Financial Performance - Period ended 31st March 2018

Description	Annual Budget	Budget to Date	Actual to Date		Variance
	£'000	£'000	£'000		£'000
Income					
NHS Activity Revenue	227,765	227,765	221,736		(6,029)
Non NHS Clinical Revenue (RTA Etc)	1,037	1,037	1,034		(2)
Education and Training Income	8,589	8,589	8,588		(1)
Other Operating Income (Incl Non Rec)	8,878	8,878	12,603		3,725
Total Income	**246,268**	**246,268**	**243,962**		(2,306)
Expenditure					
Employee Benefits Expense	(171,527)	(171,527)	(173,820)		(2,293)
Drug Expense	(18,962)	(18,962)	(18,824)		138
Clinical Supplies	(18,121)	(18,121)	(17,754)		367
Non Clinical Supplies	(15,864)	(15,864)	(15,239)		626
PFI Operating Expenses	(5,019)	(5,019)	(4,946)		73
Other Operating Expense	(23,079)	(23,079)	(22,211)		868
Sub - Total Operating Expenses	**(252,572)**	**(252,572)**	**(252,793)**		(222)
Earnings before Interest & Depreciation	**(6,303)**	**(6,303)**	**(8,831)**		**(2,528)**
Interest expense on Working Capital	51	51	24		(27)
Interest Expense on Loans and leases	(8,687)	(8,687)	(9,115)		(428)
Depreciation and Amortisation	(6,890)	(6,890)	(6,393)		497
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	1,329	1,329	1,329		0
Sub-Total Non Operating Exps	**(14,197)**	**(14,197)**	**(14,154)**		43
Total Expenses	**(266,768)**	**(266,768)**	**(266,948)**		(179)
RETAINED SURPLUS/(DEFICIT)	**(20,500)**	**(20,500)**	**(22,985)**		**(2,485)**
Adjustment for Gains on Donated Assets	(256)	(256)	(282)		(26)
Adjusted Financial Performance (Control Total)	**(20,756)**	**(20,756)**	**(23,267)**		**(2,511)**
Impairments	0	0	(1,234)		(1,234)
ADJUSTED SURPLUS/(DEFICIT)	**(20,756)**	**(20,756)**	**(24,219)**		**(3,719)**

Financial Performance

- The unadjusted financial position for the Trust at M12 is a deficit of £22,985k. This position is adjusted for 'gains on donated assets' which results in performance against control total of £23,267 deficit. There is a further technical adjustment relating to site revaluation of £1,234k giving the Trust an overall deficit of £24,219k.
- The contracted income position is down against plan (£6,029k). The underperformance was largely a consequence of reduced Obstetric activity, outpatients and elective utilisation. Other income over-performed largely as a consequence of additional funding allocations for winter (£1.85m total) and other one off income additions such as Diabetes (£800k).
- Expenditure is overspent as a result of increased staffing costs, the main cause being temporary workforce to cover nursing and medical vacancies and additional capacity. The expenditure position improved in latter months, an element of this improvement following the allocation of winter monies also review and transfer of expenditure meeting the capital definition.
- The CIP delivery for the year is £10.9m (£0.1m) behind plan, the improved performance due do additional income schemes billable in month 12 and the sale of assets £1.3m.

CIP 2017/18 Delivery

- The Trust's Annual Cost Improvement Programme requirement was £11m.
- The CIP actual delivery was £10.9m , an under achievement of just £0.1m. However, of this total £4.6m is delivered non-recurrently (includes asset sales of £1.3m), placing increased pressure on future requirement to recover this shortfall.

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding for March is £2.3m, this level of balance to ensure achievement of the Trust's External Financing Limit (EFL).
- The Trust's borrowing was set at £20.5m in line with the original planned deficit. The Trust requested additional central borrowing (£4.3m) because of the revenue overspending and to maintain payment to suppliers for goods and services.
- The interest payable on the increased borrowing adds to the future savings requirement.

Capital

- The total capital expenditure is £9.7m, with the main spending areas being the ICCU development (£5.2m), Estates Lifecycle (£1.7m), Medical Equipment (£1.1m) and Community Mobile technology (£0.6m).

Temporary Workforce

- £2.0m March 2018 (£1.7m February 2018) an increase of £0.3m month. This reflects the highest spending on Temporary Workforce since October 16 (£2.25m).

BOARD/COMMITTEE REPORT

Meeting	**Trust Board**	**Date:** 03rd May 2018
Report Title	Performance and Quality Report for March 2018	**Agenda Item:15** **Enclosure No.:13**
Lead Director to Present Report	Director of Finance & Performance, Russell Caldicott	
Report Author(s)	Head of Performance & Strategic Intelligence - Alison Phipps	
Executive Summary	The report format aligns all of the indicators to the organisational strategic objectives. **SUMMARY OF THE KEY POINTS:** Areas of note are:- 1. **A&E: Time Spent in A&E (within 4 hours): Target 95%:** Performance declined to 81.23% compared to 82.81% in February and remained below the trajectory of 93%. 2. **Ambulance Handover:** The number of delayed ambulance handovers increased in total in March to 153 compared to 129 in February, however the daily average remains similar. Of these the number delayed by more than 1 hour reduced to 9 from 21. 3. **Cancer** – All 7 national cancer metrics achieved in February. The 62day consultant upgrade metric failed to achieve the locally agreed 85% target with performance of 79.52%. Unvalidated results for March show achievement against all 8 metrics. 4. **18 Weeks Referral to Treatment Incomplete: Target 92%:** March's performance improved to 84.74%, there were no patients waiting more than 52 weeks at the end of March on an incomplete pathway. 5. **Diagnostic waits:** This failed to achieve the 99% target (98.06%). 6. **HSMR (HED) & SHMI** - January HSMR rate was 113.00. December SHMI changed to 127.25 from 103.66 in November. 113 deaths recorded in March. 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 January was 0.64. February and March are pending RCA's. 9. **Falls** - The rate of falls per 1000 bed days declined to 5.64 from 5.10 in February but was within the target of 6.63. There were no falls resulting in serious injury. 10. **Safeguarding and Prevent Training** – Compliance rates have not been achieved. Trajectories have been established to achieve by end of Q1. 11. **Open Contract Performance Notices** – A contract performance notice was received in respect of safe guarding training during March, bringing the total number open to seven. 12. **CQUINS** – Work continues on schemes for 2017-19. A forecast summary is included.	

<table>
<tr><td><u>Purpose</u></td><td>Approval
☒</td><td>Decision
☐</td><td>Discussion
☒</td><td>Note for Information
☐</td></tr>
<tr><td><u>Recommendation</u></td><td colspan="4">The Committee is asked to NOTE the content of the paper and DISCUSS any areas of concern.</td></tr>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td colspan="2">Provide Safe High Quality Care Across all of Our Services</td><td colspan="2">Embed the quality, performance 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">As above</td></tr>
<tr><td colspan="2">Work Closely with Partners in Walsall and Surrounding Areas</td><td colspan="2">As above</td></tr>
<tr><td colspan="2">Value our Colleagues so they recommend us as a place to work</td><td colspan="2">As above</td></tr>
<tr><td colspan="2">Use resources well to ensure we are Sustainable</td><td colspan="2">As above</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:
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<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="4">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="4">Not applicable to this report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="4">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="4">Trust Quality Executive – 20/04/2018
Quality and Safety Committee – 26/04/2018
Performance, Finance & Investment Committee – 27/04/2018</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="4">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="4">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
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Walsall Healthcare NHS
NHS Trust

Performance & Quality Report

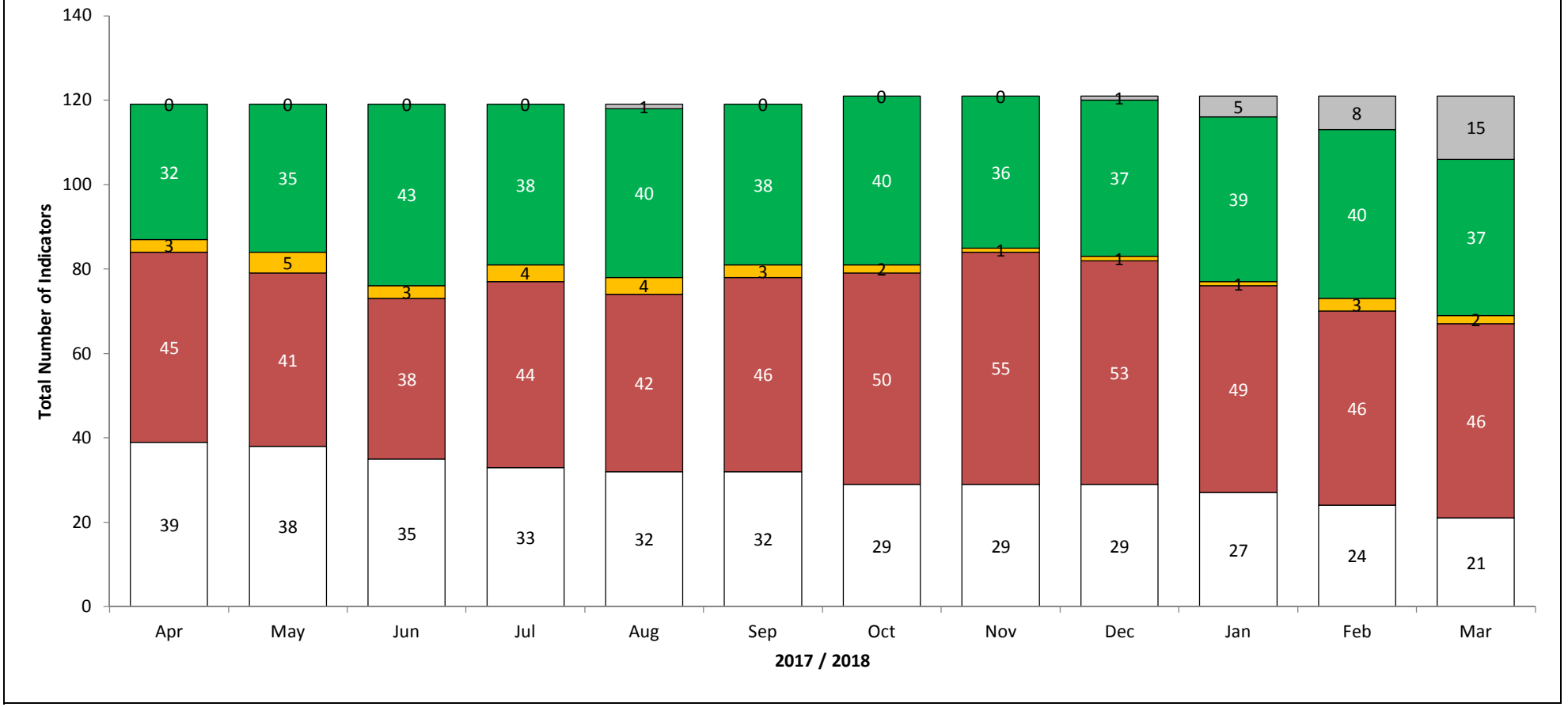
April 2018
(March 2018 Results)

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

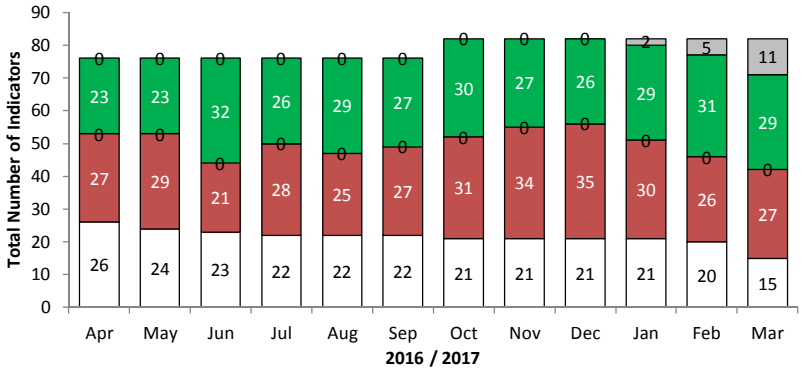
Achieving Target or On Plan

Indicators reported in Arrears or not yet available in Month

TRUST STRATEGIC VALUES FRAMEWORK

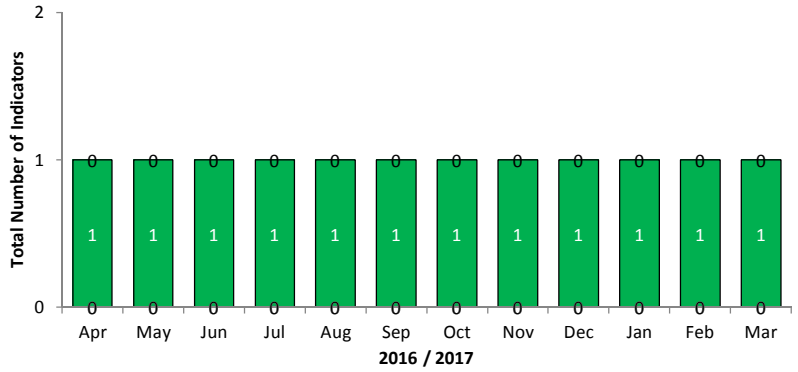
Safe, high quality care

Provide Safe, High Quality Care Across All Our Services



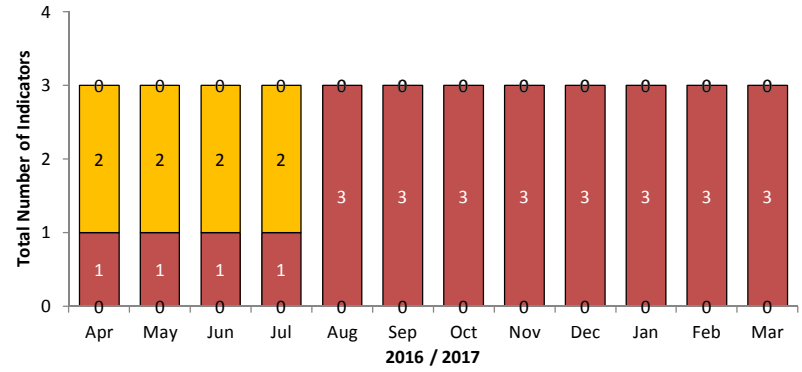
Care at home

Care For Patients at Home Whenever We Can



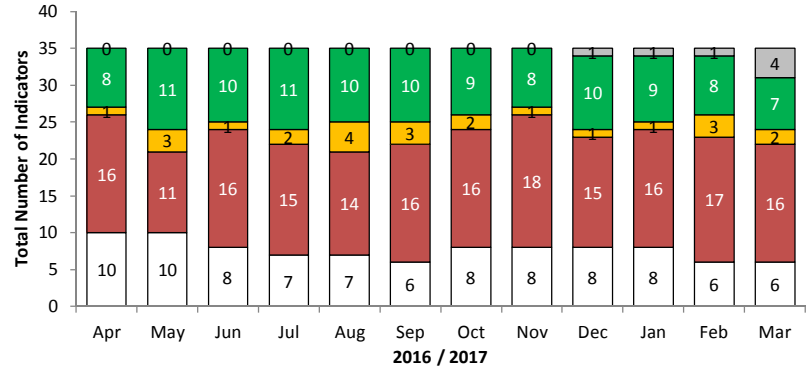
Value colleagues

Value Our Colleagues So They Recommend Us As A Place To Work



Resources

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 March. VTE performance exceeded the agreed trajectory and achieved the national target reporting performance of 95.49% .

PERFORMANCE NOT ACHIEVED: There was an increase in the number of mixed sex accommodation breaches in March from 2 to 8, however the year to date total of 66 was well below the agreed trajectory and the previous year. HSMR improved to 113.00 in January from 132.00 in December. There were 11 avoidable category 3 and 4 pressure ulcers reported for January. February and March figures are provisional. There was 1 national never event reported. There were 12 serious incidents (Acute) reported in March which exceeds the monthly trajectory of 8. There were 5 serious incidents (Community) in March which exceeds the monthly trajectory of 1. One to one care in established labour narrowly failed to achieve the 100% target with performance of 99.48%. C-Section rates failed to achieve the target of 30% reporting 31.80%. Emergency Readmissions within 30 days did not achieve in February with performance of 10.18%. EDS compliance failed to achieve in March at 89.51%. Dementia screening declined slightly to 79.55%, against a target of 90%, however methodology to determine performance of this metric is still under review. 4 FFT areas failed to achieve in March.

TO NOTE:
The number of deaths remained comparable to February in March at 113. The percentage of medication incidents resulting in harm will be re-instated from next month. A contract performance notice was received from Walsall CCG in March for Safeguarding Training and low compliance rates. Safeguarding figures are now being monitored in this report and a target is to be incorporated 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

Safe, high quality care | Care at home | Partners | Value colleagues | Resources

		OCT	NOV	DEC	JAN	FEB	MAR	YTD Actual	17/18 Target	16/17 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no	Sleeping Accommodation Breaches	7	6	9	3	2	8	**66**	0	**105**	N
no..	HSMR (HED)	84.46	88.09	132.00	113.00			**97.06**	100.00		N
no..	SHMI (HED)	101.03	103.66	127.25					100.00		BP
no	Number of Deaths in Hospital	86	80	137	139	112	113	**1166**		**1123**	BP
%..	% of patients who achieve their chosen place of death	66.00%	73.81%	46.30%	63.04%	57.78%		**55.85%**			
no	MRSA - No. of Cases	0	0	0	0	0	0	**0**	0	**0**	N
no	Clostridium Difficile - No. of cases	1	0	4	0	0	0	**11**	18	**21**	N
%..	Percentage of patients screened for Sepsis (CQUIN audit - quarterly)	92.75%	92.19%	95.00%				**93.59%**	90.00%		
no..	Pressure Ulcers - (category 2, 3 & 4's) - Avoidable per 1000 beddays	0.61	0.66	0.18	0.64	0.43	0.18				BP
no	Pressure Ulcers - No. of Avoidable (category 2, 3 & 4's) - Trust	9	10	3	11	7	3		0	**19**	BP
no	Pressure Ulcers - (category 2, 3 & 4's) - Hospital	14	12	11	15	19	19			**167**	
no	Pressure Ulcers - (category 2, 3 & 4's) - Community	16	15	9	17	14	15			**143**	
no	Falls - Total reported	96	83	95	88	83	95	**1026**		**932**	BP
no..	Falls - Rate per 1000 Beddays	6.46	5.50	5.79	5.11	5.10	5.64		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	0	2	1	1	0	0	**8**	0	**22**	BP
%..	VTE Risk Assessment	90.45%	89.95%	93.45%	91.30%	93.18%	95.49%	**88.49%**	95.00%	**90.90%**	N
no	National Never Events	0	1	0	0	0	1	**3**	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	7	16	9	9	13	12	**123**	102	**102**	L
no	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	4	5	4	8	4	5	**77**	50	**49**	L
no	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	22	31	28	22	24	18	**262**		**218**	L
no	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	10	4	2	16	4	8	**89**		**55**	L
%..	% of incidents resulting in moderate, severe harm or death as a % of total incidents	3.06%	3.27%	3.09%	3.31%	2.89%	2.33%	**2.78%**		**2.41%**	L
%..	Deteriorating patients: Percentage of observations rechecked within time	91.30%	90.16%	88.19%	88.72%	90.27%	90.52%	**90.10%**	85.00%		
%..	Medication Storage Compliance	95.00%	95.00%	93.00%	89.00%			**95.00%**			
%..	Controlled Drug Compliance (quarterly audit)			78.00%							
%..	% of Pharmacy Interventions made based on charts reviewed	20.15%	20.00%	26.56%	22.62%	22.49%		**22.59%**			
no..	Midwife to Birth Ratio	1:25.7	1:25.4	1:25.4	1:24.8	1:22.4	1:26.3		1:28	**1:30.6**	N
%..	One to One Care in Established Labour	99.07%	98.96%	98.91%	98.98%	99.43%	99.48%		100.00%	**100.00%**	N
%..	C-Section Rates	25.77%	28.62%	32.86%	27.14%	26.61%	31.80%		30.00%		

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE
2017-2018

		OCT	NOV	DEC	JAN	FEB	MAR	YTD Actual	17/18 Target	16/17 Outturn	Key
%..	Instrumental Delivery	11.95%	11.47%	8.93%	14.36%	9.09%	10.03%				
%..	Induction of Labour	35.74%	33.33%	33.45%	32.01%	31.85%	30.39%				
%..	NHS Safety Thermometer - Maternity - Women's Perception of Safety	96.20%	64.30%	91.30%	82.60%	100.00%	94.30%				
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (month in arrears)	10.75%	10.35%	11.44%	10.44%	10.18%		**10.48%**	10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	88.30%	85.38%	89.73%	91.63%	91.84%	89.51%	**89.33%**	100.00%	**88.40%**	N/L
%..	Dementia Screening 75+ (Hospital) (Internal audit Dec17 onwards)	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	22	15	13	24	23	33	**291**		**327**	BP
%..	Complaints - Percentage responded to within the agreed timescales	100.00%	92.00%	100.00%	100.00%	100.00%	90.32%	**85.19%**	70.00%	**47.75%**	BP
no	Clinical Claims (New claims received by Organisation)	13	9	10	10	14	8	**131**		**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	9.74%	8.85%	9.78%	9.96%	9.20%	9.13%	**9.13%**			
%..	Friends and Family Test - Inpatient (% Recommended)	95.00%	92.00%	91.00%	93.00%	97.00%	94.00%	**94.00%**	96.00%		N
%..	Friends and Family Test - Outpatient (% Recommended)	91.00%	90.00%	91.00%	91.00%	91.00%	92.00%	**92.00%**	96.00%		N
%..	Friends and Family Test - ED (% Recommended)	73.00%	76.00%	77.00%	75.00%	79.00%	76.00%	**76.00%**	85.00%		N
%..	Friends and Family Test - Community (% Recommended)	97.00%	99.00%	99.00%	97.00%	99.00%	97.00%	**97.00%**	97.00%		N
%..	Friends and Family Test - Maternity - Antenatal (% Recommended)	73.00%	82.00%	80.00%	97.00%	0.00%	81.00%	**81.00%**	95.00%		N
%..	Friends and Family Test - Maternity - Birth (% Recommended)	89.00%	94.00%	83.00%	100.00%	100.00%	100.00%	**100.00%**	96.00%		N
%..	Friends and Family Test - Maternity - Postnatal (% Recommended)	100.00%	79.00%	85.00%	97.00%	100.00%	96.00%	**96.00%**	92.00%		N
%..	Friends and Family Test - Maternity - Postnatal Community (% Recommended)	87.00%	100.00%	100.00%	99.00%	100.00%	98.00%	**98.00%**	97.00%		N
no..	Adult Safeguarding Training - Level 2 Compliance	54.87%	57.67%	59.50%	63.80%	66.37%	70.09%		95.00%		
no..	Adult Safeguarding Training - Level 3 Compliance	45.54%	63.19%	62.05%	71.85%	74.09%	77.64%		95.00%		
no..	Children's Safeguarding Training - Level 2 Compliance	71.68%	71.66%	73.16%	74.03%	73.84%	73.25%		95.00%		
no..	Children's Safeguarding Training - Level 3 Compliance	59.52%	62.09%	66.32%	68.87%	67.48%	71.07%		95.00%		
%..	PREVENT Training - Level 1 & 2 Compliance	99.71%	99.28%	99.61%	98.84%	98.80%	96.56%		85.00%		
%..	PREVENT Training - Level 3 Compliance	55.74%	62.89%	63.93%	69.07%	70.90%	75.97%		85.00%		
	RESOURCES										
no	Total Births	293	279	280	280	253	289	**3603**	4200	**4190**	L

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

Becoming your partners for first class integrated care

Performance, Finance & Investment Committee – Key Messages

Please refer to dashboard and exception pages for further detail

Performance, Finance & Investment Committee

PERFORMANCE ACHIEVED – OF NOTE: All national cancer measures (7) continued to achieve in February and provisional figures for March also show achievement. There were no patients reported as waiting more than 52 weeks at the end of February, the first time since July 2017. The percentage of stroke patients who spent 90% or more of their stay on a stroke unit achieved for the first time in 6 months.

PERFORMANCE NOT ACHIEVED: The ED 4 hour performance declined to 81.23%. ED median waiting time increased in March. The number of delayed ambulance handovers increased in total in March to 153 compared to 129 in February, however the daily average remains similar. Of these the number delayed by more than 1 hour reduced to 9 from 21. Cancer 62 day consultant upgrade declined to 79.52% in February from 90.91%. March provisional figures show achievement of this measure. Incomplete 18 weeks RTT for March improved to 84.74%. Diagnostic 6 week waits failed to achieve with performance of 98.06%. The number of open contract notices increased from 6 to 7.

TO NOTE: Applying the national cancer breach allocation guidance to the 62 day cancer targets for the validated February 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 continued to improve in March with performance of 10.73% 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 February (3.44%).

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 March was 70.73%, a target is to be incorporated from April 2018.

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

2017-2018

Safe, high quality care | Care at home | Partners | Value colleagues | Resources

		OCT	NOV	DEC	JAN	FEB	MAR	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)	82.75%	82.03%	83.38%	82.68%	82.81%	81.23%	**82.67%**	95.00%	**84.10%**	N
no	Total time spent in ED - No. of Trolley waits over 12 hours	0	0	0	0	0	0	**3**	0	**2**	N
no	Median Waiting Time in ED Metric (average in mins)	177	171	179	181	178	187		120		
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	62.19%	70.04%	58.42%	59.73%	71.31%	70.36%	**65.80%**	100.00%	**65.44%**	BP
no	Ambulance Handover - No. of Handovers completed between 30-60mins	193	122	246	259	108	144	**1836**	0	**1765**	N
no	Ambulance Handover - No. of Handovers completed over 60mins	35	8	35	37	21	9	**236**	0	**249**	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	97.13%	95.88%	97.42%	95.16%	96.61%	97.60%	**95.41%**	93.00%	**96.12%**	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	97.14%	96.88%	100.00%	94.12%	96.55%	100.00%	**96.45%**	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%	**98.90%**	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%	98.82%	100.00%	98.31%	**99.28%**	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%	**98.00%**	90.00%	**96.20%**	N
%..	Cancer - 62 day referral to treatment of all cancers	87.65%	85.51%	90.12%	87.36%	85.71%	85.07%	**87.87%**	85.00%	**87.10%**	N
%..	Cancer - 62 day referral to treatment from consultant upgrade	82.89%	87.84%	85.71%	90.91%	79.52%	85.42%	**86.11%**	85.00%	**92.03%**	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	84.75%	83.57%	80.99%	82.48%	83.69%	84.74%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	2	1	1	1	0	0	**13**	0	**97**	N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Admitted	1	1	0	1	0	1	**10**	0	46	N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Not Admitted	0	1	0	0	1	0	**9**	0	165	N
%..	Diagnostic Waits - % waiting under 6 weeks	99.64%	99.53%	99.15%	99.54%	99.66%	98.06%	**99.06%**	99.00%	**99.24%**	N
%..	Elective Cancellations - No. of last minute cancellations on day of operation or after patient admission	0.73%	0.58%	0.51%	0.19%	0.35%	0.39%	**0.45%**	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	77.27%	78.95%	74.29%	68.97%	70.97%	80.00%	**80.37%**	80.00%	**89.42%**	BP/SS
no	Rapid Response Team - Avoidable admissions (month in arrears)	206	237	248	326	225		**2277**			
no..	FES Avoided Admissions Metric (New metric under development)										
%..	Number of RN staffing Vacancies Metric	9.74%	8.85%	9.78%	9.96%	9.20%	9.13%	**9.13%**			
no	No. of Open Contract Performance Notices	6	6	6	6	6	7	**6**	0	**6**	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	6.89%	6.50%	7.00%	6.71%	6.18%	6.87%	**6.76%**	7.00%	**7.03%**	BP
	RESOURCES										
%..	Clinic Utilisation Rate	92.27%	92.15%	91.14%	90.13%	90.41%	92.87%	**89.90%**	90.00%	**87.27%**	L
%..	Outpatient DNA Rate (Acute and Community)	11.99%	11.77%	14.36%	12.11%	11.27%	10.73%	**12.16%**			
no..	New to follow up ratio - WHT	1.94	1.93	2.03	2.04	2.01	2.04	**1.99**	2.14	**1.95**	BP
%..	Theatre Utilisation - Overall In Session Utilisation (%)	87.58%	75.44%				.		85.00%	**81.91%**	BP
%..	Theatre Utilisation - Touch Time Utilisation (%)	65.08%	61.11%	66.31%	58.16%	63.60%	70.73%				

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

2017-2018

Safe, high quality care | Care at home | Partners | Value colleagues | Resources

		OCT	NOV	DEC	JAN	FEB	MAR	YTD Actual	17/18 Target	16/17 Outturn	Key
no..	Length of Stay	6.46	7.06	7.51	7.50	7.59	7.59	7.22	7.01	7.32	BP
%..	Delayed transfers of care	3.16%	3.27%	2.16%	3.11%	3.44%		2.45%	2.50%	2.35%	L
no	Hospital beds open at month end	468	468	483	532	514	519			470	L
%..	Day case rates	88.41%	90.32%	88.82%	90.32%	88.44%	86.78%	88.14%		87.98%	BP
%..	Bank & Locum expenditure as % of Paybill	8.11%	8.48%	8.53%	7.29%	7.42%	10.31%	7.67%	6.30%	6.22%	L
%..	Agency expenditure as % of Paybill	4.25%	4.41%	4.69%	5.39%	4.51%	3.68%	4.32%	2.75%	6.35%	L
£	Surplus or Deficit (year to date) (000's)	-£14,923	-16976	-£20,342	-£20,395	-£23,257	-£23,267	-£23,267		-£21,392	L
£	Variance from plan (year to date) (000's)	-£2,088	-3093	-£3,991	-£3,622	-£4,238	-£2,511	-£2,511		-£15,192	L
£	CIP (£) (000's)	£5,180	£5,924	£6,620	£7,213	£7,826	£10,900	£10,900	£560	£6,600	L
%..	CIP % delivered (year to date)	64.00%	68.00%	71.00%	72.30%	74.80%	99.10%	99.10%	100.00%	71.00%	L
£	Income variance from plan (year to date) (000's)	£456	£653	£464	£640	-£927	-£2,306	-£2,306	£0	-£5,423	L
£	Expenditure - Variance from Plan (year to date) (000's)	£1,500	£2,245	£4,271	£3,991	-£3,389	-£222	-£222	£0	-£9,537	L
£	Cash Against Plan (variance) (000's)	£94	£858	£526	£73	£121	£128	£128		£700	L
£	Capital spend YTD (000's)	£4,031	£4,818	£5,663	£6,674	£7,438	£9,662	£9,662		£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)	8449	7699	6419	8730	8712		89411		89125	BP
no	Total Elective Activity (Contracted)	290	275	218	250	250	322	3725		3422	L
no	Total Non Elective Activity (Contracted)	34	53	138	61	62	39	578		689	L
no	Total Outpatient attendances (Contracted)	20653	20830	15371	15932	18388	20094	230583		248452	L
no	Total Day Case Activity (Contracted)	1957	2147	1500	2089	1812	1847	22253		21515	L
no	Total Emergencies Activity (Contracted)	2845	2747	2689	2815	2551	2682	31847		30275	L
no	Total ED Attendances Type 1 Pbr (Excl Urgent Care Centre) (Contracted)	6637	6417	6577	6551	5984	6606	74003		64686	L
no	Total AHP Activity (Contracted)	1846	2145	1337	1811	1866	1799	21600		24338	L
no	Total Critical Care Days (Contracted)	994	863	1232	990	895	829	11242		10760	L
no	Total Unbundled Chemo Delivery Activity (Contracted)	359	359	241	323	318	353	3975		3425	L
no	Total Maternity Pathway	1083	894	720	881	766	801	11712		12382	L
no	Total Community Contacts (Contracted)	21720	20614	13823	23589	27787		361113	379962	344377	L
no	Total Births	293	279	280	280	253	289	3603	4200	4190	L

Green	Performance is on track against target or trajectory
Amber	Performance is within agreed tolerances of target or trajectory
Red	Performance not achieving against target or trajectory or outside agreed tolerances

Walsall Healthcare NHS
NHS Trust

People and Organisational Development Committee

Becoming your partners for first class integrated care

People & Organisational Development Committee – Key Messages

Please refer to dashboard and exception pages for further detail

People & Organisational Development Committee

NOTHING OF NOTE.

NONE APPLICABLE

PERFORMANCE NOT ACHIEVED: Sickness absence declined from 5.00% in February to 5.65% in March. PDR's compliance declined in March to 78.17% , as did mandatory training which reported 76.61% compliance.

FINANCE: Turnover remains within target. Please refer to Finance report for further details.

Walsall Healthcare NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

2017-2018

		OCT	NOV	DEC	JAN	FEB	MAR	YTD Actual	17/18 Target	16/17 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Number of RN staffing Vacancies Metric	9.74%	8.85%	9.78%	9.96%	9.20%	9.13%	**9.13%**			
	VALUE COLLEAGUES										
%..	Sickness Absence	5.76%	5.55%	5.81%	6.23%	5.00%	5.65%	**5.30%**	4.00%	**4.59%**	L
%..	PDRs	75.19%	76.25%	75.90%	78.24%	79.47%	78.17%	**78.17%**	90.00%	**84.66%**	L
%..	Mandatory Training Compliance	79.71%	78.69%	79.65%	78.14%	77.61%	76.61%	**76.61%**	90.00%	**80.71%**	L
	RESOURCES										
%..	Bank & Locum expenditure as % of Paybill	8.11%	8.48%	8.53%	7.29%	7.42%	10.31%	**7.67%**	6.30%	**6.22%**	L
%..	Agency expenditure as % of Paybill	4.25%	4.41%	4.69%	5.39%	4.51%	3.68%	**4.32%**	2.75%	**6.35%**	L
no	Staff in post (Budgeted Establishment FTE)	4094	4073	4100	4100	4116	4095	**4095**		**4201**	L
%..	Turnover	8.79%	8.89%	8.93%	8.77%	8.89%	9.13%	**9.13%**	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	Mar-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%	93.00%	81.23%	82.67%	▼	

What is driving the reported underperformance?

Performance results:

Performance in March was 81.23% which is a decline compared to 82.81% in February and below the agreed monthly trajectory of 93%.

Based on Calender Month	Jan-18	Feb-18	Mar-18
Type 1 attenders	6610	5986	6607
Type 3 attenders	3639	3147	3271
WiC attenders	3723	3164	3342
Breaches	2420	2114	2485
Admissions from ED	2224	1953	2050
% of Patients Admitted	33.65%	32.63%	31.03%
Ambulances to ED	2848	2545	2773
All Discharges	6334	5631	5965
Trolley Waits over 12 hours	0	0	0
ED Median Waits (mins)	181	178	187

In line with national agreement attendances at the Walk in Centre have been included within the calculated results as from 1st December 2017.

The Trust was at escalation level 04 for 3 days and level 03 for 27 days compared to 25 days in February.

- Average attendances per day were 213 compared to 214 (Feb)
- Average breaches per day were 80 compared to 75 (Feb)
- Admissions per day were 66 compared to 70 (Feb)
- Discharges per day were 192 compared to 201 (Feb)

There were significant daily variations in performance, at its lowest it was 73.48% and at its highest 92.20%.

Benchmarking:

For March, our position was 92nd out of 133 and 8th out of 14 regionally compared to the previous month's respective ranks of 86th and 6th.

Contractual Status:

CQN/First Exception report remains open. Monthly penalties will be applied by WCCG £120 per breach based on the agreed trajectories. Fines for March equate to £187,200.

What actions have we taken to improve performance?

New Actions:

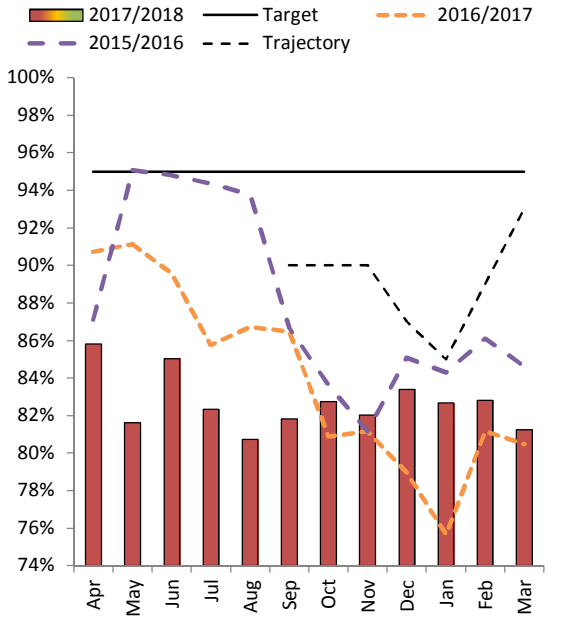
- A new framework has been developed with the support of ECIP to develop key areas identified that will assist patient flow. This include frailty, SAFER / Red2Green, escalation processes and discharge processes. A Governance structure has been agreed with the Board for all of these areas.
- ED have held improvement sessions with the support of ECIP whic has focused on Ambulance handover processes and escalation. These sessions will continue with the team on a regular basis with various topics to support Patient Flow
- Ambulatory Emergency Care are developing options with WMAS to look how patients could be accepted directly to avoid ED.

Benchmarking at other Trusts is currently being carried out.

Continuing Actions:

- Ward Managers continue to attend Capacity Meetings throughout the day with the newly established Discharge Plans that are produced.
- The ED Team have continued to provide a second Triage and second Ambulance Handover Nurse.
- 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.
- 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 £: £817,080



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	Mar-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		144	1836	▼	
	0		9	236	▲	

What is driving the reported underperformance?

Performance results:

Numbers between 30 to 60 mins was 144 compared to 108 in previous month however the daily average remains similar. Over 60 mins was 9 a decrease from previous month (21). Handover performance (excluding ambulances where no time was recorded) was 70.36% compared to 71.31% in Februar

	Feb-18		Mar-18	
<15mins	1814	69.66%	1956	68.68%
15-30	601	23.08%	671	23.56%
30-60	108	4.15%	144	5.06%
>60	21	0.81%	9	0.32%
No Time	60	2.30%	68	2.39%
Total	2604		2848	

*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 92, compared to 93 in February.
- There were over 90 ambulance arrivals to the department on 17 days during the month, a slight decrease compared to Feb (18) and 7 days where the Trust saw over a 100 ambulances to ED which is the same as February.

Benchmarking:

The Trust is ranked 2nd regionally out of 14 Trusts for March which is comparable to the previous month.

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 March a fine of £37,800 will be incurred.

What actions have we taken to improve performance?

New Actions:

- A new framework has been developed with the support of ECIP to develop key areas identified that will assist patient flow. This include frailty, SAFER / Red2Green, escalation processes and discharge processes. A Governance structure has been agreed with the Board for all of these areas.
- ED have held improvement sessions with the support of ECIP whic has focused on Ambulance handover processes and escalation. These sessions will continue with the team on a regular basis with various topics to support Patient Flow
- Ambulatory Emergency Care are developing options with WMAS to look how patients could be accepted directly to avoid ED. Benchmarking at other Trusts is currently being carried out.

Continuing Actions:

- Ward Managers continue to attend Capacity Meetings throughout the day with the newly established Discharge Plans that are produced.
- The ED Team have continued to provide a second Triage and second Ambulance Handover Nurse.
- General Managers continue to carry out daily rounds to the wards to support discharge planning and 7 day LOS review with clinicians.
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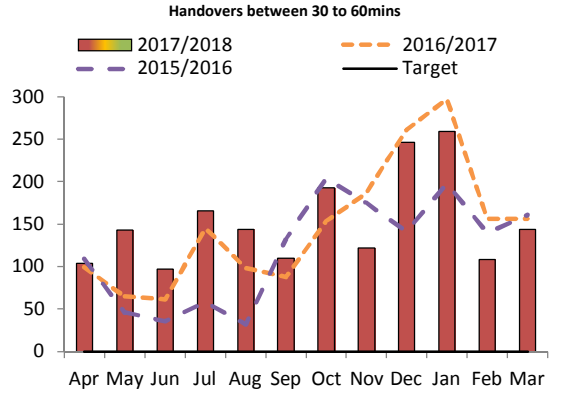
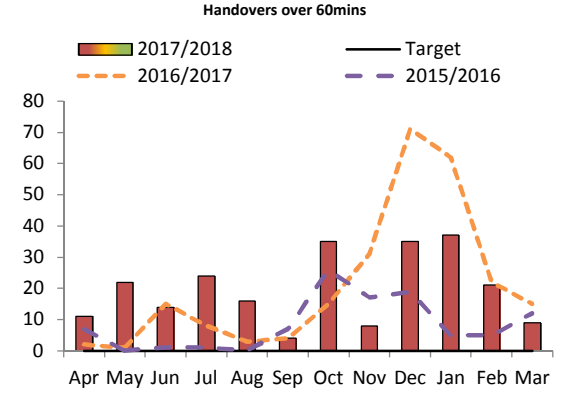
- The ED Medical team continue to support the Ambulance Handover Nurse with Medical Led Triage during times of peak pressures and to support in reducing handover waiting times.
- Transformation Managers continue to support the Patient Flow Meeting which is in place weekly.

Contractual Financial Penalties (LCA) | **YTD £** £603,200





Expected date to meet standard	New trajectories have been proposed by the MLTC Division and are pending Executive approval.
Lead Director	Chief Operating Officer

National Contract	X	#NAME?	X	Best Practice		CQUIN	

Walsall Healthcare NHS
NHS Trust

Cancer - 62 Day Referral to Treatment from Consultant Upgrade	Year Standard	Monthly Trajectory	Feb-18	YTD	Change on last month	Year End Forecast
	85.00%		79.52%	86.18%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No contractual penulties	YTD £

Performance results (Validated February 2018):
Performance of 79.52% in February is a decline compared to 90.91% in January and does not achieve the current locally agreed target of 85%.

Unvalidated performance for March 2018 shows achievement of the target. (Against the newly agreed 85% target).
There were 8.5 breaches reported out of 41.5 treatments.

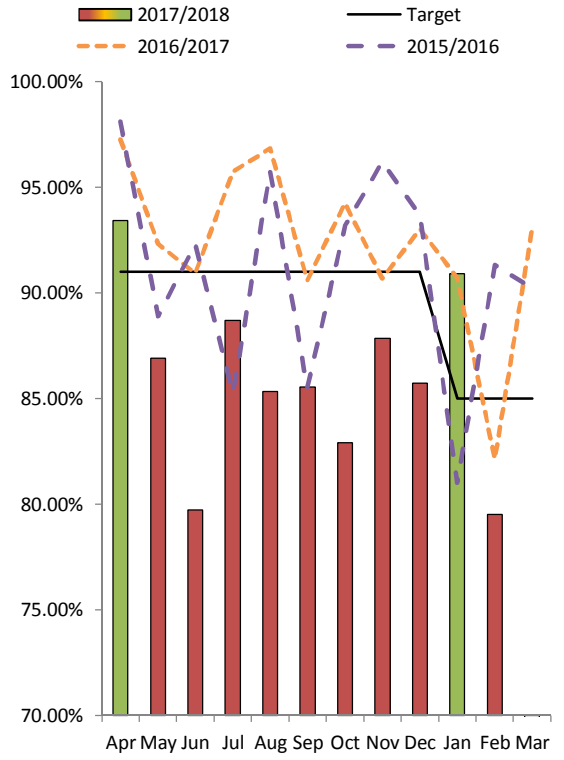
- Gynaecology: 1 patient - 0.5 breach. Treated on day 139. Currently awaiting further information around one shared breach with Sandwell & West Birmingham Hospitals NHS Trust.
- Haematology: 2 patients - 2.0 breaches. Treated on days 95 & 105 (multiple investigations).
- Head & Neck: 1 patient - 1.0 breach. Treated on day 89 (complex pathway).
- Lung: 1 patient - 1.0 breach. Treated on day 76 (multiple MDT meetings).
- Other: 1 patient - 0.5 breach. Treated on day 98 (multiple investigations).
- Sarcoma: 1 patient - 0.5 breach. Treated on day 172 (delay in investigations).
- Upper GI: 2 patients - 1.5 breaches. Treated on day 98 & 108 (complex pathway).
- Urology: 2 patients - 1.5 breaches. shared breach with The Royal Wolverhampton NHS Trust. Referred on day 57. Treated on day 71 (multiple investigations) & 112 (delay at treating trust).

Benchmarking:
For Quarter Three 17/18, the Trust ranked 85th nationally out of 133 and 11th out of 14 regionally compared to Quarter Two respective ranks of 81st and 11th.

Contractual status:
Contractual requirements apply.

New Actions:
- Introduction of senior weekly validation of all Upgrades
- Continue to monitor the Imaging delays and escalate delays.

Continuing Actions:
- The target has now been revised and agreed at 85% by WCCG and take effect from 1st January 2018. This was formally agreed at the EAPG meeting held in January 2018.
- The Trust has a new Cancer Lead who will be meeting with all MDT leads to reinforce the monitoring of the upgrades.
- NHSI is working with UHB and Wolverhampton regarding the tertiary process in order to streamline the pathway.
- From January 2018 UHB are introducing an electronic tertiary referral process which will incorporate additonal clinical information. This should result in a reduction in delays.
- The Trust continues to work with the cancer alliance to improve communication and the tertiary process.
- Cancer upgrade patients PTL is an item on the weekly Cancer PTL meeting agenda.
- Capacity issues at tertiary centres are contributing towards delays. There are specific difficulties at University Hospitals Birmingham (UHB) tracking patients progress through their pathway. Delays are escalated in line with the Cancer Escalation Policy.
- Cancer trackers review and escalate issues for patients daily across all sites.
- All breaches are referred to the monthly Clinical Harm Group for assessment.
- Continue monitoring of bronchoscopy delays escalating to the Division of Medicine for recovery plans.



Expected date to meet standard	April 2018
Lead Director	Chief Operating Officer

National Contract		Local Contract		Best Practice		CQUIN	

Walsall Healthcare NHS Trust

18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Year Standard	Monthly Trajectory	Feb-18	YTD	Change on last month	Year End Forecast
	92.00%	88.20%	83.69%		▲	

What is driving the reported underperformance?

Performance results (Validated February 2018)

The Trust achieved 83.69%, which is an improvement compared to 82.48% in January. The number of patients waiting over 18 weeks has reduced again by 201 compared to January. All divisions improved their performance.

At the end of February there were no patients breaching 52 weeks.

		Dec-17	Jan-18	Feb-18
PTL Size		15632	14889	14755
No. over 18 Weeks		2972	2608	2407
No. over 52 Weeks		1	1	0
Clock Stops	Total	4851	6757	5749
	Admitted	673	915	906
	Not Admitted	4178	5842	4843
Specialties achieving 92%		7	8	7

Performance of Divisions (target 92%):
- MLTC achieved 85.68% compared to 83.45% in January.
- Surgery achieved 80.19% compared to 79.45% in January.
- WCCSS achieved 94.53% compared to 93.98% in January.

Benchmarking:

For February, the Trust ranked 101st out of 127 Acute Trusts nationally who submitted information and 11th out of 14 Trusts regionally. 80 Acute Trusts reported breaches of over 52 week waits in February.

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:

- 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 and there was an improved position for February.
- Robotic software in place and simple closure of access plans for follow up backlog pre 2017 is underway. Lettering process to begin April, with a view to complete by the end of quarter 1 (circa 8,000 letters) . Validators continue to work on duplicate and 'attended' status access plans. Numbers reduced to below 13,500 from the original circa 53,000.

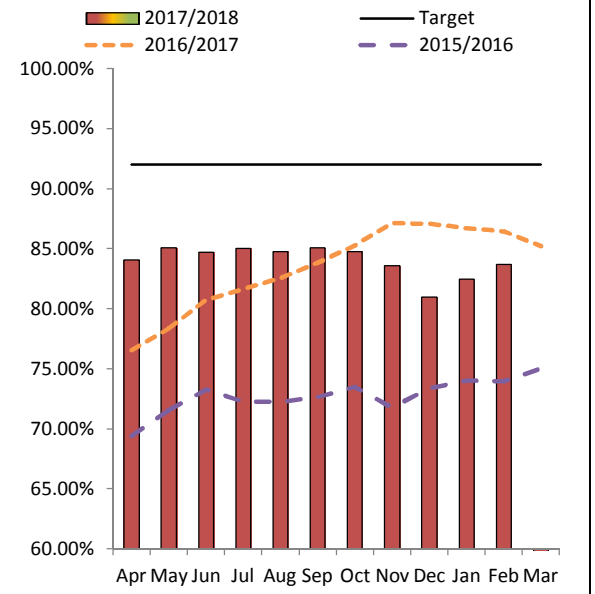
Capacity Improvements:

- WLI clinics in place to support cancer delivery and long waiters in RTT.
- Daily ops meetings continue to review bookings and replace cancellations for theatres and outpatients.
- Figures for outpatients has shown an increase in forward booking for service areas.
- Focus is to maximise booking opportunities and reduce DNA rates. Short notice patient cancellations remain between 3 to 5%.
- Voice reminder system has been switched on for patients with no mobile number. DNA rates have shown improvement during the month, with a trajectory being applied to Divisions from quarter 1.
- Partial booking for follow up patients to be rolled out starting in April, with a view to targetting specialities with high DNA rates in the first cohort.

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 £ £4,851,500



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	Achieve forecast (84.00% for March)
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Diagnostic Waits - % waiting under 6 weeks	Year Standard	Monthly Trajectory	Mar-18	YTD	Change on last month	Year End Forecast
Percentage of patients waiting for diagnostic tests.	99.00%		98.06%	99.06%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties (LCA)	YTD £

Performance results:

This indicator has not achieved against the 99% contractual target in March 2018 with performance of 98.06%, compared to 99.66% reported in February 2018. This is the first month that this measure has not achieved since September 2017.

At the end of March there were 101 breaches (tests with a wait in excess of 6 weeks) out of a total 5208 diagnostic tests yet to be performed.

These related to Non-Obstetric Ultrasound (65), Audiology Assessments (8), Flexi Sigmoidoscopy (7), Peripheral Neurophysiology (6), Gastroscopy (6), Computer Tomography (5), MRI (2) and Colonoscopy (2).

The majority of breaches were Non-Obstetric Ultrasound scans and these were incurred due to insufficient capacity to meet demand.

Divisional performance for March is as below:

Medicine and Long Term Conditions - 96.99%
Division of Surgery - 97.48%
Womens, Childrens and Clinical Support - 98.22%

***Benchmarking: to be updated by performance**

Latest benchmarking available (February 2018) ranks the Trust 37th out of 132 Acute Trusts who submitted information.
Regionally, the Trust ranked 7th out of 14 Trusts.

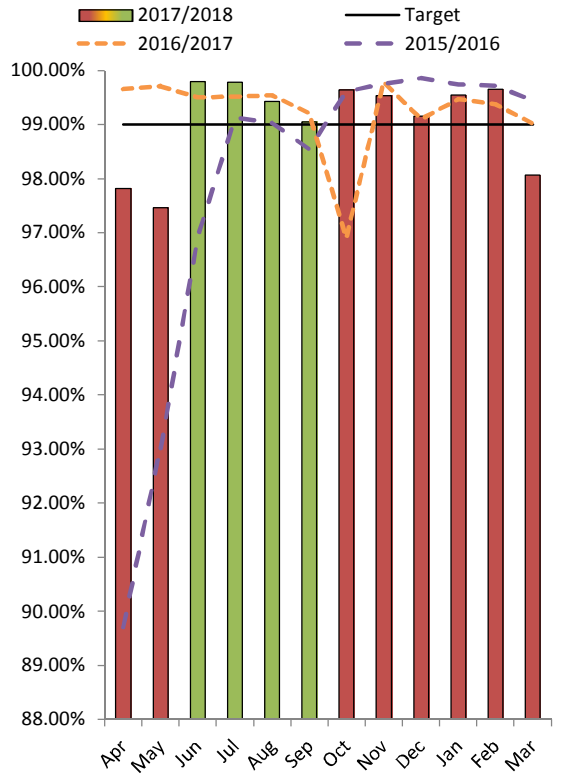
Contractual status:

No current contractual notices.

New Actions:

Actions being taken within Women's, Children's and Clinical Support Services include:-

- Robust process implemented for effective monitoring and timely escalation of breach risks for Imaging
- Reintroduction of WLIs to increase capacity
- Development of business case to address the shortfall in Radiology Staffing
- Attendance and weekly update at the Divisional PTL meeting



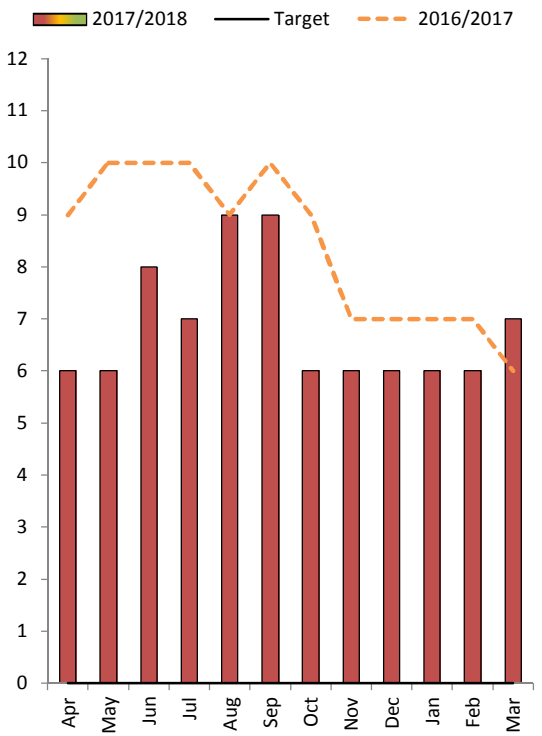
Expected date to meet standard	April 2018
Lead Director	Chief Operating Officer

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	Mar-18	YTD	Change on last month	Year End Forecast
Total number of Open Contract Performance Notices	0		7		▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties for numbers open - applied to individual performance areas.	YTD £
As at 31st March 2018, there are 7 formal contract notices outstanding. One notice was received in March for Safeguarding Training. The 7 notices which are 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) - Activity query notice - VTE initial assessment - Safeguarding Training	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	Mar-18	YTD	Change on last month	Year End Forecast
		9.00%	10.73%	12.16%	▲	

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 10.73% in March has improved by 0.54% compared to February (11.27%) but does not achieve the agreed monthly improvement trajectory of 9.00%.

Divisional Performance
- MLTC = 10.73% (compared to 11.44% in February)
- SURG = 9.83% (compared to 10.28% in February)
- WCCSS = 11.67% (compared to 12.23% in February)

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New Actions:-

- All centrally booked services to switch on voice reminder system (IVM) 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. Dermatology went live in early April, plans in place to introduce two more specialities during the month.

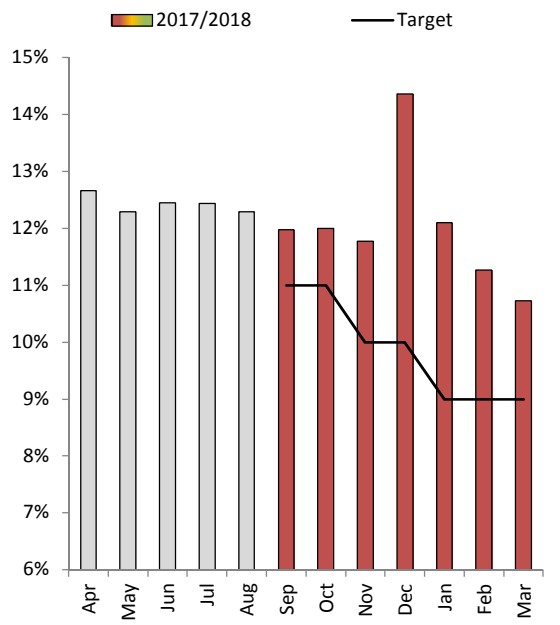
- A standard report in place to enable Care Groups to interrogate DNA rates, drilling down to booking methods and previous cancellations. DNA trajectory to be developed by Divisions to address specialities specific challenges for high DNA rates to suppoı generic strategies.

- Roll out plan for direct booking via ERS is in place for all new patients, in line with the National Paper Free Project. .

- Trust to receive electronic referrals for dental services, this will go live in April.

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.
- Care Groups continue to validate patients to reduce DNAs which also acts as a further caller reminder.



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	Awaiting divisional trajectories
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	Mar-18	YTD	Change on last month	Year End Forecast
	7.01		7.59	7.21	▼	

What is driving the reported underperformance?

Performance results:

Overall performance for LoS in March was 7.59 days. This is the same LoS as reported in February. 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 Feb	Ave LoS Mar	% LoS <72hr	% LoS of "0"
MLTC	9.34	9.03	53.82%	29.08%
SURG	5.29	6.25	62.26%	19.27%
WCCSS	2.80	3.31	92.46%	65.38%

The average LoS for Division of Surgery and Women's, Children's and Clinical Support Services declined during March compared to February however Medicine and Long Term Conditions saw an improvement.

The following specialties saw the highest increases in the month:

- Gastroenterology - 11.07 days in March compared to 7.78 days in February.
- Nephrology - 12.29 days in March compared to 9.88 days in February.

Benchmarking:

No formal national reports.

Contractual status:

No contractual requirements apply.

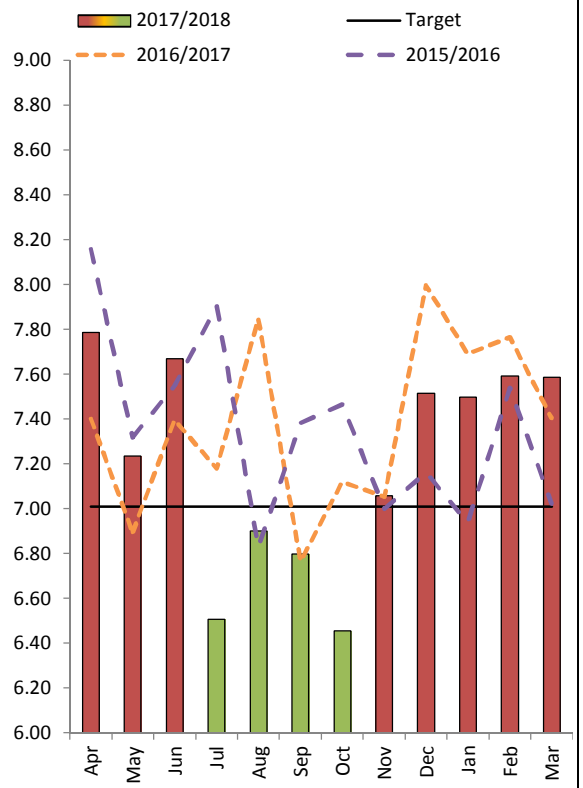
What actions have we taken to improve performance?

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	

Delayed Transfers of Care	Year Standard	Monthly Trajectory	Feb-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%		3.44%	2.45%	▼	

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 February with performance of 3.44%. This is a decline in performance compared to 3.11% reported in January.

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.

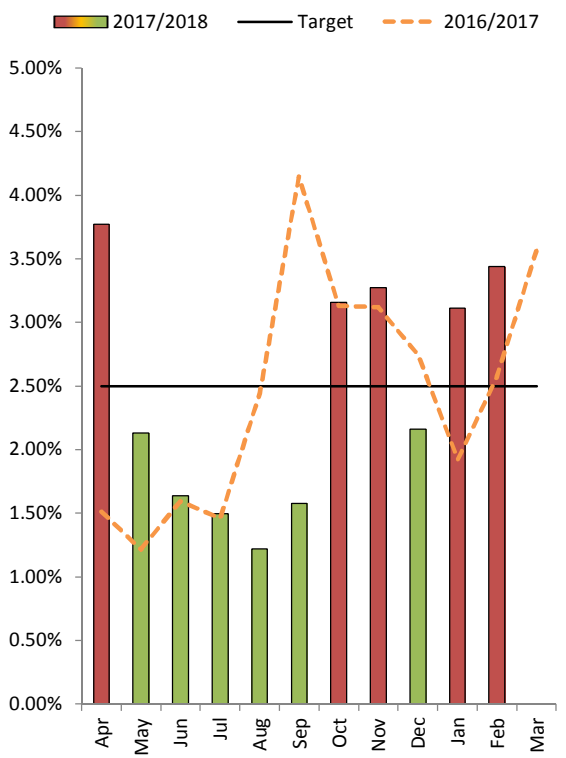
Benchmarking:
Benchmarking for this measure is based on the number of bed days impacted from delayed transfers every month.

Latest benchmarking shows, 447 bed days were impacted in February 2018 from delayed transfers taken at the snapshot position. This ranks the Trust 52nd 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.

New actions:
- The out of area South Staffs team have developed a system where care can be brokered and the full social assessment take place outside the hospital.
- The ICS team have developed a system of managing referrals via a Tier system.
- CCG will pay for spot beds for DST completion outside of hospital.
- Some of the ICS team are now based in the community to ensure that the pathways are cleared and capacity is there for patients to access from acute Trust

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 is now in place and commenced 26th February 2018
- ICS model is continuing to develop training and guidance for the acute wards on discharge planning.
- ECIP team are in the hospital to work with teams to improve Trust performance to support reduction of DTOC and improve patient flow.
- ICS model have developed patient information leaflets and posters. The choice policy is under review
- DTOC audit has been completed, awaiting recommendations and feedback.
- 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	Mar-18	YTD	Change on last month	Year End Forecast
	0	9	8	66	▼	

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 8 patient breaches reported within the Trust during March. This is a decine in performance compared to 2 reported in February however is within the monthly trajectory of 9. The year to date total of 66 was well below the agreed trajectory for the year and also below the previous year's total.

For the 8 patient breaches reported in March the length of breach incurred for each patient was one to two days. The patients breached on 2nd, 3rd, 18th, 19th, 20th, 21st and 22nd). There were were 7 patients from Walsall CCG and 1 patient from Warwickshire North 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 March shows that 47 out of 137 Acute Trusts reported sleeping accommodation breaches.

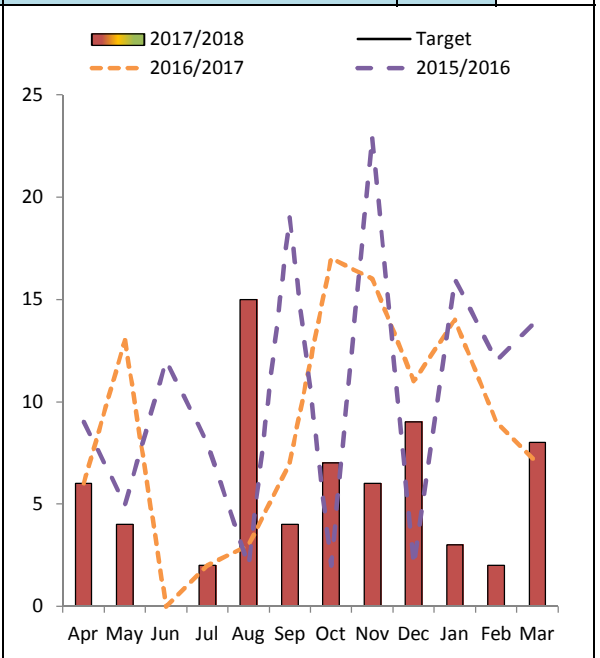
Contractual status:

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 agreed with WCCG and this was achieved.
- 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	

HSMR (HED) SHMI (HED)	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
	100		113.00	99.49	▲	
	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 113.00 for January 2018. 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 publish 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 4 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 December was 127.25.

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:

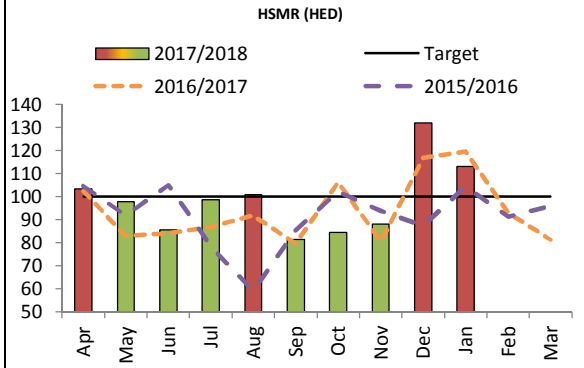
No contractual requirements apply.

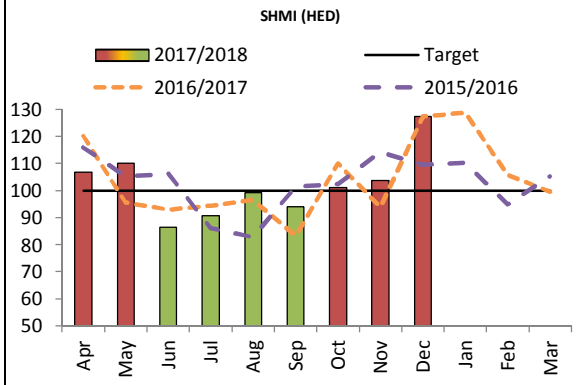
New actions:

- The review of deaths reported in December & January has been completed. The results are to be discussed with WCCG at Clinical Quality Review (CQR).
- Paediatrics continue to follow national protocols for reviewing paediatric & neonatal deaths and participating in regional & national forums and quality reviews. These will be shared monthly at the Mortality Surveillance Group
- The Trust will continue to develop and strengthen the bereavement services available for relatives & carers and implement the role of the Medical Examiner as per the Department of Health proposals to support in a wider system approach to learning from death and supporting bereaved relatives and carers.

Continuing actions:

- Escalate poor performance in reviewing deaths to DDs & CDs
- Align the actions to address poor documentation to the CQC PCIP work.
- 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.





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	Mar-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 March 2018. This brings the total number of cases within the year to 11 which is well within the trajectory of no more than 18 cases allocated to the Trust.

There were no cases of MRSA bacteraemia attributed to Walsall Healthcare NHS Trust during March 2018.

Benchmarking:
CDiff:
Data published one month in arrears by Health Protection England confirms that for February 2018, there were 0 cases of hospital attributable C.Difficile toxin at Walsall Healthcare. This compares to 0 cases at Dudley and 0 cases at Wolverhampton.

MRSA:
Data published one month in arrears shows there were 1 case of MRSA recorded regionally for February 2018.
- 1 case at Heart of England NHS Foundation Trust.

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?

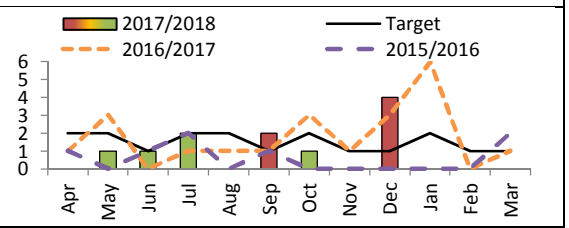
New actions:
CDiff: - As there were no C.Difficile cases reported in March 2018, there are no specific new actions currently being taken.

MRSA: - As there were no MRSA cases reported in March 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 £**

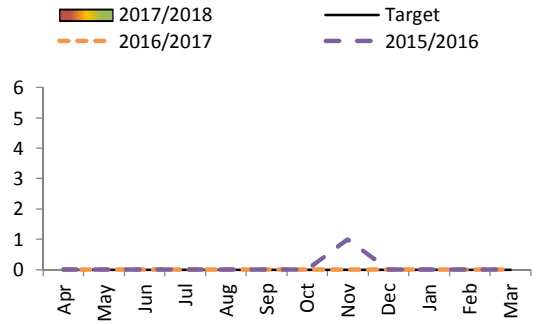
CDIFF



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	April 2018
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Pressure Ulcers - (category 2, 3 & 4's) - Avoidable per 1000 beddays	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
Figures based on all avoidable pressure ulcers acquired within the Trust			0.64		▼	

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)*
Jan-18	Cat 2	9 (3)	9 (0)
	Cat 3	1 (0)	1 (0)
	Cat 4	0 (0)	0 (0)
	Unstage	5 (5)	7 (3)
*Feb-18	Cat 2	12 (3)	10 (1)
	Cat 3	1 (0)	0 (0)
	Cat 4	0 (0)	0 (0)
	Unstage	6 (1)	4 (2)
*Mar-18	Cat 2	15 (3)	9 (0)
	Cat 3	0 (0)	0 (0)
	Cat 4	0 (0)	0 (0)
	Unstage	4 (0)	6 (0)

Rate per 1000 Beddays					
Jan-18	0.64	*Feb-18	0.43	*Mar-18	0.18

*Figures for these months are still being validated - please note there are 3 PU's for January still awaiting final validation but initial discussions have already taken place with the wards involved.
There were 32 PU related incidents reported in January.
The highest reported area of prevalence continues to be on patients heels. There have been 11 incidents confirmed as avoidable in January.

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?

Continuing actions: -

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.

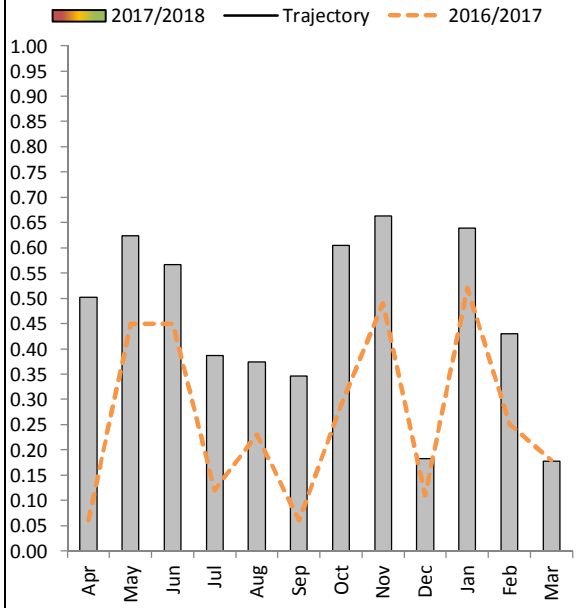
Documentation

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	Mar-18	YTD	Change on last month	Year End Forecast
			95	1026	▼	
	6.63		5.64		▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance results:

There were 95 falls reported during March 2018, equating to a rate of 5.64 falls per 1000 beddays for the month which is a decline compared to 5.10 in February but achieves the Trust target of 6.63.

Based on Calendar Month		Jan-18	Feb-18	Mar-18
Count of Falls	Total	88	83	95
	MLTC	64	66	80
	Surgery	23	16	14
	WCCSS	0	1	1
	Comm / Corporate	1	0	0
	Other	0	0	0
Rate per 1000 beddays - All Falls		5.11	5.10	5.64
Rate per 1000 beddays - Moderate & Severe Falls		0.12	0.06	0.00

There were 15 reported incidents of patients falling more than once in March which is more than in February (10). In total these patients had 34 falls. The highest no.of falls were reported on Acute Medical Unit (14 falls), Ward 29 (11 falls) and Ward 3 (9 falls).
There were no falls resulting in moderate or severe harm .
NHS Safety Thermometer results for March show performance of 0.22% 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.

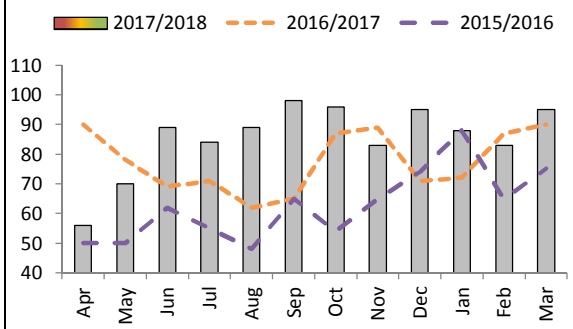
New actions:

- 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.

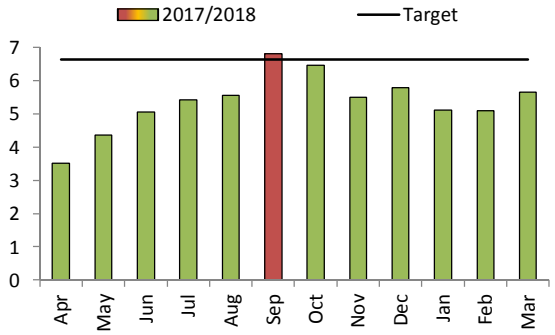
Continuing actions:

- 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.

Number of Falls reported



Rate per 1000 Bed Days



Expected date to meet standard	Achieved in March 2018
Lead Director	Director of Nursing

National Contract		Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Never Events	Year Standard	Monthly Trajectory	Mar-18	YTD	Change on last month	Year End Forecast
	0		1	3	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £	TBC

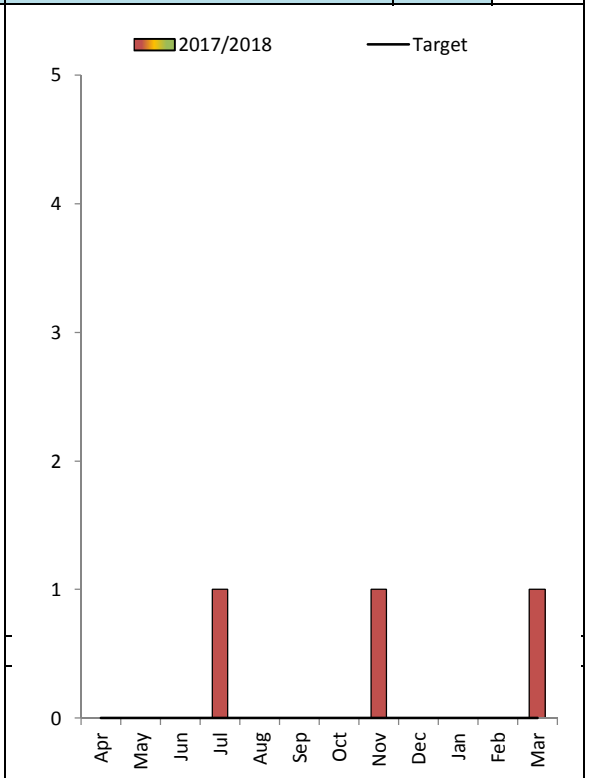
Performance results:
There was one Never Event reported during March 2018. This is the third event reported this financial year.

The Serious Incident related to a wrong site surgical procedure (gynaecological) which subsequently required re-admission for further surgical intervention.
The patient was discharged home after an uneventful recovery.

Contractual status:
If a Never Event occurs, the relevant Commissioner may deduct from payments due to the Provider, in accordance with Never Events Policy Framework, a sum equal to the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event. The March fine is to be confirmed via finance.

Please see monthly Serious Incident Report

- Initial verbal and written Duty of Candour has been completed
- Patient offered additional support and open access to return to Gynae/EPAU if any concerns and follow up appointment arranged
- A Root Cause Analysis has been scheduled to identify root causes and address learning.



Expected date to meet standard	April 2018
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Serious Incidents (inc cat 3&4 pressure ulcers, HCAI's & Falls)

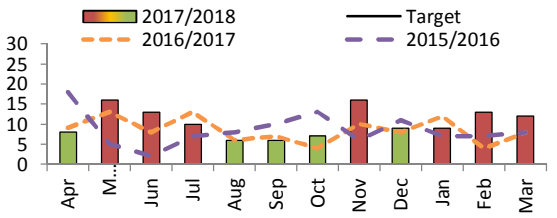
Walsall Healthcare NHS Trust

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	Mar-18	YTD	Change on last month	Year End Forecast
	102	8	12	125	▲	
	50	1	5	77	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?
There were 17 Serious Incidents reported to WCCG in March 2018, which is the same as February 2018. Breakdown of Serious Incidents:- • 6 x non-pressure ulcer related incidents • 5 x unstageable pressure ulcers – community acquired • 3 x unstageable pressure ulcers – hospital acquired • 3 x HCAI related incidents Non-pressure ulcer Serious Incidents include: • 2 x diagnostic issues • 2 x surgical invasive procedure (including 1 Never Event) • 1 x information governance issue • 1 x treatment delay	Please see monthly Serious Incident Report New trajectories will be considered for the year 2018/19.

Contractual Financial Penalties — **YTD £**

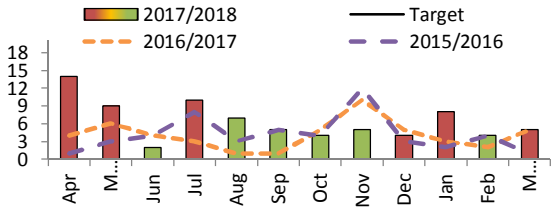
Serious Incidents - Hospital



Trajectory - Hospital

Apr	May	Jun	Jul	Aug	Sept
18	5	2	7	8	10
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
13	6	11	7	7	8

Serious Incidents - Community



Trajectory - Community

Apr	May	Jun	Jul	Aug	Sept
1	3	4	8	3	5
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
4	12	3	2	4	1

Expected date to meet standard	Targets currently based on last years activity.
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

% of Emergency Readmissions within 30 Days of a discharge from hospital	Year Standard	Monthly Trajectory	Feb-18	YTD	Change on last month	Year End Forecast
	10.00%		10.18%		▲	

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 February was 10.18% which is an improvement compared to 10.44% in January 2018 and narrowly misses the internal target of 10%.

There were 515 emergency readmissions in February, of which, 33 were related to GAU cohort.

Of the patients who were re-admitted in February:-
- Approximately 28% of the readmissions were aged under 30 (an increase compared to 27% in January).
- Approximately 28% of the readmissions were aged over 70 (a decrease compared to 31% in January).

The average number of days between the original admission and the re-admission is 9 the same as January.

For those patients discharged in the month who were an emergency readmission within 30 days, the average length of stay of the readmission was 3.9 which is an decrease compared to 4.4 in January.

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?

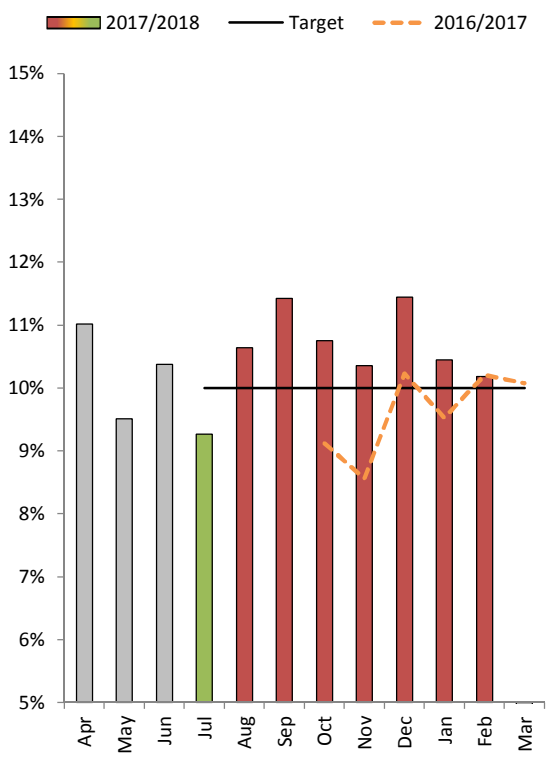
New Actions:

- In depth analysis is to be undertaken during the coming months to review emergency readmissions to establish trends and identify patients with high number of admissions.

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	Mar-18	YTD	Change on last month	Year End Forecast
Number of EDS completed within 48 hrs of the point of patient discharge	100.00%		89.51%	89.33%	▼	

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 declined in March to 89.51% compared to 91.84% in February, below the locally agreed target of 95%.

Divisional performance for March 2018 was as follows:-
- Surgery: 89.88% (91.87% in February)
- MLTC: 90.43% (93.11% in February)
- WCCSS: 88.03% (89.82% in February)

Benchmarking:

No national or regional benchmarking available for this measure.

Contractual status:

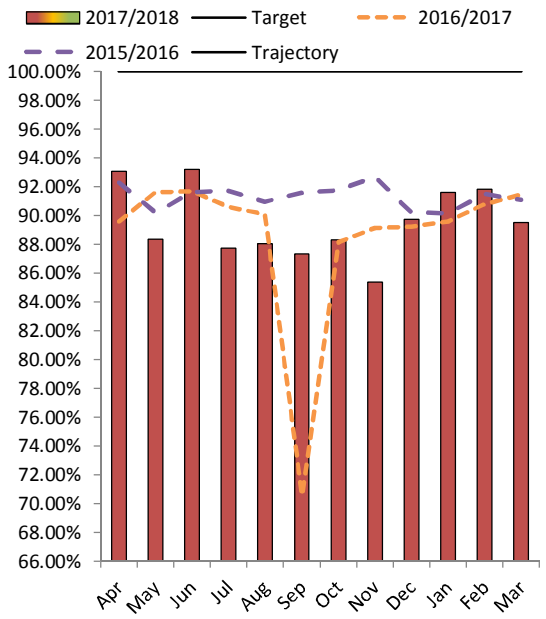
The NHS contract states when transferring or discharging a Service User from an inpatient or daycase or accident and emergency service, the Provider must within 24 hours following that transfer or discharge issue a Discharge Summary to the Service User's GP and/or Referrer and to any third party provider, 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:

- MDT review of documentation within patient records is due to take place which will include reviewing documentation around discharge summaries in line with the governance structure.

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	

Dementia Screening 75+ (Hospital)	Year Standard	Monthly Trajectory	Jan-18	YTD	Change on last month	Year End Forecast
	90.00%		79.55%	58.79%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties apply	YTD £

Performance results (based on peer monthly audit data):
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 services. The target for all 3 requirements (screen, assess and refer) remains at 90%.

During January 2018 the Trust failed to achieve the 90% screening target for patients aged 75 years and over with performance of 79.55%. This is a decline compared to the reported result in December 2017 (80.79%).

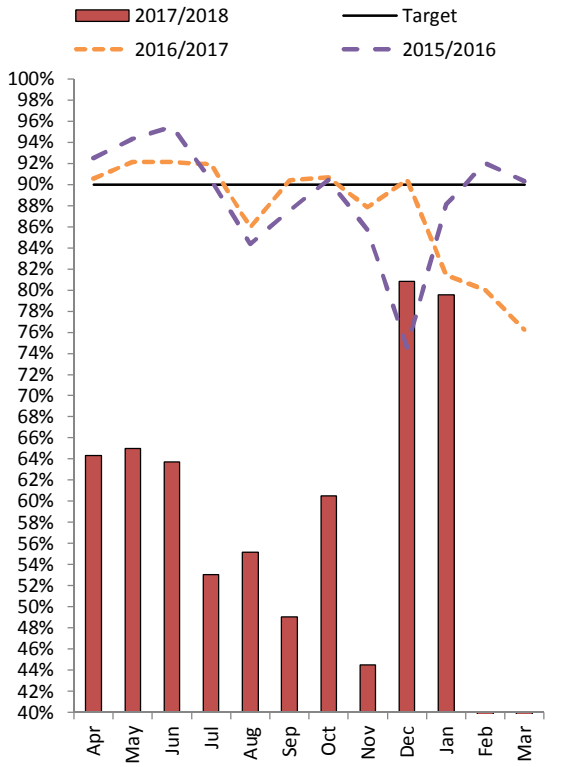
In agreement with WCCG and the Trusts executive lead, the reporting methodology has changed to utlising an audit approach rather than against the full cohort as it was not possible to capture the assessments for all applicable patients due to electronic system limitations.

Benchmarking:
As a national submission has not been made since November pending the discussions regarding methodology, no more recent benchmarking 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 presented by the Director of Nursing and discussed with fellow Execs. Following this a meeting was scheduled with Walsall CCG to discuss an approach. Unfortunately the meeting had to be postponed and is therefore being arranged to take place as soon as possible.

Continuing actions:
- 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	To be agreed
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	Mar-18	YTD	Change on last month	Year End Forecast
	85.00%		76.00%		▼	
	96.00%		94.00%		▼	

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	Feb	Mar
Inpatient	96%	97%	94%
Outpatient	96%	91%	92%
ED	85%	79%	76%
Community	97%	99%	97%
Maternity-Antenatal	95%	0%*	81%
Maternity-Birth	96%	100%	100%
Maternity-Postnatal Ward	92%	100%	96%
Maternity-Postnatal Community	97%	100%	98%

Posters have been displayed within areas informing patients about the process to provide feedback on their care. Patients have the option to opt out of the electronic method by either informing the staff within the area or responding to the text message issued which provides an opt out opportunity.

Benchmarking:

For ED, the latest benchmarking (February) ranks the Trust 119th out of 131.

For Inpatients, the latest benchmarking (February) ranks the Trust 62nd 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 and help improve response rates.
- The implementation of the 'Quiet Protocol' to promote rest and sleep for patients at night has been planned for May-Jun 2018. The protocol materials have been co-produced with Staff and Service Users.
- More service users are now using the national award-winning Walsall Healthcare Paediatric app when coming to the hospital.
- Work has begun on the rollout of the Always Event® programme with the AMU team . AMU will be the first pilot area for this programme.

ED:

- The Volunteer Service is actively promoting volunteering in ED which has boosted the number of ED volunteers to support improving patient's experience of this area.

Outpatients:

- Team leaders promoting FFT to patients and discussing results within their teams. Focus on improving the patient registration information quality.

Maternity:

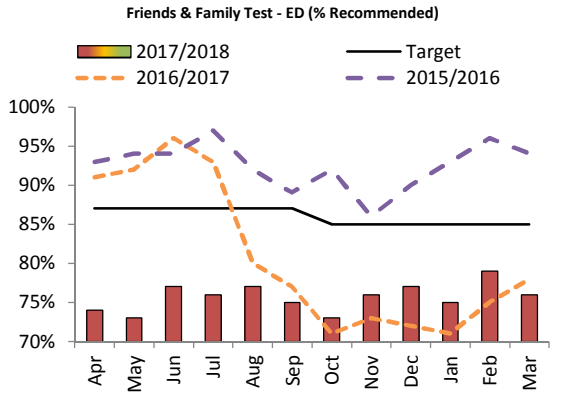
- Local ward teams have been encouraged to increase use of ipads for gaining feedback.

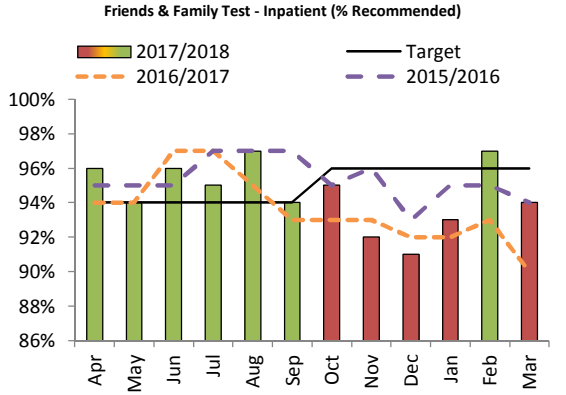
Community:

- 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.





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	Mar-18	YTD	Change on last month	Year End Forecast
	4.00%		5.65%	5.30%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £

Performance status:
Sickness levels declined in March with performance of 5.65% compared to 5.00% in February 2018 and did not achieve the target of 4.00%. This represents a rise of 1.25% compared to same period 2016/17.

Monthly short-term sickness during March 2018 totalled an estimated cost of £222k and long-term sickness totalled an estimated cost of £304k.

There were 166 long-term episodes of sickness during March 2018 and 13 LTS cases extend to 6 months or more.
The largest cause of absence during March 2018 was Anxiety/stress/depression/other psychiatric illnesses - 1536 FTE Days across 96 episode(s) including 54 long-term.
The second largest cause of short-term absence was Other musculoskeletal problems - 824 FTE Days across 55 episode(s) including 31 long-term.
The sickness absence during the past 12 months stands at 5.30%, 1.91% above the Trust target.

Benchmarking:
No national or regional benchmarking available for this measure.

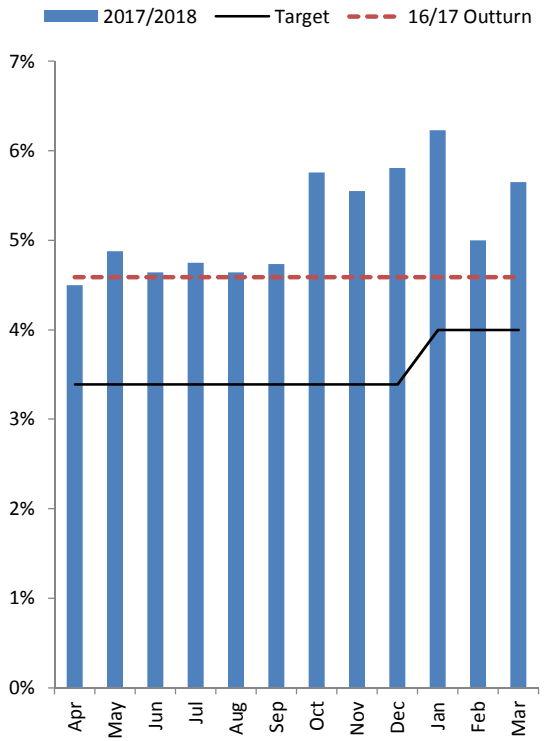
Contractual status:
No contractual requirements apply.

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 2019
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS
NHS Trust

PDR Compliance	Year Standard	Monthly Trajectory	Mar-18	YTD	Change on last month	Year End Forecast
	90.00%		78.17%	78.17%	▼	

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 March 2018 was 78.17%, a decrease on February's 79.47%. This represents a fall of 1.30% month on month.

115 Band 7 & above colleagues required an annual appraisal at the end of March 2018, resulting in a 80% compliance rate for this group.

The majority of divisions experienced a fall in compliance levels over the past month, of between 1% and 4%.

The Women's, Children's & Clinical Support Services division has the highest level of compliance at 87.31%.

Benchmarking:
No national or regional benchmarking available for this measure.

Contractual status:
No contractual requirements apply.

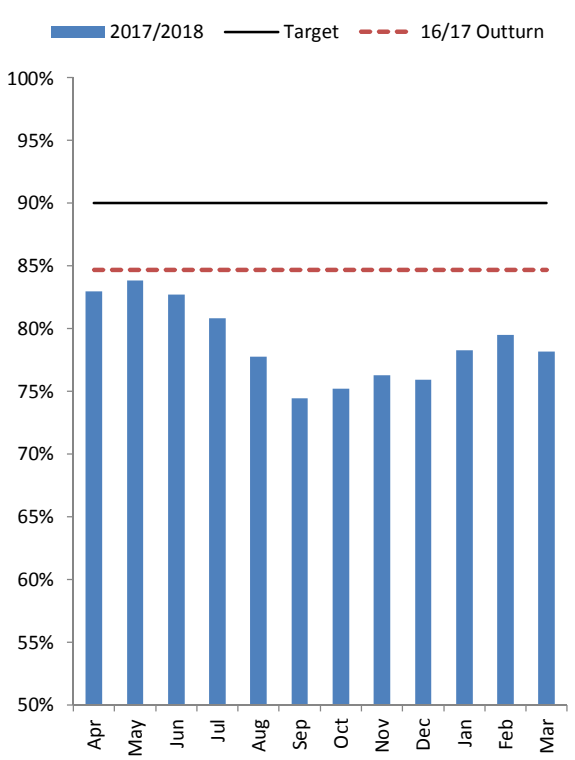
Continuing Actions:
- HR KPI reports have been developed based upon line management, rather than organisational, hierarchy lines.

- 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	TBC (pending review)
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS
NHS Trust

Mandatory Training Compliance	Year Standard	Monthly Trajectory	Mar-18	YTD	Change on last month	Year End Forecast
	90.00%		76.61%	76.61%	▼	

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 March have declined to 76.61% compared to 77.61% reported in February. A fall of 1.00% month on month. This represents a fall of 3.04% since the end of Q3 17/18 and a fall of 4.10% 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 Equality & diversity, whereby compliance rose by 1.19% month on month.
All divisions have experienced a fall in compliance levels over the past month, of between 3% and 12%.

Women's, Children's & Clinical Support Services holds the highest level of divisional compliance, at 85%; which is 5% below the Trust target for Mandatory Training compliance.
Medicine & Long-Term Conditions holds the lowest levels of compliance, at 68%; this is 22% below agreed target levels.

Benchmarking:
No national or regional benchmarking available for this measure.

Contractual status:
No contractual requirements apply.

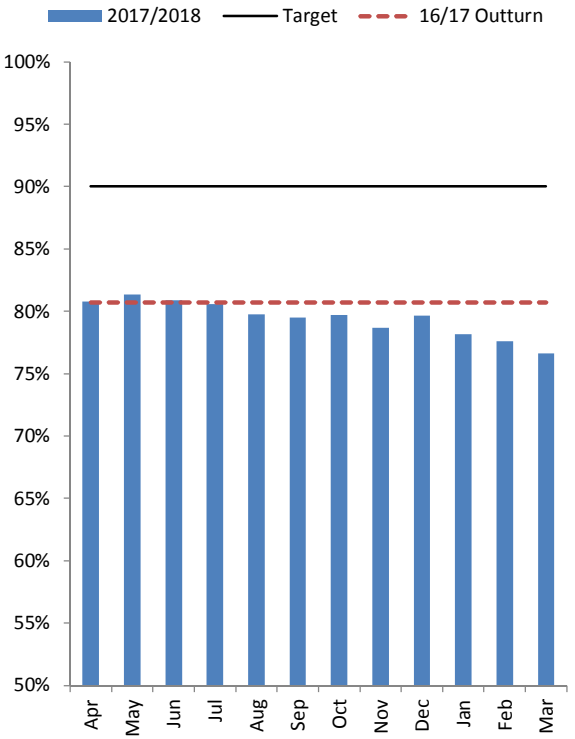
Continuing Actions:
- HR KPI reports have been developed based upon line management, rather than organisational, hierarchy lines.

- This will allow managers to focus on the performance of their individual teams, with easy to follow updates released on a weekly basis.

- It is hoped that this alternative approach to KPI reporting will promote a culture of ownership and competition.

- Allied to this will be the upcoming publication of HR KPI league tables, with the performance of services ranked in a meaningful and engaging way.

- This approach to performance management has been implemented within other local organisations successfully, with tangible improvements evidenced when both managers and service leads share not only performance levels openly but also best practice.



Expected date to meet standard	August 2018
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

CQUINs

2017/18 CQUIN SCHEMES - Status as at 31st March 2018 (values based on initial contract & are subject to change if the contract value changes.)

	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 3 from original cohort being discharged from the MH services). New baseline total attendances = 132.
					£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. **Status**: **Achieved 57.6% reduction.** (56 total attendances)
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. Status: **Achieved 79% compliance.**
						2018/19: year 2 : Q2 Achieve the nationally set target - 60%
						year 2 : Q4 Achieve the nationally set target - 80%
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. **Risk**: Confirmed by WCCG Achieved
			£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%) **Status: 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, a request was formally made to WCCG & NHS E to revise Q3 target to 0.5 and Q4 target to 0.2. WCCG rejected the proposal. The Trust therefore failed to achieve Q3.
					£64,421	**Q4**: Target 100% of Referrals to 1st O/P Services & achieve 0.04 or less ASI issues. **Status:** The Trust failed to publish all the services to the DOS. ASI rate to be confirmed (waiting for NHS Digital to publish) however it is unlikely that the target of 0.04 has been achieved based on the weekly reports.
Sub totals	£257,685	£64,421	£64,421	£64,421	£64,421	
Offering advice and guidance D of S&T	£257,685	£64,421				**Offering advice and guidance** The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative. **QTR 1: 30 July 2017:** Agree specialties with highest volume of GP referrals for A&G implementation. Agree trajectory for A&G services to cover a group of specialties responsible for at least 35% of GP referrals by Q4 2017/18. Agree timetable and implementation plan for introduction of A&G to these specialties during the remainder of 2017/18. Agree local quality standard for provision of A&G, including that 80% of asynchronous responses are provided within 2 working days **Risk:** Confirmed by WCCG Achieved.
			£64,421			**QTR 2: 31 October 2017:** A&G services mobilised for first agreed tranche of specialties in line with implementation plan and trajectory. Local quality standard for provision of A&G finalised and a Baseline data for main indicator provided **Status**: Project team established, fortnightly meetings scheduled. Consultant Connect currently provides 10.97% (Gen. surgery, gastro, urology, diabetics and endocrinology). plans to be agreed when WCCG decommission this service to transfer these services over to ERS. **Risk:** Q2 submitted Confirmed by WCCG Achieved.
				£64,421		**QTR 3: 31 January 2018:** A&G services operational for first agreed tranche of specialties, Quality standards for provision of A&G met, Data for main indicators provided and Timetable, implementation plan and trajectory agreed for rollout of A&G services to cover a group of specialties responsible for at least 75% of GP referrals by Q4 2018/19 **Status: Q3 submitted**. During Q3 activity was recorded using Consultant Connect providing evidence that A&G is operational, however achievement is pending WCCG decision.
					£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 **Status**: Q4 failed to achieve. Tariff for Advice & Guidance still to be agreed with WCCG.
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. There were 241 patients identified (100% of the community matrons caseload)
					£77,306	**QTR 4a:** To confirm what proportion of relevant staff have undertaken training in personalised care and support planning. **Status:** 87.5% of staff trained Achieved
					£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 **Status:** Achieved. There were 8 patients who
						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 Confirmed Achieved . **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: Achieved. **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 achieved. **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 achieved. **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 achieved. **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		£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	£3,221	£3,221	£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.
		£4,832	£4,832	£4,832		
		£3,221	£3,221	£3,221	£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.
		£4,832	£4,832	£4,832		
	£257,685	£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)			£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.**
	£460,151			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, 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 work continues to achieve a weekly flow.
					£4,602	Q4: 95% of patients have both a valid Chief Complaint . Chief complaint should be any value from the ECDS Chief Complaint code set (SNOMED CT). **Target:** Sliding scale for payment: <90% = zero, 90-95% = 50%, ≥95% = 100%. Q4: 86.91% failed to achieve.
					£4,602	Q4: 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). **Target:** Sliding scale for payment: <90% = zero, 90-95% = 50%, >95% = 100%. Q4: 56.07% failed to achieve.
					£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%. Due to the increased usage of "discharge to assess beds" it is unclear how to calculate the percentage. WCCG have been contacted to advise.
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: expected to achieve
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 & Q3 achieved. Q4 expected to achieve - 100% of new and existing patients switched to biosimilar or generic drugs.**
			£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 & Q3 achieved Q4 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** Q4 expected to achieve.
	£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 awaiting NHS E decision**
	£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 & Q3 achieved .** Q3 IVIG supplementary information received showing 100% - achieved. SACT potential risk.
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 Q4 expected to achieve.
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**			**Date: 3rd May 2018**
Report Title	Partnership Update			**Agenda Item: 17** **Enclosure No.: 14**
Lead Director to Present Report	**Daren Fradgley, Director of Strategy & Improvement**			
Report Author(s)	**Daren Fradgley, Director of Strategy & Improvement**			
Executive Summary	This report provides a update on National Event hosted by the Kings Fund that I attended last week on Integrated Care Systems, the new name for the formally known Accountable Care Systems. In the Trust case the Black Country STP. Progress this month on the Walsall Together Partnership with Place Based Teams and their deployment of Mobile Technology. In addition, I have provided a further update on the progress of the Case for Change and the work that is being undertaken to prepare the Trust for this and it's ambition to be the Host Provider An update is provided on the Trusts work with St Giles Hospice and some planned future engagement. Progress on developing the thinking for the Black Country STP and how the Trust can use the information from the Clinical Sustainability Reviews to understand what clinical partnerships are required next.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	The Board is asked to NOTE FOR INFORMATION the contents of the paper.			

<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 continual service improvement as the way we do things linked to our Improvement Plan</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 continual service improvement as the way we do things linked to our improvement plan</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Embed the quality, performance experience improvements that we have begun in 2016/17</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr>
<tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☒</td></tr>
<tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">12. That the overall strategy does not deliver required changes resulting in services that are not affordable to the Local Health Economy.
15. If the Trust does not agree a suitable alliance approach with Local Health Economy partners it will be unable to deliver a sustainable integrated care model.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2"></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">None</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2"></td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

Partnership Update

May 2018

During this month's report I will take the opportunity to report on a variety of items. The report will highlight both future planning with partners but also delivery of items that are currently in train. I will also provide a short brief on a Kings Fund workshop that I attended last week on Integrated Care Systems, the new name for the formally known Accountable Care Systems. In the Trust case the Black Country STP.

KINGS FUND

During the event, which was widely attended by all parts of the UK NHS, it was reinforced that future Health and Care provision is only sustainable if all in the system work together in unison with the commissioners. NHS England, who were part of one of the expert panels outlined their ambition to bring together commissioning and provision so that local systems could take control of the challenges and formulate a sustainable model in response to the populations health and care needs.

It was clear from the event, which presented perspectives from fore running pilot sites, that demand management needs to be realised from place-based level care. In the Trusts case this is our Walsall Together Partnership and most recently the case for change. The Kings Fund in particular, outlined that most of the provider sectors operation (up to 80%) should be influenced and focussed in developing these partnerships as a way of maturing the level of place-based care and directly improving the populations health.

Whilst the wider clinical sustainability piece is equally as important as place-based care, the direct demand management of these services are influenced by the activity that comes from the population. Again, in the case of the Trust, this work should be routed in the needs of the local population through Walsall Together.

Speakers at the event outlined how wider clinical sustainability was being established and challenged by working in networks with other providers to establish bigger workforce footprints and reducing variations in provision and outcomes. The areas that are making the most progress, Northumberland and Frimley for example, are establishing change through clinical pathway groups rather than looking at organisational context. The work that is being undertaken with the Black Country Provider Partnership through the STP will be the Trusts response to this. The road map for this work will be through the developing Clinical Sustainability programme that is being undertaken by the Trust. However, for this to be successful, mirror roadmaps will need to be developed by other providers across the Black Country and work is underway to establish this thinking more widely.

I heard a GP from Frimley Heath talking about a patient referral, electronically sent into the local placed based system that outlined the patients needs rather than the services that were required. In response the integrated place-based teams coordinated the care of the patient at home rather than waiting for multiple visits or deterioration into other acute based services. It was reported that for the first time in this area, Acute PBR had fallen and more funds were being diverted into place-based services. As a result, the GP reported that his life as a Healthcare professional had dramatically changed for the better.

WALSALL TOGETHER

Following my update last month on the progress of the integrated place-based teams, I am happy to report a successful team leaders workshop where plans where established to deliver a single referral process similar to the description outlined by the GP from Frimley.

In Walsall, this will start with an electronic referral form from EMIS, the GP's system, into the teams through one of our hosts systems. This process is currently being explored by IT to establish how long this will take to achieve.

In tandem with this work, the team leaders are looking at how the teams are matching and responding to the most complex needs of our patients and citizens through coordinated case management and response. I will bring further updates to the Board as this thinking matures.

Mobile Technology is now fully deployed in the Adult Community Locality Teams and is delivering some promising results. During the first few months of operation we have already seen up to 1000 visits per day being managed on the system, one area being the West teams become almost paper free, and resources becoming closer matched to the demand that is being presented. At a recent visit to the West teams, staff reported the ability to add additional patients to their lists each day due to the flexibility of knowing staff's location minute by minute. The next phase of the project is to complete the full interface with the GP systems so that free messages can be passed both ways.

CASE FOR CHANGE UPDATE

Work continues to prepare the Trust and partners for the plan outlined in the Case for Change. The document has now been through all the planned governance and is moving to the next stage of delivery. A formal update paper went to the Partnership Board last week outlining the next steps which include the formation of a leadership team and the writing of a full business case. The Trust is in discussions with NHSI about the required approvals as we go through this process as are the commissioners with NHSE. Work also continues to establish a process of selection for a Host Provider with the Trust registering its formal intent to be considered.

Advanced thinking is also in train to understand what leadership and governance is required for our teams and how they will integrate with partners on an operational level with a single structure. This work is likely to run in advance of the full business case given the maturity of the place-based teams and Boards Members will be kept fully briefed on progress.

A provider board is planned to outline the next steps this coming week but is not included in this report at the time of writing.

ST GILES

During the last year, members of the Trusts Palliative Care Team have been working with St Giles Hospice to establish a Hospice at Home function. This is now in place and is delivering additional wrap around care for patients at the end of their lives whilst in their own homes. Clearly, this is a key piece of work for the Trust given the nature of the population we serve and the needs of this patient group during this part of their lives. In support of this work and some wider thinking, I have been asked to talk to St Giles Board about the Walsall Together Programme and how they can support these patient groups in the future.

BLACK COUNTRY PARTNERSHIPS - STP

In the first part of my report, I touched on the importance of a wider clinical sustainability review that the Trust is undertaking over the next few months. To support this work, conversations are continuing with neighboring Trusts through a variety of routes to establish how we can all support each other in the future. Some of this work will be through the Black Country Provider Partnership but in some cases may be broader. Route maps for all organisations are required as a matter of urgency to establish a series of next steps. Further work on this will be reported in future months.

In support of this work, the Trust with other partners in the STP are participating in a development programme sponsored by NHSE. I attended this first workshop this week where agreement was reached to have clear programme plans for the following items within the next 12 weeks

- A vision and strategy for the Black Country STP sponsored by all organisations
- A transparent business plan which will include a full set of accounts through the Director of Finance Group
- A clear approach to governance across the STP
- A stakeholder and partnership management plan.

The progress of this work together with how this relates to the Trusts Clinical Sustainability reviews will be frequently shared with board members.

Daren Fradgley
27th April 2018

BOARD REPORT

Meeting	**Trust Board**	**Date: 3rd May 2018**
Report Title	Annual Plan 2018/2019	**Agenda Item: 18** **Enclosure No.: 15**
Lead Director to Present Report	Daren Fradgley Director of Strategy & Improvement Russell Caldicott – Director of Finance & Performance	
Report Author(s)	*Malcolm Roper-Moore; Roseanne Crossey; Barbara Beal; Kara Blackwell; Joanne Adams: Chris Rawlings; Sebastian Smith-Cox; Marsha Belle; Daren Fradgley; Paul Steventon; Dylan Morris; Tony Kettle; et al.*	
Executive Summary	*The Trust is required to provide an update to its 2017/19 two year operational plan by 30 April 2018. As is good practice, the organisation has updated the whole plan to set the road map for the year ahead and beyond.* *The plan is in seven sections covering:* *1: Overview of the Plan* *2: Activity* *3: Quality* *4: Workforce* *5: Finance* *6: Partnerships* *7:Risk and Mitigation* *The plan is designed to provide confidence to regulators that the organisation is sustainable and in control of its operation. Each section provides an update on progress, and our approach to continued improvements and monitoring in 2018/19. The new high level objectives are included, together with quarterly trajectories of progress.* *Our activity plans have been revised in light clarity on some of the assumptions previously made, including work in our elective and ED models, and the anticipated patient flow from the Midland Metropolitan Hospital, which has been delayed.* *The implementation of the Quality Commitment is on-going and centered around the production of an Integrated Improvement Plan.* *The workforce plan is based on staff in post rather than establishment numbers. The plan outlines an approach to introduce new roles to support sustainability and to improve patient care, as well as an update on addressing some of the cultural issues within the organisation, with a drive to improve engagement, and to meet national standards for, e.g. mandatory training.* *The finance plan includes a CIP of £14m (including £1m contingency) and a planned deficit of £18.6m* *The plan clearly signals our intentions to move the organisation from an overall CQC rating of "Requires Improvement" to at least one of "Good". It also signals our determination to be the host provider for the Walsall Together Partnership this year. It also outlines the work with other partners to deliver a clinically led sustainability review of all our services to facilitate a future health and social care system that delivers best care, and best value for the public purse.*	

<table>
<tr><td><u>Purpose</u></td><td>Approval
☒</td><td>Decision
☐</td><td>Discussion
☐</td><td>Note for Information
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<tr><td><u>Recommendation</u></td><td colspan="4">The Board is asked to APPROVE the plan.</td></tr>
<tr><td><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, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td></td><td colspan="2">Care for Patients at Home Whenever we can</td><td colspan="2">With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td></td><td colspan="2">Work Closely with Partners in Walsall and Surrounding Areas</td><td colspan="2">Deliver a sustainability review of all our services to set plans for next 5 years</td></tr>
<tr><td></td><td colspan="2">Value our Colleagues so they recommend us as a place to work</td><td colspan="2">Embed an engaged, empowered and clinically led organisational culture</td></tr>
<tr><td></td><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">As outlined in the plan</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="4">The plan is a requirement of NHSI.</td></tr>
<tr><td><u>Report History</u></td><td colspan="4">Versions of the plan have been seen at Quality and Safety committee and PFIC, with a final review and approval at an Extraordinary Meeting of the Trust Board – 30th April 2018</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="4">Each area of the plan is signed to an executive director for implementation. The plan will be monitored and assured through the Trust's governance structure.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="4">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
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Walsall Healthcare NHS Trust
Operational Plan 2018 – 2019
April 2018

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1. Overview

Over the last year Walsall Healthcare NHS Trust has made significant progress on its improvement journey. This was recognised `by the Care Quality Commission who inspected the Trust in June 2017, saying it was "a very different organisation" to the one it had inspected previously; and going on to describe our staff as "kind, caring and compassionate". Some 70% of our service ratings are now **Good** or **Outstanding** – an improvement on 44% at the previous inspection.

Our community end of life care services and our community services have continued to improve, and we are especially pleased that this has been recognised with an **"Outstanding"** rating by the CQC, making us one of a very few Trusts in the country to receive this rating for community services.

The improvement work undertaken by the team in our Emergency Department has resulted in an overall rating of **"Requires Improvement"** with a **"Good"** rating for its **Caring** and **Well Led** domains.

We recognise that the inspection is not the end of our improvement plans and that we still have much work to do, especially in maternity services, patient, safety, culture and quality improvement. Nevertheless, the Trust remains focused and committed to improving its rating and coming out of special measures in 2018.

We committed ourselves to a five-year journey to deliver our vision of **becoming your partners for first class, integrated care**. This vision, supported by five strategic objectives, form the basis for our two-year operational plans for 2017/18 – 2018/19– years two and three of our five year plan. By 2021 we will be an organisation that is community focussed, with a workforce that is engaged and empowered, and working with partners to ensure financial and clinical sustainability. Embedding service improvement tools and methodologies will be an integral part of our approach to ensure that the organisation builds and maintains a culture of continuous improvement and efficiency.

Specifically, in 2018/19 we will deliver the organisational change agreed through the Walsall Together Partnership (section 6). This includes in year implementation of place-based care (see below), which is critical to this programme, and ensuring we are in a position to meet our aspiration of becoming the host provider.

In the borough of Walsall we have agreed to a programme of work to transform the way we deliver placed based care as an integrated system.

At its simplest we will embed the improvements in quality and safety, and culture and performance that we began this year while also tackling our significant financial challenge to ensure we are sustainable. Our strategic objectives direct us to deliver:

- **Safe, High Quality Care** – by continuing to improve the quality of the care we provide; delivering a renewed focus on patient experience and continuing to reduce long waits for care
- **Care at Home** – with our partners in Walsall's health and social care economy, progressing the delivery of the Walsall integrated model for health and social care. This will be through integrated locality teams and an integrated intermediate care with a discharge to assess service. We have agreed to work with Walsall CCG to seek to keep hospital activity at 2016/7 forecast outturn levels during the period of this plan

- **Work with Partners** – continuing to grow the Walsall Together and Black Country Providers' Partnership as well as developing stronger relationships with our local GP Federations;
- **Value our Colleagues** – embed *Listening into Action* as "the way we do things", along with a clinically-led model for our services and a longer-term workforce plan, which develops new roles and reduces reliance on agency staff;
- **Use Resources Well** – take definitive steps to tackle our financial challenges by delivering deficits of no more than £20.5m in 2017/18 and £18.6m in 2018/19, delivering respectively an £11m and £13m savings programme. This includes a capital programme of £52m to complete our redevelopment plans for ITU, maternity and neonatal, and ED and our acute assessment unit, plus MRI and gamma camera diagnostic capacity. We will achieve this by developing an integrated improvement programme that directly triangulates and monitors the Trust's delivery of, safety, effectiveness, patient experience and efficient use of our resources.

Our commitment to wider partnership work continues as we collaborate with organisations across the Black Country STP on plans for pathology and maternity services; as well as centralising acute stroke services at Royal Wolverhampton NHS Trust.

The financial challenge we face is significant and is shared by Walsall CCG as our main commissioner. After a number of years of increasing deficits, we are seeking to halt this trend and begin to reduce the deficit over the life of this plan.

We have established a robust and collaborative clinical sustainability review that will drive us to resolve sustainability issues with our services and will underpin our financial improvement plan. This programme of work will be done collaboratively with other partners in the Black Country and the wider STP.

1.1 Trust Objectives 2018/19

Through the planning process the annual objectives have been reviewed with our clinical leadership teams and have been revised as shown below. As part of our commitment to embedding clinical leadership, the descriptions of our objectives are at a higher level than previously, so that each of our management teams can devolve more operationally focused objectives to their teams.

Image 1: Trust Objectives 2018/19

The Trust's vision, strategic objectives and annual objectives have been brought together into a single "plan on a page" that accompanies this document, (Appendix 1). In addition, a set of progress measures against each objective are in Appendix 2.

2. Approach to Activity

2.1 Demand and Capacity

The Trust has been working through demand and capacity plans that will support the on-going planning process at both a Trust and a strategic level. These will drive strategic level plans that will inform both commissioners and our partners for STP planning.

The Trust has modelled the 2018/19 predicted demand based on the 2017/18 forecast outturn, plus growth. This has been tested and agreed with each of the clinical divisions and sub-specialities.

Capacity plans for 2018/19 have also been set using the 2017/18 forecast outturn plus any additional capacity already modelled based on achievements in theatres and outpatients.

Going forward the Trust will continue its deployment of the IMAS IST tools for demand and capacity planning; these are currently being built for each of our care groups. The demand and capacity manager is working through the initial models with a view to installing a Trust based structure during Q1 2018/19. Initially, this will be viewed internally with the Trust and then the commissioners. Demand and capacity plans will be periodically reviewed with a view to them being used for operational management and business cases. There is a process of updating the plans on a quarterly basis through 2018/19 as the capability is developed.

The Trust is also participating in the NHSI Demand and Capacity Train the Trainer programme. Subsequently all of our care group managers will be trained in demand and capacity planning, with regular skills workshops to continue to embed the process into operational decision making.

A fundamental principle of our programme management office is to achieve increases in productivity and reductions in patient waiting times through the delivery of efficiencies in our clinics and theatres this year. This will be supported through demand and capacity planning.

2.2 Agreeing Activity levels with the CCG

The Trust has agreed a contractual position with the CCG and this is highlighted in the table below.

Activity Line (POD)	Trust 16/17 Outturn	Forecast outturn 17/18	18/19 Plan
Total Referrals (GP and Other)	98,396	96,898	99,048
Consultant led Total 1st Outpatient attendances	65,936	63,028	67,046
Consultant led Follow up outpatient attendances	176,729	168,911	175,836
Total Elective admissions (spells)	27,840	27,966	29,004
Total Non-elective admissions (spells)	30,887	32,379	33,420
Total A&E attendances (Type 1)	73,823	76,259	77,100
Community Activity (Contracted)	360,919	361,940	370,265

Table 1: Agreed activity levels by POD

Through our demand and capacity work it is proposed to link with other providers within the STP and where appropriate, develop a route map for strategic partnership opportunities. While this doesn't affect the period covered by this plan, the Trust will continue to monitor and liaise with SWBH and Sandwell CCG to understand the impact potential for the opening of the Birmingham Metropolitan Hospital.

2.3 Constitutional Standards and Trajectories

Standard %	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
18 Weeks Referral to Treatment (Standard)	**92.0**	**92.0**	**92.0**	**92.0**	**92.0**	**92.0**	**92.0**	**92.0**	**92.0**	**92.0**	**92.0**	**92.0**
18 Weeks Referral to Treatment (Trajectory)	**84.2**	**84.8**	**85.5**	**86.3**	**85.5**	**85.9**	**87.2**	**88.1**	**87.2**	**87.2**	**88.1**	**89.3**
Cancer 62 day (urgent GP referral to treatment) wait for 1st treatment * (Standard)	**85.0**	**85.0**	**85.0**	**85.0**	**85.0**	**85.0**	**85.0**	**85.0**	**85.0**	**85.0**	**85.0**	**85.0**
Cancer 62 day (urgent GP referral to treatment) wait for 1st treatment (Trajectory)	**85.2**	**85.7**	**85.0**	**85.1**	**85.7**	**85.1**	**85.7**	**85.0**	**85.7**	**86.0**	**85.7**	**85.7**
ED 4 hour (Standard)	**95.0**	**95.0**	**95.0**	**95.0**	**95.0**	**95.0**	**95.0**	**95.0**	**95.0**	**95.0**	**95.0**	**95.0**
ED 4 hour (Trajectory)	**83.0**	**85.0**	**86.0**	**87.0**	**88.0**	**90.0**	**90.0**	**90.0**	**87.0**	**85.0**	**89.0**	**95.0**

Table 2: Constitutional standards and trajectories 2018/19

These trajectories are included in the plan as specific mention of them has been requested by NHS Improvement. The Trust is aware that there will be a new standard applicable to cancer services from April 2018 (details are still outstanding), and that the ED trajectory is to be confirmed with the Commissioners.

2.3.1 Elective Care

The year 2018/19 will require a focus upon sustainable acute services and their linkages to community teams and our other partners. National guidance has hindered the ability to fully support elective care through January following the DoH decision to suspend non-urgent elective procedures. The Trust will develop a recovery plan to redress the position.

2.3.2 Emergency Care

The Trust has asked the Emergency Care Improvement Programme (ECIP) for support to improve patient flow along emergency pathways based on the principles outlined in the Good Practice Guide. The aim is to improve and maintain ED performance to above 90% in 2018/19.

The priority areas for the programme are:

1. Establish an improvement approach to support the UEC improvement programme
2. Test and implement effective emergency department and acute pathway improvements
3. Test and implement improved ward processes including; the SAFER patient flow bundle and Red2Green days approach and a robust model for escalation, response and constraint resolution
4. Co-design, test and implement new ways of working to improve the management of frail older adults across Walsall

5. Improve admission, transfer and discharge processes including; discharge to assess, home first and trusted assessment.

The programme structure and governance is shown below:

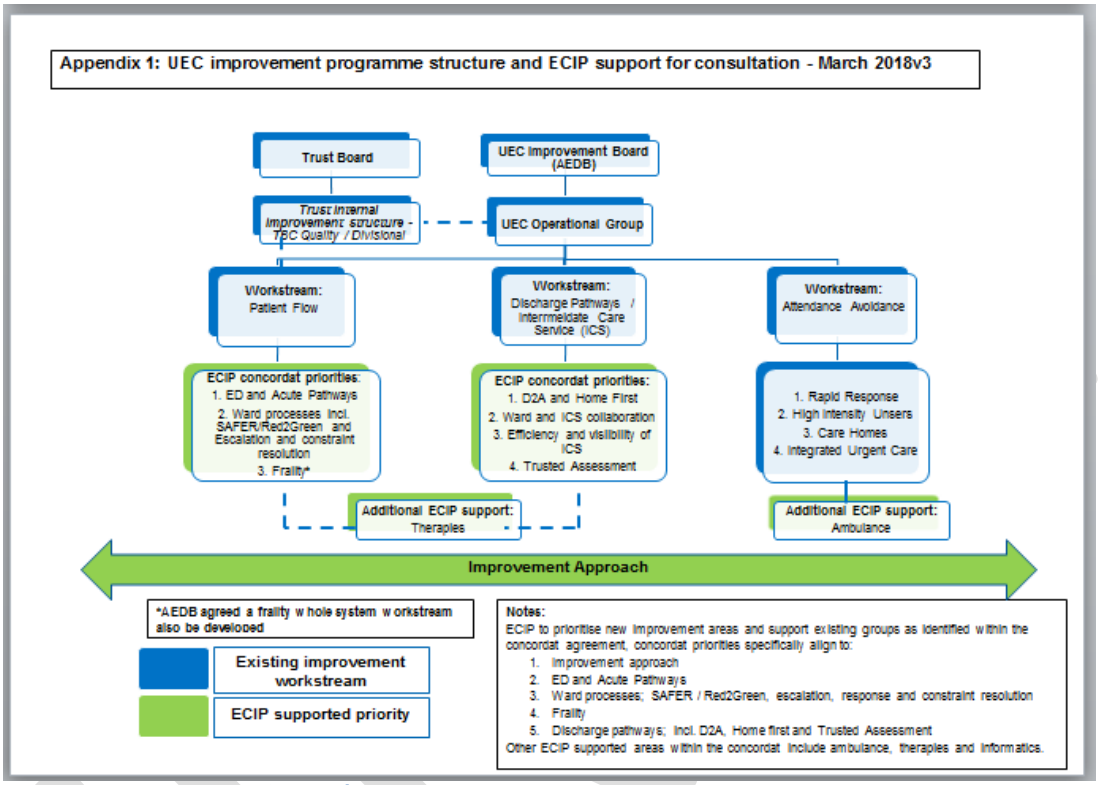


Image 2: Improvement programme structure and governance

Pathways between ED, community and rapid response services have been redesigned, achieving positive outcomes in terms of reducing pressures on the front door. The Trust has moved forwards with partnerships within intermediate care and is now midway through implementing an integrated service with the Local Authority that includes a shared management team.

3. Approach to Quality Planning

3.1 Approach to Quality Improvement

The Board is committed to ensuring patients receive the highest level of safe, high quality, compassionate care through a shift to a culture of continuous quality improvement based upon the sustainable implementation of a Trust-wide Integrated Improvement Programme. It's the Trust's ambition to continue our improvement journey from a CQC rating of Requires Improvement to Good.

A Service Improvement Strategy was developed in 2017 outlining the approach in improvements to clinical services and how they would be developed to be sustainable in the future. This is now underpinned by the recent establishment of a quality improvement academy.

Executive leadership, accountability and responsibility for quality governance is held by the Director of Nursing and the Medical Director. Improved quality governance oversight and integration with corporate governance will be overseen by the Trust's new Director of Governance.

The Trust's Quality Strategy, our ''Quality Commitment'' has been approved at Trust Board. This framework sets out what our strategic commitment to safe, high quality care means in practice. It incorporates national and local drivers, commissioning priorities and is consistent with STP quality priorities. It is based on the three pillars of quality:

- Provide effective care – Improve Patient Outcomes
- Improve safety – Reduce Harm
- Care and compassion – Improve Patient Experience

The most recent CQC inspection report demonstrated improvement in the Trust's quality performance. The Trust is now rated as 'Requires Improvement', with community services rated as 'Outstanding' and this is an important step in our ambition for all our services to achieve a rating of at least 'Good'.

The Integrated Improvement Programme (IIP) is being developed to incorporate ongoing "must do" actions following the CQC inspection report and will include prospective quality and safety ambitions driven by our Quality Commitment, together with Urgent and Emergency Care service improvement depicted in action 2.3.2. The development of the IIP will lead to a natural revision of the improvement aims set out in the Quality Commitment.

A new Quality Improvement Academy led by the Director of Strategy and Improvement, has strong clinical leadership. The Academy is established and encompasses the existing Listening into Action Programme, the quality service improvement methodology from NHSI and the Service Improvement Team. The first phase of its work has been focusing on human factors in Maternity and Gynaecology with additional areas being considered.

The current governance and assurance structure is aligned with the clinically led management model in the Divisions, providing ward to board reporting and assurance. Plans to consolidate resources are also being considered; this will provide an improved level of skill, resource and expertise to deliver sustainable quality improvement, patient safety and governance aligned to financial and workforce trajectories and plans.

Onward reporting from operational and performance assurance groups and is to the Chief Executive who chairs Trust Quality Executive (TQE). This in turn reports to the Quality and Safety sub-Committee (QSC) of the Trust Board, chaired by a non-executive director, and provides leadership and assurance of the effectiveness of the Trust's arrangements for quality governance. All of these will be reviewed to provide enhanced assurance, accountability and responsibility at every level.

3.2 Summary of the Quality Improvement Plan

The table below summarises our quality improvement plan:

Provide Effective Care	Improve Safety	Care and Compassion
Review and improve pathways of care: - Improve pathway from ED to AMU - At end of life - acute and community - Paediatric pathways especially from ED -> Wards - Step down critical care beds - Normal Birth – reduce C-section/intervention rates - Fractured Neck of Femur Pathway	Implement best practice standards around timely identification of patients with sepsis and utilisation of the sepsis bundle. *	Deliver patient experience work plan including key thematic work streams:
	- Including assessments of clinical antibiotic review between 24 – 72 hrs of patients with sepsis who are still inpatients at 72 hrs.	- Response to inpatient survey – communication
	Implement best practice standards around acting on deterioration of patients – late observations, escalation & clinical review *	- Improve customer care at front desks.
	Improve antibiotic stewardship and deliver planned reduction in antibiotic use.	- Reduce internal transfers
	Improve medicines safety standards	Improve FFT response rates to understand from patient / Women's views - Inpatients - Maternity - Emergency Department
	Reduction of avoidable harm events - specifically:	
	- Hospital / community acquired pressure ulcers	
- Improve response times/delays – C-section and induction	- Hospital / community acquired falls	
Implement actions to meet the National	- Hospital / community acquired infection	Embed interpreter service and improve access

Provide Effective Care	Improve Safety	Care and Compassion
7 day service clinical standard		to services
Embed monitoring and learning from: - Mortality reviews and mortality alerts - Clinical incidents	- Hospital / community acquired VTE	Ensure safeguarding vulnerable people's standards met
	Embed compliance with DNACPR standards	Ensure Duty of Candour standards are met
	Ensure safe staffing levels measured using recognised acuity tools, capacity / demand modelling and national guidance.	Use equality impact assessment to ensure fairness of services
Improve process for responding to NICE technology appraisals and CAS alerts	Conduct a bi-annual safety culture survey via MAPSAF	Embed public / patient engagement approaches
Introduce SAFER bundle	Ensure 'no harm' to patient waiting times in excess of accepted standards.	Improve information for patients and relatives on admission and at discharge.
Improve our elective care pathway: - 18 weeks - Cancer - OPD / Follow Up Back Log	Ensure staff are trained and have the right equipment to do their job.	Ensure patient access to food and fluids meets their individual needs
	Consistently evidence that maternity safe staffing meets dependency and acuity	Complete assessment of Trust compliance with Equality & Diversity System 2 and plan action as a result. *
	Deliver actions agreed from specialty risk summits – urology, respiratory, diagnostics	Develop and implement division and care group patient experience improvement plans
	Deliver actions agreed from specialty risk summits - respiratory	Dementia– increase use of screening tool
Establish a sustainable future for stroke services	Embed new approach to incident investigation.	Personalised care and support planning for people with Long Term Conditions
Deploy mobile technology for community services	Use quality impact assessment to inform safety impact of transformation or savings programmes	Ensuring the needs for patients with learning disabilities are met by making appropriate and timely reasonable adjustments and use of the patient passport.
Development of integrated locality teams with partner agencies	Improve care/treatment on AMU	
Develop and introduce new roles within clinical workforce	Alcohol and Tobacco Screening and Brief Advice	
Improve medicines delivery system and therefore access to medications	Improving assessment of wounds which have failed to heal after 4 weeks	
Improving services for people with mental health needs who present to A&E	Improve neonatal critical care community outreach	
To set up and operate advice and guidance services for non-urgent GP referrals		
All first outpatient services to be available on NHS e-referral service		
Supporting proactive and safe discharge – Acute Providers		

Table 3: Quality improvement

The quality improvement plans in relation to certain initiatives to be implemented in the next two-year period, are summarised below:

Quality Initiative	Summary Description
Health Records	Improve the quality and accuracy of the clinical record and the physical record, develop a clear strategy for an electronic patient record (EPR)
Embed learning from clinical incidents and other sources	Continue to review all areas of failure and develop plans. Encompassed with the new initiative of learning in excellence. This also included the continued development of mortality reviews and reporting.
7 - day hospital services	Continue to implement the four priority standards within the national timetable.
Safe staffing	Continues as a high monitoring priority for the Trust
Learning from deaths	Continue to embed and improve policy and procedures developed in 2017.
Sepsis	Continue to improve the identification and care of patients with sepsis
Reducing harm from falls and pressure ulcers	Achieve less than the national average per 100 bed days. Overseen by the Senior Nurse & Midwifery Advisory Group

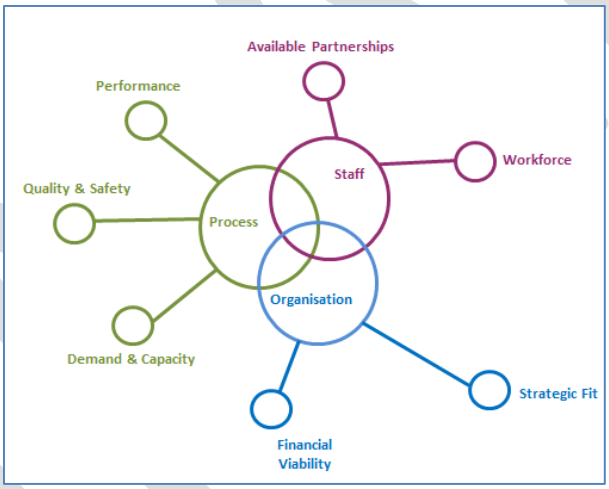
Table 4: Quality initiatives

3.3 Sustainability Reviews

In 2017/2018 the Trust undertook a sustainability review of its stroke services, concluding that the acute element was not sustainable at Walsall, and has now transferred to Royal Wolverhampton NHS Trust. The community and rehabilitation elements of the pathway remain within the Trust and have undergone significant redesign as a result of the review.

Following the successful testing of our sustainability process the Trust has now commenced sustainability reviews for each of its services using a three-phase approach:

Phase 1 - a service self-assessment. This was completed in Q4 of 2017/18.
Phase 2 - an in-depth and analytical review of each service against 7 domains as shown in the image below. The structure of the review is based upon the NHS Sustainability model and will be completed by the end Quarter 1 (June 2018). Services will be reviewed in priority order. The information collated will be triangulated against external references such as data within the model hospital, NHS Benchmarking Institute and other valid sources.
Phase 3 – An initial plan will be established for each service that is considered to have a significant sustainability issue. The Trust will also select services where opportunity to take the lead across the STP and prioritise them in same manner. This information will be built into a route map of service sustainability outlining which actions need to be taken with or without partners over the next 12 months.



3.4 Seven-day Services

It has been determined that there are four priority clinical standards of the suite of ten that are considered to have the greatest impact on the quality of care patients receive, these are:

1. Time to first consultant review
2. Availability of diagnostics
3. Consultant led interventions
4. On-going consultant review

The Trust is working towards delivery of these standards by April 2020 with a tolerance of 95% achievement for all patients admitted as an emergency. The organisation reports regularly self-assessment against the four standards.

The Medical Workforce Improvement Programme continues to ensure the medical workforce resource is effectively managed. The Programme incorporates a recruitment strategy, embedding ALLOCATE, a multifunctional medical staffing IT solution, reconciliation of information, review of systems, processes, controls and the functionality of the medical staffing department. This will result in the development of workforce target operating model and implementation of a formal annual job planning process.

3.5 Deanery Reviews

Following a formal review in July, 2017 sufficient progress had been made against the action plan and Medicine have been regraded from a level 4 to a level 2 – a significant achievement. The Education Leads for the Trust are leading work to ensure that all changes are embedded and sustained. Examples of progress include: improved incident reporting and receipt of associated feedback; improvements to registrar-level rota in ED; development of the Short Stay Ward facility.

3.6 CQUIN Schemes

The Trust continues the work required to deliver the quality improvements as detailed in the national CQUIN schemes which cover the 2 years - 2017/19. Updates to the schemes which include timelines and percentage value are currently under negotiation.

- NHS Staff & Wellbeing
- Proactive & Safe Discharge
- Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)
- Improving services for people with mental health needs who present to A&E
- e-Referrals
- Wound Care – Community
- Preventing ill health by risky behaviours – alcohol and tobacco
- Personalised Care / support planning – Community
- Offering Advice & Guidance.
- Paediatric Networked Care – non PICU Centres
- Hospital Medicines Optimisation
- Neonatal Community Outreach
- Secondary Care Dental

3.7 Improving Safety

The December 2107 Chief Inspector of Hospital's Inspection Report demonstrated considerable improvement in one of the two areas of greatest concern from the previous report, the Emergency Department, but only marginal improvement in Maternity. The Task Force approach will continue with the Maternity service to drive improvement and support the new management team to achieve a rating of at least good in the next CQC inspection. The Task Force meets monthly and, with Chief Executive leadership, provides oversight of the range of actions required within these service areas. Examples of progress include: improved compliance with CTG monitoring, implementation of the Birth-rate Plus Acuity Tool to ensure continuous evaluation and provision of safe staffing and HDU trained midwives on every shift.

The development of a more comprehensive and integrated quality improvement programme that builds on the existing work streams and adds in the outstanding actions from the existing Patient Care Improvement Plan (PCIP) is in development. This will have the support of the QI Academy and be embedded in the performance and assurance systems extant in the Trust. Divisional management leads report progress, which is monitored at local level and also through regular confirm and challenge meetings with the Director of Nursing and Medical Director. These cover the Quality Commitment, the IIP and risk registers and in so doing, ensures all leads have the opportunity to discuss progress with their plan in detail. Progress reports are made to Trust Quality Executive (TQE) and the Quality & Safety Committee (QSC) of the Trust Board.

3.8 Care and Compassion

The Patient Experience Strategy has four ambitions: improve experience overall; improve information and communication; recognise diversity needs; and to demonstrate real learning from feedback continues to be embedded across the Trust. This work is overseen by the Patient Experience Group led by the Deputy Director of Nursing, and which in-turn reports to TQE and QSC.

The Trust continues to make improvements in turn-around time and quality of complaint responses. Customer care skills training using the "hand in hand" approach continues to be delivered across the Trust and receives positive feedback. The Friends and Family Test is now more accessible; resulting in better methods of data collection and reporting, providing the Trust with more feedback, which in turn means more teams are learning from this and embedding the learning using the "you said, we did" approach.

The Trust continues to learn from and implement actions to improve our patient experience based on the feedback received from the national Patient Surveys. Improvements have been realised in our Maternity Patient Experience Survey in 2018.

3.9 Key Risks and Mitigation

The following table details the risk and mitigations relating to our quality ambitions.

Key Risk	Mitigation
Sufficient numbers of skilled medical and nursing workforce	A detailed workforce service improvement programme is in place which details plans in relation to controls associated with workforce rostering, and recruitment, retention and new ways of working initiatives; for example, to deliver the Nurse Associate Band 4 and Advanced Care Practitioners workforce changes.
Staff engagement	A staff engagement programme is under way to establish new Trust values and behaviours through engagement model. This is supported by the development of QI Academy a reorganisation of Executive Committees to create a new Trust Management Board and a strengthening of our clinical leadership development.
The pace of change required and capacity to deliver this	The IIP will drive a coordinated response to the pace of change required. This will include new developments such as a PMO, QI Academy and service improvement through the sustainability reviews.
Inadequate environment in several key areas;	An Estates Strategy in place, including confirmation of external investment in two key areas - to support the build of a new Critical Care Unit and expansion of the Neonatal Unit. There is a forward plan for an A&E rebuild.
Changes in the commissioning intentions and contract delivery landscape	The Trust is fully engaged in tender processes and has robust communications and relationships with associated commissioning partners. A comprehensive case for change maps out the next 12 months of activity to establish an integrated health and care model with partners in Walsall.
Changes to social care provision	The Trust is a leading partner in health and social care transformational work streams.

Table 5: Quality risks and mitigations

3.9 Quality Impact Assessment (QIA) Process

Each division, with its clinically-led Teams of Three, develops local cost improvement efficiency schemes with reference to national benchmarking, NICE guidance, best practice, and local and national priorities. Running in tandem are nine overarching service improvement work streams, coordinated by the Director of Finance and the Programme Management Office (PMO). Baseline datasets are recorded to take account of seasonal variations and are described in the Project Initiation Document, with quality impact monitoring undertaken against three core quality domains of safety, effectiveness and patient experience, as well as any impact on staff experience.

There is a formal assurance process whereby the Director of Nursing and Medical Director further assess any potential quality impact before approval and sign-off for all service improvement and cost improvement schemes. Built into this is a formal review of quality impact against key performance metrics, and any adverse impacts are alerted to the Director of Nursing and Medical Director. A quarterly report is shared with oversight being exercised by the Trust Board via Quality Safety Committee (QSE) whereby the potential cumulative effect of several schemes in relation to a particular service is considered.

3.10 Triangulation of Indicators

Our approach to triangulating evidence from quality, workforce and finance is through a number of mechanisms:

- Monthly through the Divisional and Care Group Quality Teams reports to the Executive. These forums also receive peer reviews and associated action plans, such as the West Midlands Quality Reviews, Endoscopy Joint Accreditation, Deanery reviews etc.
- In parallel, and to complement this, there are the two professional routes led by the Director of Nursing and Medical Director respectively. They chair well-established professional forums to discuss safety, effectiveness and patient experience.
- Monthly through the programme of executive-led divisional reviews, which consider quality, safety, performance, workforce and financial aspects.

Key indicators that the Trust use include, but are not limited to, are:

- Quality Dashboards for key specialties – ED/Maternity/ Paeds/Adult in-patient/ Community. e.g. serious incidents, falls, pressure damage and infection rates
- Mortality rates - SHMI / HSMR
- Incident reporting – process and outcome measures (separate moderate – severe low reducing)
- Audit outcomes from national standards e.g. stroke
- Patient access times
- Patient feedback and complaints
- Staff survey results
- Vacancies/Turnover rates
- Sickness absence rates
- Agency utilisation
- Financial position
- National CQUINS for 2017/19
- CIP delivery.
- The number and severity of risks as identified on both Divisional and Corporate Risk Registers
- CQC and Deanery rating

The development of the Integrated Improvement Plan will include identifying indicators to monitor the achievement of high level objectives, either existing indicators or the development of new ones. In turn these will be mapped to indicators at Divisional and Care Group level so that there is a clear line of sight from the Board to the ward and back again for objectives and performance. Dashboards will be introduced that present information in an appropriate form that managers can use to inform their decisions and exception reporting to identify where performance is below that which is expected; the cause, the actions and a trajectory to get back on track.

4. Approach to Workforce Planning

All our strategic and operational objectives depend on the collective skills, power and strength of our workforce.

The principles set out in the People Strategy are reinforced in the Workforce Strategy which was launched in November 2017. The overall aim of the Strategy is to ensure that the foundations are in place to develop an on-going workforce plan that will analyse, forecast and plan workforce supply and demand by assessing gaps and determining interventions to ensure the Trust is able to fulfil its strategic objectives in service delivery. This will be achieved by implementing the following objectives:

- Develop a Trust approach to workforce planning that ensures a consistent methodology to the collection and analysis of data required to develop a workforce plan
- Review current job roles to assess if they are still fit for purpose and if necessary, how competencies to support these roles can be developed or changed to meet future service needs

- Review current working practices and identify new ways of working that deliver the best use of resources, including new technology and its effect on the workforce, across multidisciplinary teams
- Identify where and how new roles can be developed and introduced to meet future service needs
- Develop an Education Strategy and a forward looking Training Needs Analysis which captures the development required for the whole Trust based on workforce planning
- Review current policies and procedures, designed to support staff wellbeing, recruitment and retention, to identify if the offering can be improved with a view to attract and retain staff
- Assess safe workforce numbers against nationally recognised ratios in order to support quality impact assessments.

4.1 Organisational Development

To complement the improvements that have been raised and achieved as a result of LiA work, a large-scale engagement programme took place across the Trust during 2017 that included focus groups and continues into 2018 through Pulse Survey and other events. The aim was to look specifically at staff; how the Trust engages and the behaviour of people. Feedback from these events have been collated and presented to Board and are being developed as part of an engagement action plan. These are further validated through the presence of a six monthly Pulse check established as part of the LIA process.

4.2 A Robust Governance Process

Colleagues will continue to mitigate against risk, through co-ordinated planning exercises and comprehensive due diligence processes. The formation and viability of workforce plans continues to be monitored. Transformation plans are reviewed by the Trust Executive and People & Organisational Development Committee meetings, before being presented at Trust Board for discussion and approval. Finalised plans are reviewed by Board members before subsequently being appraised by both the CCG and HEE.

4.3 Well-modelled Alignment

Work continues to ensure that workforce and finance plans are produced in collaboration, so that transformation initiatives are sustainable and cost improvement programmes are aligned.

As part of a wider network the Trust has delivered some examples of collaboration through some of the early work with local STP partners. The STP brings together 18 local partner organisations in order to develop a transformational plan to ensure a flexible, people-focused workforce within social care, healthcare, primary care and other stakeholders for the local health and care system. Current STP plans include working with partners to deliver a clear workforce plan for the Black Country STP system focusing on the existing and future needs of the services and financial implications with local partner organisations.

4.4 Workforce Improvement Schemes and Support to the Current Workforce

Current workforce requirements analysis needs to be based on a robust assessment of supply and demand. Therefore, demand and capacity models will be used to develop a clear plan of how the current workforce can meet the challenges ahead, learning from best practice on retention, retraining and changing skill-mix. Opportunities to rebalance supply and demand will include new ways of working for professional groups across the available workforce.

The cultural challenge is to develop flexibility in perceptions of roles spanning existing professional groups. As a result, there are barriers to developing teams of multi skilled staff who are flexible with the breadth of skills and knowledge that allows for greater adaptability, and work is underway to develop in this area.

We are also working to strengthen our equality, diversity and inclusion approach, both as an employer and a service provider. In order to achieve this, we will finalise robust monitoring arrangements during the course of this year. This will ensure we collect and analyse data relating to staff with protected characteristics in connection with recruitment,

promotion, disciplinary action and leavers. We will present this information through regular reporting to Equality Diversity & Inclusion Committee (EDIC) for discussion and actions.

To achieve this, we will establish base lines on the following measures and agree improvements through the year once the baseline are confirmed for:

- Levels of grievances and disciplinary,
- Proportion of senior mgmt.
- Appointed from short listed.

The Trust is participating in a national NHS event in May – Equality, Diversity & Human Rights Week 2018 - to celebrate good practice, raise awareness about what equality, diversity and inclusion means and our plans to improve. We have also scheduled an internal Trust event in June which will seek views on any change that would make a real difference across the Trust to patients and staff.

We will look to invite staff currently participating on the national Stepping Up Programme to access mentoring opportunities with members of the Trust Board.

Meeting workforce demands begins with making the most of the staff that are already available, developing their skills and knowledge in new and innovative ways to support effective patient care in the future.

The Trust has started to meet this challenge by being a Trailblazer Trust for the introduction of Nurse Associates. The first cohort of 26 Trainee Nursing Associates are due to graduate in January 2019. The Apprenticeship standard for Nursing Associates has now been approved for delivery and staff began the apprenticeship in March 2018; there are plans to run another cohort from September 2018.

As part of the introduction of new roles, a programme is being developed across the Trust to manage the recruitment and deployment of ACP's as part of effective workforce planning. This is to ensure a consistent approach that has expected outcomes, which can be measured as part of benefits realisation. Additionally, we are looking to use the skills and knowledge of current staff to fill long term vacancies at middle grade doctor level, while addressing retention issues around opportunities to progress.

Other new roles include the development of Maternity Support Workers (MSW's). It is envisaged they will work within Antenatal and have the right skills and competencies to work effectively as part of a multi skilled team required to deliver safe and effective care

The Trust will continue to develop roles that are multi skilled to help to meet changing requirements to deliver a service that is able to flex to meet contrasting demands of patients.

4.5 Plans for Workforce Initiatives

The Trust's improvement and workforce strategies are aligned to the five key strategic strands outlined with the local STP plan. As part of the Trust's vision for a community-focused workforce, in 2018/19 the Trust will start working with GPs and other system partners to ensure that care is delivered at the right levels, at the right time, by the right people. To set the foundations for this, Walsall Together has established a clear link with General Practice and the Integrated Health and Care Teams.

Work to develop modules of competencies to enhance roles and develop staff, expanding their current skill set to meet different patient demands, has been introduced as part of 'Grow Your Own'. Modules are designed to reflect national initiatives, as well as local needs identified within areas of the Trust as part of their 5 Year Plan.

New ways of working will be designed to include growing a flexible workforce which can be deployed when needed to cover staff shortages as a result of annual leave, sickness or major incidents. It will look at a task holistically to identify the skills, and the level needed within a team to deliver the task, rather than focusing on the people or the role. This will also help ensure that support workers are an integral part of the delivery of patient care and their skills and contribution are recognised.

The Trust will also work across the boundaries of staff in different services, organisations and sectors of care. The development of competencies and activities to up-skill staff to provide integrated care can be as effective as developing new roles.

The Apprenticeship programme continues to grow and the Levy, introduced in May 2017, which incentivises employers to take advantage of the benefits of the apprenticeship programme. The removal of eligibility criteria makes it easier to use apprenticeship-based training for existing employees. The investment in apprenticeships will provide staff with valuable qualifications and support a culture of valuing staff by 'growing your own'. The Levy can also be used to attract new staff, as an affordable alternative to the traditional university route. Offering new employees the opportunity to further their career and gain a qualification while being paid can be very attractive.

The use of apprenticeships will be based on careful workforce planning to ensure that the training is designed to develop the workforce required to deliver quality service in the future. It is also necessary to identify available roles for staff at the end of their training.

The Trust is an active member of the Local Workforce Action Board (LWAB), engaging with stakeholders. The Director of HR&OD is the Trust LWAB representative and she liaises regularly with Black Country partners to address the workforce priorities of; recruitment and retention, sustainable workforce models and an integrated workforce.

4.6 CCG Partners

Partners are engaged at the earliest opportunity to discuss commissioning intentions. A copy of the annual Workforce Plan will be submitted to Walsall CCG.

	Year Ending 31/03/2018	18/19 WTE Change	Year Ending 31/03/2019
ALL STAFF	3,963.08	-103.60	3,859.48
Bank Staff	241.29	88.45	329.73
Agency Staff	102.07	-83.07	18.99
Substantive Staff	3,619.73	-108.98	3,510.75
Registered Nursing & Midwifery	1,165.40	-39.65	1,125.75
Allied Health Professionals	205.78	-6.72	199.06
Other Scientific, Therapeutic & Technical	123.44	-0.94	122.50
Health Care Scientists	92.78	-6.63	86.15
Support to clinical staff	1,130.64	-27.42	1,103.21
NHS Infrastructure Support	630.97	-16.86	614.11
Career/Staff Grades	67.01	-13.78	53.23
Trainee Grades	51.44	0.51	51.94
Consultants	152.28	2.52	154.80

Table 6: Workforce changes 2017/18 - 2018/19

Productivity initiatives will carry links to proposals in the Model Hospital with a particular focus on maximising staff utilisation through the use of technology and data.

This approach will contribute towards continued reductions in temporary staffing reliance during the next 12 months, with a remodelling of the workforce required to ensure continued sustainability going forward. This component is one of the key domains in the Trust's newly adopted sustainability model. To mitigate against the resulting workforce supply verses demand risk, redesign of the Trust's delivery will be required. The Trust will lead the redesign of local workforce models through the previously mentioned case for change. which is being delivered in partnership with other local providers and commissioners.

Internally, safe levels of care will be met through the adoption of new roles such as Trainee Nurse Associates, Advanced Clinical Practitioners and Physician Associates, reducing reliance upon hard-to-fill nursing and medical posts and contributing to reduced temporary staffing expenditure.

The introduction of new roles must be carefully considered and have robust processes in place to demonstrate expected impact, contribution to sustainability and where cost savings will be released. The integration into the establishment and budgets made available as part of financial planning must also be considered. This is a move away from the historical process of workforce planning being driven by finance rather than based on service requirements to meet patient needs and the Trust's vision.

Staff Engagement programmes, such as Listening Into Action, will play an important role in ensuring the workforce remains engaged and empowered during significant service improvement, mitigating against the risks associated with such a rapid and significant pace of change. Changes to working practices will be owned and implemented in partnership with colleagues.

The above plans support our ambition to be an employer of choice with highly motivated and trained staff, equipped to deliver high quality care.

5. Finance: Forecast Outturn 2017/18 and Financial modelling 2018/19

5.1 2017/18 Forecast Outturn

The Trust did not accept its control total for 2017/18 because of the level of CIP that would be required to deliver the position. Instead the Trust Board agreed a financial plan of £20.5m deficit with a CIP requirement of £11.0m.

The Trust will achieve a deficit position of £23.2m (subject to audit), which is £2.7m adverse variance to the plan. This position includes the profit from the sale of assets £1.3m

The risk to delivery of the £20.5m plan was highlighted early in the financial year and with the approval of NHSI the Trust appointed KPMG in August 2017 to assist in the delivery of the financial recovery as part of FIP 2 programme.

The major reasons for the deterioration in the position are;

- under-performance against contract income due to reduced obstetric activity, outpatients and electives
- overspending on temporary workforce, nursing and medical staffing
- under-delivery of recurrent CIP

With the CQC inspection highlighting concerns in maternity services identifying shortfalls in staffing and increasing births, the Trust sought to address the issue through increased recruitment and agreeing a cap on deliveries in contracts with commissioners. Birth numbers reduced far greater than anticipated and there has been severe underperformance on contracted numbers. Outpatient performance and theatre utilisation were targeted as part of the recovery work-streams identified with KPMG.

Difficulties with recruitment of nursing and medical staffing continued in year. The Trust has attempted to recruit and looked to overseas recruitment to aid the vacancy position. The Trust overspent on ward nursing and on temporary staffing as a result of vacancies. The Trust was set a target to control agency spending to £7.0m for 2017/18 by NHSI, the Trust established an internal plan of £8.2m and has delivered £7.5m. The Trust reviewed its bank pay rates in year in an attempt to control the use of agency. While this had some success, the demands of servicing winter capacity placed increased pressures on the staffing of services alongside a change in policy for Nursing, focussing on filling all RN shifts with RN within the established wards (employed and temporary workforce) resulted in increased spending in the latter months of the year.

The Trust has delivered £10.9m of efficiency savings, only £0.1m behind the planned target of £11.0m although £4.6m of this total is delivered non-recurrently and includes asset sales.

5.2 2018/19 Financial Plan

The table below shows the original Financial Plan for 2018/19, the revised draft plan following budget setting and areas of variance between the two estimates.

Description	Original 2018/19 Plan £m's	2018/19 Draft Plan £m's	Variance £m's
INCOME			
CCG	197.9	198.1	0.2
NHSE	20.3	19.7	(0.6)
Local Authority	10.3	9.5	(0.8)
Non contract activity	1.2	1.0	(0.2)
Other – Cat c	14.9	14.6	(0.3)
TOTAL INCOME	**244.6**	**242.9**	**(1.7)**
EXPENDITURE			
Pay	(160.8)	(169.1)	(8.3)
Non pay	(79.9)	(75.8)	4.1
Capital charges	(7.8)	(6.6)	1.2
Finance Costs	(8.8)	(10.0)	(1.2)
TOTAL EXPENDITURE	**(257.3)**	**(261.5)**	**(4.2)**
SURPLUS / (DEFICIT)	**(12.7)**	**(18.6)**	**(5.9)**

Table 7: Original 2018/19 Income and Expenditure Plan and comparison with draft financial plan

5.2.1. Income

The original plan for 2018/19 submitted as part of the two year planning exercise, included a number of assumptions, which have now been updated in line with local agreements and national guidance. The changes in planning assumptions that have had a material impact on the agreement of Trust contracts with commissioners are, the unforeseen delay in opening of Midland Metropolitan Hospital; the adoption of growth assumptions detailed in the 2018/19 National Planning Guidance, and variances in performance compared to plan in 2017/18 .

There are further reductions in respect of contracts with the Local Authority commissioner for health visiting (£0.5m), infection control (£0.2m), smoking cessation (£0.3m) and other minor services (£0.2m).

Movements in Growth Assumptions: During 2017/18 the Trust has experienced significant variances to planned levels of activity in A&E (4.7% above plan) and Non-Elective Inpatients (2.2% above plan).

The original two year plan had growth assumptions agreed within the Black Country STP. These have now been superseded by the growth assumptions detailed within the refreshed National NHS Planning Guidance. These movements are detailed below but the impact is yet to be fully agreed with commissioners.

Point Of Delivery	STP Growth	18/19 National Planning Growth	Movement
Elective Inpatients	1.8%	0.3%	(1.5%)
Elective Daycases	1.8%	4.2%	2.4%
Non Elective Inpatients >0 LOS	2.3%	1.0%	(1.3%)
Non Elective Inpatients =0 LOS	2.3%	7.3%	5.0%
A&E	2.2%	1.1%	(1.1%)
Outpatient New	3.6%	6.4%	2.8%
Outpatient Follow Up	3.6%	4.1%	0.5%
Outpatient Procedures	3.6%	4.9%	1.3%

Table 8: Updated growth assumptions

5.2.3 Expenditure

Overall, the total of expenditure between the original and the draft plan for 2018/19 is circa £0.9m. However, there are major areas of variance between the two plans, explanation as follows;

Pay: The estimate for pay expenditure has increased £8.3m over the original estimate, changes being, increased costs for local pressures/FYE developments (£5.3m), national pressure assumptions (£0.5m), non-recurrent delivery/slippage in 2017/18 planned CIP (£2.5m) off set by assumed cost increases to service increased activity following Midland Metropolitan development, now delayed.

Non-pay: Decrease costs of £4.1m, covering local pressures off set by assumed cost increases to service increased activity following Midland Metropolitan development, now delayed. The Trust has had to manage several large increases in NHSLA contributions in recent years, actual contribution for 2018/19 is a reduction on the 2017/18 figure of £1.8m.

The following Table provides a comparison of price inflation.

Expenditure	2017/18 %	2018/19 Original %	2018/19 draft %
Pay & pensions	2.00	1.60	2.00
Drugs	4.60	3.60	3.60
Procurement	1.80	2.10	2.10
Capital charges	3.20	3.20	3.20
Other	1.80	2.10	2.10

Table 9: Table; Inflation/expenditure table

5.2.4 Control Total

The Income and expenditure position and control total requirement is summarised below

Description	2017/18 Forecast £m's	2018/19 draft Forecast £m's
Total Income	244	243
Total Expenditure	(267)	(262)
Outturn (deficit)	(23)	(19)
Issued Control Totals (NHSI) including STF of £10m	(4)	4
Note; PSF included within income above	0	0
Note; total value of PSF available in year	7	10
CIP targeted in year (included in expenditure)	(11)	(13)

Table 10: Income and expenditure and control total

The Trust was unable to attain recurrent CIP delivery during 2017/18, with these costs increasing the baseline for 2018/19 and the impact of the loss of income assumed following the Midland Metropolitan development and other local pressures/developments would result in the need to deliver a circa £26m CIP to achieve the NHSI control total for 2018/19.

The Trust Board has agreed a CIP target of £13m for 2018/19 and as such cannot accept the control total and therefore is not eligible for receipt of Provider Sustainability Fund (PSF formally STF).

5.3 Efficiency Savings

The Trust's targeted efficiency saving is £13m for 2018/19, though plans are still in formation (noting the programme is targeting £14m to give a contingency of £1m for slippage). The Trust is working to enhance the schemes detail to enable the modelled £13m savings delivery. Schemes are listed by work stream as follows:

Table: Efficiency Savings by work stream	2018/19 Target £m's
Pathology (BCP)	0.3
Procurement (Price)	1.0
Theatres Productivity	2.5
Outpatients Productivity	1.5
Patient Flow	1.0
Back Office Functions	0.5
Pharmacy Sub Co	0.5
IM&T	0.5
Workforce (Medical, Nursing, Other)	0 (in Div Targets)
Subtotal (Trust wide work streams)	**7.8**
Divisional led schemes	6.2
Total programme value	**14.0**

Table 11: Efficiency savings by work stream

The PMO is being restructured to support the delivery of work streams and strengthening the CIP support. The team now under the Director of Finance and a new post has been created as Director of PMO and Performance to facilitate the change.

5.4 Capital Plan

The Trust has an agreed capital programme which includes three major schemes, namely;

- Integrated Critical Care Unit (ICCU)
- Second dedicated maternity theatre and expansion of our neonatal unit to 20 cots
- ED redevelopment and additional emergency medical ward capacity. /emergency ward.

The following table presents the original 2 year, 2017/18 forecast outturn and the impact on the 2018/19 capital programme.

Description	2017/18 Plan £m's	2017/18 Forecast £m's	2018/19 Original £m's	2018/19 Draft £m's	Movement £m's
Lifecycle Maintenance	1.2	0.7	1.0	0.7	(0.3)
Medical Equipment	0.8	0.6	0.8	0.5	(0.3)
IM&T Replacement	0.3	0.2	0.3	0.1	(0.2)
IM&T Other	0.1	0.2	0.1	0.1	0.0
Community Mobile technology	0.0	0.6	0.0	0.0	0.0
Gamma Camera	0.6	0.5	0.0	0.0	0.0
Integrated Critical Care Unit	7.8	6.2	1.4	2.5	1.1
Maternity Expansion	5.2	0.1	0.4	5.6	5.2
A&E Development	2.0	0.0	15.2	10.0	(5.2)
PFI Lifecycle	0.8	0.8	0.8	0.8	0.0
Donated Assets	0.1	0.2	0.1	0.1	0.0
TOTAL EXPENDITURE	**18.9**	**10.1**	**20.1**	**20.4**	**0.3**

Table 12: Capital spend

The scheme for development of mobile technology in community services was agreed with Walsall CCG as part of the 2017/18 contract.

The ICCU scheme commenced in year and will span approximately 18 months. The Trust has secured loan funding for of £6.487m, the balance being met through depreciation funds. The ICCU works replace the current outdated HDU and ITU facilities delivering a safer and more efficient service also freeing up the ability for the Trust to develop A&E buildings.

The business case for the maternity expansion has received NHSI approval. The Maternity scheme utilises funds remaining from the Trust's allocation as part of the Mid Staffordshire Hospital review, supported by Trust's own depreciation funding. This development also addresses the estate requirements identified in the CQC report. The scheme was planned to start in 17/18 and is in the final stages of agreement with the Trust's PFI estate provider.

The Trust submitted an Outline Business Case (OBC) to NHSI in November 2017 for the upgrade and expansion of A&E facilities to include an emergency ward. This work is required in anticipation of the flow of additional patients that will occur following development of the Midland Metropolitan hospital and is supported by local commissioners and the Black Country STP. The OBC is presently going through the NHSI approval process and following this a Full Business Case (FBC) is required with confirmation of scheme costs. Completion of the Midland Metropolitan is now delayed following the financial collapse of the building contractor.

6 Link to the Black Country Sustainability and Transformation Plan

6.1 Walsall Together Partnership

The Walsall Together Partnership is collaboration with the key health and social care organisations in Walsall.

- Walsall CCG
- Walsall Healthcare NHS Trust
- Walsall Adult Social Care Services
- Dudley & Walsall Mental Health NHS Trust
- GP Federations (x5)
- Walsall Public Health.

The Partnership Board meets monthly with an aim of reducing barriers and duplication and to improve the flow of patients to deliver better care closer to people's homes. This Board is now well established and is further supported by the Provider Board which is coordinating the production of a Case for Change approach. This document was endorsed by the Trust Board in March 2018 and outlines a proposed future integrated state building upon the work already commenced in the Walsall Together program. See image below

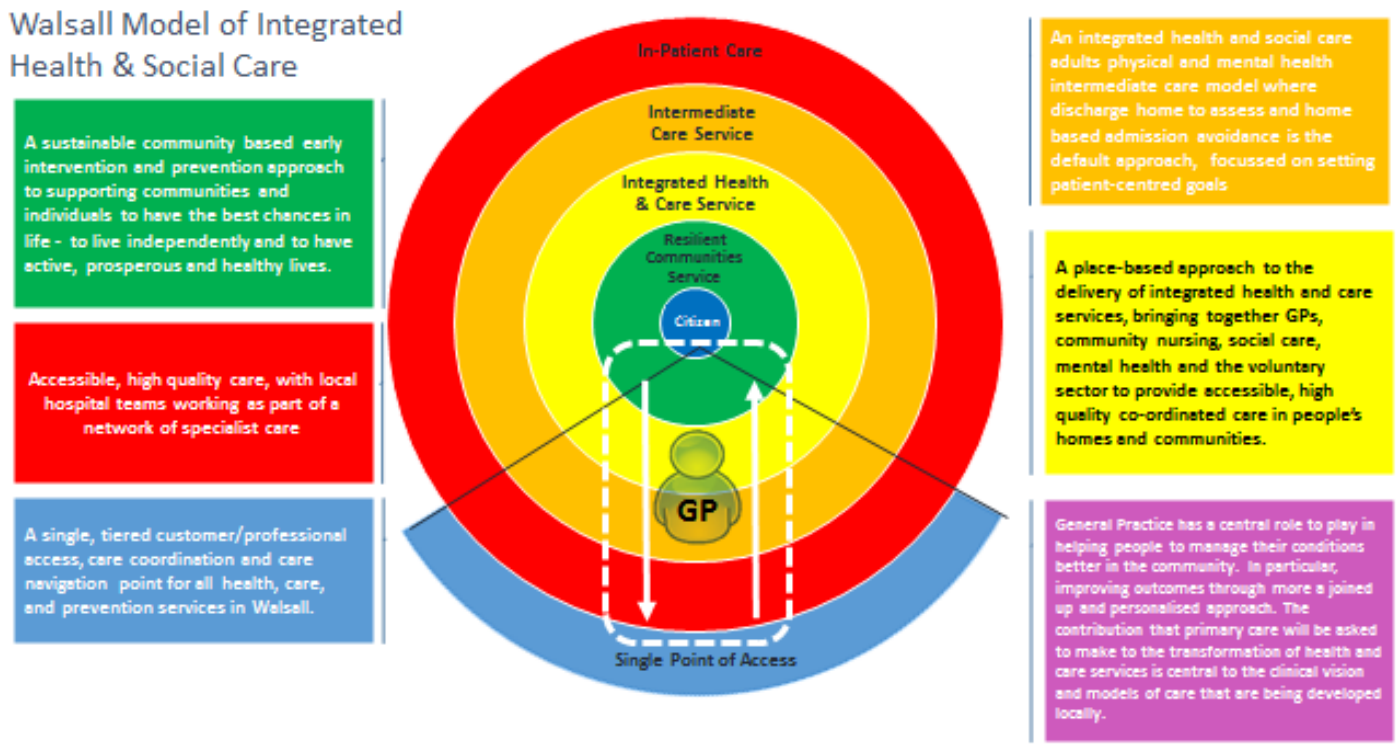


Image 4: Walsall model of integrated health and social care

The Case for Change describes a proposed new model of care that brings together organisations through pathway redesign to respond more efficiently to the needs of our population (see graphic below). The Case for Change will be developed over the next year coordinated by a senior leadership team appointed by the contributing organisations represented on the Provider Board. It is proposed that the future model will be formalised in April 2019 with a single Host Provider contract with the CCG and a series of sub contracts to the current providers. The next stage of the work is to develop a full business case for the borough with the support and guidance of NHSI, NHSE and appropriate external support.

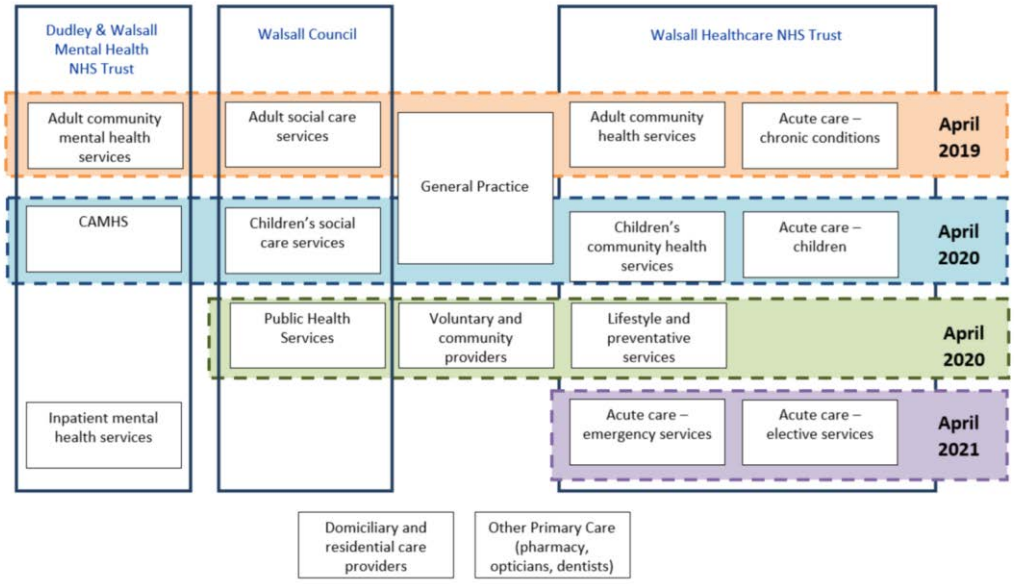


Image 5: Case for change pathway approach

The Provider Board is coordinating the selection of a Host Provider and the construction of a work and engagement program over the next 12 months. Once completed, the Provider Board will move into the Host Provider's governance structure.

The work will be further complemented with additional work on clinically driven integrated pathways connecting primary care with the specialist services provided by the Trust. In addition the Trust is discussing options on formal partnerships to provide a local response to the new models of care for Walsall.

The Trust's contribution to this partnership has already begun with the alignment of seven integrated health and care teams which bring together community services with social care, mental health and primary care partners in delivering place-based care. These teams are now complete, and work is underway on specific estate reconfigurations to allow consistent colocation.

The Trust has recently deployed mobile technology to its adult community teams, which start a program of a single patient record through system integration. The system deployed also plans workforce movement and productivity to ensure that the Trust staff are as efficient as possible

6.2 Black Country Provider Partnership

In 2015, the Trust formed an alliance with two other local Trusts to launch The Black Country Alliance. This was a partnership between us, The Dudley Group NHS Foundation Trust, Sandwell and West Birmingham Hospitals NHS Trust.

Increasingly however, the services we are taking forward collaboratively include The Royal Wolverhampton NHS Trust. This is evident in the plans to develop a shared Black Country Pathology Service. There are a number of other projects that we are continuing to progress across all four Trusts and because of this, and the fit with the now emerging Sustainability & Transformation Plan, the Trust has developed a new collaboration with all four acute Trusts, called the Black Country Provider Partnership (BCPP).

The projects that we have successfully been delivering in partnership will continue to progress such as Atrial Fibrillation and Neurology and we will expect to see even more programs of collaboration in the future. Urgent and Emergency Care and Cancer are examples of these. We have also recently written and submitted to NHS England a draft Local Maternity Strategy for the Black Country. The sustainability work undertaken will inform the Trust's road map for collaboration on clinical services strategy across the BCPP

To support these new arrangements the Chief Executives of the four Trusts will meet on a monthly basis with agreed terms of reference to consider progress on the list of projects. This will be supported by a series of executive and clinical groups looking at pathways of change and service sustainability across the Black Country. The annual work program for the partnership and progress with projects will continue to be reported to the four Trust Boards. The outputs will feed into the Sustainability & Transformation Partnership workstreams.

6.3 Black Country Sustainability Transformation Partnership (STP)

The Trust is an active partner in the Black Country STP. This plan brings together over 10 healthcare providers numerous Local Authorities and 4 CCG's. We have already submitted several drafts of our plan.

The STP's vision is to transform health and care in the Black Country and West Birmingham ensuring that we bridge three critical gaps:

1. Our populations suffer significant deprivation, resulting in poor health and wellbeing
2. The quality of the care offered varies unnecessarily from place to place, so not everyone has the best experience of care or the best outcomes
3. The Trusts risk not being able to afford all the services our populations need unless early action is taken to avoid future costs, creating a sustainable health and care system that helps Black Country and West Birmingham lives to thrive.

It is clear that the current way of operating is unsustainable. Under the STP plan, individual organisations and partnerships will continue to make the improvements and efficiencies that are directly within their own control but the overall scale of opportunity will be transformed by working together as a single system with a common interest.

At the heart of the STP plan is a focus on standardising service delivery and outcomes, reducing variation through place-based models of care provided closer to home and through extended collaboration between hospitals and other organisations. Mental Health and Learning Disabilities services form part of this but are also identified as a discrete strand to reinforce parity of esteem, the necessity of which is confirmed by a study we commissioned that shows the much reduced life expectancy of mental health service users. Maternity and infant health is also an essential focus for us given our challenges around maternal health (in particular, maternal smoking) and its impact on neonatal death rates and other infant outcomes. Maternity and neonatal service capacity also needs to be reviewed.

Local Place-based Care	Extended Hospital Collaboration	Mental Health & Learning Disabilities Services	Maternity and Infant Health
Enablers Workforce-infrastructure – Future Commissioning			
Addressing the Wider Determinants of Health with the West Midlands Combined Authority			

Image 6: STP ambitions

The Trust has agreed that this STP should build on the existing local partnerships in each area. This should incorporate and add to this work rather than contradict or second-guess it. This is really important given the work that is already advancing with the Walsall Together Partnership as our local placed based plan.

As the STP is developing it is clear that opportunities exist to establish sustainable services moving forward. The STP sponsor group has now agreed a high level milestone plan highlighting co-ordinated STP activities. The Trust will fully participate in populating this plan and developing opportunities for service reconfiguration as and where appropriate. However, given the developing nature of the STP both in terms of partnerships and milestone planning it is not yet possible to fully articulate what the impact of possible service improvement/change will be even within the period that this plan covers. It should therefore be recognised that this presents both an opportunity and risk in equal measures. The Trust will keep NHSI fully briefed on the progress of the plan and discuss any potential impacts.

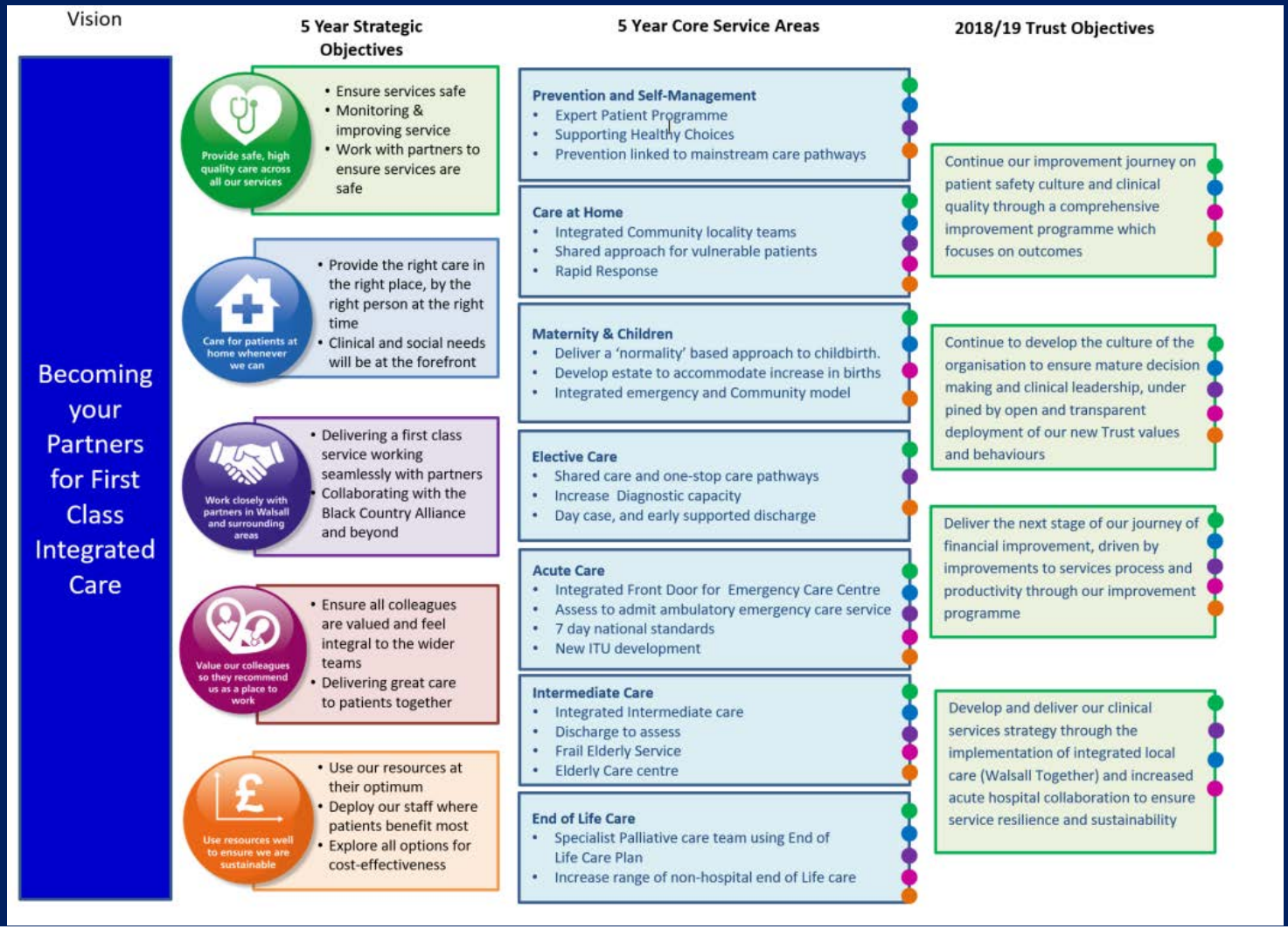
7. Risks and Mitigations to the Plan

The chart below outlines the risk and mitigations for successful delivery of the Trust's plan:

Issue	Risk	Initial Mitigation
Sustainable Staffing	The Trust cannot deliver safe sustainable staffing levels reducing reliance on expensive agency staff.	Strengthened oversight of approval processes for agency staff. Detailed action plan established & monitored weekly by Workforce Steering Group. Monthly review of progress at Performance, Finance & Investment Committee. Workforce workstreams established to review recruitment and retention strategies.
Delivery of National Standards	The Trust is not able to recover performance on national standards.	Strengthened oversight of performance with new management team.
Staff engagement and Culture Change	the Trust is not successful in our work to establish a clinically-led, engaged & empowered culture.	Clear commitment from the Board to lead culture change. Clinically led model implemented & developed at divisional level.
Capital Availability	the Trust does not have sufficient capital to address our major estate issues.	Major projects progressing with timelines established. Awaiting confirmation from NHS Improvement on a number of projects.
Availability of resources	The Trust cannot identify sufficient resources to deliver the 2018/19 plan.	Current plan includes some provision – will be assessed as plan developed further.
Successful Partnership Working	Our partnership approach in Walsall does not lead to improved care pathways.	. Walsall Together Partnership sponsoring the case for change .
STP	Further regional reconfiguration may affect our assumptions with services lost/gained.	Trust to input, influence and inform discussions prior to adoption so that our position and impacts are mitigated.

Table 13: Risks and mitigations to the plan

Appendix 1: Plan on a Page –



Appendix 2: Objectives and measures 2018/19

Objective 2018/19		Lead	Measures for 2018/19	Q1	Q2	Q3	Q4
1. Continue our improvement journey on patient safety culture and clinical quality through a comprehensive improvement programme which focuses on outcomes	1.1	MD& DN	**Deliver the Integrated Improvement Plan which includes delivery of our Quality Commitment**	Plan to be developed and approved	% of actions delivered TBC	% of actions delivered TBC	% of actions delivered TBC
	1.2	COO& MD	**Improve quality and patient experience for our elective care pathways – ensuring a continuing reduction of patients waiting over 18 weeks**	85.5%	85.9%	87.2%	89.3%
	1.3	COO& MD	**Improved quality and patient experience in our emergency care pathways – ensuring 90% seen within 4 hours in ED by September 2018.**	86.0%	90%	87.0%	93.0%
	1.4	Lead Execs	**Ensure each of our Improvement Work streams deliver tangible improvement for patients and staff:**				
			➢ **Outpatients – Improve clinic utilisation rates**	TBC %	TBC %	TBC %	TBC %
			➢ **Theatres –Improve theatre utilisation rates**	TBC %	TBC %	TBC %	TBC %
			➢ **Patient Flow – Reduce overall bed occupancy**	TBC %	TBC %	TBC %	TBC %
	1.5	DSI	**Invest in IT and new technologies to enable technology supported change to include:**				
			➢ **Bed Management System**	Design	Bus Case	Plan	Review
			➢ **Electronic records**	Bus case	Plan	TBC	TBC
			➢ **E-prescribing rollout**	Bus Case	Plan	TBC	TBC
	1.6	DSI	**Wider Development Control Plan for next stage of hospital (modular block upgrade, office accommodation, on-site MLU) and community estate approved by the Board by June 2018.**	Com mission	Plan	TBC	TBC
	1.7	DFP & DSI	**Finalise the approval for a new Emergency Department and have a clear plan for its delivery**	FBC approval	TBC	TBC	TBC
2.Continue to develop the culture of the organisation to ensure mature decision making and clinical leadership, under pined by open and transparent deployment of our new Trust values and behaviours	2.1	DHR& OD	**Improved colleague satisfaction measured through the 2018 and 2019 staff surveys / pulse checks and Staff Friends and Family**	TBC %	TBC %	TBC %	TBC %
	2.2	DHR& OD	**Embed new Trust Values with an associated behavioural framework and approach to feedback to drive improvement which reflects the Trust's approach to a clinically led model.**	Launch	Develop	Measure	Audit
	2.3	DHR& OD & COO	**Deliver standards for appraisal by September 2018.**	90%	90%	90%	90%
	2.4	DHR& OD& COO	**Continued reductions in sickness absence.**	%	%	%	%
	2.5	DSI	**Empower staff to make appropriate service decisions supported by accurate demand and capacity modelling**	Overview	D&C Plan	Progress Update	2019/20 Plan
	2.6	DSI	**Skill the workforce in quality improvement tools facilitated by the QI Academy.**	20	40	60	80

Objective 2018/19		Lead	Measures for 2018/19	Q1	Q2	Q3	Q4
3.Deliver the next stage of our journey of financial improvement, driven by improvements to services process and productivity through our improvement programme	3.1	DFP	Annual deficit in line with plan - £18m in 2018/19	(£4.5m)	(£9.0m)	(£13.5m)	(£18m)
	3.2	DFP	Deliver savings program of £13m in 2018/19.	£3.5m	£7m	£10.5m	£13m
	3.3	MD& DN	Plan agreed for reducing agency spend and delivered as planned to ensure we reduce agency below our £7.6m	Actuals	Actuals	Actuals	Actuals
	3.4	DFP & DSI	Identify and build a program of work around outlying metrics in Model Hospital	Narrative update	Narrative update	Narrative update	Narrative update
4. Develop and deliver our clinical services strategy through the implementation of integrated local care (Walsall Together) and increased acute hospital collaboration to ensure service resilience and sustainability	4.1	DSI	Development of integrated Health and Care approach through a programme of work outlined in the case for change.	Establish Team	50% Program plan	FBC	Deployment
	4.2	COO	Complete the deployment of an Integrated Intermediate Care Service. Reduce medically fit for discharge patients in hospital beds	80	50	80	80
	4.3	DFP& MD	Deliver a Black Country Pathology Service in line with our agreed plan.	Narrative update	Narrative update	Narrative update	Narrative update
	4.4	MD & DSI	Work across the STP and with the Black Country Provider Partnership to develop a shared strategy for the future services	Phase 2 of sustainability reviews	Partner Workshops with Top 4 services	TBC	TBC
	4.5	DSI	Continue our work to undertake a strategic review of each service to assess their potential for sustainability - Clear view by Q 2 2018/19.	Phase 2	Outcome	Decision	Monitor

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date:** 3 May 2018
Report Title	Audit Committee Highlight Report			**Agenda Item: 19** **Enclosure No.: 16**
Lead Director to Present Report	Chair of Audit Committee, Non-executive Director, Sukhbinder Heer			
Report Author(s)				
Executive Summary	Attached are the approved minutes of the Audit Committee meeting held on 12th March 2018 – a verbal update was provided at the April Trust Board.			
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>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 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 raised within the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">All NHS organisations are required to have an Audit Committee that that reports to its governing body (Trust Board for Walsall Healthcare NHS Trust). The formal requirements to have an Audit Committee are set out for non-NHS Trusts in the NHS Improvement Code of Conduct and Accountability.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The Audit Committee reports to the Trust Board on a monthly basis following its meetings. The Board receives the approved minutes from the previous Audit 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 Audit Committee meeting held on 30TH April 2018 will be submitted to the Board at its next meeting.</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>

Walsall Healthcare NHS
NHS Trust

MINUTES OF THE AUDIT COMMITTEE
HELD ON MONDAY, 12TH MARCH 2018
AT 2.00 P.M. IN MEETING SUITE A, MLCC

Present:	Mr S Heer	Non-executive Director Committee - Chair
	Mr J Dunn	Non-executive Director
	Prof R Beale	Non-executive Director
In Attendance:	Mr R Beeken	Chief Executive
	Mr R Caldicott	Director of Finance and Performance
	Mr J Kelly	Local Counter Fraud Officer
	Mr T Kettle	Deputy Director of Finance
	Mr C Larby	Internal Audit
	Mr C Knight	Internal Audit
	Mr M Surridge	Ernst Young – External Auditors
	Ms N Ryan	Ernst Young – External Auditors
	Ms A Mawson	Ernst Young – External Auditors
	Mr N Rashid	Divisional Director, MLTC Division
	Mr P Thomas-Hands	Chief Operating Officer
	Mrs C Dawes	Executive Assistant (Minutes)
Apologies:	Mr P Gayle	Non-executive Director

ACTION

122/17 **Apologies for Absence**
Mr Heer opened the meeting and attendees were welcomed to the meeting and introductions were made. The meeting was declared quorate.

122/17 **Declarations of Interest**
The Chair asked if there were any declarations of interest in relation to the agenda items. There were no declarations of interest raised.

123/17 **Minutes of the Meetings held on 20th November 2017**
The minutes of the previous meeting held on 20th November 2017 were agreed as a correct record.

124/17 **Matters Arising and Action Sheet**
The Committee received the updated action tracker report and noted that the majority of the items were covered on the agenda. Verbal updates were noted as:

007/17 Internal Audit Progress Report – Locum Doctors process: Mr Rashid attended on behalf of the Medical Director to provide an update on the process

086/17 Business Continuity Plans: The Chief Operating Officer attended to present a more detailed report and summary position.

Resolution:
The Committee:
- **Received and noted the updated action tracker and verbal updates.**

125/17 Locum Doctors Progress Report

Mr Rashid, Divisional Director for MLTC Division attended on behalf of the Medical Director to provide an update on the locum doctor process.

It was noted the first step to reducing the locum spend had been to transfer regular agency workers onto the Trust Bank to reduce commission and uncapped rates being applied, which had been successful in reducing costs.

A process for authorising medical locums had been implemented and meetings held on a weekly basis to scrutinise the medical posts, however extensive pressure had been experienced over the winter period and locums were retained to provide cover. Mr Rashid explained a number of overseas doctors (MTIs) had been employed as acute advanced nurse practitioners who were able to provide another skill mix to assist with pressures.

The committee noted that expenditure on the medical workforce had shown a reduction in agency costs from the previous year but reiterated the concerns previously raised that doctors were being appointed outside of the authorising process and has asked for assurance this was no longer the case. Mr Rashid advised compliance was around 90% and decisions made at the weekend or at short notice would make up the difference.

There was a discussion on capped rates and a question was raised about how many times they were breached. The committee thanked Mr Rashid for the update though informed him the information had not addressed the concerns raised in September 2017 on authorisation controls. It was requested the process be re-audited to give assurance that controls were in place and being adhered to and the nature of any non-compliance be fully explained and the outcome presented to the committee at the end of April 2018.

Mr Rashid advised he would feedback the comments from the committee to the Medical Director. The Director of Finance & Performance agreed to Internal Audit reviewing the approvals process **NR/CL**

<u>Resolution</u>:
The Committee:

- **Received and noted the content of the report.**
- **Noted the Divisional Director would feedback comments to the Medical Director**
- **Agreed Internal Audit would undertake a re-audit of the authorisation process and feedback at the meeting on 30th April 2018**

126/17 Update on Risk Management

The Committee received and noted the update on Risk Management.

<u>Resolution</u>:
The Committee received and noted the update on Risk Management

127/17 Performance, Finance and Investment Committee Update and Minutes from October and November 2017 and January 2018

The Committee received the minutes of the Performance, Finance and Investment Committee meetings held in October and November 2017 and January 2018.

Mr Dunn advised the committee had met in February and the focus was around the financial performance for the delivery of the Financial Recovery Plan and noted the good performance on cancer through the winter period.

Resolution:
The Committee received and noted the minutes of the October and November 2017 and January 2018 Performance, Finance and Investment Committee meetings.

128/17 Quality & Safety Committee. Update and Minutes from October November and December 2017 and January 2018

The Committee received the minutes of the Quality & Safety Committee meetings held in October November and December 2017 and January 2018. Prof Beale advised the committee focus was on the performance in theatres as little progress was being made.

Mr Dunn explained weekly meetings were taking place to review the performance of the theatre/outpatients/temporary staffing workstreams.

Resolution:
The Committee received and noted the minutes of the October November and December 2017 and January 2018 Quality & Safety Committee meetings.

129/17 People & Organisational Development Committee Update and Minutes from October November and December 2017.

The Committee received the minutes of the People & Organisational Development Committee meeting held in October November and December 2017.

Resolution:
The Committee received the minutes and update from the October November and December 2017 People & Organisational Development Committee meeting.

Mr Heer advised the four sub-committee chairs had previously agreed to meet prior to Audit Committee meetings but had not yet met. It was agreed arrangements would be made for the four sub-committee chairs to meet 30 minutes prior to each Audit Committee meeting.

Resolution:
The four Sub-Committee Chairs agreed to meet 30 minutes prior to each Audit Committee meeting

130/17 Annual Report and Accounts Timetable

The Director of Finance & Performance presented the Annual Accounts Timetable which highlighted key dates for the production and submission of the annual accounts, annual report and quality accounts for the 2017/18 financial year. It was noted the change in process was the requirement to

submit the audited accounts to NHS Improvement as previously the external audit team were responsible for submission of them to the Department of Health.

The committee commented on the issues encountered the previous year and questioned how these would be avoided. There was a discussion on the processes being put in place including holding regular meetings with the auditing team and to flag any issues to the committee at the earliest opportunity. Mr Surridge advised he would be leaving Ernst Young and confirmed handover meetings would take place to ensure continuity of engagement.

Mr Surridge explained data analytics was the key driver of the audit and the engagement with the finance team in providing the information. There was a discussion on ensuring the required information was provided in a timely manner to enable the smooth running audit and the committee questioned if there was anything else that could done prior to the audit. It was noted the valuation of the estate had not yet been tested but it was confirmed there were no issues at present.

Mr Caldicott raised concerns over the team being new in post (the key officers for the audit all being new in post) as this leads to greater concerns over meeting the challenging timeframes for issue of an opinion on the accounts for the 2017/18 financial year.

Resolution:
The Committee:

- **Received and noted the content of the report.**
- **Noted regular meetings would be held with the auditing team**
- **Noted the Director of Finance would raise any concerns to the committee, with the Chair to receive weekly updates from the External Auditors** **EY**

131/17 Quality Accounts Timetable

The committee received the Quality Accounts Timetables and noted there was no one was in attendance to present the report.

The committee stressed representatives must attend to present reports and provide status updates. The Director of Finance & Performance agreed to feedback the comments.

Members requested assurance over the production of the Annual Plan to next Committee.

Resolution:
The Committee:

- **Received the report.**
- **Noted no-one attend to present the report**
- **Noted the Director of Finance would feedback their comments** **FD**

132/17 External Audit Planning Report

Mr Surridge gave an overview of the approach and scope of the 2017/18

external audit plan. It was explained that there were two presumed risks in every audit: in relation to the risk of fraud in revenue and expenditure recognition and the risk of management override of controls. In addition, a significant risk relating to the valuation of the Manor Hospital building was highlighted. This related to fair reflection in the financial statements and ensuring that ongoing depreciation charges were correctly accounted for. A further area of the audit had been identified that was not classified as significant risk, but was important when considering the risks of material misstatement to the financial statements and disclosures related to the accounting for the PFI to ensure that it fairly reflected the financial position.

The value for money risks were identified as: the Trust had improved its CQC rating, under the Single Oversight Framework the Trust had been classified as 4 'Special Measures'; the financial deficit position and underachievement of CIPs was indicative that inadequate arrangements were in place to secure financial resilience; the Trust's National Staff Survey Results published in March 2017 were disappointing and the work of internal audit and its findings through the progress reports highlighted a number of areas either "require improvement" or have "insufficient" assurance.

The committee noted the risks highlighted and requested any issues in relation to the timetable be raised at the earliest opportunity. Mr Surridge advised that the expectation was for a better process for 2017/2018 with close working between the EY and Trust teams.

Clarification was given about the level of materiality set at £2.64m; representing 1% of the Trust's 2018 budgeted expenditure. It was noted that whilst this had in the past been set as high as £4m, the current level reflected the degree of challenge and risk currently facing the Trust and could not be set higher than 1% of revenue.

There was a discussion on the issues experienced the previous year which had created pressure in the delivery and to ensure there was a robust plan and escalation process in place this year to adhere to the deadlines agreed. An update on the plan to be presented at the next meeting. The Chief Executive stated the Trust Secretary had left a contingency plan which would be reviewed and a report back at the next meeting. **MS** **RB**

Resolution:
The Committee:

- **Received and noted the External Audit Plan.**
- **Noted the highlighted risks.**

133/17 Items for 2018 Accounts

The Director of Finance & Performance presented the items for the 2018 Accounts advising of key financial transactions.

It was noted the sale of two properties had been agreed (two blocks in Town Wharf and Manor Quays) and also the management assessment of the organisation as a "Going Concern" and there was evidence of investment.

A full revaluation of the estate is undertaken every 3 years and the Trust

had engaged its valuer to complete this exercise. The Accounts would be prepared on that basis.

Mr Surridge stated EY received the report an proposed transactions that would be subject to audit review and following review would report back to members

Resolution:
The Committee:

- **Received and noted the Items for 2018 Accounts**
- **EY to confirm if the above treatment was of concern at the next meeting** **EY**

134/17 Internal Audit Progress Report

Mr Larby presented the Internal Audit Progress Report. Thirteen reports had been finalised since the last meeting:

Temporary Staffing Non Medic/Non Nursing, Business Continuity and Safer Bundles Compliance were rated as "Insufficient" and Quality & Content of Patient Records, Temporary Staffing – Medics, Right Person/Right Consultant, Safe Staffing, Ransomware Preparedness and Investment Effectiveness were rated as 'Requires Improvement' and Temporary Staffing – Nursing, Data Quality – Caner Waits, Recruitment Process Compliance, Attendance Policy Compliance was rated 'Substantial').

Five reports were in draft form and eight assignments were in progress. It was noted five audits had been deferred.

There was a discussion on the recommendations outlined in the Business Continuity Report. A total of 80 areas had been identified that require business impact assessments and business continuity plans. It was noted the Internal Audit had been completed in October 2017 and there may have been movement in the outcome since.

Mr Thomas-Hands advised the EPR Manager had left in October 2017 and a replacement was being progressed, in the interim the role was being covered within the Medicine Division. He confirmed Core Standards for 2017 the Trust declared Substantially Compliant, 60 Business Impact Assessments at Ward/Departmental level were completed, a BC disaster recovery IT desktop exercise took place in August 2017; this simulated a Cyber-attack on the Trusts IT systems, and a Command and Control exercise simulating the arrival of multiple casualties was undertaken on the 14 July 2017.

There was a discussion on the recommendations outlined in the Safer Bundles Report that had highlighted an issue relating to inadequate policies and procedures. Mr Thomas-Hands reported there had been dispute from the clinicians in relation to the outcome and findings. Over the winter agreed processes had been implemented within Medicine and the organisation was working with Emergency Care Improvement Programme (ECIP).

There was a discussion on the recommendations outlined in the

Temporary Staffing Non Medic/Non Nursing Report and the Director of Finance advised the Exec Lead was the Interim Director of HR & OD who had developed and implemented processes and controls

There was a discussion on the Safe Staffing report that reviewed compliance with the national/local safe staffing levels and the monitoring and reporting arrangements. It was noted there were issues with shifts not being recorded in Rosterpro and internal audit had been asked to undertake a review as separate assurance was required as may be a potential counter fraud issue. A report to be provided to the committee on this detailed piece of work. **IA**

The committee noted to content of the report and the verbal updates and as good governance asked to be cited on any referrals.

Resolution:
The Committee:

- **Received and noted the content of the report.**
- **Asked to be cited on any referrals**

135/17 Internal Audit Recommendations Implementation

Mr Larby reported there had been 31 outstanding recommendations at December 2017, of which 8 had now been implemented, resulting in 23 recommendations past the due date.

The committee asked that responses were requested from executives and the incorporated in the log with the status back by the end of the week. **CL**
The Chief Executive agreed to raise the matter with the executive team. **RB**

Resolution:
The Committee:

- **Received and noted the content of the report.**
- **Requested updates from executives and an updated log within the week**

136/17 Counter Fraud and Security Progress Report

Mr Kelly presented the Counter Fraud and Security Progress Report. Updates were provided relating to ongoing cases together with activity undertaken in relation to counter fraud awareness. There had been three new allegations of fraud since the last Committee.

It was noted a protocol had been written on working whilst off sick including advice and guidance from NHS Counter Fraud Authority and the Crown Prosecution Service and shared with the HR Department. Legal advice was awaited to amend the wording in sickness-absence policy and to reflect the changes in contracts of employment for new starters.

It was noted there had been two further allegations of working whilst on sick leave since the last update.

Resolution:
The Committee:

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

137/17 Losses and Special Payments

Mr Caldicott presented the Losses and Special Payments report to the Committee. The following issues were noted:

Losses for the period 1st November 2017 to 28th February 2018 were £35,007.88 of which £2,989.30 was in respect of losses and £32,018.58 special payments.

Resolution:
The Committee received and noted the content of the report.

138/17 Single Tender Actions/Rolling Schedule of Contracts

Mr Kettle outlined the contract awards from 1st January to 31st January 2018 with a value exceeding £50,000 that had not been the subject of a competitive tender.

The Director of Finance & Performance explained the information was provided to enable to committee to challenge the interpretation of the decisions of awarding contracts.

Mr Heer reiterated the committee had raised a question on why a competitive tender exercise had not been undertaken for the Executive recruitments.

The Director of Finance & Performance explained the Chief Executive had explained he had sought competetive quotations from the market and the award was based on the best value for money provider being selected.

Resolution:
The Committee:

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

139/17 Any Other Business

The committee expressed their thanks and best wishes to Mr Surridge who was leaving Ernst Young.

140/17 Reflections on the meeting

Mr Heer addressed members of the committee and asked them to give their feedback on how the meeting had progressed. The responses were noted.

141/17 Date of Next Meeting

The next meeting would be held on 3rd April 2018 at 3pm in Meeting Suite A, MLCC.

BOARD/COMMITTEE REPORT

Meeting	Trust Board		**Date:** 3 May 2018
Report Title	Use of the Trust Seal		**Agenda Item: 20** **Enclosure No.: 17**
Lead Director to Present Report	Jackie White, Interim Trust Sectretary		
Report Author(s)	Jackie White, Interim Trust Sectretary		
Executive Summary	In accordance with the Trust's Standing Orders the report notifies the Trust Board that the Trust Seal has been used on the following occasion: 9 April 2018 to the following documents relating to the Neonatal Unit and Maternity Theatres project: • Contractor Collateral Warrenty		
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	The Board is recommended to note the report for INFORMATION.		
Trust Objectives	**Provide Safe High Quality Care Across all**	**Not Relevant**	

<table>
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<tr><td><u>Resource Implications</u></td><td colspan="2">None identified within the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">In accordance with Trust Standing Orders.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Not previously received.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Not applicable.</td></tr>
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</table>

USE OF THE TRUST SEAL

1. INTRODUCTION

The Standing Orders of the Trust require the Trust Board to receive a report on the sealing of all documents under the seal of the Walsall Healthcare NHS Trust.

2. SEALING OF DOCUMENTS

2.1 The Trust Board is notified that the seal of the Trust was used on the following occasion in April 2018.

2.2 On the 9 April 2018 the seal of the Trust was affixed to the following document in relation to the Neonatal Unit and Maternity Theatres project:

- Contractor Collateral Warrenty

The documents were signed by Mr Russell Caldicott, Director of Finance and Performance in the presence of Ms Louise Ludgrove, Director of OD & HR and Mr Amir Khan, Medical Director.

The register for the use of the seal was updated and the Register Numbers for the transactions is No. 158.

3 RECOMMENDATION

The Board is requested to note the report for INFORMATION.

BOARD/COMMITTEE REPORT

Meeting	**Trust Board**			**Date: May 2018**
Report Title	*2017/18 Data Security Protection Requirements Summary of Compliance - April 2018*			**Agenda Item: 21 Enclosure No.: 18**
Lead Director to Present Report	*Daren Fradgley – Director of Strategy and Improvement / Senior Information Risk Owner*			
Report Author(s)	*Mark Taylor – Assistant Director IT Services*			

Executive Summary	• In January 2018, to improve data security and protection for health and care organisations the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards – the 17/18 Data Security Protection Requirements (2017/18 DSPR) – that all providers of health and care must comply with.
	• As a trust we must now confirm whether or not we are complying with the 2017/18 DSPR standards. To do this, you are required to submit a response using a web based form.
	• The paper details the questions and our responses for confirmation by the group before the submission is made.
	• The trust is deemed to be have
	  ○ Fully implemented 5 of the standards
	  ○ Partially implement 4 of the standards
	  ○ Has not implemented 1 of the standards
	• The Trust Board or one of the Board Committees is required to have oversight of this submission and advised to request updates from the SIRO as an when items change within the return.			

Purpose	**Approval** ☒	**Decision** ☐	**Discussion** ☐	**Note for Information** ☐
Recommendation	Accept the report and to approve updating the NHSI submission for the 2017/18 DSPR standards as per Table 1: Overview of standards.			
Trust Objectives Supported by this Report	**Provide Safe High Quality Care Across all of Our Services**	**Not Relevant**		
	Care for Patients at Home Whenever we can	**Not Relevant**		

<table>
<tr><td></td><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Not Relevant</td></tr>
<tr><td></td><td>Value our Colleagues so they recommend us as a place to work</td><td>Not Relevant</td></tr>
<tr><td></td><td>Use resources well to ensure we are Sustainable</td><td>Ensure our hospital estate is future proof and fit for purpose</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr>
<tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☒</td></tr>
<tr><td><u>Well-Led</u></td><td>☐</td><td></td><td></td></tr>
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<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2"></td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2"></td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">17/18 Data Security Protection Requirements (2017/18 DSPR)</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">None</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Receive updates as required from the Trusts SIRO</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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2017/18 Data Security Protection Requirements
Summary of Compliance - April 2018

Background

In January 2018, to improve data security and protection for health and care organisations the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards – the 17/18 Data Security Protection Requirements (2017/18 DSPR) – that all providers of health and care must comply with.

The 2017/18 DSPR standards are based on those recommended by Dame Fiona Caldicott, the National Data Guardian (NDG) for health and care, and confirmed by government in July 2017.

As a trust we must now confirm whether or not we are complying with the 2017/18 DSPR standards. To do this, you are required to submit a response using a web based form by 11th May 2018. This response requires Trust Board oversight as part of the compliance submission.

This paper details the questions and our responses for confirmation by the group before the submission is made.

2017/18 DSPR Standards

The table below provides a view of all the standards; it is intended we shall respond to the survey as detailed below.

DSP Requirement	Title & description	Fully Implemented	Partially implemented	Not Implemented
1	Senior level responsibility	✓		
2	Completing IGTK v14.1	✓		
3	Preparing for the introduction of the GDPR		✓	
4	Training staff	✓		
5	Acting on CareCERT advisories		✓	
6	Business Continuity planning		✓	
7	Reporting incidents	✓		
8	Unsupported systems	✓		
9	Onsite cyber & data security assessments by NHS Digital			✓
10	Checking supplier certification		✓	

Table1: Overview of the standards.

Detailed Response

The organisation is compliant and has fully implemented 5 requirements of the 10 DSPRs.

1. Senior level responsibility: There must be a named senior executive responsible for data and cyber security in your organisation. Ideally this person will also be your senior information risk owner (SIRO), and where applicable a member of your organisation's board.
Evidence Daren Fradgley, Director of Strategy and Improvements is the SIRO for the organisation and has ICT residing in his portfolio.

2. Completing the Information Governance toolkit v14.1: By 31 March 2018 organisations are required to achieve at least level 2 on the Information Governance (IG) toolkit. More information about the IG toolkit v14.1
Evidence The IG Toolkit for the 2017/18 year has level 2 compliance for all requirements, the toolkit was submitted to the IG Steering Group in March 2018

4. Training staff All staff must complete appropriate annual data security and protection training. As per the IG toolkit, staff are defined as: all staff, including new starters, locums, temporary, students and staff contracted to work in the organisation.
Evidence As part of the IG toolkit a percentage of staff must have completed either the previous IG training or the new training in the last twelve months, this figure is now recorded as being above 95% In addition staff receive regular updates around IT related IG issues via the daily dose

7. Reporting incidents Staff across the organisation must report data security incidents and near misses, and incidents should be reported to CareCERT in line with reporting guidelines.
Evidence Staff are informed via IG training that any incident or concern is to be logged on the IT service desk or via the Safeguard Risk Management system

8. Unsupported systems Identify unsupported systems (including software, hardware and applications), the trust is to have a plan in place by May 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems.
Evidence An application landscape and infrastructure information system exists, details those applications and Infrastructure that are deemed to be unsupported by the supplier. Unsupported or due to become unsupported systems are on the trust risk register with mitigations until replacements.

The organisation has partially implemented the following 3 requirements:

3. Preparing for the introduction of the General Data Protection Regulation in May 2018 The beta version of the Data Security and Protection toolkit was released in February 2018 and will help organisations understand what actions they need to take to implement the General Data Protection Regulation (GDPR) which comes into effect in May 2018.
Actions required ▪ A recent audit of the preparations for GDPR confirmed the trust had made good progress. ▪ Greater visibility of this plan is required at executive and board level. This will be compliant when GDPR is in place during May

5. Acting on CareCERT advisories: The organisation does not have robust process in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place, but is developing a process. The organisation has plans in place for all CareCERT advisories up to 31/3/18 that are applicable to the organisation and has in post a primary point of contact that is responsible for receiving and coordinating CareCERT advisories. A Threat Assessment Group within IT Services meets on a weekly basis to discuss the CareCert advisory's that have been released.
Actions required ▪ Develop a robust process to handle High Severity CareCert advisories.

6. Business Continuity Planning:
Comprehensive continuity plans must be in place to support the organisation's response to data and cyber security incidents.

- Partially implemented: The organisation is developing a business continuity plan(s) for data and cyber security incidents. The plan(s) will take into account the potential impact of any loss of services on external organisations in the health and care system.
- The business continuity plan for cyber security incidents has been tested in 2017/18 with a report being submitted to the Emergency Planning Group

Actions required
- Work with the newly appointed emergency planning officer on the business continuity plans for the trust

10. Checking Supplier Certification:
Organisation should ensure that any supplier of critical IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification (suppliers may include other health and care organisations).

- Partially implemented: The organisation has checked that the suppliers of IT systems that relate to patient data, involve clinical care or identifiable data have appropriate certification, and can evidence that all suppliers have such certification.

Actions required
- Contact suppliers that have not supplied the appropriate evidence of certification

The organisation has not implemented following requirement:

9. On-site cyber and data security assessments
Your organisation must:
- Have undertaken or have signed up to an on-site cyber and data security assessment by NHS Digital
- Act on the outcome of that assessment, including any recommendation, and share the outcome of the assessment with your commissioner.

Actions required
- Liaise with NHS Digital to undertake an on-site cyber and data security assessment.

Recommendations

The board is required to have oversight of the response before the first submission on 11th May 2018. It is recommended that members accept the report and request an update at regular interval as advised by the SIRO.