Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 7 JUNE 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.	Staff Story	Learning		Verbal	10.00
CHAIR'S BUSINESS					
2.	Apologies for Absence	Information	Chair	Verbal	10.30
3.	Declarations of Interest	Information	Chair	ENC 1	
4.	Minutes of the Board Meeting Held on 3 May 2018	Approval	Chair	ENC 2	
5.	Matters Arising and Action Sheet	Review	Chair	ENC 3	10.35
6.	Chair's Report	Information	Chair	ENC 4	10.40
7.	Chief Executive's Report	Information	Chief Executive	ENC 5	10.45
QUALITY IMPROVEMENT					
8.	Serious Incident Report	Discussion	Acting Director of Nursing	ENC 6	10.55
9.	Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Acting Director of Nursing	ENC 7	11.00
10.	Patient experience report	Discussion	Acting Director of Nursing	ENC 8	11.10
11.	Quality Account 2017/18	Approval	Acting Director of Nursing	ENC 9	11.20
12.	Quality and Safety Committee Highlight Report and Minutes	Information	Committee Chair	ENC 10	11.30
13.	CQC preparation	Information	Chief Executive	ENC 11	11.40

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
14.	CNST Incentive Scheme Response	Approval	Acting Director of Nursing	ENC 12	11.50
STAFF ENGAGEMENT AND DEVELOPMENT OF A CLINICALLY LED ORGANISATION					
15.	Workforce update	Information	Committee Chair	Verbal	12.00
BREAK – TEA/COFFEE PROVIDED					12.10
FINANCIAL IMPROVEMENT					
16.	Financial Performance Month 1	Discussion	Director of Finance & Performance	ENC 13	12.20
17.	Performance and Quality Report Month 1	Discussion	Director of Finance & Performance	ENC 14	12.30
18.	Performance, Finance & Investment Committee Highlight Report & Minutes	Information	Committee Chair	ENC 15	12.40
DEVELOPING OUR CLINICAL SERVICES STRATEGY					
19.	Partnership Update	Information	Director of Strategy & Improvement	ENC 16	12.50
GOVERNANCE AND COMPLIANCE					
20.	Audit Committee Highlight Report and Minutes	Information	Committee Chair	ENC 17	13.00
21.	Annual self certification provider licence	Approval	Director of Strategy & Improvement	ENC 18	13.10
22.	Annual report 2017/18	Approval	Director of Finance & Performance	ENC 19	13.20
	Reflections from Meeting - Chair				
23.	**QUESTIONS FROM THE PUBLIC**				
24.	**DATE OF NEXT MEETING** Public meeting on **Thursday 5 July 2018** at 10.00 a.m. at the Manor Learning and Conference Centre, Manor Hospital				
25.	**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).				

MEETING OF THE PUBLIC TRUST BOARD – 7th June 2018					
Declarations of Interest					**AGENDA ITEM: 3**
Report Author and Job Title:	Jackie White Interim Trust Secretary		**Responsible Director:**	Danielle Oum	
Action Required	**Approval**	**Decision**	**Assurance and Information X**		
			To receive and discuss	**To receive**	
Recommendation	Members of the Trust Board are asked to: Note the report				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.				
Resource implications	There are no resource implications associated with this report.				
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.				
Operational Objectives 2018/19	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme				
	Develop the culture of the organisation to ensure mature decision making and clinical leadership			**X**	
	Improve our financial health through our robust improvement programme				
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts				

EXECUTIVE SUMMARY

The report presents a Register of Directors' interests to reflect the interests of the Trust Board members.

The register is available to the public and to the Trust's internal and external auditors, and is published on the Trust's website to ensure both transparency and also compliance with the Information Commissioner's Office Publication Scheme.

Walsall Healthcare NHS
NHS Trust

Register of Directors Interests at May 2018

Name	Position/Role at Walsall Healthcare NHS Trust	Interest Declared
Ms Danielle Oum	Chair	Board Member: WM 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 Kara Blackwell	Acting Director of Nursing	No Interests to declare.
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.

Mrs Jackie White	Interim Trust Secretary	Director of Applied Interim Management Solutions Ltd

Report Author: Jackie White, Interim Trust Secretary
Date of report: 7th June 2018

RECOMMENDATIONS

The Board are asked to note the report

Walsall Healthcare NHS Trust

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 3RD MAY 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
Mr P Thomas-Hands	Chief Operating Officer
Ms K Blackwell	Acting Director of Nursing

In Attendance:

Ms L Ludgrove	Interim Director of Organisational Development and Human Resources
Mrs J White	Interim Trust Secretary
Miss J Wells	Senior Executive PA (Minutes)

Members of the Public 0
Members of Staff 4
Members of the Press / Media 0
Observers 3

The meeting was quorate in line with Item 3.11 of the Standing Orders, Reservation and Delegation of powers and Standing Financial Instructions; no business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and members (including at least one member who is also an Officer Member of the Trust and one member who is not) is present.

021/18 Patient Story

Mr Baker and Ms Ward with their baby son, Aston-Lee attended the meeting to share their positive experience recently within the Neo-natal Unit.

Mr Baker explained that Aston-Lee was due on 12th May 2018 but was born prematurely on 19th March 2018. The care and consideration of the staff had been fantastic within the maternity ward. The monitoring of both mother and baby was exceptional, thorough and accurate. Mr Baker advised that it was a scary time for the parents but the staff instilled confidence. Mr Baker discussed that the way the staff were with the other babies in the department and their family members could not be faulted.

Ms Oum thanked Mr Baker and Ms Ward for sharing their feedback with the board members, adding that it was great to hear positive feedback. The Neo-Natal Unit had been an area of improvement which had received focus in order to achieve better standards.
Mr Baker replied that he had seen the Requires Improvement rating and signage and was surprised by this as it did not reflect the good standard of care received which appeared to be the same for all of the other patients on the ward and in massive contrast to what was outlined in the ratings.

Questions and Comments

Ms Oum asked if there were any areas that could have been improved.
Mr Baker responded that there were none. All staff were very welcoming and nothing was too much trouble, both over the phone and in person which made the whole experience much easier to cope with.

Ms Oum congratulated Nicola Wenlock, Divisional Director of Midwifery and Fateh Ghazal, Deputy Clinical Director for Obstetrics & Gynaecology, who were in attendance and members of the teams involved.

Professor Beale stated it was refreshing to hear a positive story. Professor Beale advised that work had been undertaken in the midwifery unit to improve communication by staff and asked whether Mr Baker could offer his thoughts.
Mr Baker replied that staff were helpful, friendly, thorough, and coherent, with clear explanations given.
Ms Ward added that it was reassuring to know they could leave the hospital and know Aston-Lee would be looked after, reducing worry and knowing that he was in the best place.

Mr Gayle thanked Mr Baker and Ms Ward for sharing their story and congratulated the Neo-Natal team. It was encouraging to hear positive comments of the service received by patients and their families.

Mrs Ludgrove appreciated Mr Baker and Ms Ward taking the time to come and share their story and giving their feedback.

Ms Blackwell advised that it was really reassuring to hear of the improvements made as much work had taken pace in order to achieve a better experience for patients.

022/18 Apologies for Absence

Apologies were noted from;

- Mr Daren Fradgley, Director of Strategy & Improvement

023/18 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.

Resolution

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

024/18 Minutes of the Board Meeting Held in Public 5th April 2018

The minutes of the meeting held on 5th April 2018 were approved as a correct record.

Resolution

The Board approved the minutes of the meeting held on the 5th April 2018 as an accurate record.

025/18 Matters Arising and Action Sheet

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

195/17 – Reports were ongoing and not a one off action.
306/17 – Would remain on the action log until it was fully completed.
226/17 – Measures and actions had started but were still a distance from completion. Assurance would be sought through the Quality and Safety Committee.

Mr Heer suggested a refresh of the RAG ratings.

Resolution

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

026/18 Chair's Report

Ms Oum presented the report which was taken as read.

Resolution

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

027/18 Chief Executive's Report

Mr Beeken presented the report which outlined his thoughts, reflections and intentions in the form of the Trust four priorities for the financial year;

Improving Quality

Preparation for the third CQC inspection was about to commence. There was still a lack of certainty whether the inspection would focus on specific areas or a full inspection across the organisation but the Trust would prepare for a full inspection and focus on the well-led elements. The use of resources assessment would form part of the

work lead by NHSI.
The Trust had secured the support of a former Director of Nursing and NHSI Director to assist with inspection preparation. Work would continue with Mrs Sue Holden, NHSI Improvement Director to track quality improvement.

Culture, staff engagement and clinical leadership

Mr Beeken encouraged Board members to attend the CEO briefing the following week. Mr Simon Johnson, Engagement Lead would be in attendance, leading an interactive session of the staff survey results and three key areas of concern seeking ideas of how to tackle them in a meaningful way. This was a critical area of work which the Board needed to sponsor.

Financial Improvement

Financial Improvement Programme meetings with Executive sponsors had been scheduled over the next two weeks.

Clinical Strategy

The report highlighted some leadership changes within the Black Country STP. Contribution through place based care would continue and assist in accelerating clarity of clinical strategy.

Questions and Comments

Mr Dunn referenced the CQC inspection and queried how the Board could be assured that the Trust were on track to achieve the required preparation.
Mr Beeken replied that defined mechanics were not yet in place but would be shaped with the assistance of NHSI. Regular reports would be provided to the Board.
Mr Dunn supported the approach and asked when the Board would likely receive the first report.
Mr Beeken advised that negotiations were being concluded for a start date of 10th May 2108 for the Improvement Consultant and a report would be presented to the Board at the June meeting.

Mrs Furnival informed that the STP had struggled to engage with local government. Involvement had been sought from Black Country local government Executives and positive feedback was received.

Mr Heer welcomed a Board summary report in relation to CQC preparation but asked how pace could be injected given that there was a small window of opportunity for influence.
Mr Beeken responded that the leadership teams would determine weaknesses in capacity, capability and system approaches that prevented staff making decisions themselves. The proposal of forming an Operational Management Board formed a later agenda item

Mr Thomas-Hands made reference to pace and informed that an Operational Management Board was a big step forward in reducing the number of meetings that clinicians attended, releasing them for other duties.
Mr Gayle referenced the improvement in CQC rating to Requires Improvement and questioned whether Mr Beeken felt there was a lot

of work to be done to retain that rating or a move to Good. Community Services were rated as Outstanding and how were they being used to assist others to make improvements.
Mr Beeken replied that care needed to be taken to not stagnate on the fundamentals. Mandatory training was not where it needed to be nor were IDPR figures. Requires Improvement meant requires improvement and staff should be reminded of that fact. Posters that publicised progress made were being removed because the mind-set now needed to change in order to move on. There was lots of work still to do and colleagues needed to recognise that it was constant.
Community services needed to be bought more to the fore. Methods and approaches needed to be picked up and disseminated.
Ms Oum stated that her staff visits echoed that there were a lot of staff who were innovative and keen.

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

028/18 Serious Incident Report
Ms Blackwell presented the Serious Incident report and highlighted the following key points;

- There were 17 new Serious Incidents reported in March 2018.
- 8 pressure ulcers were reported, 3 infection control incidents and a Never Event.
- An investigation was underway in terms of the Never Event.

Questions and Comments

Mr Dunn reviewed the Serious Incident graph but asked for clarification of aspirations, what plans were in place to achieve and the timescales.
Ms Blackwell replied that a large proportion of Serious Incidents were pressure ulcers that did not require reporting last year and did not form part of the report previously. A review of pressure ulcers was ongoing in order to formulate a plan to agree timescales and reduce the number.
Mr Dunn asked whether the Board would receive a programme and targets to measure against.
Ms Blackwell replied that they would and a pressure ulcer report would highlight the actions.
Mr Beeken advised that a top patient safety measure adopted in the new Improvement Programme was tracking over time the increase in reporting of incidents and lowering the percentage of harm to patients.

Mr Heer informed that a larger local Trust had never reported more than three pressure ulcers in any month which could be a benchmark. Mr Heer queried how the Board could be assured that immediate lessons learnt from the Never Event were in place whilst the investigation was underway.
Ms Blackwell replied that following an immediate review, actions

were put in place. The wider learning specifics were yet to be released.

Mr Khan agreed with Mr Beeken's comment that we should be aiming to improve reporting and look to reduce moderate harm incidents.
In relation to the three reported infection control incidents, discussion had taken place at the Quality and Safety Committee. Mr Khan gave credit to the teams to minimise flow issues during pressure periods and ward closures.
In regard to the Never Event, immediate actions were put in place to ensure there could be no repeat and was shared with the wider organisation. An external chair had been appointed as an independent review to understand how it occurred.

Mr Thomas-Hands reassured that a medical ward was emptied during April 2018. Wards affected by norovirus would be deep cleaned following advice from infection control recommendations.

Professor Beale queried whether any audit was in place to ensure that actions and procedures were being followed.
Mr Khan stated that processes put in place were regularly audited and presented at the Quality and Safety Committee.

Ms Oum asked that Serious Incidents were reviewed at the new Operational Management Board and included specific reporting in relation to pressure ulcers prior to review by the Quality and Safety Committee.
Lessons learnt from closed incidents needed consideration and support to staff who were over stretched incorporated into their IDPR.
Mr Khan advised that the workload of the diagnostics team and medicines was under review and actions were in place with a view to alleviate pressure. Findings would be shared at the Quality and Safety Committee.

Mrs Ludgrove advised that there were some key clinical areas where all Trusts struggled to recruit staff. The Trust was committed to making necessary culture changes in order to progress and embrace the alternatives. Activity was increasing and equalling pressure to staff.

Resolution
The Board:

- **Received and noted the content of the report.**
- **A pressure ulcer report would be shared.**
- **Benchmarking would be put in place.**

029/18 Monthly Nursing and Midwifery Safer Staffing Report

Ms Blackwell presented the report and highlighted the following key points;

- The overall vacancy total was 72 WTE in March 2018.
- Agency use of Registered Nurses and Support Workers increased during March 2018, however it was noted that there was an increased pressure of norovirus.
- A total of 6 overseas nurses were working within the Trust.
- 7 posts had been offered to trained staff in Theatres following a recruitment campaign.

Questions and Comments

Mr Heer advised that the report was lengthy and difficult to understand which appeared to contain conflicts and missing data.

Mr Dunn shared frustration with the report. It appeared that many recruitment exercises had taken place but minimal progress made. The changed rate for bank staff also had little impact. The use of Thornberry as the highest priced agency needed to be eliminated.
Mr Dunn requested a more structured approach detailing the short, medium and long term objectives.

Mr Gayle noted the bank staff recruitment figures over the past 3 months as 45 recruited RNs and 40 CSWs but queried the benefit as agency costs had still risen.
Ms Blackwell replied that the number of shifts filled by bank staff per month was in the region of 62 though there were difficulties as they were employed elsewhere. Ms Blackwell added that quality standards had improved.

Mr Beeken cautioned that agency and bank staff should not be used in the same context and that the use of temporary workforce should not be seen as negative.
Mr Heer advised that being bold was recognition of the inability to recruit to posts and encouraged to embrace big, bold changes and building a framework around it.

Professor Beale queried long term viability due to the high vacancy figures and asked whether enough was being done in terms of recruitment and restructure.
Ms Blackwell advised there was a national shortage of RNs and a number of Trusts were pitching for the same staff. Regular recruitment days were being held and focus on overseas nurse recruitment though they were not large numbers.

Mr Khan expressed the need to be realistic about what was right for the population of Walsall. Changes were made to the stroke service to create a collaboration which was the right thing to do. Focus had shifted to Pathology services with the same mind-set, being open and honest to look at working with partners in order to achieve a sustainable service for the patients of Walsall.
Mr Khan welcomed the Associate Nursing initiative.

Mrs Ludgrove advised that new roles would address a proportion of the vacancy numbers. Nursing figures had lifted though they were still small. Traditional methods of recruitment hadn't been

successful. Mrs Ludgrove was looking to get a view from current staff from a number of areas to ascertain what would make the posts more attractive.

Ms Oum acknowledged that Ms Blackwell had inherited the paper from a predecessor and would take on board the feedback given for future reports.

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

030/18 Update on NHS Improvement Review of Internal Nursing Temporary Workforce Arrangements

Ms Blackwell advised the paper gave an update of the key objectives in relation to the NHSI review which started on 17th April 2018. It was anticipated that a report and findings would be provided by the end of May 2018.

Questions and Comments

Ms Oum welcomed the report and the outcome of the findings once received.

Mr Heer welcomed the review but queried how it aligned to the Trust in terms of finance, quality and safety impacts and whether there would be separate reports that needed to be pulled together.
Mr Beeken replied that the report would be simplified and brought together in a coherent set of objectives for the Board to review.

Professor Beale questioned whether a review of current practices in detail would assist in fixing the issues which were already well known.
Ms Oum responded that review of how other Trusts operated would be useful.
Ms Blackwell advised there was a workforce action plan based on internal audit recommendations.

Ms Oum asked Executive colleagues to work together to review the benefits and report findings to be reported through the Quality and Safety Committee.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Noted Executive colleagues would work with NHSI and report findings to the Quality and Safety Committee.**

031/18 Quality and Safety Committee Highlight Report and Minutes

Mrs Harris presented the highlight report from the most recent meeting held on 26th April 2018, together with the approved minutes of the meeting held on 29th March 2018. The following key points were highlighted:

- The Patient Care Improvement Programme was discussed.

Work was in progress.

- The Trust was operating a 7 day trauma list. Issues with compliance and representation had been resolved.
- Statistics of pressure ulcers had been reviewed. It was noted that in terms of communities and ethnicity there was a broad representation and further work needed to be done.
- Mortality rates were discussed, noting the rise in deaths during December and January along with an increase in deaths within a 0-1 day length of stay.
- VTE performance had improved and focus was on sustaining that improvement.

Mr Khan advised that mortality figures did take time to return to a normal range. A review was underway to establish what could be done differently. HSMR and SHMI were currently within limit. In regard to deaths in 0-1 day length of stay, actions were being put in place for the following year with operational teams and linking with community teams. A rise in deaths during the winter period could not just be accepted and the introduction of a Medical Examiner was being looked in to.

Mr Khan informed that there were no breaches on wards, only within critical care. The new building scheduled to be built would help to reduce the number of breaches.

Questions and Comments

Mr Caldicott praised that VTE achieved 95%, noting that performance had improved and appeared on track to increase over the coming months. Lots of work was underway to tackle safeguarding and training compliance.

Professor Beale referenced the breast screening issue that was being reported nationally in the news and asked what impact it would have and whether the necessary recalls had been put in place.
Mr Khan replied that breast screening was delivered by Sandwell, not Walsall. An update would be shared once it was available from Sandwell.

Mrs Furnival advised that with reference to deaths in the community, patients should be able to pass away in their place of choice, expressing the need to work with alliance and placed based teams to work more systematically to facilitate what people want, ultimately assisting the hospital to address pressures.

Mr Thomas-Hands advised that system breakdowns had been discussed at the A&E delivery board. Locality teams were conducting a review into attendance avoidance.

Ms Oum welcomed the information regarding pressure ulcers in the community but expressed concern that there was some time taken to conduct the in depth review to get to the heart of the issues.
Ms Blackwell replied that there was an element of compliance. One aspect that formed part of managing pressure ulcers was to provide

the information that was understood, skilling staff in order to assess correctly.

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

032/18 People and Organisational Development Committee Highlight Report and Minutes

Mr Gayle presented the highlight report from the meeting held on 16th April 2018, highlighting the following key points;

- The workforce impact assessment paper was presented and discussion took place regarding the failure to engage with staff members who would be affected by ward closures.
- KPI information was received and noted a significant reduction in sickness during February 2018, though concerns remained regarding updating ESR.
- Recruitment to be launched shortly for a six month secondment role to lead on internal focus around E, D and I.
- An initiative launched by the Department of Health regarding bullying in the NHS was presented. Understanding what bullying constituted and clear understanding was discussed.
- Executive Attendance at the committee would be beneficial.

Questions and Comments

Mr Beeken informed that he and Mrs White were reviewing Executive attendance at all committees and would be discussing plans shortly with the team.

Professor Beale was concerned to hear about data quality issues, adding that inputting incorrect data was not acceptable.
Mrs Ludgrove advised that there was a mandatory training issue as ESR was not a user friendly system. Main issues related to the timeliness and discipline of data entry and the closing of those incidents.
Professor Beale did not understand why it took so long to convey the importance of accurate data.
Mrs Ludgrove replied that it took time to change practices and managers tended to prioritise other tasks. A deep dive needed to be undertaken to establish the issues and managers needed to be reminded to understand maintaining timeliness of inputs.
Mr Beeken stated that ESR was a difficult system which led to unwillingness to engage with it, however ESR would be the one version system that the Trust utilised.

Mr Caldicott informed that the apprentice levy resource availability would be reported through a sub-committee of the Performance, Finance and Investment Committee for all to have sight of.

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

033/18 DRAFT terms of reference and proposal to establish a Trust Management Board

Mr Beeken informed that there was a proposal to create a Trust Management Board to include Executive Directors, Clinical Managers and Clinical Heads of service. A highlight report would be presented at Trust Board. The Management Board would review business cases, service plans, annual plans and focus on mitigation of risk and Board Assurance Framework. The establishment of the meeting would supersede Trust Clinical Executive, Trust Workforce Executive and Trust Quality Executive meetings. Due to risks with the financial plan, Performance and Finance Executive would remain but would be reviewed in 6 months.

Divisional reviews would move to monthly to maintain the intensity of performance oversight with each division.

Mr Beeken sought approval to establish the Trust Management Board.

Questions and Comments

Mr Dunn queried the timescales involved, priorities and would like to see a structure. Mr Dunn added that a 'Board' may not be an appropriate title.

Mr Beeken replied that the main priority would be the Trust strategic expectations and would consider alternative names.

Professor Beale thought the establishment would be a good step forward, though the membership appeared extensive. Professor Beale advised that attendees should be expected to attend 90% of the meetings, referencing that 60% as outlined in the paper was too low.

Mr Beeken replied that 90% attendance was likely and would consider revision of the membership.

Mr Heer was not enthusiastic of the decision, stating that a membership of 25-30 people attending a decision making forum was not conducive of a fast paced organisation, adding that twice a month was too frequent and should not consist of more than 10 attendees.

Mr Beeken replied that there was undoubtedly a clinical engagement and cultural change issue. There were known capacity and capability issues within the organisation and the establishment of the Management Board would give the opportunity to encourage decisions to be made within teams in an appropriate forum with senior leaders.

Mrs Ludgrove informed that the organisation was investing in developing senior clinical staff and looking at proposals. It had been reported that staff did not currently feel that they were at a level footing for discussion.

Ms Oum observed that it was a new way of working. There were concerns and caveats raised but added it was an opportunity to engage with clinical leadership. The meeting would be established with the caveats discussed and noted the Board's majority approval. A review would take place in 6 months.

Resolution
The Board:

- **Received and noted the content of the report.**
- **A majority vote approved the establishment of a Trust Management Board with the caveat of a revised membership and title.**

034/18 Financial Performance Month 12

The Financial Performance for month 12 was reviewed and the following key points were highlighted;

- The Trust had achieved a £23.0m deficit against the original planned deficit £20.5m
- Income position was down against plan. The underperformance was a consequence of reduced Obstetric activity, outpatients and elective reduction in births. Births had reduced to 3600 from the 4200 cap which should be maintained.
- Expenditure was high in relation to temporary workforce. NHSI would form part of a support network to ensure that costs were minimised into the new year.

Questions and Comments

Mr Dunn noted that the exit run rate was higher than anticipated and asked how this would be corrected into the current year.
Mr Caldicott replied that there was a run rate risk and additional resource had been built into the plan as a result. Specific work was underway to reduce the risk. Thorough plans were in place, assurance could not be given at this stage.

Mr Dunn asked how assurance would be given in relation to capability issues and filling gaps following the departure of KPMG.
Mr Caldicott replied that a new team had been developed including appointment of a PMO Director. The Performance, Finance and Investment Committee would review progress.

Mr Heer called for more focus on energy and issues in terms of cash flow, particularly during the first quarter.
Mr Caldicott agreed and stated that the Trust were on a journey to financial sustainability. The Divisional Operations teams were discussing workforce models with a view to irradiating costs.

Mr Thomas-Hands advised that he was anxious post KPMG but was assured that people were in place and working with accountable officers.

Mr Gayle queried the temporary workforce figures asking whether locum numbers were included, noting that they were at the highest point since October 2017.
Mr Caldicott replied that the figures included nurses, admin, medical locum and agency staffing.
Mr Gayle added that the summary financial report was not easy to

read, particular for the visually impaired.

Mr Dunn asked whether all briefings had been completed and all targets and objectives shared in readiness for the new financial year. Mr Caldicott confirmed that budget setting processes had been signed off by the divisional teams and budget managers. Cost pressures had been built in and reviews had taken place with Executive Directors.

Mrs Blackwell advised that temporary nursing spend systems were in place though further work was required to strengthen the process and to include risk assessments. Weekly review meetings with Directors of Nursing were taking place.

Mr Thomas-Hands explained that teams were very clear on expectations of their work streams and metrics which had been developed with the clinical operational teams. Weekly meetings with the relevant responsible officers were taking place.

Ms Oum observed that the Trust had established a PMO Director and were backfilling to increase capability in the teams but queried what was different this year in order to deliver the financial plan.
Mr Caldicott replied that robust KPIs had been developed to track performance with weekly reported trajectories in order to obtain clarity of productivity aspects. The divisions had developed and signed up to the targets.
Mr Thomas-Hands added that there had been more clinical involvement than previously, following the work undertaken with KPMG.
Mr Beeken advised that the percentage of CIP was showing signs of improvement during the new financial year. There was growing demand therefore the utilisation of the resources had to be clear and making attempts of being bold and different with the workforce.

Mrs Ludgrove had seen more open and honest conversations taking place at Board meetings where all were clear about the reality of being held to account and that message was also clear throughout the organisation.

Mr Heer felt that enough change was not being made in the system of momentum, monitoring and the ability to motivate when energy was lacking.

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

035/18 Performance and Quality Report Month 12

Mr Caldicott presented the Performance and Quality Report for month 12 and highlighted the following key points:

- VTE figures had improved.
- 6 week diagnostics failed to achieve targets.

- A&E Performance was reported at 81.2% which was a slight fall due to previous months and was due largely to operational pressures as a result of the norovirus.

Questions and Comments

Mr Beeken advised that A&E 4 hour performance had been considerably ahead during April 2018. There was a potential risk in terms of diagnostic waiting times where an opportunity may have been missed to prioritise patient flow and investigation following GP referral.

Mr Thomas-Hands stated that the implementation of the improvement programme was underway and an accountability meeting was being held the following week with the expectation for performance to improve above trajectory.
Mr Thomas-Hands added that RTT in April was over performing and DNA rate had dropped to 11%.

Mrs Furnival advised of the statutory responsibility for safeguarding and offered assistance. There were challenges throughout the system and recommended being part of the multi-agency training. **K Blackwell**
Ms Oum asked Ms Blackwell to liaise with Mrs Furnival regarding the offer of assistance.

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

036/18 Performance, Finance & Investment Committee Highlight Report and Minutes

Mr Dunn presented the highlight report, advising that the previous two Performance, Finance and Investment Committees were cancelled due to quorate issues, however the finance plan had been reviewed for the coming year.

Ms Oum referenced the quoracy issues and asked the Non-Executive Directors to ensure that focus was on priority areas.

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

037/18 Partnership Update

Mr Beeken presented the report on behalf of Mr Fradgley and highlighted the following key points;

- Practical and productive conversations had taken place regarding the Walsall Together leadership scheme, coordinating care in the community and assigning costs.
- Clarity of the host provider was being sought from Commissioners.
- There was a risk issue with engagement of primary care and the GP federations not always being represented. The CCG were to provide clarity of the locality of clinical leadership and involvement which could be built into the operating mode.

- Mr Beeken and Ms Oum had met with all acute organisations counterparts. A route map was requested by NHSI and NHSE outlining how the STP leadership team would work across the entire Black Country.

Questions and Comments

Mrs Furnival informed that Board meetings had been held within the last week, discussing the case for change which was being reviewed through decision making bodies who had endorsed the case and work had started to assign staff leads.
A full business case was anticipated by October 2018. Key components were to focus on the commercial, clinical integration.

Mr Dunn expressed concern of the business case due by October 2018 and queried whether an interim would be put in place to assist.
Mr Beeken replied that substantive teams would not be put in place until the business case had been approved. Secondment and interim arrangements would be considered in order to mitigate risk.
Mrs Harris asked whether there were available resources or funding.
Mrs Furnival responded that funding was available and costings would be quantified during the next phase.

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

038/18 Annual Plan Update

Mr Caldicott advised that the Annual Plan had been reviewed at the Quality and Safety Committee, Performance, Finance and Investment Committee and Extraordinary Trust Board. The following key points were highlighted;

- Focus remained on the quality commitment and the Integrated Improvement Plan.
- The Critical Care Unit was due to open. There was capital investment in maternity and Neo-natal and the Emergency Department facility.
- There was an £18.6 deficit plan with a £13m CIP target.
- A control total given for run rate risk had not been accepted as a mitigated level therefore the Trust would not receive sustainability funding in the new financial year.
- Staff engagement was crucial.
- Pathology integration continued with partners.
- There was a commitment to move forward with Walsall Together though timeframes are tight.

Ms Oum added that the Trust was clearly focused on the 4 priorities.

Questions and Comments

Mr Heer queried why the control total was rejected.
Mr Caldicott explained that a move from £18m deficit to a £5m control total would require £13m savings and the highest CIP target ever tackled by the Trust which the board felt unable to accept.

The Annual Plan was approved by the Board members.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Approved the Annual Plan.**

039/18 Audit Committee Highlight Report and Minutes

Mr Heer provided a verbal update of the meeting held on 30th April 2018 with the approved minutes of the meeting held on 12th March 2018. The following key points were highlighted;

- External Audit advised that the Trust were on track to deliver.
- An Extraordinary Audit Committee had been scheduled on 24th May 2018 to approve documents in readiness to formally adopt the accounts on 25th May 2018.
- It was recommended that the Board provided final approval.

Questions and Comments

Ms Oum suggested that the majority of Board members attended the Audit Committee scheduled for 24th May 2018, therefore the invite would be extended to all Board members to attend. Mrs White would forward invites to members not included in the membership. **J White**

Resolution
The Board:

- **Received and noted the content of the report.**
- **Noted the approval of adoption of accounts at the Audit Committee meeting on 24th May 2018.**

040/18 Use of the Trust Seal

Mrs White presented the paper which was for information and taken as read.

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

041/18 2017/18 Data Security Protection Requirements - Summary of Compliance - April 2018

Mr Thomas-Hands had to briefly leave the meeting therefore was not able to provide the update on behalf of Mr Fradgley.
The report outlined areas of work that were underway and would be reviewed at the Performance, Finance and Investment Committee.

Questions and Comments

Mr Gayle noted that some areas were partially achieved and asked whether they would be fully compliant by 25th May 2018.
Mr Caldicott replied that they would be.

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

042/18 Questions from the Public

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

043/18 Date of Next Meeting

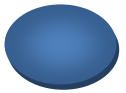
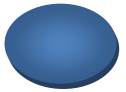
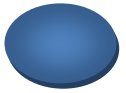
The next meeting of the Trust Board held in public would be on Thursday 7th June 2018 at 10:00a.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

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 3

Walsall Healthcare NHS Trust

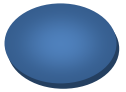
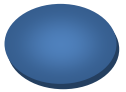
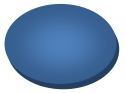
PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
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.	
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~~ 05/07/18	**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~~ 05/07/18	**Update** A review of the risk register will take place during May with a view to an updated risk register being presented to Board in July	

ENC 3

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

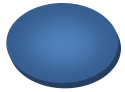
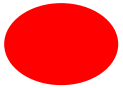
Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
	Review Board Assurance Framework to ensure the right challenges were articulated with a view to there being fewer BAF risks.	Trust Secretary	~~08/03/2018~~ 05/07/18	**Update** A review of the board assurance framework will take place during May with a view to a Board session to agree the risks in June / July	
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	
035/18 Performance & Quality Report	Ms Blackwell to liaise with Mrs Furnival regarding the offer of assistance in relation to multi-agency training.	Acting Director or Nursing	07/06/2018		

Key to RAG rating

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

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

 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.

MEETING OF THE PUBLIC TRUST BOARD – 7th June 2018					
Chair's Report				**AGENDA ITEM: 6**	
Report Author and Job Title:	Danielle Oum, Chair		**Responsible Director:**	Danielle Oum, Chair	
Action Required	**Approval**	**Decision**	**Assurance and Information**		
			To receive and discuss	**To receive X**	
Recommendation	Members of the Trust Board are asked to: Note the report				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.				
Resource implications	There are no resource implications associated with this report.				
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.				
Operational Objectives 2018/19	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme			**X**	
	Develop the culture of the organisation to ensure mature decision making and clinical leadership			**X**	
	Improve our financial health through our robust improvement programme			**X**	
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts			**X**	

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.

Walsall Healthcare NHS
NHS Trust

Chair's Update

PRIORITY OBJECTIVES FOR 2018/19

1. **Quality improvement**
   I was impressed by the sense of order and purpose at a bed meeting I attended recently, indicating improved management of patient flow.

2. **Financial improvement**
   I was pleased to chair an Extraordinary Board meeting to approve last year's financial accounts and also this year's annual plan which sets out our ambitions for the coming year.

3. **Improving staff engagement and development of a clinically led organisation**
   I welcomed the opportunity to attend the Chief Exec Briefing sessions which facilitated discussion around the issues highlighted in the National Staff Survey.

   Colleagues continue to be generous in accommodating me to work shadow and visit services. I am seeing high levels of professionalism and ambitions to improve services for patients. I am also seeing challenges facing colleagues delivering services on the frontline, providing important context when considering issues at board level – I welcome more invitations to visit services.

4. **Developing our Clinical Services Strategy through organisational collaboration**
   This month I have focused on national and regional networking and collaboration, primarily looking at working in partnership to develop strategic solutions to workforce issues of recruitment, retention, leadership, equality, diversity and inclusion.

Meetings attended / services visited

Emergency Department
Learning Disability Team
Freedom to Speak Up Guardians
Volunteers' Week
Children's Safeguarding
Theatres
PALS
Walsall Together Partnership
HFMA Chairs, Non Executives and Lay Members Forum
Regional Talent Board Workshop
WM NHS Workforce Race Equality Workshop
Senior BAME Influencers Group

RECOMMENDATIONS
The Board are asked to note the report

Danielle Oum

June 2018

<table>
<tr><td colspan="5">MEETING OF THE PUBLIC TRUST BOARD – 7th June 2018</td></tr>
<tr><td colspan="4">Chief Executive's report</td><td>AGENDA ITEM: 5</td></tr>
<tr><td>Report Author and Job Title:</td><td colspan="2">Richard Beeken, Chief Executive
Jackie White, Interim Company Secretary</td><td>Responsible Director:</td><td>Chief Executive</td></tr>
<tr><td rowspan="2">Action Required</td><td rowspan="2">Approval</td><td rowspan="2">Decision</td><td colspan="2">Assurance and Information X</td></tr>
<tr><td>To receive and discuss</td><td>To receive</td></tr>
<tr><td>Recommendation</td><td colspan="4">Members of the Trust Board are asked to:
• Receive the update from the CEO with regards to key actions related to delivery of the four Trust priorities for 2018/19
• Receive the attachment which sets out national regulatory guidance, instruction and best practice received by the CEO's office during May 2018
• Seek assurance that the key actions in relation to regulatory requests and best practice, are being taken forward by the appropriate executive director. An assurance system has been established by the Interim Company Secretary which will oversee evidence of each key request having been actioned</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="4">The report contains actions and information which are relevant to all Trust strategic objectives and will, in some part, address BAF and Trust risks</td></tr>
<tr><td>Resource implications</td><td colspan="4">There are no explicit financial resource implications with respect to this report</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="4">There are no legal or equality & diversity implications associated with this paper</td></tr>
<tr><td rowspan="4">Operational Objectives 2018/19</td><td colspan="3">Continue our journey on patient safety and clinical quality through a comprehensive improvement programme</td><td>X</td></tr>
<tr><td colspan="3">Develop the culture of the organisation to ensure mature decision making and clinical leadership</td><td>X</td></tr>
<tr><td colspan="3">Improve our financial health through our robust improvement programme</td><td>X</td></tr>
<tr><td colspan="3">Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts</td><td>X</td></tr>
</table>

EXECUTIVE SUMMARY

Chief Executive's report

1. PURPOSE OF REPORT

The purpose of the reports is to keep the Board appraised of the high level, critical activities which the organisation has been engaged in during the past month, with regard to the delivery of the four organisational priorities for 2018/19. The report also seeks to set out to the Board, the significant level of guidance, instruction and best practice adoption we received during May 2018 and assures the Board through an allocation to the relevant executive director.

2. BACKGROUND

The Trust has agreed four priorities for 2018/19. These will drive the bulk of our action as a wider leadership team and organisation:

- Continue our journey on patient safety and clinical quality through a comprehensive improvement programme
- Develop the culture of the organisation to ensure mature decision making and clinical leadership
- Improve our financial health through our robust improvement programme
- Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts

3. DETAILS

Continue our journey on patient safety and clinical quality through a comprehensive improvement programme

Suzie Loader has now started work as our Improvement Consultant, with a particular focus on the implementation of a CQC inspection preparation plan and to advise us on the well-led element of our inspection and the development of our improvement programme.

It is vital that the Trust show its achievements on clinical quality in the forthcoming CQC inspection. We do not know the likely date of that inspection yet, or its nature, but we are planning for a full inspection. This will be good discipline for the organisation and will also stand us in good stead because that preparation will focus on the fundamentals of care and good quality governance, which we need as a baseline from which to start our journey from "requires improvement to good and beyond".

Until the improvement programme content is developed, the Patient Care Improvement Plan (PCIP) is the extant vehicle for assuring ourselves regarding quality improvement against those fundamentals, at both corporate and divisional level. We have become

concerned that the intensity and focus of oversight of PCIP progress has fallen away and to that end, both the executive team and the Quality Committee, have committed to stepping up that oversight and reporting exceptions through the Trust Board.

Develop the culture of the organisation to ensure mature decision making and clinical leadership

In two weeks time, the Trust Management Board will be launched. The executive team have committed to ensuring that as much operational and executive decision making as appropriate, be done in partnership with the clinical leaders and professional heads in the organisation. The Trust Clinical Executive terms of reference are being revamped and the forum will be used as an internal clinical 'senate', to consult with the clinical body of the Trust on significant proposed service changes and reconfigurations.

The search process for a new Director of Nursing and Medical Director is well underway, with interviews planned for these roles on 3rd and 4th July. There will be extensive internal and external stakeholder engagement in this process.

The executive and senior leaders of the organisation have committed to a comprehensive programme of departmental/service visits to publicise the LiA "Pulsecheck" survey. It is our intention to ensure that our response rate will be such that a great deal of significance can then be attached to the results. We will share these with the Board at its August meeting.

The final agenda and speakers at the Trust's leadership conference on 6th July, have been confirmed. The keynote speaker will be Sarah-Jane Marsh, CEO of Birmingham Women's and Children's FT and the afternoon session will be dedicated to both quality improvement leadership and the launch of the new Trust values and behaviours framework. This critical launch will reflect the work done by the Staff Engagement Lead, with hundreds of front line staff.

Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts

Our acute hospital sustainability review work is now nearing its conclusion and will provide us with the raw material from which we can engage other organisations in the Black Country regarding the potential for further clinical collaboration. Successful starts have been made to the collaborations on both stroke and pathology from which we can learn.

Discussions are underway between the Walsall Together providers and the commissioners, about a fair and equitable share of the leadership costs, legal costs and advisory costs associated with the development of the intended host provider model. Once complete, these negotiations will be a trigger for the initiation of the full business case process and the appointment of the interim leadership team which will start to change the MDT and multi-agency working in all community services in Walsall.

4. RECOMMENDATIONS

Members of the Trust Board are asked to:

- Receive the update from the CEO with regards to key actions related to delivery of the four Trust priorities for 2018/19
- Receive the attachment which sets out national regulatory guidance, instruction and best practice received by the CEO's office during May 2018

Seek assurance that the key actions in relation to regulatory requests and best practice, are being taken forward by the appropriate executive director. An assurance system has been established by the Interim Company Secretary which will oversee evidence of each key request having been actioned

Report Author: Richard Beeken, Chief Executive
Jackie White, Interim Company Secretary
Date of report: 31/5/18

APPENDICES
Appendix 1 – New National Guidance, Reports and Consultations.

NEW NATIONAL GUIDANCE, REPORTS AND CONSULTATIONS

The following guidance and policy actions, which have been received from the wider regulatory and policy system during May, have been sent to Executive Directors for review and decision on whether any actions are required for follow up or consideration by Board Committees.

No	Document	Guidance/ Report/ Consultation	Lead
1.			
	Audited accounts for 2017/18 A reminder to Finance directors and governance leads to submit audited accounts for 2017/18 with accompanying documents through the trust portal by midday, Tuesday 29 May. Some of these documents are required as a hard copy, which must be posted on or before Tuesday 29 May	Report / Action	Director of Finance & Performance / Director of Governance
	Pathology data for Q3 and Q4 As part of the next phase of our programme to improve pathology efficiency, the Trust is required to submit data for Q3 and Q4.	Report / Action	Chief Operating Officer
	Rotas for doctors in training — meeting code of practice commitments as we approach the August rotation Guidance document on ensuring as positive an experience as possible for doctors in training, ensuring the notification of new rotas is done in good time.	Guidance	Medical Director / Director of OD & HR
	Launch of NHS Workforce Health and Wellbeing Framework The Framework which has been launched in collaboration with NHS Employers and NHS Improvement, supports collective aims for improving staff health and wellbeing as part of the national workforce strategy. It includes an organisational diagnostic, practical advice and guidance, as well as case studies from trusts	Guidance	Director of OD & HR
	Supporting Research in the NHS NHS England has published their response to the public consultation 'Supporting Research in the NHS: A consultation covering changes to simplify arrangements for research in the NHS and associated changes to the terms of the NHS Standard Contract'. The response summarises the feedback received and outlines the next steps for	Guidance	Medical Director

	implementation		
	Infection prevention and control: board assurance required on Gram negative bloodstream infections Further work is required of boards to ensure robust oversight of the Gram negative bloodstream infection agenda. The Boards must ensure it is compliant with the Health and Social Care Act 2008 by: • regularly monitoring the occurrence of Gram negative bloodstream infections (including E.coli) • making your annual IPC report publicly available as part of your board assurance programme.	Report / Action	Medical Director / Director of Governance
	New and improved reports for patient safety incident reporting A revised format of the summary reports created using the National Reporting and Learning System (NRLS) have been introduced tool to help boards and patient safety teams better understand and improve patient safety culture and incident reporting.	Report / Action	Director of Nursing / Director of Governance
	New data security regulations have come into force As of 10 May 2018 the Network and Information Systems (NIS) regulations place security and reporting requirements on NHS trusts and foundation trusts, and action can be taken where requirements are not met, including penalties of up to £17 million. The NIS regulations have been incorporated into the implementation of the National Data Guardian's ten data security standards	Report / Action	Director of Strategy & Improvement / Director of Governance
	New tool to help boards with effective workforce planning You can use our new operational workforce planning self-assessment tool to carry out an organisational assessment against six key indicators: leadership, technology, information, method and governance, engagement and integration, and strategy.	Information	Director of OD & HR
	Three trusts' innovative approaches to retention Sandwell and West Birmingham Hospitals NHS	Information	Director of OD & HR / Director of

	Trust redesigned the way they recruit nurses, have a protected training budget to up-skill their new staff, and focus on raising awareness of employee benefits. These innovative approaches to retention have led to a reduction in nursing turnover over the past 12 months.		Nursing
	A reminder of your consultancy spending requirements Following some recent breaches, a reminder of your requirement to obtain appropriate approvals (both internally and externally) before commissioning any proposed consultancy support above the £50,000 threshold. For more information, please see the consultancy spending approval criteria and review your financial governance arrangements if necessary	Information	Director of Finance & Performance
	Using the updated Standard Contract Updated Standard Contract and guidance documents have been published by NHS England, alongside updates to the eContract systemopens in a new window. The Trust should ensure the appropriate National Variation is implemented for all of contracts by 25 May. For any new contracts, the Trust must use these updated versions with immediate effect.	Report / Action	Director of Finance & Performance
	Retaining staff and cost savings for your emergency department Health Education England has launched the Specialty Associate Specialist doctor's development and retention toolkit. The toolkit was developed and implemented by Derby NHS Foundation Trust, who then saw improvements in recruitment and retention, a positive impact on the 4-hour performance target and financial savings including a lower agency spend.	Information	Director of OD & HR / Medical Director
	Patient safety alert: Adoption of NEWS2 to detect deterioration in adult patients NHS England and the Royal College of Physicians have issued a new alert to support acute and ambulance trusts to adopt the revised National Early Warning Score (NEWS2). The Trust need to identify a NEWS2 champion and establish an action plan to support the trust-wide adoption of NEWS2 by March 2019.	Report / Action	Director of Nursing

	Freedom to Speak Up: guidance for boards Guidance has been issued to help Trusts identify areas for development and improve the effectiveness of leadership and governance arrangements in relation to Freedom to Speak Up (FTSU). Ian Dalton and National Guardian, Henrietta Hughes, have also outlined expectations of boards and board members opens in a new window, which include using the guidance to take your board through a self-review exercise and create an improvement action plan.	Report / Action	Director of Governance / Director of OD & HR
	Less than a week left to register to submit cyber security compliance information The Trust is required to complete a mandatory cyber security submission before the deadline you must register by 8 May.	Report / Action	Director of Strategy & Improvement
	Savings for top 10 medicines published on Model Hospital Guidance on switching from high-cost branded medicines to equally safe and effective biosimilar and generic versions saved the NHS more than £324 million in 2017/18.	Information	Medical Director / Director of Finance & Performance
	New online library of quality, service improvement and redesign (QSIR) tools The ACT Academy has launched an online library of QSIR tools — a comprehensive collection of over 90 proven tools, theories and techniques that can be applied to a wide variety of quality improvement projects.	Information	Director of Strategy & Improvement
	Pathology networks toolkit: new resources NHSI have provided some more resources to the pathology networks toolkit, including: • Clinical governance toolkit • Operational governance guide • Essential services laboratory design: blood sciences • Consolidation framework • Legal watchpoints guide	Information	Director of Strategy & Improvement
	Voluntary, community and social enterprise (VCSE) webinar Wednesday 16 May, 3.30 – 4.30pm There is to be a second phase of the Joint VCSE Review which considers how the VCSE	Information	Director of Strategy & Improvement

	sector and health and social care agencies can partner together. It will include a revised set of recommendations to prompt local and national action.		
	Creating coherent system leadership NHS England and NHS Improvement have met together as a public board to look at how they are going to work closer together as system leaders for the health service. This includes the majority of their national functions moving to single integrated teams reporting to both organisations, or hosted teams working in one organisation on behalf of both. They also considered how local NHS services can better work together, building care around patients rather than institutions, and the NHS' 2018/19 operating plan covering both trusts and CCGs.	Information	All
	Professor Jane Cummings has announced that she will be retiring from the role of Chief Nursing Officer for England She has recommended to the Board that the Chief Nursing Officer should be the executive nurse lead for both NHS England and NHS Improvement as organisations move towards greater alignment. Jane was appointed as chief nursing officer for England in March 2012, taking on the professional lead for nursing and midwifery in England. She is also NHS England's lead executive director for learning disabilities; maternity; equality and diversity; and patient participation and experience. Since September 2017, Jane has also been NHS England's regional director in London. She will play an instrumental role in supporting the alignment of the two nursing teams across NHS England and NHS Improvement over the next six months.	Information	All
	New local health and care partnerships could save lives NHS England has announced that doctors and nurses will be able to reduce unnecessary patient tests and improve safety through better working between hospitals and GPs and social care. New partnerships will be introduced giving health and care staff better and faster access to	Information	Director of Strategy & Improvement

	vital information about the person in their care, so they can determine the right action as quickly as possible, whether that is urgent tests or a referral to a specialist. NHS England has announced that three areas, covering 14 million people, have been chosen to become 'Local Health and Care Record Exemplars' (LHCRE). Each new partnership will receive up to £7.5 million over two years to put in place an electronic shared local health and care record that makes the relevant information about people instantly available to everyone involved in their care and support. The selected areas are: Greater Manchester; Wessex; One London NHS England will work with the other sites that bid to join the programme over the next few weeks to understand more about their plans and how we can work with them to help realise their ambitions. Each Local Health and Care Record Exemplar will work on a larger scale than existing local projects, providing healthcare staff who need it access to the information they need for people's individual care. The new partnerships will also work to better understand demand for local services and to plan effectively for future demand. In the future the NHS and Government will seek to establish Digital Innovation Hubs to provide a safe, controlled and secure environment for research that can bring patients benefits from scientific breakthroughs much faster		
	Corporate Retention and Disposal Schedule and Guidance v2.0 This document gives advice and guidance to all NHS England staff with regards to the retention and disposal of records.	Guidance	Director of Governance
	NHS England's Privacy Notice NHS England's Privacy Notice explains the purposes for which personal data are collected and used, how the data are used and disclosed, how long it is kept, and the controller's legal basis for processing.	Guidance	Director of Governance
	Local Health and Care Record Exemplars This document provides a summary of the Local Health and Care Records Exemplars programme.	Guidance	Director of Strategy & Improvement
	Managing the Friends and Family Test (FFT) in line with GDPR This guidance document provides information	Guidance	Director of Governance

	on the General Data Protection Regulation (GDPR) and what impact it will have for the Friends and Family Test (FFT).		
	Ask, Listen, Do project – easy read leaflet This east read leaflet provides information about the Ask Listen Do learning disabilities project. Making feedback, concerns and complaints easier for people with a learning disability, autism or both, their families and carers.	Guidance	Director of Governance
	NHS England Safeguarding: Annual Update 2018 This report identifies the progress and accomplishments made within safeguarding, across the health sector, since the last update in March 2017 and provides details regarding the key safeguarding priorities for the year ahead.	Report	Director of Nursing
	The Fifteen Steps for Maternity – Quality from the perspective of people who use maternity services This document, focusing on maternity, is part of a suite of toolkits for The Fifteen Steps Challenge, which help to explore the experience of people who use maternity services and are a way of involving them in quality assurance processes.	Guidance	Director of Nursing
	The Perinatal Mental Health Care Pathways This document sets out policy drivers and strategic context for transforming perinatal mental health care, as well as pathways to deliver transformation. It provides services with evidence on what works in perinatal mental health and case studies of positive practice. As set out in Implementing the Five Year Forward View for Mental Health £365 million is being invested in specialist perinatal mental health services so that by 2021 an additional 30,000 women each year can receive evidence-based treatment, closer to home, when they need it. The guidance provides services with evidence on what works in perinatal mental health care, as well as case studies describing how areas are starting to make this a reality.	Guidance	Chief Operating Officer
	Leading Change, Adding Value: learning tool to support all nursing, midwifery and care staff This document provide details of the Leading Change, Adding Value (LCAV) framework and supports all nursing, midwifery and care staff to identify and address unwarranted variation in	Guidance	Chief Operating Officer / Director of Nursing

	practice – recognising unequal standards of care and changing them.		
	NHS launches public campaign to highlight new stronger protections around health and care information NHS England launched a six week public campaign to raise awareness of new stronger protections for patient information. The NHS campaign will initially focus on General Data Protection Regulation and then from early June it will promote the choice the public have with the new national data opt-out. This staged approach is designed to support clinicians and ensure messages are reaching the public in a clear and accessible way. As with every campaign, the impact will be monitored to ensure messages are reaching the public.	Campaign	Director of Governance / SIRO

Walsall Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD (Public) – 7th June 2018					
Serious Incident Report				**AGENDA ITEM: 8**	
Report Author and Job Title:	Chris Rawlings Head of Clinical Governance		**Responsible Director:**	Kara Blackwell Acting Director of Nursing	
Action Required	**Approval**	**Decision**	**Assurance and Information**		
			To receive and discuss	**To receive X**	
Recommendation	Members of the Public Trust Board are asked to note the Serious Incident Report – April 2018 for information.				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• Corporate Risk 201 – Failure to recognise and respond to the deteriorating patient and those with early signs of sepsis leading to increased incidents of harm to patients' including death. • Corporate Risk 844 – Failure to implement and embed 'National Safety Standards for Invasive Procedures (NATSIPS)' across the organisation within required timescales set out in the Patient Safety Alert.				
Resource implications	There are no resource implications associated with this report.				
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.				
Trust Strategy	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme			**X**	
	Develop the culture of the organisation to ensure mature decision making and clinical leadership				
	Improve our financial health through our robust improvement programme				
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts				

EXECUTIVE SUMMARY

The Private Trust Board are advised of the Serious Incident reported during April 2018..

- 1230 patient safety incidents were reported in April:
    - 3.4% were reported as significant harm – moderate or severe with none associated with death.
- There were 22 new Serious Incidents reported in April 2018 an increasing trend predominantly due to the increased numbers of pressure ulcers reported as SIs.
    - 17 Pressure ulcers were reported – (compared to 8 incidents in March 2018) - 8 community acquired and 9 hospital acquired and predominantly associated with unstageable pressures).
    - 2 patients' suffered a fall and sustained serious harm. The general theme relates to completion of falls documentation (lying and standing BP was not recorded).
    - 2 infection control incidents were reported.
    - 1 Information Governance SI was also reported

Serious Incident Report – April 2018

1. PURPOSE OF REPORT

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

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

2. BACKGROUND

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 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

3. DETAILS OF THE REPORT

3.1 Total Incidents

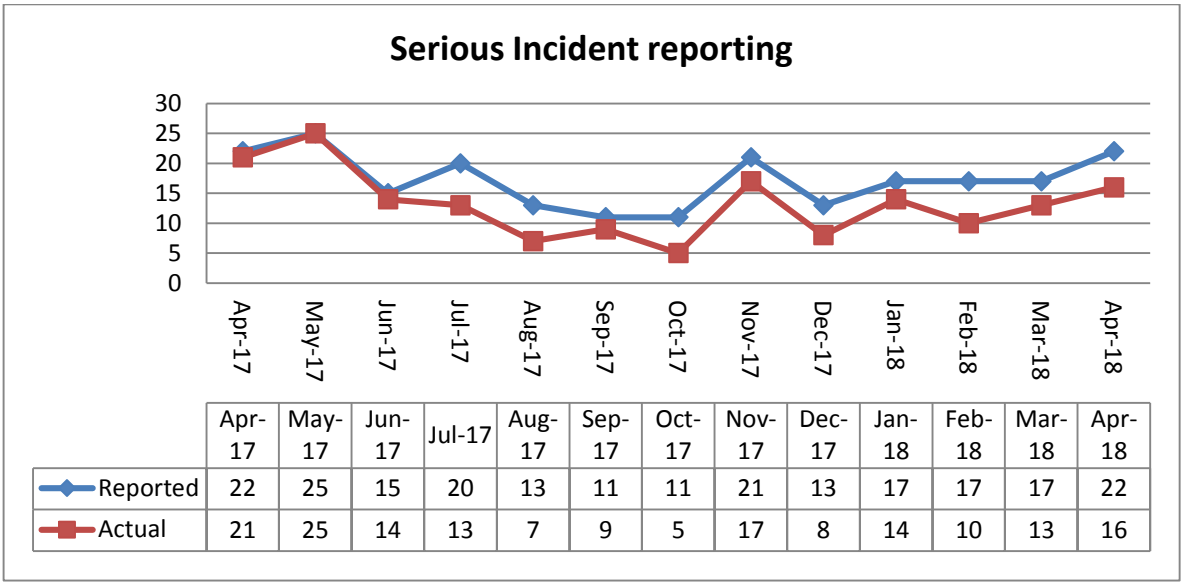
There were a total of 1230 incidents reported in April 2018. The breakdown of harm is shown below:

Actual Impact	**Incidents reported**
Near Miss	14 (1.1%)
No Harm/Low Harm	1175 (95.5%)
Moderate Harm	38 (3.2%)
Severe Harm	3 (0.2%)
Catastrophic Harm (Death)	0 (0.0%)
TOTAL	**1230**

[1] NHSE Serious Incident Framework 2015

3.2 Serious Incidents reported in April 2018 and the previous 12 months

The comparison of monthly Serious Incident reporting rates compared to the actual rates following approval of downgrade decision by Walsall CCG that the incident does not meet the criteria for a Serious Incident or has been classified as an unavoidable pressure ulcer.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Reported	22	25	15	20	13	11	11	21	13	17	17	17	22
Actual	21	25	14	13	7	9	5	17	8	14	10	13	16

3.3 Key Trends/Themes in new Serious Incidents

Two patients' suffered a fall and sustained serious harm during April 2018. The general theme relates to completion of falls documentation (lying and standing BP was not recorded).

Pressure ulcer reporting has increased during April 2018 – (17 incidents compared to 8 incidents in March 2018) and is predominantly associated with unstageable pressure ulcers across both the acute hospital and community settings. Pressure Ulcers equate to 77% of all Serious Incidents reported in April 2018.

3.4 New Incidents

There were 22 new Serious Incidents reported in April 2018.

- 17 Pressure Ulcers (9 hospital acquired & 8 community acquired)
- 2 Patient Falls
- 2 Infection Control issues
- 1 Information Governance issue

3.5 Closed Incidents – Lessons Learned

	2017/14529		**Sub-optimal care of the deteriorating patient**
	Patient underwent ankle surgery and required antibiotic treatment for an unrelated infection. The patient's condition deteriorated and new pain symptoms were noted with a plan made for Trauma & Orthopaedic review. The patient was generally unwell for a period of 2 weeks during their inpatient stay and CT scan was ordered to investigate further in conjunction with additional antibiotic treatment. CT confirmed		

	a complicated finding with a plan to undertake a minimally invasive procedure due to the high risk patient status. The patient was monitored for another week by the surgical team however their condition deteriorated further and the procedure was never undertaken as the patient had died.
Lessons Learned	• Consultant to Consultant referral Standard Operating Procedure to be agreed and formalised • Cascade wider learning regarding all specialty referrals should be Consultant to Consultant • Combined meeting to review partnerships working with Surgery and Trauma & Orthopaedic Team • Share contact numbers to ensure concerns are escalated to appropriate Consultant. Improved working between specialties. • The use of E-handover across both specialties • Audit to be completed to check the use of the deteriorating patient stamp in Trauma & Orthopaedics and General Surgery. • Deteriorating patient audit data and learning to be shared with Care Groups. • Training sessions to be held around recognising deteriorating patients • Review warfarin management guideline and managing anti-coagulation with new oral anti-coagulants preoperatively and operatively • Key message campaign regarding anti-coagulation to be shared across the Trust.
Key Changes to Practice	• Reinforce agreed process for Consultant to Consultant referrals in a SOP. • Consultant to Consultant specialty referral process agreed at Medical Advisory Committee and Trustwide audit. • Review of partnership working within both specialties. • Review communication pathways between both teams to contact Consultants from one specialty to another. • E-handover process to be shared amongst both teams to improve handovers between teams. • Review use of deteriorating patient stamp in Surgery and Trauma and Orthopaedic teams. • Deteriorating patient audit data to be tabled at TAO and General Surgery Care Group/Quality meetings. • Update provided to both specialties on deteriorating patient training. • Review and update of warfarin management guidelines.

	2017/18281		**Patient Fall**
	Patient was admitted feeling generally unwell and with previous diagnosis of gastroenterology issues. The patient was deemed to be at medium risk of falls however whilst self-mobilising on the ward, they suffered an unwitnessed fall and sustained a fractured hip. The patient underwent hip surgery and was discharged home after an eventful recovery.		
Lessons Learned	• Commodes should not be left for patients who do not need to use them. Adherence to care plans needs to be followed. • There needs to be some learning around diabetic management		

	for the ward and medical staff. • During the investigation it was evident from the medical notes there needs to be improved documentation with regards to writing being unclear so that staff could not be identified and no times being logged • There is further training needed on the falls assessment documentation on ward 10 and 20B.
Key Changes to Practice	• Incident to be shared at ward/team level to highlight what can occur if usual process and care plans are not followed • Consideration of diabetic management training to be provided to all nursing staff on the ward • Discrepancies to be addressed in the appropriate team meeting i.e. nursing or medical for wider learning. Where possible address the discrepancy with the individual staff member • Training with team to ensure the new falls assessments are thoroughly understood by both wards including the documentation.

	2017/12212		**Diagnostic Incident**
	Patient was previously diagnosed with a low grade cancer and was initially followed up after three months. Subsequent follow-up appointments were not scheduled due to a follow in the process/audit trail and the patient presented 10 years later with symptoms that were confirmed as a recurrence of the cancer. The patient underwent further treatment and management.		
Lessons Learned	• There was no robust process in place in regards to following patients up. This still requires work to ensure that there is no re-occurrence of such incidents in the future. • There is not a robust process in terms of paper/electronic outcomes – potential for further incidents.		
Key Changes to Practice	• Process mapping and scoping of corporate risk around the use of paper based booking forms from Outpatients clinic instead of electronic. • Audit to ensure all confirmed cancer patients are fully booked following Outpatient appointment as states in the Access Policy. • Radiology to clarify process for red flag/urgent/non urgent scans and ensure all specialities are aware. • Development of KPI's within Urology and other specialities to identify how many patients are booked following clinic. • The Access team highlighted that any speciality can request to have a patient fully booked if they wish, this is not widely known and would require a change to the booking form		

	2017/13345		**Diagnostic Incident**
	Patient had a previous cancer diagnosis and was initially followed up. Repeat scanning and follow-up did not take place for 3 years and the patient developed symptoms requiring further investigation. Referral to a specialist provider confirmed the cancer as being present in both primary and secondary stages and locations. The patient has a poor prognosis and was commenced on appropriate chemotherapy treatment.		
Lessons Learned	• Robust risk assessment undertaken in relation to the use of		

	paper based outcome forms. • No current audit process in place to ensure all cancer patients are fully booked following their Outpatient appointment
Key Changes to Practice	• Process mapping and scoping of corporate risk around the use of paper based booking forms from Outpatients clinic instead of electronic. • Audit to ensure all confirmed cancer patients are fully booked following Outpatient appointment as states in the Access Policy

	2017/25405		**Diagnostic Incident**
	Patient had history of gastroenterology related symptoms which were investigated via CT scanning and for further management via their GP. The patient was admitted 2 years later following a fall and CT scan was ordered which noted an abnormality for surgical review. Further investigations confirmed the presence of a large abdominal mass which required urgent surgical intervention and was identifiable during the previous CT scan but not acted upon.		
Lessons Learned	• Ensure the use of minimal bowel prep CT for cases involving unwell; frail, demented patients who wouldn't be able to have Colonoscopies to rule out caecal cancer. • Clear guidance of a flow chart for suspected cancer symptoms to be developed and shared Trust wide to allow for prevention of future similar incidents		
Key Changes to Practice	• NICE guidance on Colorectal cancer to be re-distributed across the Trust to ensure that with patients who have suspected Colorectal cancer can be given the right plan to ensure that the cancer can be confirmed or fully ruled out. • Raise at Care Groups, Divisions and Trust-wide through the lessons learnt bulletin the need to discuss with relevant specialities when symptoms occur in patients which may suspect a form of cancer to ensure the correct plan is in place and that possible referrals to MDT's are made if necessary. • Presentation at Grand round on vague and suspected symptoms of cancer. • Cancer Awareness event as part of world cancer day to do a big cancer symptoms awareness day for both clinicians and members of the public. • Case to be shared with Imaging Audit and Discrepancy to ensure that the learning from this case is embedded with the clinicians who will be reviewing images of similar cases to ensure prevention of missed cancers. • Awareness to be raised in the Trust of minimum bowel prep CT's instead of Colonoscopies to be used when patients cannot tolerate the invasive Colonoscopy.		

	2017/1886		**Maternity Incident (affecting baby)**
	Patient was booked for management of her first pregnancy and received midwife led care with some queries around the fundal height/ growth at 34 weeks. At term gestation additional fetal monitoring was deemed to be abnormal and commencement to delivery of the baby via caesarean section was progressed quickly. The baby was born in poor condition requiring additional neonatal support and with an unidentified growth restriction.		

Lessons Learned	• All babies term to NNU must be registered on Safeguard system, taking into consideration any additional information which may alter the grading of the incident. • For senior staff to physically review the CTG findings / classifications and discuss with team members to ensure clarity over classification, management and time frames for review are acted and agreed upon. And, to escalate any concerns to a consultant for opinion if concerns remain following discussion with the DS Team Leader
Key Changes to Practice	• All clinicians have been encouraged to actively escalate any concerns up to consultant level if required. And, for the continuation of CTG to be recognised in the management timeframe when transferred from one clinical area to another. • Reflective practice of Team Leader. • Identified locum registrar made aware of the outcome of the case. • Completion of updated Trust guideline in line with NICE recommendations 2017. • Updating of Trust RFM guideline to ensure clarity of management and actions to be undertaken at each episode of RFM • All clinical staff to document own care provided and relevant management plans. Demonstrate and share the use of SBAR as a tool on BadgerNet. • For TL or nominated senior staff to be present at potentially difficult or emergency deliveries as per necessity. • Provision of consultant presence on Delivery Suite as per recommendations. • The midwife involved in Vitamin K administration error has undertaken a piece of reflective practice and complete random audit of clinical notes; and to review the use of a prescription sheet to further document the administration of Vitamin K. • Colleagues were requested to enhance the quality of incidents reported through Safeguard.

	2016/29721		**Maternity incident (affecting mother)**
	A patient attended A&E in early stages of pregnancy and a diagnosis of urinary tract infection was made requiring a course of antibiotic treatment. The patient represented to the A&E with continuous pain and was subsequently admitted with a plan for gynaecological review the following day. A diagnosis of ruptured pregnancy was made requiring emergency gynaecological surgery. The patient was discharged home after an uneventful recovery.		
Lessons Learned	• Where there is any concern regarding the clinical decision, a second opinion must be sought from a senior colleague including Consultant to provide assurance on the effectiveness of the decision. • The Acute Medical Unit is not an appropriate location to deliver care for a patient who is having a possible miscarriage. • Sonography reports should always state the location of the fetus in the uterus in order to rule out ectopic pregnancy		
Key Changes to Practice	• Following the introduction of BadgerNet MEWS charts are now electronically recorded.		

	• Shared learning from case and greater understanding of signs and symptoms has occurred. • The Registrar has undertaken a reflective entry on e-portfolio and declared it on Form R for ARCP progression. • A joint meeting has been held between Obstetrics & Gynaecology service and A&E to discuss cases and ensure safe robust procedures between areas. • A drop down box on CRIS has been introduced to confirm completion of the position of the fetus in the uterus to ensure a high sensitivity for the detection of ectopic pregnancies. • Formal positive written feedback has been provided to A&E FY1 and Gynaecology Registrar (2) following the identification of their good practice

4. RECOMMENDATIONS

Members of the Public Trust Board are asked to note the report for information.

Report Author: Chris Rawlings, Head of Clinical Governance
Date of report: 30th May 2018

MEETING OF THE PUBLIC TRUST BOARD – 7th June 2018				
Monthly Nurse Staffing Report				**AGENDA ITEM: 9**
Report Author and Job Title:	Kara Blackwell Acting Director of Nursing		**Responsible Director:**	Kara Blackwell Acting Director of Nursing
Action Required	**Approval**	**Decision**	**Assurance and Information X**	
			To receive and discuss X	**To receive**
Recommendation	The Trust Board are asked to note the information contained in this report, the planned developments in relation to the daily assessment of acuity to help inform the deployment of staff and to note the continued work being undertaken to control the use of temporary staffing through pro-active roster management.			
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 7 - That we cannot deliver safe, sustainable staffing levels reducing our reliance upon expensive agency staff. Risk Register 211 – Failure to meet safe nurse staffing levels will lead to harm to patients.			
Resource implications	There are no resource implications associated with this report.			
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.			
Trust Strategy	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme			X
	Develop the culture of the organisation to ensure mature decision making and clinical leadership			X
	Improve our financial health through our robust improvement programme			X
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts			

EXECUTIVE SUMMARY

This report provides an overview of the Nursing and Midwifery workforce during the month of April 2018 and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 under the headings of *Right Staff, Right Skills, and Right Time and Place.*

The report outlines performance against key national staffing indicators: Unify Safe Staffing Fill Rates and Care Hours per Patient Day (CHPPD). The Trust was compliant with an overall fill rate for nurse staffing (registered nurses and care staff) of greater than 90% for days and nights in April 2018. Exceptions reports for individual clinical areas which fell below the 90% fill rate target for either registered nurses or CSW on days or nights are provided in the report. The CHPPD improved to 6.5 during April although remain below the regional comparison of 7.5.

The report also outlines the continued focus being placed on the reduction of temporary staffing across the Trust and highlights the reduction in the use of temporary registered nursing hours in April 2018 compared to the previous month. This has been driven by the closure of an additional capacity ward and the on-going work being undertaken in relation to proactive roster management and management of short notice requests. The planned development in relation to the daily assessment of acuity to help inform the deployment of staff is also highlighted.

Walsall Healthcare NHS
NHS Trust

1.0 Introduction

This report provides an overview of the Nursing and Midwifery workforce during the month of April 2018 and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 under the headings of *Right Staff, Right Skills, and Right Time and Place.*

It provides assurance that arrangements are in place to safely staff our services with the right number of nurses and midwives, with the right skills, at the right time.

2.0 Details - Right Staff

2.1 Safe Staffing UNIFY Data

The monthly staffing fill rates for April 2018 submitted to Unify are outlined below.

Figure 1: Unify Safe Staffing Fill Rate April 2018

Day				Night			
RN/Midwives		**Care Staff**		**RN/Midwives**		**Care Staff**	
%Bank	%Agency	%Bank	%Agency	%Bank	%Agency	%Bank	%Agency
6.55	**5.62**	**17.83**	**3.83**	**10.81**	**15.86**	**26.77**	**3.47**
Average Fill Rate - RN/Midwives (%)		**Average Fill Rate - Care Staff (%)**		**Average Fill Rate - RN/Midwives (%)**		**Average Fill Rate - Care Staff (%)**	
97.5%		**98.5%**		**98.4%**		**107.5%**	

The overall fill rate for registered staff in April 2018 was 97.88%, in comparison to an unregistered staff fill rate of 102%, with an overall fill rate of 99.7%. The target of above 90% fill rate was achieved across both registered and unregistered staffing on both days and nights. There are times when it is appropriate, following a risk assessment by the senior nurse on duty to utilise unregistered staff to support safe staffing in the absence of a registered nurse. Divisional Directors of Nursing, matrons, ward leads and site nurse practitioners make these operational patient safety decisions on a shift by shift basis to ensure all clinical areas are safely staffed.

Clinical Area Exception Reporting <90% Fill Rate

Those clinical areas with <90% fill rate for RNs or CSW on days or nights are reviewed below:

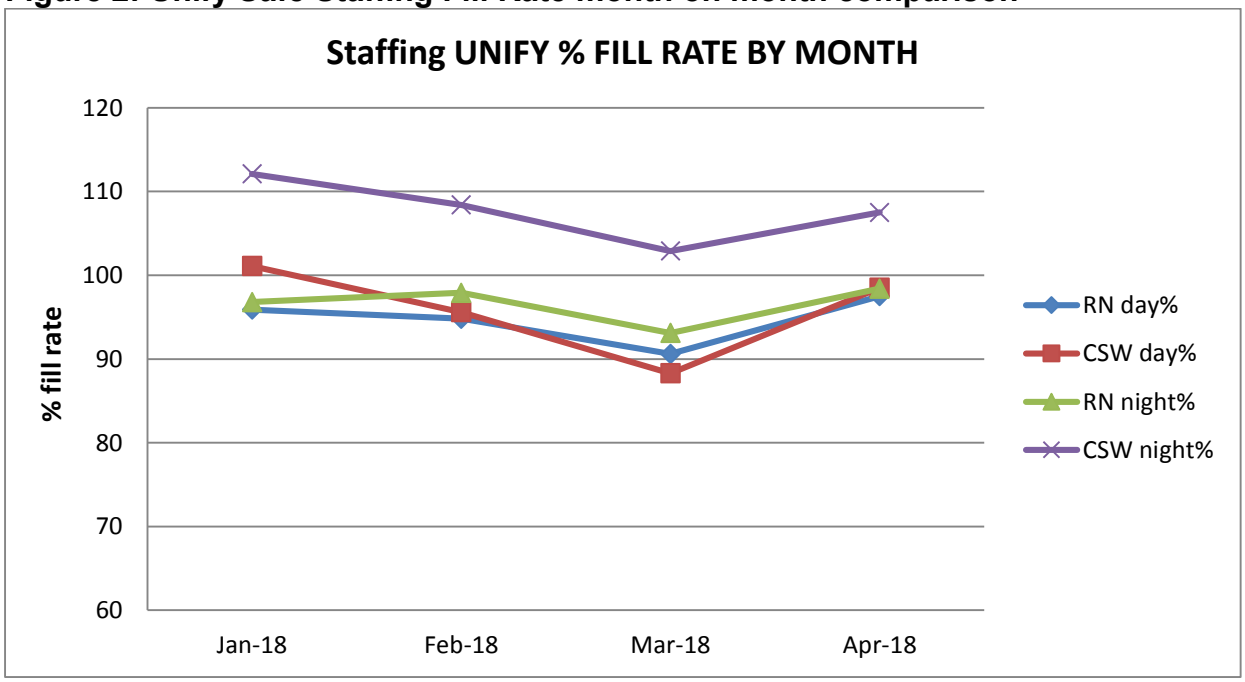
Registered Nurse Day Fill Rate Compliance < 90% by Clinical Area		
Ward	**Fill Rate**	**Exception Report Comments**
Ward 4	79%	Analysis identified that planned hours inaccurate
Ward 15	89%	No incidents were reported in which staffing a factor was. The fill rate for CSWs was 104% on days compensating for some of the gaps in RN shifts
CSW Day Fill Rate Compliance <90% by Clinical Area		
Ward	**Fill Rate**	**Exception Report Comments**
PAU	86%	No incidents were reported in which staffing was a factor
Ward 23	69%	Paediatric workforce used flexibly based on activity. No incidents reported in which staffing was a factor
Ward 24/25	76%	Overall fill rate 97.5% as actual hours over planned for registered midwives. E-roster re-aligned as wards currently merged so staffing template requirements for planned hours altered

Comparison of Fill Rates by Month

Comparison of the fill rates for registered and unregistered nursing staff for Q4 of 2017-2018 and April of 2018 are outlined below. This shows that with the exception of the fill rate for CSWs for days in March 2018 the Trust was above the 90% compliance rate every month.

There was also an increased fill rate across all staffing fill rates in April 2018.

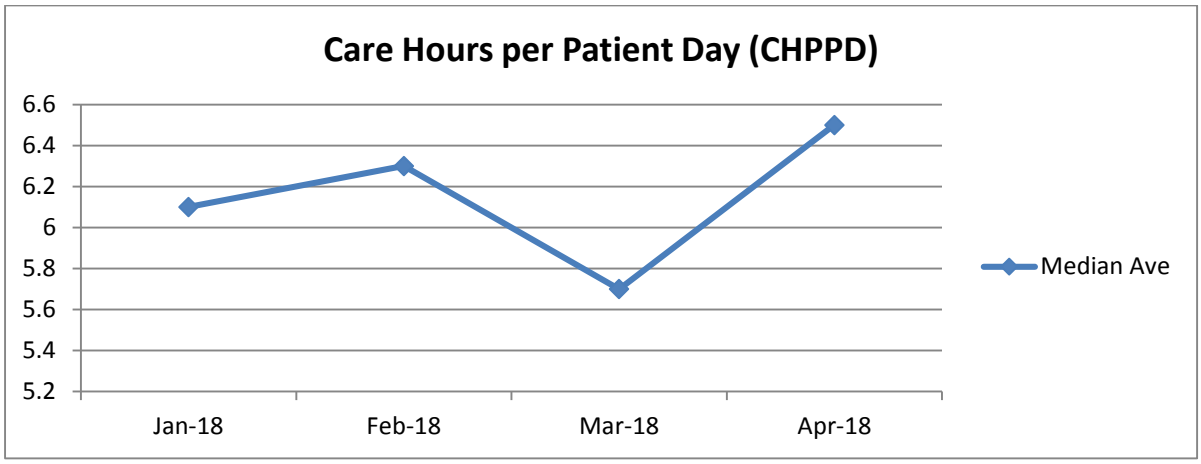
Figure 2: Unify Safe Staffing Fill Rate month on month comparison



2.2 Average Care Hours per Patient Day (CHPPD)

Care Hours per Patient Day (CHPDD) continues to be collated on a monthly basis and reported as part of the Unify data report. The CHPPD for April 2018 was 6.5; this was an improvement on the previous month. The national average, reported via the Model Hospital is 7.6 CHPPD and regional comparison of 7.5.

Figure 3: Care Hours per Patient Day



2.3 Safe Staffing, Quality and Safety KPIs

No relationships were identified in April 2018 between the levels of staffing within the clinical areas and quality metrics although the senior nursing team reviews any correlation between clinical incidents concerning staffing and patient care. Further work is being undertaken to assess if the nurse staffing on a shift is meeting the care needs of the patient, this includes the recording of 'red flag' events (NICE 2014) and implementation of a daily acuity tool.
Any gaps in staffing which may have impacted on care are already considered as part of the RCAs process for falls with harm and category 3, 4 and unstageable pressure ulcers. There was one incident on Ward 14 reported in April 2018 when a patient sustained a fall with a fracture and a shortage of staffing was reported as being a factor. However, the investigation showed that all staffing was in place on that shift.

2.4 Evidence based workforce planning

In order to ensure the safe and effective delivery of patient care it is essential that we have the right establishment of posts and the right staff in place. The unify safe staffing data submitted monthly outlines the staff fill rates by clinical area based on the planned hours and hours used. It does not take account of acuity and dependency and nor does it inform what the agreed establishments should be for each individual clinical area. The Safer Nursing Care Tool audit (SNCT) is undertaken bi-annually and should be used to guide establishment and skill mix setting for clinical areas, alongside professional judgement, peer benchmarking and nationally available staffing data. The most recent SNCT audit data is currently being

analysed and the recommendations are currently being completed and it is anticipated these will be reported to Board in July alongside the report from NHSi.

3.0 Right Skills

The senior nursing team continue to work with HR colleagues in relation to the recruitment and retention programme for nursing staff which includes band 5 recruitment initiatives, the development of new roles and responsibilities (including TNAs, ACPs and maternity support workers) and the development of careers pathways for all care staff. A quarterly review of vacancies, turnover, recruitment and retention initiatives will be included in the Nurse Staffing report.

4.0 Right Place and Time

The senior nursing team and the finance team are currently working on the development of a Nurse staffing dashboard to enable all KPIs to be displayed and monitored; this will facilitate the management of performance against these KPIs. These dashboards will provide this data at individual ward, care group, Divisional and corporate level

4.1 Efficient Deployment and minimising agency

There is a continued focus on reduction of agency staff across the Trust. There was a reduction in the use of agency registered nursing hours in April 2018 compared to the previous month. This has been driven by the closure of an additional capacity ward and the on-going work which is being undertaken regarding proactive rostering and management of short notice requests.

Figure 4: Registered Nursing Temporary staffing hours April 2018

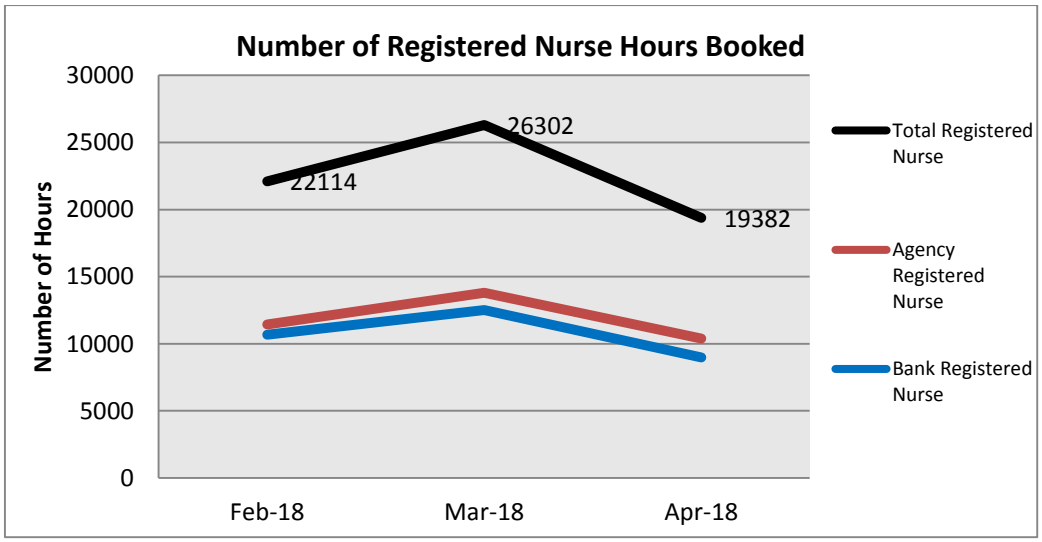
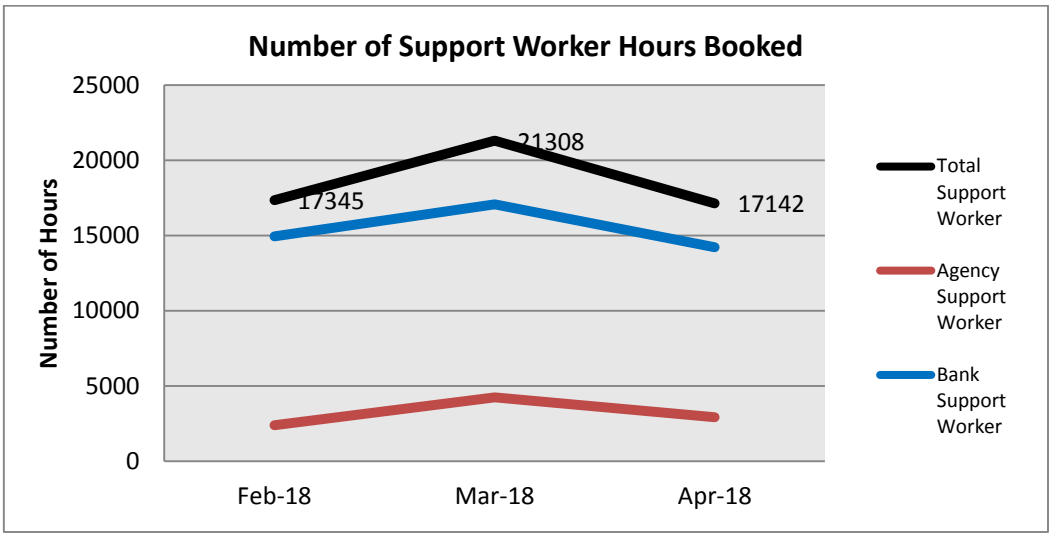


Figure 5: CSW Temporary staffing hours April 2018



- There were 6920 less registered nurses (RN) temporary staffing hours used in April 2018 compared to March 2018.
- There were 3403 less agency RN staffing hours utilised in April 2018 compared to March 2018; this equates to approximately 22WTE RNs
- There were 4166 less CSW temporary staffing hours used in April 2018 compared to March 2018, this included 1320 less agency CSW hours which equates to approximately 9 WTE
- Alongside the reduction in agency hours used the number of bank hours fell in April compared to March, this was due to less bank staff being available during the 2 weeks Easter holiday period

The number of NHSi Cap breaches and the use of Off Framework (Thornbury) also deceased in April 2018. Agency Cap breaches decreased from 502 in March to 347 shifts in April 2018. There were 26 Off Framework RN shifts used during April 18 compared to 95 used during March 18.

A RN HIT team (allocate on arrival) has been introduced to help achieve a reduction in Tier 3 and off framework registered nursing usage. This commenced on 21st May18.

4.2 Productivity Working and Eliminating Waste

From February 2018 increased focus has been in place to ensure that all wards are producing effective, fair, safe and efficient rosters. Roster clinics are mandated monthly for the ward managers and matrons to attend. In April 91% of rosters were signed off 42 days in advance by ward managers and matrons. Ward managers and matrons are also expected to request Bank at sign off of the rosters to optimise the opportunity to fill with bank; however, only 42% of shifts were released to bank at roster sign off in April 2018. Work is on-going to improve compliance against these measures. The roster planning schedule was amended during May to reflect the NHSi recommendation to move to 8 week sign off.

There have been some improvements in other KPIs which include management of contracted hours and skill mix. When more data points are available a trend chart will become part of this monthly report.

4.3 Efficient Deployment and Flexibility

The plans to roll out a daily acuity tool to all inpatient areas will provide real-time visibility across the Trust of appropriate levels of staffing for our patients. The patient acuity and staffing data will be collected twice daily at the beginning of the day and night shift. This will highlight and support decision making in relation to the deployment of temporary nursing staff or the need to move substantive staff to support patient care and safety in another area.

5.0 Recommendations

The Board is asked to note information presented in this report**,** the planned developments in relation to the daily assessment of acuity to help inform staffing requirements and the real-time deployment of staff. The Board is also asked to note the continued work being undertaken to control the use of temporary staffing through pro-active roster management.

<table>
<tr><td colspan="5">MEETING OF THE PUBLIC TRUST BOARD – 7th June 2018</td></tr>
<tr><td colspan="4">Patient Experience Report</td><td>AGENDA ITEM: 10</td></tr>
<tr><td>Report Author and Job Title:</td><td colspan="2">Louise Mabley, Patient Experience Lead

Garry Perry, Head of Patient Relations</td><td>Responsible Director:</td><td>Kara Blackwell
Acting Director of Nursing</td></tr>
<tr><td>Action Required</td><td>Approval</td><td>Decision</td><td colspan="2">Assurance and Information X
To receive and discuss X | To receive</td></tr>
<tr><td>Recommendation</td><td colspan="4">The Trust Board are asked to note the information contained in this report, the improvements in relation to the FFT response rates for Outpatients and the Emergency Department in Quarter 4 and the improvements across all maternity services in relation to ‘would recommend’ scores and In Q4, and the reduction in the ‘would not recommend’ negative scores. The Board is also asked to note the ongoing patient experience work being undertaken across the Trust.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="4">Corporate Risk Register 15 – National Surveys- Score Rating of 12

• Reputation Risks
• External standards</td></tr>
<tr><td>Resource implications</td><td colspan="4">There are no resource implications associated with this report.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="4">CQC – includes a standard for management of complaints</td></tr>
<tr><td rowspan="4">Trust Strategy</td><td colspan="3">Continue our journey on patient safety and clinical quality through a comprehensive improvement programme</td><td>X</td></tr>
<tr><td colspan="3">Develop the culture of the organisation to ensure mature decision making and clinical leadership</td><td></td></tr>
<tr><td colspan="3">Improve our financial health through our robust improvement programme</td><td></td></tr>
<tr><td colspan="3">Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts</td><td></td></tr>
</table>

EXECUTIVE SUMMARY

This report provides an overview of the complaints and patient experience feedback for the Quarter 4 period, January to March 2018. The report outlines the complaints and PALS activity, the Friends and Family Test (FFT) response rates and scores, and the results of the National Maternity Survey published in January 2018. An update on voluntary services and patient experience initiatives are also presented.

Between January to March 2018 there was an increase in complaints and concerns raised by patients and families in the Trust, with the highest number of complaints received being for the Emergency and Acute Care Group. In Quarter 4 there were improvements in relation to the Friends and Family Test response rates for both Outpatients and the Emergency Department. Whilst response rates remain low across maternity services there was an improvement across all maternity services in relation to '*would recommend'* scores and a reduction in the '*would not recommend'* negative scores. Divisional action plans are in place to address areas for improvement identified from patient feedback from National Surveys and FFT results and are monitored through the Patient Experience Committee. Ongoing work is being undertaken to address common themes identified from patient complaints and feedback.

Patient Experience Report

1.0 Introduction

This report provides an overview of the complaints and patient experience feedback for the Quarter 4 period, January to March 2018. The report focuses on the complaints and PALS activity, the Friends and Family Test (FFT) response rates and scores, and the results of the National Maternity Survey published in January 2018. An update on voluntary services and patient experience news and developments are also presented.

2.0 Detail

This section of the report provides a comprehensive review of the complaints and PALS activity for Walsall Healthcare NHS Trust over the Q4 period of 2017-2018. The report provides details of the complaints and concerns received, those recently closed, and an analysis against previous comparable periods to indicate any trends or variation in activity. The numbers and themes of formal complaints by Division and the actions taken in response to these following investigations are presented. An updated on complaints reported to the Parliamentary Health Service Ombudsman (PHSO) is included.

2.1 Complaints

This section provides details of Formal Complaints (KO14a) and concerns received during Q4, January to March 2018. In total there were 80 formal written complaints in Q4, which represented 19% (n=13) from those received in Q3. However, this was the busiest time of the year, with additional beds open and attendances via the Emergency Department.

Type	Jan	Feb	Mar
Formal Written Complaints (KO14a)	24	23	33
Concerns	222	263	259
Overall total	**246**	**286**	**292**

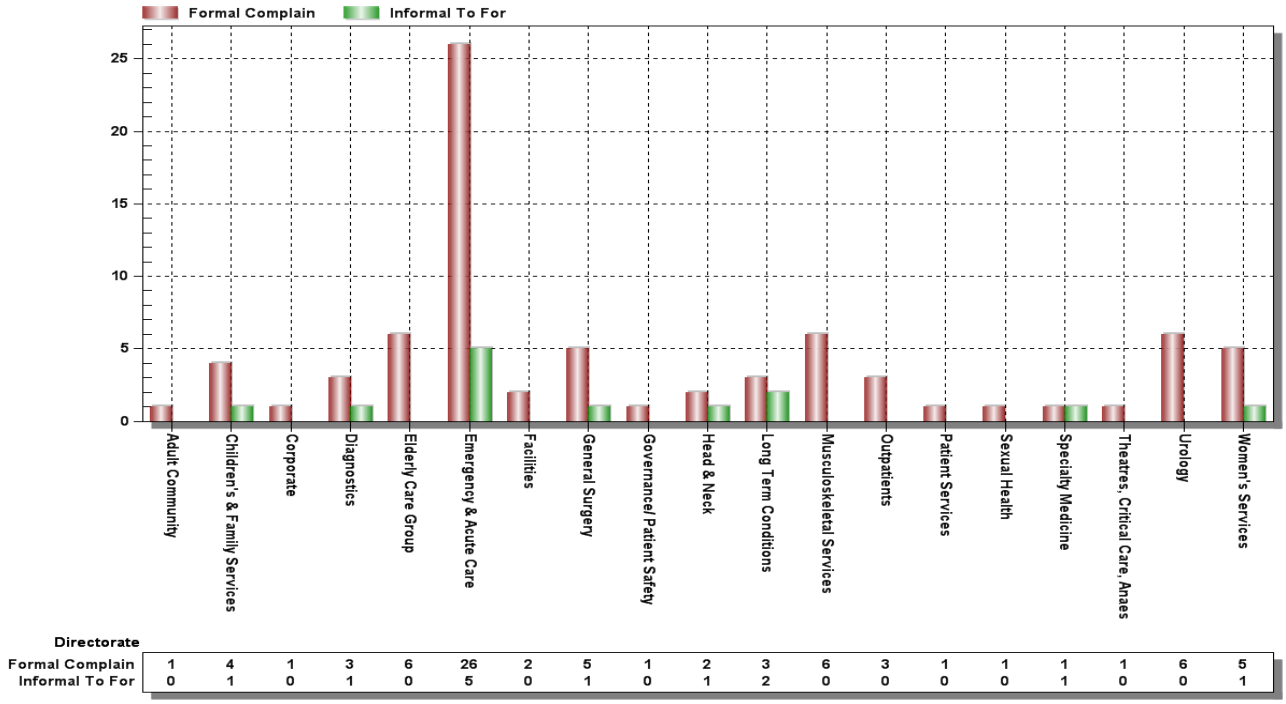
Table 1 *'K041a' written complaints are referred to as 'complaints' and these are managed through the Trust's complaints process and information on these is reported quarterly to the HSCIC (Health and Social Care Information Centre). The term 'concerns' is used in relation to informal concerns which are managed and resolved either on the spot, at a local level or issues which do not meet the criteria of the NHS complaint regulations or are 'out of time'.*

2.2 Formal Complaints by Care Group

The highest number of complaints by Care Group in Q4 was in Emergency and Acute Care, Musculoskeletal, Paediatrics/Family Services, General Surgery and Elderly Care. Emergency and Acute Care, received the highest number of complaints in Q4, this was in keeping with Q3 when this care group also received the highest number of complaints. However, the number of complaints received in Q4 increased by 9 complaints for this care group.

Musculoskeletal and Paediatrics/Family Services also saw an increase in overall complaints in Q4 compared to Q3. General surgery and Elderly care saw a reduction in the overall complaints received in comparison to the previous Q3.

The formal complaints received by each Care Group in Q4, January to March 2018 are highlighted below:

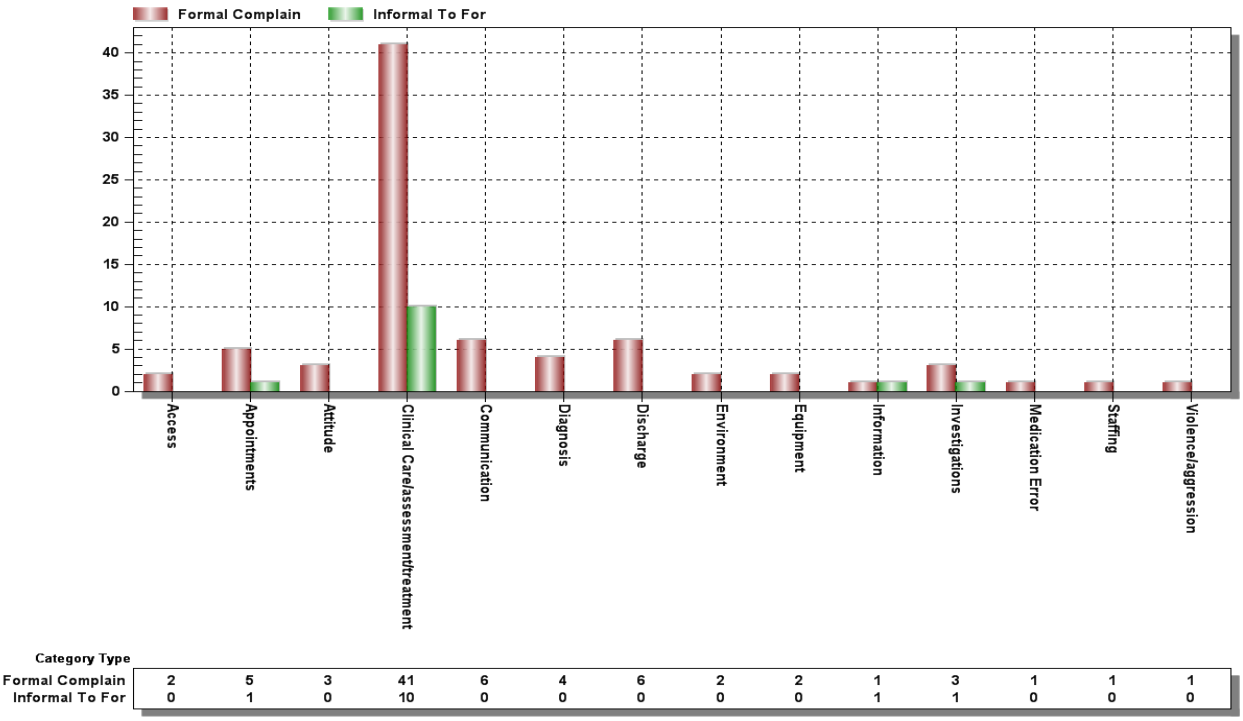


Directorate	Adult Community	Children's & Family Services	Corporate	Diagnostics	Elderly Care Group	Emergency & Acute Care	Facilities	General Surgery	Governance/ Patient Safety	Head & Neck	Long Term Conditions	Musculoskeletal Services	Outpatients	Patient Services	Sexual Health	Specialty Medicine	Theatres, Critical Care, Anaes	Urology	Women's Services
Formal Complain	1	4	1	3	6	26	2	5	1	2	3	6	3	1	1	1	1	6	5
Informal To For	0	1	0	1	0	5	0	1	0	1	2	0	0	0	0	1	0	0	1

During Q3 and Q4, the Trust had a mean average of 97% of all written complaints responded to within a 30 – 45 working day timeframe. This has been a significant improvement from the baseline of 69% in Q1 of 2017-2018.

2.3 Formal Complaints – Themes

The most common theme included in 63% of the complaints received in Q4 related to disatifaction with aspects of clinical care/assessment/treatment, followed by communication, issues related to discharge, communication and appointments. These themes are consistent with those reported in Q3 and previous Quarters in 2017-2018.



Category Type														
Formal Complain	2	5	3	41	6	4	6	2	2	1	3	1	1	1
Informal To For	0	1	0	10	0	0	0	0	0	1	1	0	0	0

2.4 Parliamentary Health Service Ombudsman Cases

If a complainant is dissatisfied with the response they receive from the Trust they have the right to contact the Parliamentary and Health Service Ombudsman (PHSO) to request an investigation. There are currently four PHSO ombudsman cases open in Q4. Three of these have draft outcomes, two being partially upheld and one not upheld. The remaining case is still under investigation. There were two PHSO cases closed in Q4, the outcome for both of these complaints were partially upheld and action plans have been completed and returned**.**

2.5 Patient Relation Team Concerns Received in Q4

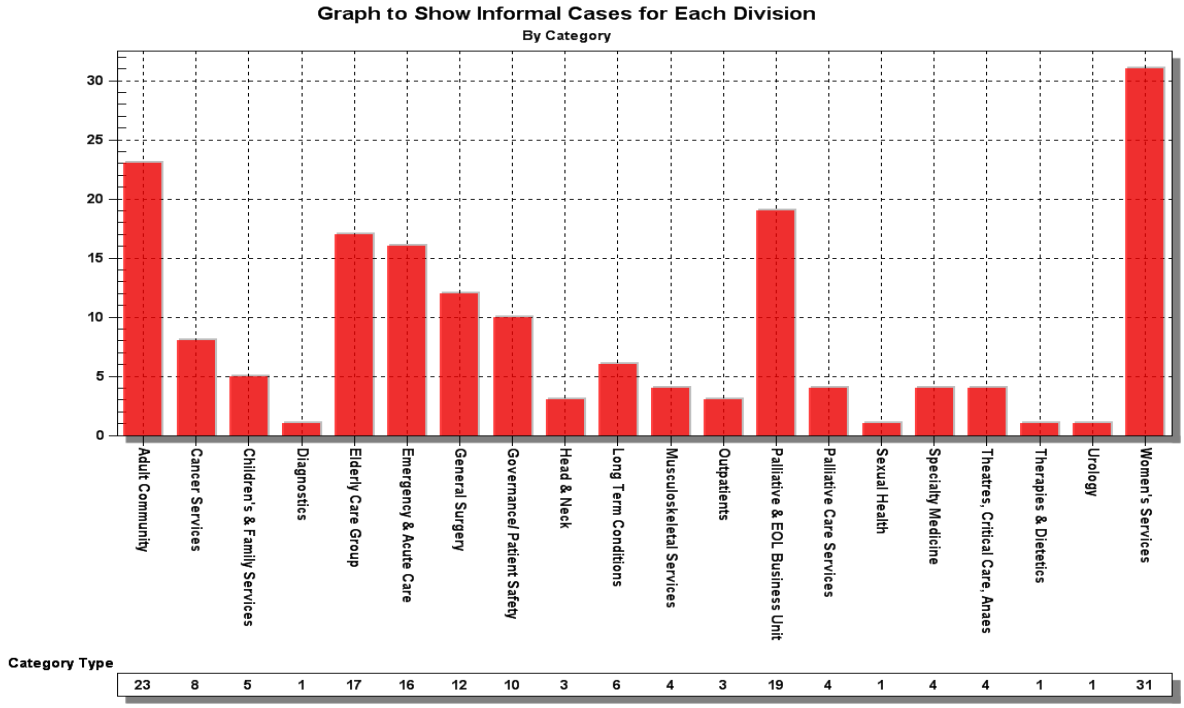
During Q4, 845 concerns were received via the Patient Relations Team which is an increase of 17% from the previous 722 reported in Q3. The top three categories for all concerns raised were: appointments, clinical care/ assessment, and information requests, accounting for over 74% of the total number of concerns raised.

In the Division of Surgery, the Care Group for Musculoskeletal services received the highest number of concerns (n=70), this was an increase from the previous 52 concerns received in Q3. Outpatients received the next highest number of concerns (n=59) with appointment queries and cancelled appointments being the most common themes identified. There were also 4 incidents reported relating to the unavailability of patient case notes.

In the Division of Medicine and Long Term Conditions, the Emergency and Acute Care Group received the highest number of concerns (n=100), this was a 25% increase from Q3. The most common theme identified from these concerns related to clinical care and communication, which is similar to the previous Q3 data.

2.6 Compliments

A total of 173 compliments were received for quarter 4 with the highest number received for Women's Services, Elderly Care, Adult Community Care and Palliative Care Compliments recorded account for 6% of all of the Patient Relation Team contacts received.



2.7 CQC/NHS Choices/Care Opinion

Between January and March 2018 there have been 21 comments made about the Trust via the NHS Choices/Care Opinion website. This figure includes 5 Compliments. The key category type is Clinical Care, Assessment and Treatment and communication. Feedback posted on the NHS Choice/Patient Opinion website is acknowledged and personalised with a request to contact the Trust to discuss the situation further offered.

In terms of CQC there was one new patient concerns logged for the period January-March 2018, this was also received as a formal complaint. CQC concerns are investigated and responded to directly via the CQC liaison Manager. Monthly updates are provided with details of actions taken as are also shared.

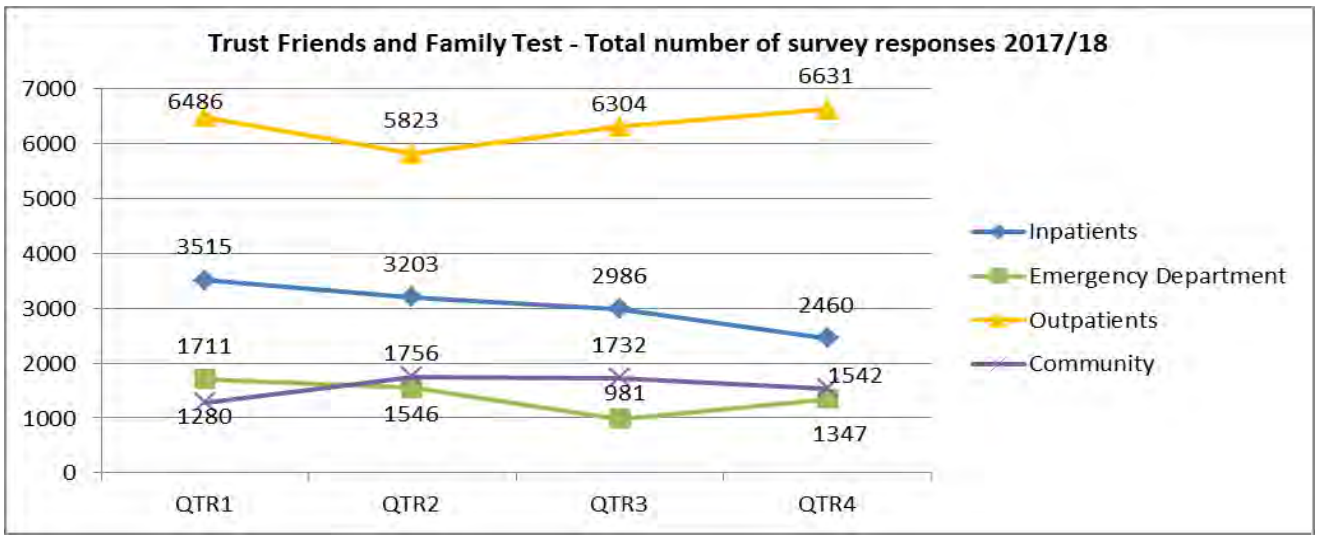
3.0 Friends and Family Test (FFT)

During Q4 Walsall Healthcare NHS Trust received 11980 Friends and Family Test (FFT) responses from patients about their experience of care and treatment across the different acute and community services. Overall, the Trust received over 52,000 responses; this was a 56% increase on the previous year.

3.1 Inpatients, Outpatients, Emergency Department and Community Services FFT

FFT Response Rates

The FFT response rates for Inpatients, Outpatients, the Emergency Department and Community services for Q1-Q4 of 2017-2018 are shown below:

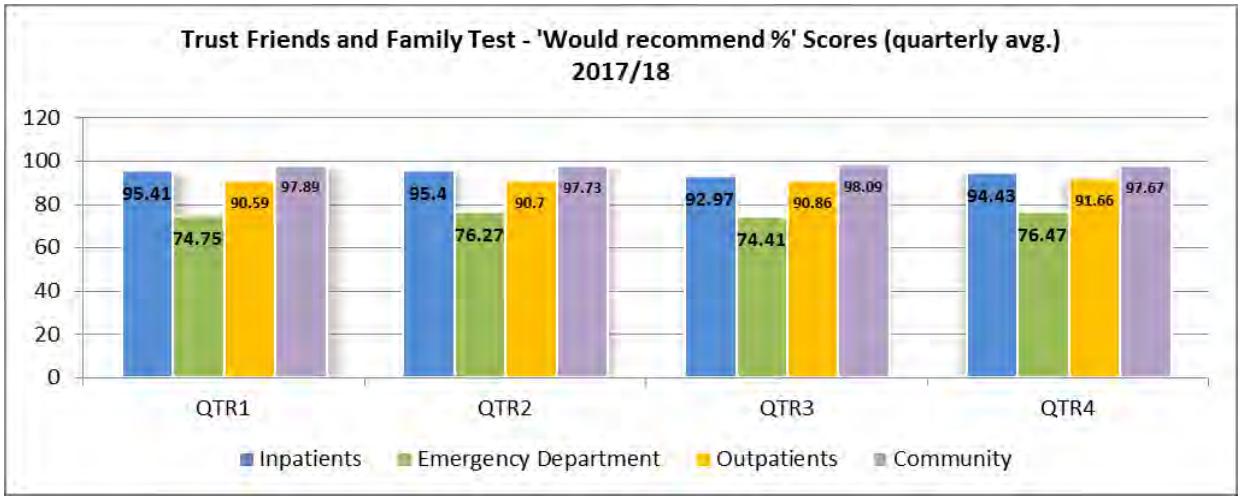


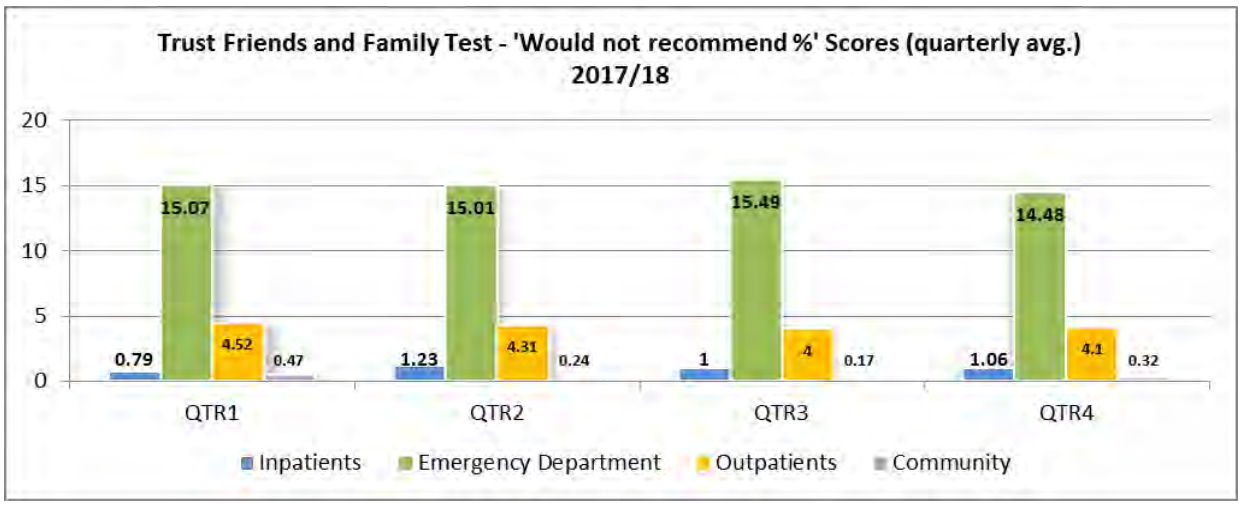
In Q4 Outpatients (OP) continued the trend of an improving FFT responses rate, with a 327 increase in responses compared to Q3. The Emergency Department (ED) also improved its response rate by 366 responses from a very poor performance in Q3. The ED response rate was on a par with the national average.

The inpatient (IP) response rates showed a downward trend through the year but the average response rates were at least 10 -12 points above the national average overall for the year.

Friends and Family Test Score Results

The "***would recommend***" scores for Inpatients, Outpatients, the Emergency Department and Community services are shown for Q1-Q4. All services, with the exception of community services showed an improvement in their "would recommend scores in Q4 compared to Q3.





The Inpatient "***would recommend***" scores were on a par/slightly below (+ or - 1%) compared to the national average. When compared with the national averages, the Outpatient recommendation scores were generally below 2%-3% throughout the year.

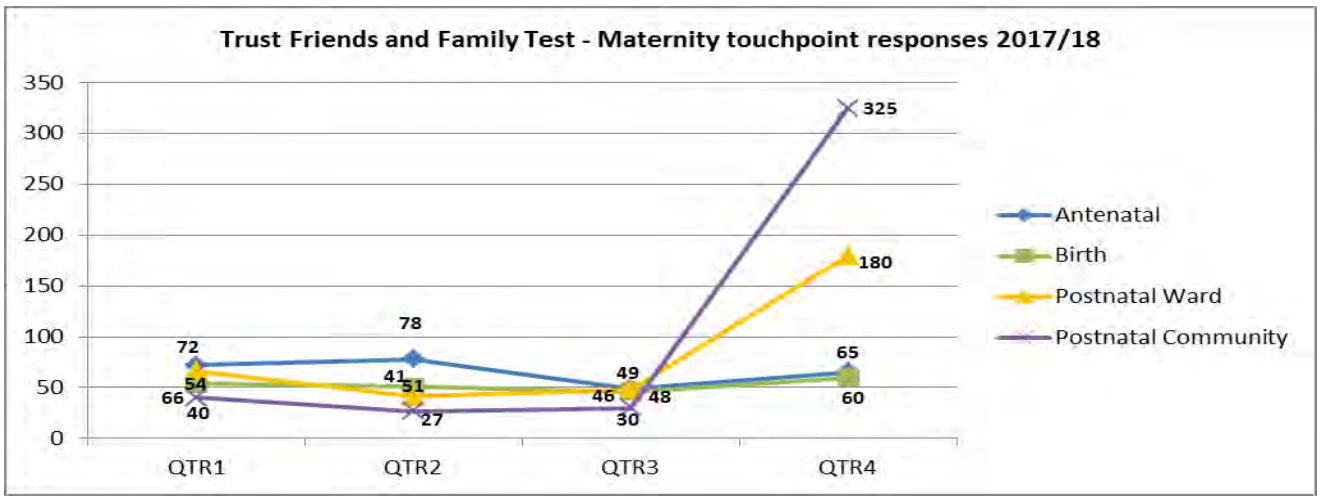
The Emergency Department (ED) recommendation scores continue to trail the national average by about 10% and the '***not recommend'*** scores remain almost double the national average. The Emergency Care Group has developed a patient experience action plan aimed at improving the experience of people accessing the department. The matron for ED is responsible for implementing and monitoring this action plan which includes: the use of volunteers to help support people waiting in the department, improved communication by displaying information relating to waits and triaging, and improving the cleanliness in the department.

The Community Services' average recommendation score of 98% ranks high when compared to national peers. Currently, most of the community services conduct FFT only once a month using paper surveys. Use of 'Badgernet' devices for online FFT surveys has been agreed in principle with phased roll out proposed from June/July 2018. This will facilitate wider coverage and real time feedback collection/reporting

3.2 Friends and Family Test Response Rates Maternity Services

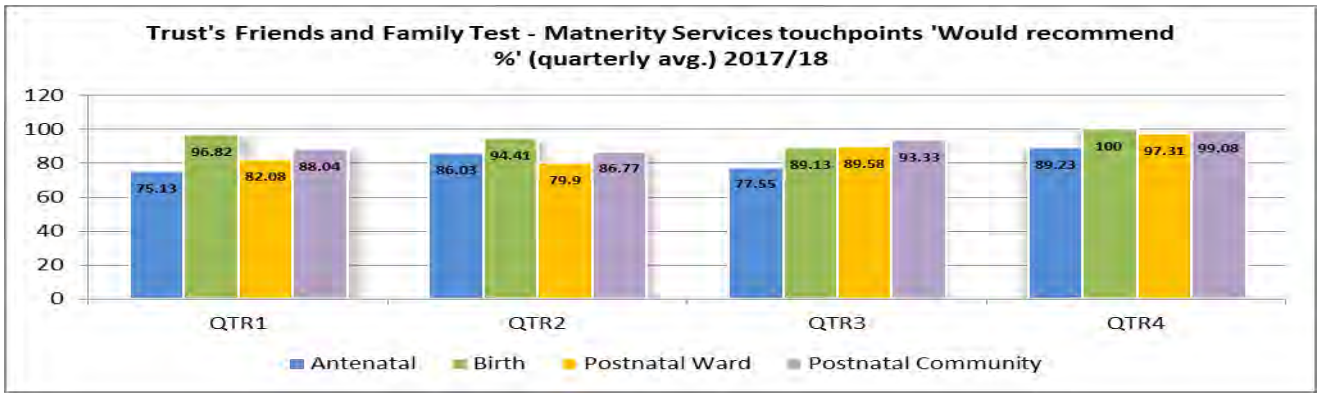
Maternity FFT Response Rates

The FFT response rates remain low across all the Maternity Service touch points. However, the postnatal ward and postnatal community services have seen significant increase in their response rates in Q4.

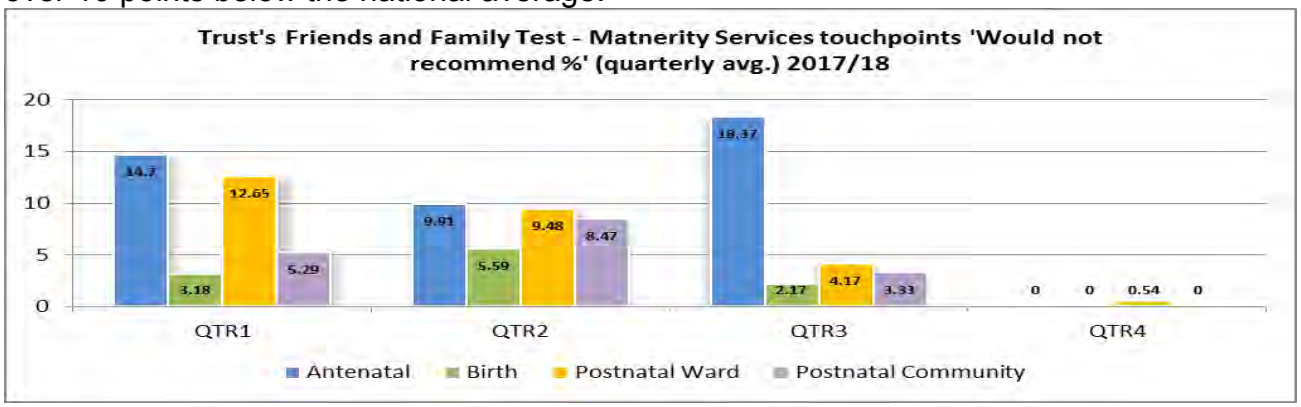


Maternity Friends and Family Test Score Results

The "***would recommend***" scores for all maternity services are shown for Q1-Q4. All maternity services demonstrated an improvement in their "***would recommend*** scores in Q4 compared to the previous quarter.



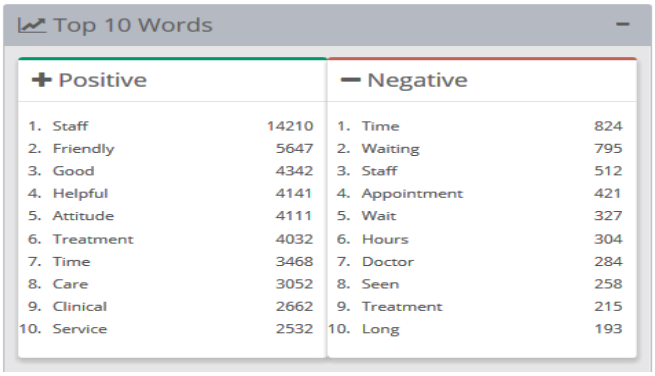
The recommendation scores for all maternity touch points are below the national average. The recommendation score for the antenatal touch point are significantly lower than the national average by more than 13%. The birth touch point, which is monitored nationally, is over 10 points below the national average.



In Q4, the antenatal, birth, postnatal ward and postnatal community services touch points all reduced their '***would not recommend'*** negative scores.

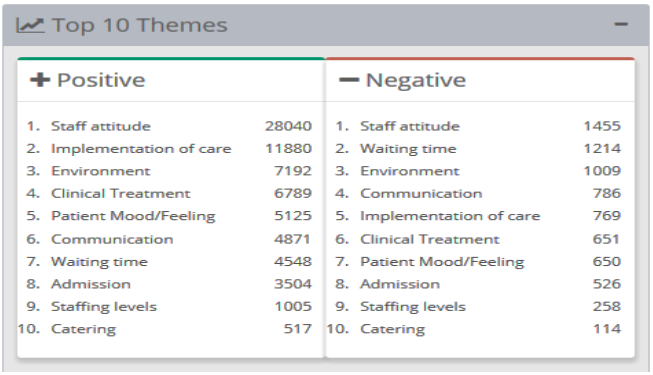
3.3 Analysis of FFT Free Text Comments

Staff attitude, implementation of care and hospital environment feature as the top positive themes from patient comments. In addition to waiting times, staff attitude and environment are also included in the top 3 negative comments.



Top 10 Words

	Positive		Negative	
1.	Staff	14210	Time	824
2.	Friendly	5647	Waiting	795
3.	Good	4342	Staff	512
4.	Helpful	4141	Appointment	421
5.	Attitude	4111	Wait	327
6.	Treatment	4032	Hours	304
7.	Time	3468	Doctor	284
8.	Care	3052	Seen	258
9.	Clinical	2662	Treatment	215
10.	Service	2532	Long	193



Top 10 Themes

	Positive		Negative	
1.	Staff attitude	28040	Staff attitude	1455
2.	Implementation of care	11880	Waiting time	1214
3.	Environment	7192	Environment	1009
4.	Clinical Treatment	6789	Communication	786
5.	Patient Mood/Feeling	5125	Implementation of care	769
6.	Communication	4871	Clinical Treatment	651
7.	Waiting time	4548	Patient Mood/Feeling	650
8.	Admission	3504	Admission	526
9.	Staffing levels	1005	Staffing levels	258
10.	Catering	517	Catering	114

Communication, attitude and environment are common feedback themes in both the FFT, formal and informal complaints and national survey results. Work has commenced in relation to the patients' experience of communication with the multidisciplinary team to explore this further and identify actions to improve this is also enrolled in the NHSi ' always events' patient experience programme. This co-based design work is being piloted on the AMU.

4.0 National Maternity Survey Results

The National Maternity Survey was published by the Care Quality Commission in January 2018. Mother who gave birth at Walsall Healthcare NHS Trust during January and February 2017 took part in the survey, providing feedback about their experience of care and treatment. A total of 300 surveys were posted, with a response rate of 31%. The results showed that the Trust performed '*about the same'* on most of the questions when benchmarked against other Trusts nationally. The only two questions that the Trust performed worse on were: skin to skin contact with the baby shortly after the birth and not always being informed about arranging a postnatal check-up of the mother's own health with her GP.

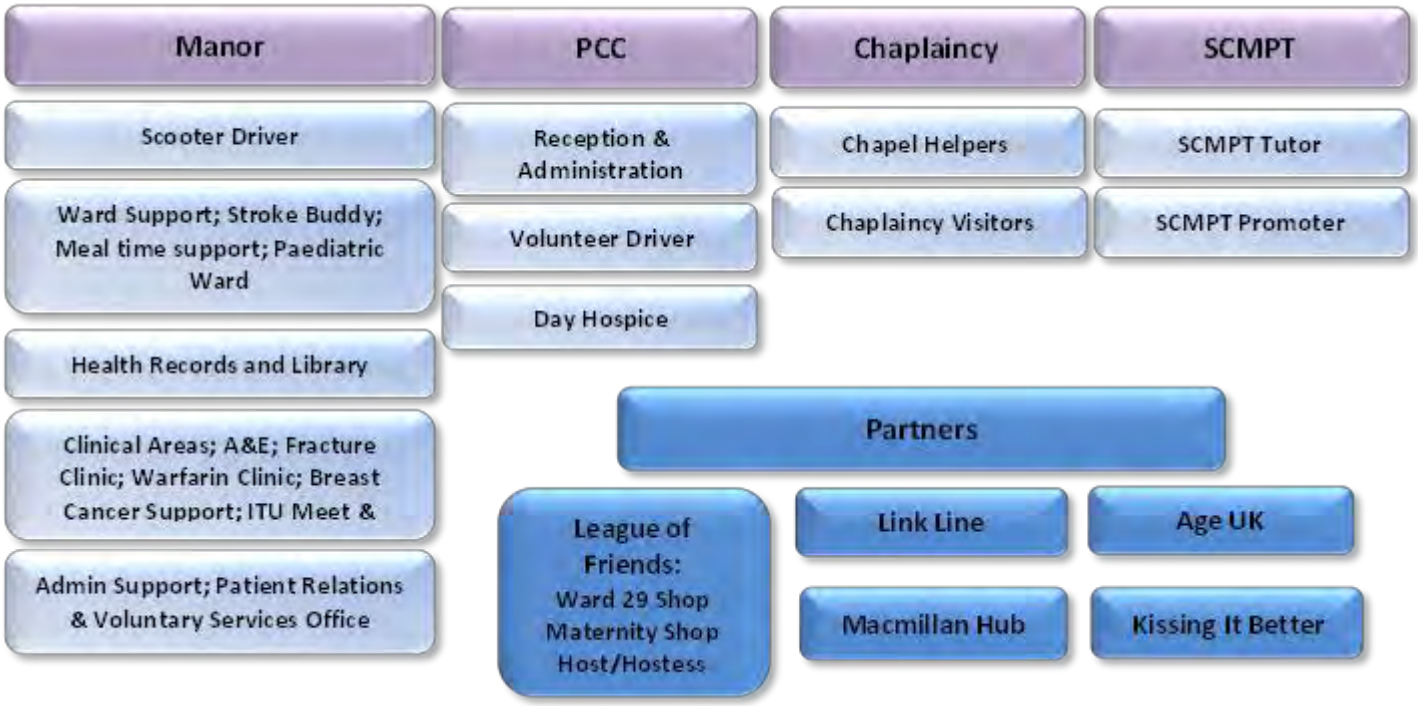
Comparison with the 2015 Maternity Survey results, shows that in the 2017 Survey maternity services at the Trust improved in 73% of the questions and there was a slight decline in performance in 27% of the questions. Provision of information to mothers on their own physical recovery after the birth was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

Maternity services have developed actions to address the feedback included in the national survey; actions have been incorporated into the maternity Patient Care Improvement Plan (PCIP).

5.0 Update on Volunteering

5.1 Volunteer Roles

There are currently 291 volunteers across the Trust undertaking activities in the hospital, Palliative Care Centre, Chaplaincy and with the Self-management Programme. These volunteers undertake a number of volunteer roles across the Trust and work with other partners, these are shown below**:**



At present the Patient Experience lead is attempting to recruit more volunteers to undertake mealtime support and support the patient experience improvement initiatives in the Emergency department.

5.2 Self Care Management Programmes

The Self Care Management Team (SCMT) provides group based peer support and learning for skill development for individuals living with or caring for someone who has a long term health condition. Training is led by people who have personal experience of living with a long-term condition but have no professional expertise in the area. It teaches problem solving, decision making, utilising resources, developing partnerships with health providers and taking action. None of the skills gained have anything to do with the condition(s), they are to do with managing lives, using information and power. Self-management is not intended to replace medical treatment, but to be complementary by helping people with a long term condition to use their skills and expertise alongside the skills and expertise of the medical professionals. Courses have included patients with diabetes, respiratory diseases, depression and anxiety, hypertension, cardiac conditions and for carers. In Q4, a further 57 courses were completed, and a total of 380 courses were completed throughout 2017-2018.

5.3 Friends of Expert Patients Programme (Friends of EPP)

The Friends of EPP has been meeting since December 2010. At these meetings patients routinely share their views and experiences about the life-changing effect of attending the self-care management course, as well as gaining a plethora of information from a range of professionals. A further 2 events have been held in Q4 and a total of 2140 patients have now attended since these events commenced in 2010 attending. The events are held every 2 months and are supported by the self-care management team and volunteers together with a range of partners.

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

6.0 Conclusion

The report provides a wealth of patient feedback which needs to be incorporated into the Trust quality improvement programme to ensure that patient experience is improved. Divisional action plans which address areas for improvement identified from patient feedback from National Surveys and FFT results are in place and are monitored through the Patient Experience Committee.

There needs to be an increased focus on address common themes identified from patient complaints and feedback both at corporate, Divisional and Care Group level. This work has started corporately and will be included as part of the monthly Divisional Review process being put in place.

<table>
<tr><td colspan="5">MEETING OF THE PUBLIC TRUST BOARD – 7th June 2018</td></tr>
<tr><td colspan="4">Quality Account 2017/18</td><td>AGENDA ITEM: 11</td></tr>
<tr><td>Report Author and Job Title:</td><td colspan="2">Chris Rawlings
Head of Clinical Governance</td><td>Responsible Director:</td><td>Kara Blackwell
Director of Nursing</td></tr>
<tr><td rowspan="2">Action Required</td><td rowspan="2">Approval X</td><td rowspan="2">Decision</td><td colspan="2">Assurance and Information</td></tr>
<tr><td>To receive and discuss</td><td>To receive</td></tr>
<tr><td>Recommendation</td><td colspan="4">Members of the Trust Board are asked to:
• Approve the completed sections of the Quality Account
• Delegate final approval rights to the Quality and Safety Committee to enable publication before 30th June 2018</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="4">There are no risk implications associated with this report.</td></tr>
<tr><td>Resource implications</td><td colspan="4">There are no resource implications associated with this report.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="4">The Quality Account Regulations require NHS Trust to publish a Quality Account annually before 30th June each year.</td></tr>
<tr><td rowspan="4">Operational Objectives 2018/19</td><td colspan="3">Continue our journey on patient safety and clinical quality through a comprehensive improvement programme</td><td>X</td></tr>
<tr><td colspan="3">Develop the culture of the organisation to ensure mature decision making and clinical leadership</td><td></td></tr>
<tr><td colspan="3">Improve our financial health through our robust improvement programme</td><td></td></tr>
<tr><td colspan="3">Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts</td><td></td></tr>
</table>

Walsall Healthcare NHS
NHS Trust

EXECUTIVE SUMMARY

The annual Quality Account has been prepared for 2017/18. It has been prepared in accordance with regulations and the audit opinion will be provided as external assurance. It describes the Trust's quality performance over the past financial year and sets out quality improvement priorities for 2018/19

A small number of items are awaited to provide the complete report, including the external audit opinion and the CQC Inpatient Survey report.

The Board is asked to delegate authority to the Quality and Safety Committee to approve the completed account at its June meeting to allow publication before the statutory deadline of 30th June.

Walsall Healthcare NHS
NHS Trust

Quality Account 2017/18

1. PURPOSE OF REPORT

The purpose of the report is to seek the approval of the Trust Board for the annual Quality Account.

2. BACKGROUND

NHS Trusts are required by regulations to produce an annual Quality Account by 30th June each year. The report consists of a statement by the Chief Executive on the quality of services delivered by the Trust and includes an introduction to the Quality Account. The past year's performance is considered and reported. Mandatory assurance statements are provided as part of this review. The quality improvement priorities for the following financial year are also set out.

The draft Quality Account has been prepared in accordance with the regulations and guidance issued by NHS England. External assurance on the content and accuracy of the account is sought and this will be provided by Ernst and Young. Key stakeholders as asked to provide a commentary which must be included verbatim. This paper provides an update on the current development of the Quality Account and the plan to publish it by the required date of 2018.

3. DETAILS

The Quality Account is nearing completion. There are a small number of outstanding items which fall into two categories:

- The receipt of the audit opinion
- Delay in receipt of information – including the 2017 Inpatient survey
- NHS Digital cannot provide year-end information at this time

The Board is therefore asked to delegate authority for the approval of the Quality Account to the Quality & Safety Committee which will review the completed Account and approve it for publication before the 30th June 2018.

Ernst & Young have reviewed the Quality Account and will be providing their audit opinion in June, prior to approval of the Quality Account.

Key stakeholders have been extended an invitation to provide a commentary on the Quality Account. These has been received from Walsall Healthwatch and Walsall CCG. The Overview and Scrutiny Committee have indicated that providing a commentary does not fit in with their business plan.

4. RECOMMENDATIONS

Members of the Board are asked to:

- Approve the completed sections of the Quality Account
- Delegate final approval rights to the Quality and Safety Committee for publication before 30th June 2018

Report Author: Chris Rawlings, Head of Clinical Governance
Date of report: 7th June 2018

APPENDICES
The draft Quality Account 2017/18

Walsall Healthcare NHS
NHS Trust






Quality Account 2017/18

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Becoming your partners for first class integrated care

Section 1: Statement on quality from the Chief Executive

1.1 Introduction
- Our services
- Our strategic plan
- Our approach to quality improvement

Section 2 – Review of Quality Performance

2.1 Progress since the CQC inspection report
2.2 Progress with our improvement priorities for 2017/18
- The Quality Commitment

2.3 Patient Safety
2.4 Clinical Effectiveness
2.5 Patient Experience
2.6 What our staff say
2.7 Equality & Diversity
2.8 Overall Activity Levels and Performance against Core Operating Standards
2.9 CQUIN

Section 3 – priorities for improvement 2018/19

3.1 Priorities for improvement 2018/19
3.2 CQUIN 2018/19
3.3 Who has been involved in setting our improvement priorities

Appendices:

1. Assurance Statements
   - Review of Services
   - National Confidential Enquiry and Clinical Audit participation
   - Goals agreed with Commissioners
   - Research and Development
   - Registration with the Care Quality Commission
   - Quality of Data
   - Learning from Deaths
   - Mandatory Indicators and National Targets
2. Statements
   - Healthwatch
   - Overview & Scrutiny Committee
   - Clinical Commissioning Groups
3. Statement of Director"s responsibilities in respect of the Quality Account
4. Independent Assurance Report

Glossary

Walsall Healthcare NHS Trust is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete.
This data quality agenda presents an on-going challenge from ward to Board.
Identified risks and relevant mitigation measures are included in the WAHT risk register.
This report is the most complete and accurate position available.
Work continues to ensure the completeness and validity of data entry, analysis and reporting.

Section 1: Statement on Quality from the Chief Executive 2016/17

I am pleased to present the annual Quality Account for Walsall Healthcare NHS Trust which provides a full picture of the quality of the services we provide both in our hospital and the community. It details the progress made in meeting our quality improvement priorities over the last year, our performance against key measures and also where we will be concentrating our improvement efforts in 2018/19. Some of the year"s highlights are also included.

I may have only joined the Trust recently – in February 2018 – but I have seen first-hand the excellent progress that has been made here so far. The focus is now on keeping up this momentum and not losing sight of what still needs to be done.

After being rated as “inadequate” by the Care Quality Commission following its 2015 inspection, the re-inspection the Trust had in June 2017 was an important indicator for the organisation of how well it had responded to the issues identified.
The new rating of “requires improvement” given in December 2017 is an important step on the way to “good and beyond” and reflects the considerable work of the Trust"s staff and their desire to provide better care. The “outstanding” rating received for community services was also a real achievement
Maternity was the one service that remained “inadequate” but the continuing drive to improve is monitored by the Trust, its commissioners, the CQC and NHS Improvement and significant change is being implemented and felt positively. The Chief Inspector of Hospitals Inspection Report is described in more detail on page 10

Performance snapshot:

The Trust experienced significant emergency pressures combined with a difficult winter which resulted in utilisation of additional capacity to service increased emergency activity and additional sessional work needed to support referral to treatment (RTT).

Full details of our performance against key measures are contained in this report but improvements included:

- Cancer 2 Week Waits – 25th (Q4 17/18) compared to 41st (Q3 17/18)
- Total Time Spent in ED Overall – 79th (Apr 18) compared to 92nd (Mar 18)

The Trust has declined in:

- SHMI* – 110th (Oct16-Sept17) compared to 101st (Jul16-Jun17)
- Cancer 62 Day RTT – 38th (Q4 17/18) compared to 28th (Q3 17/18)

* Standardised Hospital Mortality Indicator

Quality Priorities:

For 2017/18 The Trust set itself three quality priorities:

1 Medicines safety
2 Care of deteriorating patients in hospital
3 Assessment and development of equality and diversity

While the first two priorities have seen improvements through strong internal and external focuses, we acknowledge that we still have a lot of work to do around equality and diversity.

All three improvement priorities will be continued into 2018/19 with an additional priority: The quality of the health record.

Learning from feedback:

Another important indicator of how well the Trust is doing is feedback from patients and their families as well as our own staff.

The 2017 national staff survey results for Walsall Healthcare showed that colleagues are not as satisfied with their experience at work and feeling engaged in the organisation‟s objectives, as many other Trusts.

Whilst the results have not deteriorated from 2016 they have only marginally improved. There are clear signs that staff feel they are listened to compared with last year and have more of a say than previously. But there are also clear signs of the pressure staff are feeling, with more people feeling work-related stress and also feeling less well paid than previously.

These results must motivate the Trust to continue trying to improve the culture of the organisation while accepting that change will take time.

Over the last year we have continued to implement our patient experience strategy that puts the patient voice at the heart of our services and ensures that the Trust has a co-ordinated approach of „listening to‟ and „learning from‟ patient feedback.
We saw patients reporting a better experience in our hospital through the Friends and Family Test (FFT), national and local surveys. More than 52,000 patients responded to our feedback surveys and 91% said they would recommend our services.

Key improvements included the introduction of the Quiet Protocol to help patients sleep well at night, establishing a patients‟ reading panel, piloting the Always Event® improvement programme and the „Observe and Act‟ tool for a better feel of the total experience journey. Key areas highlighted for improvements in our national surveys included communication, patient involvement in decisions about care and treatment, arrangements around discharge and waiting times.

Investment:

Work is well underway to house two new state-of-the-art MRI scanners at Walsall Manor Hospital as part of the Trust‟s overall £50 million investment in healthcare services. This investment will also see the creation of our new Integrated Critical Care Unit, a new Obstetric Theatre and expansion of the Neonatal Unit and the redevelopment of the Emergency Department.

This major investment will not only enhance our patients‟ experience but will also improve the working environment for staff; helping the Trust to retain its workforce and build on training and advancement opportunities.

Quality Commitment:

In conclusion, to achieve a rating of “good” or “outstanding” for the whole Trust we know we need to use a more sophisticated approach to quality improvement. This approach is described on page 8 and explains our aim to develop an Integrated Improvement Programme which will help revise and focus our Quality Commitment.

We have built on the success of our internal Listening into Action approach and created a Quality Improvement Academy to help colleagues at all levels of the organisation improve the quality of their work through guidance and training. Learning from what goes well is as important as learning from errors, so Learning from Excellence has been introduced to balance incident reporting and use the same review methods to undertake a “right cause analysis”.

It is my personal aim to work with the Trust Board and colleagues across all levels of the organisation to empower staff to make the changes they want to make to improve the quality of care received by all patients who use our services.

I am responsible for the preparation of this report and its contents. To the best of my knowledge, the information contained in this Quality Account is accurate and a fair representation of the quality of services provided by Walsall Healthcare NHS Trust.

Richard Beeken
Chief Executive

1.1 Introduction

NHS Trusts are required to publish a Quality Accounts every year under section eight of the Health Act (2009). They are reports to the public from NHS providers about the quality of the services they deliver and must include prescribed information set out in the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (quality Account) Amendment Regulations 2012. Additionally, every year, NSE England (the organisation that runs NHS services in England) requires that further specific pieces of information are included within the document.

The report aims to enhance accountability to the public for the quality of NHS services. The Quality Account for Walsall Healthcare NHS Trust sets out where the Trust is doing well, where improvements in quality can be made and the priorities for the coming year, where we hope to do better still.

Copies of this document are available from our website (www.walsallhealthcare.nhs.uk), by email to communications@walsallhealthcare.nhs.uk or in writing from:

Trust HQ
Walsall Healthcare NHS Trust,
Walsall Manor Hospital,
Moat Road,
Walsall,
WS2 9PS

Please contact us if you would like a copy of the Quality Account in large print or in another community language for people in Walsall.

A glossary is provided at the end of this document to explain the main terms and abbreviations that you will see used in the document.

We welcome your feedback on our Quality Account. We welcome your feedback on any aspect of this document. You can let us know by using the contact details above.

Our Services

Walsall Healthcare NHS Trust was formed on 1 April 2011, bringing together the teams at Walsall Hospitals NHS Trust and NHS Walsall Community Health. We are an integrated healthcare organisation with an annual turnover of circa. £240m and our 4,000 staff serve the 269,000 residents of the borough of Walsall providing a comprehensive range of hospital and community healthcare services in their own homes. As an integrated provider of healthcare, many services have moved beyond traditional boundaries for the benefit of patients.

Walsall Manor Hospital houses the full range of district general hospital services under one roof. The £170 million development of our Pleck Road site was completed in 2010 and the continued up-grading of existing areas ensures the Trust has state of the art operating theatres, treatment areas and equipment.

The Trust has 606 inpatient beds including 536 Acute and general beds, 57 Maternity Beds and 13 Critical Care Adult beds and a specialist Palliative Care Centre. We also provide high quality, friendly and effective community health services from some 60 community settings, such as health centres, GP surgeries and, importantly, in people"s own homes. Covering Walsall and beyond, our multidisciplinary services include rapid response in the community and home based care, so that those with long term conditions and the frail elderly, can remain in their own homes to be cared for.

The Trust"s Palliative Care Centre in Goscote is our base for a wide range of palliative care and end of life services. Our teams, in the centre and the community, provide high quality medical, nursing and therapy care for local people living with cancer and other serious illnesses, as well as offering support for their families and carers.

Our extensive Lifestyle Management service provides smoking cessation, drug and alcohol support, a Physical Activity team and a Health Training service. Working with all areas of the Trust, the team ensure lifestyle management features across our range of healthcare services.

Services are organised for management purposes into four divisions:

- Surgical Division,
- Medical and Long Term Conditions (includes adult community services),
- Women's, Children's and Support Services (includes children's community Services and Mid-wife led unit) and also Diagnostic and therapy services including Pathology, Pharmacy, Physiotherapy.
- Corporate Services (includes estates management, Specialist services including Tissue Viability, infection control and the Palliative Care (including Goscote Palliative Care Centre).

Our strategic plan

In 2016 we committed ourselves to a five-year journey to deliver our vision of **becoming your partners for first class, integrated care**. This vision was supported by five strategic objectives form the basis for our two year operational plans for 2017/18 – 2018/19– years 2 and 3 of the 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 sustainability. Embedding service improvement tools and methodologies will be integral part of our approach to ensure that the organisation builds and maintains a culture of continuous improvement and efficiency.

Our commitment to partnership work continues as we work 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. In the borough of Walsall we have agreed to a programme of work to transform the way we delivery placed based care as a integrated system.

At its simplest we will embed the improvements in quality and safety, culture and performance that we have begun this year whilst also tackling our significant financial challenge to ensure we are sustainable. We are aiming to deliver:

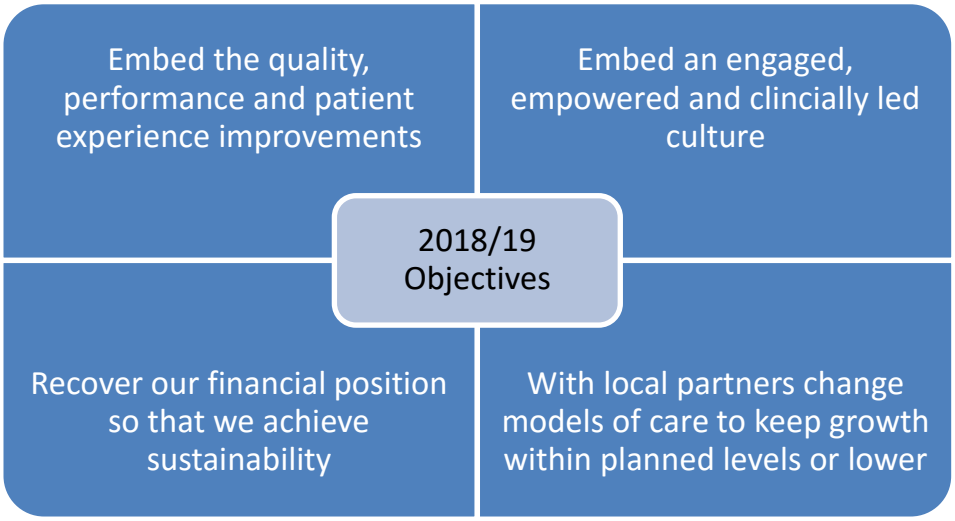
- **Safe, High Quality Care** – by continuing to improve the quality of the care we provide, delivering a renewed focus on patient experience and continuing to reduce long waits for care;
- **Care at Home** – with our partners in the Walsall health and social care economy, progressing the delivery of 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 developing new roles and reducing 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 £15m in 2018/19, delivering a £11m and £13m savings programme respectively. 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.

There is no doubt that 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.

The work that commenced in 2017/18 to review our service sustainability will continue at pace in 2018/19. It will see a shift from a short-term focus on ensuring our services are safer and performance improves, to a longer-term focus on the delivery of a safe and sustainable model of care. Phase one of this work was completed in February 2018 and the next phase will commence in March 2018. Further information is available in the Trust's Annual Report.

Trust Objectives 2018/19

As part of our annual planning process we reviewed our annual objectives with our clinical leadership teams and have revised them as shown below. As part of our commitment to embedding clinical leadership, the descriptions of our objectives are at a higher level than previous, so that each of our management teams can devolve more operationally focused objectives to their teams. These high-level objectives are set out below.



Trust Objectives 2018-2019

Our 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

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.

Executive leadership, accountability and responsibility for quality governance are 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" was approved at Trust Board in November 2016 and continued through 2017/18. 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 three main sections:

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

The actions to implement the Quality Commitment and those included in the Patient Care Improvement Plan developed after the 2015 CQC inspection helped to improve our ratings and the Trust is now rated overall as „Requires Improvement". The results are provided in this report.

To get all our services to a "good" or "outstanding" rating, we know we have to change and improve our approach to quality improvement. This approach will include agreeing a set of measurable improvements which will be underpinned by a clear line of sight that shows how services and colleagues at every level contribute to achieving them, giving colleagues the skills to improve, and a system which will monitor, support and hold leaders to account for the improved performance or achievements of the aims.

An Integrated Improvement Programme (IIP) will be developed to incorporate on-going "must do" actions following the CQC inspection report. It will also include the aspirational quality and safety ambitions driven by our clinical teams' vision for outstanding services.

The Quality Commitment will be revised to capture the high level aims and replicated at Divisional and Care Group level to show the contributions from the individual services and measures of performance. The plan will set out achievable, sustainable, incremental plans that include thematic corporate, divisional and care group actions.

A new Quality Improvement Faculty has been established to support colleagues on the improvement journey. This encompasses the existing Listening into Action (LIA) Programme and the Service Improvement Team. This will provide additional innovative, research, and evidence based support to the services and clinicians. The first phase focuses on Human Factors in Maternity and Gynaecology.

The revised governance and assurance structure implemented in 2015 continues and is aligned with the clinically led management model in the Divisions providing ward to board

reporting and assurance. However the intention is to review these arrangements during the first quarter of 2018/19.

The Quality Governance Advisors embedded in the three Divisions have delivered expertise in embedding governance structures and processes at a clinical and managerial level and whilst they will continue to do so it is also planned to strengthen this at divisional and care group level so as to ensure we move to high performing clinical leaders from ward to board.

Section 2 – Review of Quality Performance

2.1 Progress since the CQC inspection report

The 2015 Chief Inspector of Hospital"s report rated the Trust as inadequate. The considerable amount of work and initiatives undertaken to engage with patients and staff, an improvement plan captured in the Trust"s Quality Commitment, the Patient Care Improvement Plan (PCIP) and supported by initiatives such as the Listening into Action (LiA) to enable bottom up change, has helped the Trust to improve the quality of services it delivers.

The December 2017 Chief Inspector of Hospital"s Inspection Report demonstrated this improvement:

- **Trust** was rated overall **Requires Improvement**.
  - **Caring** **Good**
  - **Maternity Services** **Inadequate**
  - **Community services** **Outstanding**

The feedback from the inspectors was that they saw “a very different Trust” to the one they visited back in 2015 confirming that our improvement journey is starting to show significant results. Our staff has been the driving force behind many of these improvements and we thank them again in this report for their commitment and pride in their services. Particular credit should go to our community services teams for their rating of “Outstanding” and to our Emergency Department team who are no longer rated “Inadequate”

Overall Trust Rating: Requires Improvement

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Walsall Manor Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good

Community Services Rating: Outstanding ☆

The Maternity service saw marginal improvement but remained with an “Inadequate” rating. In the nine months since the inspection, further improvements have been made in the Maternity Service under the new leadership team. The Task Force approach will however continue 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 Urgent and Emergency Services were previously rated „inadequate“ but have improved significantly. Work continues to improve the service and we have therefore 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: Focus on improving patient flow.

The aim is to improve and maintain ED performance against the 4hr wait standard 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, 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.

We have improved the pathways between the ED and community and rapid response services, and this is 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 an integrated service with the Local Authority which includes a shared management team.

The size and condition of the Emergency department also needs to be addressed. A business case to build an Emergency Department that can adequately cater for the needs of Walsall“s population is progressing and there is confidence that it will be agreed during 2018/19.

We have always been very clear that this latest inspection was an important milestone on our improvement journey but that it was not the end of the journey. We know that we need to continue to build on the foundations we“ve laid and to work with partners across the health

and social care system to collectively deliver services that meet the needs of the communities we serve.

The Integrated Improvement Plan will support our ongoing strategy and we will be working with our clinical teams to take the action needed to ensure that all of our teams are able to achieve “good” or “outstanding” ratings in the future.

Other quality highlights from 2017/18:

While there was an understandable focus on the CQC re-inspection in 2017, a considerable amount of improvement work was under way at all levels of the Trust and a selection of the improvements made, achievements attained and awards received by our services and staff are described below.

Listening Into Action (LiA)

LiA is about re-engaging with employees and unlocking their potential so they can get on and contribute to the success of your organisation, in a way that makes them feel proud.

To date over **60 teams** have used LiA as a way of engaging with stakeholders around improvements in their areas and the wider health economy.

Outcomes during the past 12 months include: -

- Infection prevention and control have increased the knowledge of ANTT (Aseptic Non-touch technique) in key target areas from 40% to 96% in just 20 weeks.
- The communications team have reduced the number of global emails sent out by 70% since the introduction of Daily Dose.
- Learning from Excellence launch has seen over 160 nominations for outstanding clinical practice.
- Tissue Viability have secured replacement mattresses and have predicted savings of £120k in 2018-19. Early review has seen a 50% reduction in pressure ulcers.
- Paediatrics OPD has reduced DNA rates by 4% and increased 4% increase in clinic utilisation.

Maternity Dashboards Sept 17 to end Feb 18:

- Emergency C-Section rates **reduced by 7.8%**
- Overall C-Section rates **reduced by 1.3%**
- Skin to skin rates for term (>37 weeks) babies within the first hour of birth have increased from 46.45% (16/17 FY) to 53.38% **A Rise of 6.93%**
- Referrals to Quit Smoking Team have increased by 68% Sept 2017-end Feb 2018

NNU data trend:

- % of term admissions to NNU/TC with low temp (<36.5) has been reduced from: 25% (2016) to 16% (Jan-March 2017) to **10.9%** (Oct - Dec 2017)

Urology OPD

- 62% reduction in OPD follow-up backlog list.
- Achieving 31 and 62 day cancer targets

Consent

- Consent training figures increased from 2 in 2016 to 150 in 2017

Infrastructure developments:

- Building work on the new **Integrated Critical Care Unit** has started with completion due in the Winter of 2018.
    - The new development is bringing together Walsall Manor Hospital's Intensive Therapy Unit (ITU) and the High Dependency Unit (HDU) creating an 18-bedded unit, which is an increase of five beds.
    - The new ICCU will allow the Trust to treat many patients in individual rooms, preventing cross infection and ensuring their dignity and privacy.
    - The standardisation of equipment at every bed space will mean any bed can be used for either an HDU or ITU patient, preventing them having to be moved.
    - Each bed will have a ceiling-mounted pendant that supplies a comprehensive range of essential services including essential gases, power for equipment and IT links.

- Community nursing teams have gone live with **mobile technology** as part of an £800,000 Walsall Healthcare investment.
    - The new Totalmobile system is a switch from a paper-based patient assessment system and means that community staff can give patients the results of their blood tests for example, reducing any delay in starting treatment.
    - They can also access details of new patients more quickly and the devices offer greater security for lone workers.
    - The new system incorporates the capture of referral and contact information, dynamically schedules appointments and allows visit information to be inputted on to the system via Samsung Galaxy Tablets.

- A new **Gamma Camera** has been installed in the Manor Hospital.
    - The equipment, which is used to detect cancerous tumours and a host of other medical problems, is costing in excess of £650,000.
    - The existing camera was installed a decade ago and is outdated. The new has a SPECT/CT attachment. This will improve image quality and diagnosis and offer an improved service to patients. It will be possible to perform modern examinations, and patients who currently have to travel to other hospitals for their examination will now be able to receive this in Walsall.

Initiatives:

The **High Flyers** project commenced in 2014 following three serious incidents occurring within a short period of time to complex patients who did not meet the normal criteria for requiring hospital admission and care, but had multiple long standing social and lifestyle issues, including alcohol abuse, which impacted on their health and required additional support. The aim was to reduce the impact of not intervening, the revolving door of attendances to A&E, the missed opportunities to intervene and catastrophic outcomes for the patients.

We looked for:

- Patterns in attendances and admission - Who attends particularly A&E, how often and themes
- Were there already plans in place to support complex patients and why were they proving ineffective?

We found:

- The top 15 attenders accounted for 499 attendances to A&E in a seven month period.
- The top 5 attenders accounted for 53% of this total.

We took action:

- A multidisciplinary team was created to review the first ten „High Flyers". A lead agency was identified for each with an individual management plan in place, copied to their GP.
- A No Fixed Abode (NFA) Algorithm was been developed, regarding how to better manage these patients when they present to A&E or are admitted to ensure safe discharge
- GPs were provided with information on how to refer patients to the team

The results were impressive with a 47% reduction in attendances in the first nine months. Fewer admissions were also seen releasing beds and reducing costs.

This work continued through 2017/18 and has been recognised nationally. The team have recently been invited to present to the All Parliamentary Alcohol Select Committee in June 2018 to present on the work. There will be a presentation with questions and a report will be produced to share with other local authorities/ healthcare trusts, in order to further replicate similar projects across the country. The Isle of Wight Local Authority have also contacted the team asking them to support a project development relating again to High Flyers, and sharing Walsall's approach

learning from excellence

If we can learn when things go wrong, shouldn't we be able to learn when things go right? This is the premise behind Learning from Excellence (LfE). Inspired by initiatives in local Trusts (notably Birmingham Children's Hospital) and now gaining national recognition, we have adapted our incident reporting system as a means to capture "Excellence Nominations". Staff can quickly enter the details of an individual or team who have excelled. Between August 2017 and March 2018 164 nominations were made. Each of these was reviewed by the team guiding the initiative and selected excellence events have been subjected to a „Right Cause Analysis" to understand what went right and to see if the same approach could be used elsewhere.

> *Following the successful MRI brain scan of a very frightened child, we dreamt, "What if it was this good, every time." We then interviewed all those involved in the patient pathway- consultant, play specialist, radiographer, parent and child, asking the question, "What made it so excellent?" We then re-designed the process around this great experience and develop a Standard Operating Protocol (SOP).*

Although the initiative is in its early days, it"s clear that learning from what goes right balances some of the perceived negativity of incident reporting, which, by definition, something hasn"t gone right. It extends beyond just patient safety and learning from improved processes and patient experiences is just as valuable.

The team presented a poster at the international Learning from Excellence Conference in November 2017. Further information is available at: https://learningfromexcellence.com/

Awards:

Children's Services APP won the Patient Experience Network (PEN) National Awards

Category: **Innovative Use of Technology/Social Media**

- Walsall Healthcare NHS Trust won this national award thanks to an innovative app designed to help young patients and carers have a great experience while in hospital.
- Independent body The Patient Experience Network (PEN) recognised the app, developed by Paediatric Consultant Dr Hesham Abdalla; noting it to be significant in improving communication between staff and patients.
- The Walsall Children"s Healthcare app was prompted by Dr Abdalla"s experience of shadowing a patient on the hospital"s Paediatric Assessment Unit and seeing the alarm on a mother"s face when her daughter"s oxygen levels started to dip.
- The app, which is free to download from Google Play and Apple App store, includes helpful guidance such as frequently asked questions, video clips on what to expect with procedures such as MRI scans and even fun games to keep the patients entertained while on the ward.

Walsall Healthcare's 0-5 Health Visiting (Healthy Child Programme) service has achieved the prestigious Baby Friendly Award.

- The Baby Friendly Initiative, part of Unicef (United Nations Children"s Fund), recognises the excellent support in infant feeding and parent-infant relationships Walsall Health visiting Service offers to Walsall families.
- "We decided to implement the initiative to increase breastfeeding rates and to improve care for all mothers in Walsall," said Caroline Mansell, Baby Friendly Implementation Manager.

The Patient Safety Teams have been shortlisted for the 2018 Patient Safety Awards – being held in June 2018

Category: Clinical Governance & Risk Management
Title: An integrated approach of changing cultures in Clinical Governance/ Patient Safety

Patient Safety teams for Medicine and Surgery with Walsall Healthcare have been shortlisted for a national award which recognises services that have gone above and beyond in delivering safe care for patients.

The role of Patient Safety is to help monitor risk, to support with incident reporting and to facilitate investigations where necessary; all with an end goal of supporting colleagues to learn from incidents that will prevent them from happening again.

2.2 Progress with quality improvement priorities for 2017/18

We have made some good progress with two of the three improvement priorities included in the 2017/18 Quality account but each of them requires further work to sustain the improvements made and to achieve the intended result.

Priority 1 : Improve Medicine Safety Standards specifically: • **Controlled drugs standards** • **Safe Storage** • **Reduction in missed doses** • **Use of Medicines Safety Thermometer** • **Preventing Harm from Insulin**	Partly achieved

Overview of performance / achievement of the priority:

Controlled Drugs (CD) Standards = Not achieved
Controlled Drugs Standards in the Trust were identified as a corporate risk over a year ago. Subsequent audits have identified that the risk remains despite action plans drawn up for completion by ward managers after each quarterly audit cycle. Quarterly Controlled Drug audit results have been routinely reported at monthly SMNAG, DQTS and MMC, highlighting areas of non-compliance and recommendations regarding improvement.

Safe storage of medicines = Achieved
Weekly ward storage audits continue to be carried out in 32 wards and departments. The results are shared at the time of the audit with the ward manager. Furthermore, the monthly RAG rating report for each division is shared with ward managers and matrons. Percentage compliance remains relatively stable above 90% overall.

A monthly drug trolley audit commenced in February 2018 with compliance in March 2018 at 77%

Medicines Safety Thermometer = Partially achieved
A Medicines Safety Thermometer audit will be conducted on an annual basis each year. There are four key measures worthy of note. The overall results since data collection began showed that:

We performed better than the national average (between June 2014 and June 2017) in three categories:

- Proportion of patients with reconciliation started within 24 hours of admission
- Proportion of patients with a medicine allergy status documented
- Proportion of patients with an omission of a critical medicine in the last 24 hours

We performed worse than average in one category:

- Proportion of patients who have had an omitted dose in the past 24 hours

Prescribing Safety Thermometer = Partially achieved
The Prescribing safety Thermometer audit was undertaken for a local CQUIN directed at improving prescribing standards. The audit will now be completed on an annual basis. In April 2017, the insulin prescribing standards targets had been achieved. Although the saline flush prescribing standard and the warfarin prescribing standard targets had not been achieved the compliance with standards had improved since the start of the audit. Oxygen prescribing standard target remained consistent throughout the audit period at just over 93%

How the improvement will be sustained:

Safe storage of medicines
It is anticipated that the percentage compliance with the weekly ward storage audit standards will continue to remain above 90%. The key to sustaining improvement is good communication between pharmacy staff and ward managers in addressing medicine storage issues arising from weekly ward storage audit results. It is anticipated that percentage compliance with drug trolley audits will follow suit once routinely embedded.

Next steps:

Controlled Drugs (CD) Standards
It has been agreed by the Director of Pharmacy, the Medication Safety Officer and senior nursing colleagues that nursing staff will carry out a monthly CD self-audit with the pharmacy continuing to carry out the quarterly CD audit; this will ensure that nursing staff are identifying any issues in a timely way before the pharmacy quarterly audit is completed and will ensure that compliance rating is not solely based in the quarterly audit result. Furthermore, key messages regarding CD standards i.e. what staff are expected to achieve, will be attached to the front of each ward/department CD register.

Medicines Safety Thermometer
The Medicines Safety Thermometer audit is due to be revisited in June 2018 and the results will be reported to MMC and MAC. In the meantime an omitted doses audit, using a template agreed at the West Midlands Medicines Safety Group, has been completed with the full report to follow shortly.

Reducing the rate of medication omissions is one of the actions on the Medicines Safety Group work plan for the next year.

Prescribing Safety Thermometer
The Prescribing Safety Thermometer audit is due to be revisited in May 2018 and the results will be reported to MMC and MAC.

Improving Prescribing of high risk medicines such as Warfarin, Insulin, Opiates is one of the actions on the Medicines Safety Group work plan for the next year.

Priority 2: Implement best practice around resuscitation, acting on deterioration and utilisation of the sepsis bundle	Partly achieved

Overview of performance / achievement of the priority:

While progress has been made in achieving this priority, we continue to work to implement best practice. With regards to deterioration and sepsis, training has continued for all clinical staff in the form of bespoke sessions and on the mandatory clinical update sessions. Audit for both Deterioration and Sepsis has continued throughout the year.

Sepsis – there continues to be difficulty in evidencing that antibiotics have been administered to the patient within 1 hour on the inpatient wards. Screening has improved however use of the sepsis bundle could be improved to evidence care given

Deterioration – work continues around timeliness of observation to improve and sustain performance, documentation of escalation and treatment plan to be improved.

How the improvement will be sustained:

Both deterioration and sepsis are audited monthly.

- Sepsis is a national CQUIN and audited in line with national guidance which involves the auditing the records of 50 patients within A&E and 50 in patients with regards to Sepsis screening, antibiotic usage and review of antibiotics.
- Deterioration is audited by reviewing all patients, in 1 week, who on their observations (pulse, blood pressure, temperature, respirations etc.) scored 5 or above on the early warning score which highlighted the need for a clinical review. Key elements such as timing of observations, escalations to medical staff and documentation of clinical review are audited.

Next steps:

As the improvement priority has not yet been completed, these are the steps we will be taking to continue to implement best practice with monitoring by the Resuscitation Committee:

- The West Midlands Quality Review Service (WMQRS) will undertake an audit of deterioration and Sepsis in September 2018
- Mandatory training to be reviewed regarding content and competence.
- Continue to feedback results of audits and learning points through Resuscitation Committee and TQE
- Learning points to be included in reports from incidents raised and investigated.
- To learn from incidents that have „gone well" using Quality improvement initiatives.
- To review skills of nursing staff on base wards to include bladder catheterisation, ABGs, Competence to certify deaths which will relieve some of the low level tasks that out of hours services such as ACPs/outreach team are requested to do and hence releasing time to treat and manage the sickest patients.
- To review Patient Group Directives (PGDs) across all wards, but specifically on the assessment areas allowing the nursing staff to administer the first antibiotics within the specified 60 minutes.
- Trust wide re-education and training about the difference between the dying patients (who invariably deteriorates) versus the deteriorating patient. Support will be sought from the palliative team to improve education for clinicians so that they feel confident to make the distinction.

Priority 3: Complete the assessment of the Trust's compliance with Equality and Diversity System 2	Not achieved

Overview of performance / achievement of the priority:

In October 2016 an Equality and Diversity Practitioner (RMB) was commissioned to undertake a review of Equality and Diversity provision across the Trust. The review included a progress map against key requirements, targets and indicators used to measure success or compliance with the Public Sector Equality Duty. The Trust has made some progress in embedding some of the actions arising from the review including a revised governance structure and the setting up of an Equality, Diversity and Inclusion Committee (EDIC) led by a Non-Executive Director. The RMB report also identified several clear opportunities for further development including the creation of an expert corporate role for equality and diversity across the Trust to help drive the agenda forward for patients. In July 2017 the Trust approved a jointly funded post with Dudley Group NHS Foundation Trust NHS as part of the Employers Diversity Partner Programme and following a recruitment process the post-holder commenced employment in November 2017 on a 12 month fixed term basis.

Completion of EDS2 and grading assessment remains a key and urgent priority. The Trust has already agreed to engage with patients and colleagues, utilising our internal data sources to identify a schedule of departments to „deep dive". There will be a key balance

between identifying areas that require support and areas where we can learn from excellence. This work has somewhat stalled due to the workforce lead leaving the Trust. However in December, the Patient Equalities lead supported by the Head of Learning Development, attended by invite the West Midlands Ambulance Service (WMAS) EDS2 Grading event. WMAS is ranked as one of the leading NHS providers – outstanding in all fields for implementing and learning from EDS2. In attending the grading event WMAS has agreed to support the process here at Walsall in order for us to progress and complete this well overdue action.

How the improvement will be sustained:

The agreement to a fixed term post has enabled both Trusts to start to make progress on a number of shared priorities and benefit from work undertaken across both sites. In re-confirming the commitment made, the main focus of this work is to support the development of patient/service elements of equality work. This should enable us to evidence better engagement with those groups and establish key areas to improve service delivery; supporting a robust equality impact process and agree actions; and improve data collection on patients using our services.

Next steps:

EDS 2 deep dive is underway. Information collated will allow an initial and then final grading event to take place.

The Quality Commitment

The actions to achieve the 66 individual elements included in the Quality Commitment have been reviewed using confirm & challenge meetings with the Divisions which also tested progress with their own Divisional Level Quality Commitments.

The year-end position is provided overleaf.

As can be seen elsewhere in this and the CQC Inspection Report, progress has been made and the Quality Commitment has served a useful role in focussing activity. However, the ratings show that the timeliness or level of achievement has fallen behind where we ideally wanted to be.

The development of the Quality Commitment alongside the Integrated Improvement Plan is described in an earlier section of this report and will take place early in 2018/19.This will help to further evolve and effectively direct our improvement efforts in the coming years.

Provide safe, high quality care across all our services

Walsall Healthcare NHS Trust

OUR QUALITY COMMITMENT

Provide safe, high quality care across all our services

PROMISES

- **Part of one team** working together with well-informed colleagues who understand each other's roles to deliver and improve services
- **Supported to meet our high standards** in a team that sets clear expectations, supports and challenges you to live up to them, is open and honest about what's going well and what's not and takes time to reflect and improve
- **Appreciated** by colleagues who value and respect them as individuals and recognise their efforts and achievements

- **In safe hands** of highly skilled, efficient, reassuringly professional teams providing first class joined-up care

- **Cared for** as an individual by kind and considerate people who involve you and your family in your care
- **Welcomed** by friendly, helpful and attentive staff who value your time

AIM

Provide Effective Care – Improve Patient Outcomes

To deliver sustainable evidence based care/best practice and effective pathways and to improve clinician and patient reported outcomes

Improve Safety – Reduce Harm

To reduce avoidable death and injury, to improve patient safety culture and leadership and to reduce the risk of error and adverse incidents

Care and Compassion – Improve Patient Experience

To listen, respond to and learn from patient feedback and as a result improve patient experience of care

17/18 PRIORITIES

Clinical Effectiveness Committee / Trust Quality Executive		RAG
	Review and improve pathways of care:	
E1	- Improve pathway from ED -> AMU	
E2	- At end of life - acute and community	
E3	- Paediatric pathways especially from ED -> Wards	
E4	- Step down critical care beds	
E5	- Normal Birth – reduce C-section/intervention rates	
E6	- Fractured Neck of Femur Pathway	
E7	- Improve response times/delays – C-section and induction	
E8	Implement actions to meet the National 7 day service clinical standard	
	Embed monitoring and learning from:	
E9	- Mortality reviews and mortality alerts	
E10	- Clinical incidents	
E11	Improve process for responding to NICE technology appraisals and CAS alerts	
E12	Introduce SAFER bundle	
	Improve our elective care pathway:	
E13	- 18 weeks	
E14	- Cancer	
E15	- OPD / Follow Up Back Log	
E16	Establish a sustainable future for stroke services	
E17	Deploy mobile technology for community services	
E18	Development of integrated locality teams with partner agencies	
E19	Develop and introduce new roles within clinical workforce	
E20	Improve medicines delivery system and therefore access to medications	
E21	Improving services for people with mental health needs who present to A&E	
E22	To set up and operate advice and guidance services for non-urgent GP referrals	
E23	All first outpatient services to be available on NHS e-referral service	
E24	Supporting proactive and safe discharge – Acute Providers	

Risk Management Committee / Trust Quality Executive		RAG
S1	Implement best practice standards around timely identification of patients with sepsis and utilisation of the sepsis bundle. *	
S2	- Including assessments of clinical antibiotic review between 24 – 72 hrs of patients with sepsis who are still inpatients at 72 hrs.	
S3	Implement best practice standards around acting on deterioration of patients – late observations, escalation & clinical review *	
S4	Improve antibiotics stewardship and deliver planned reduction in antibiotic use.	
S5	Improve medicines safety standards	
S6	- Hospital / community acquired pressure ulcers	
S7	- Hospital / community acquired falls	
S8	- Hospital / community acquired infection	
S9	- Hospital / community acquired VTE	
S10	Embed compliance with DNACPR standards	
S11	Ensure safe staffing levels measured using recognised acuity tools, capacity / demand modelling and national guidance.	
S12	Conduct a bi-annual safety culture survey via MAPSAF	
S13	Ensure 'no harm' to patient waiting times in excess of accepted standards.	
S14	Ensure staff are trained and have the right equipment to do their job.	
S15	Ensure maternity staffing meets acuity	
S16	Deliver actions agreed from specialty risk summits – urology	
S17	Deliver actions agreed from specialty risk summits - respiratory	
S18	Embed new approach to incident investigation.	
S19	Use quality impact assessment to inform safety impact of transformation or savings programmes	
S20	Improve care/treatment on AMU	
S21	Alcohol and Tobacco Screening and Brief Advice	
S22	Improving assessment of wounds which have failed to heal after 4 weeks	
S23	Improve neonatal critical care community outreach	

Patient Experience Committee / Trust Quality Executive		RAG
	Deliver patient experience work plan including key thematic work streams:	
C1	- Response to inpatient survey – communication	
C2	- Improve customer care at front desks.	
C3	- Reduce internal transfers	
C4	Improve FFT response rates to understand patient views	
C5	- Inpatients	
C6	- Maternity	
C7	- Emergency Department	
C8	Embed interpreter service and improve access to services	
C9	Ensure safeguarding vulnerable people's standards met	
C10	Ensure Duty of Candour standards are met	
C11	Use equality impact assessment to ensure fairness of services	
C12	Embed public / patient engagement approaches	
C13	Improve information for patients and relatives on admission and at discharge.	
C14	Ensure patient access to food and fluids meets their individual needs	
C15	Complete assessment of Trust compliance with Equality & Diversity System 2 and plan action as a result. *	
C16	Develop division and care group patient experience improvement plans	
C17	Dementia– increase use of screening tool	
C18	Personalised care and support planning for people with Long Term Conditions	
C19	Ensuring the needs for patients with learning disabilities are met by making appropriate and timely reasonable adjustments.	

	Significantly behind plan/not delivering expected standards
	Behind plan and / or standards not quite met
	On plan / standards met
	Not commenced

Staff and Public Engagement / Communication

Supporting Work Programmes / Infrastructure

Quality System | Organisational learning, culture and leadership | Staff numbers, skills & competence | Audit & measurement | Systems & Processes | Service Improvement and transformation

Quality Account * | Inclusion in CQUIN programme | Local quality priority | Depicts CQC action/national priority

2.3 – Patient Safety

Incident reporting

The aim of reporting incidents is to learn and improve the safety and effectiveness of the service we provide to our patients. Investigations into specific incidents help to identify the cause and patterns or trends in report to target reviews help to show where we need to look more deeply to understand what is happening. The reporting of incidents is encouraged to promote an open and transparent culture and maximise the opportunities for learning.

The Trust has an electronic incident management system to record incidents or near miss event. A high number of incidents reported reflect a good reporting culture. Incidents are reviewed: those which caused the least harm are looked at by the team where the event happened. The more serious incidents have a deeper level of investigation.

A total of **14,336** incidents *(including clinical, health and safety and non-clinical) were reported by Trust staff during 2017/18, representing a 5% increase on 2016/17.*

Actual Impact	Incidents Reported	
Near Miss	381	2.6%
No harm/minor harm	13608	95.0%
Moderate harm	304	2.1%
Major harm	37	0.2%
Catastrophic harm	6	0.1%
TOTAL	**14336**	

The low number of near misses reported is likely to be caused by the design of the system we use to record incidents. Near misses have a separate form but this is not well used and near misses are frequently reported as no harm incidents.

The Trust is in the top 25% of reporters of patient safety incidents when compared with similar Trusts reporting to the National Reporting and Learning System (NRLS) and was the second highest reporting trust in the report published for the six month period ending in September 2017

The most frequently reported patient safety incidents were associated with

- Non-pressure ulcer wounds sustained during WHT care, including skin tears and impact injuries
- Patient falls
- Medication Errors
- Staffing
- Pressure Ulcers acquired whilst receiving WHT care
- Health Records

The top five most frequently reported health and safety incident/non-clinical incidents were:

- Violence and aggression
- Data protection – security breaches
- Environment issues
- Attitude
- Needles and sharps

Serious Incidents

A Serious Incident is an event that has caused serious harm. This is when the harm is life changing or may even be the unexpected or unexplained death of a person. We consider each case very carefully.

The three clinical Divisions hold a Safety Huddle each week to review incidents. Any incidents that have, or may have caused significant harm are taken to the weekly Serious Incident Meeting to decide whether it is a serious incident, the level of investigation required, the lines of enquiry to follow, the investigation lead and checks whether the Duty of Candour has commenced.

This not only helps to identify serious incidents but also where to target our investigation resources to maximise learning opportunities.

The team selected to review the incident includes an investigator from a specialty not involved in delivering the care. The areas to investigate are determined from an initial case review to target efforts. Information is drawn from medical records, staff accounts and comparison between what happened and what should have happened. The aim of the review is to learn and reduce the risk of a similar incident occurring again so the recommendations are developed with this in mind.

The management team responsible for the area where the incident occurred develop actions based on the recommendations and are responsible for their implementation and testing whether they have been effective.

A total of **167** Serious Incidents occurred in 2017/18, compared with 135 in 2016/17.

This increase is attributable to the local agreement made with the CCG to report unstageable pressure damage (with effect from April 2017), as a Serious Incident.

Pressure Ulcers acquired in hospitals continues to be the highest reported category of Serious Incident during 2017/18 and 98 incidents were reported compared to 64 incidents during 2016/17. Benchmarking will be undertaken to determine comparison of pressure ulcer reporting against other organisations in 2018/19 but a comparison with other Trusts shows very wide variations in the categories and numbers of SIs reported in the West Midlands.

Serious Incident Category	Total
Pressure ulcer meeting SI criteria	98
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	14
HCAI/Infection control incident meeting SI criteria	11
Slips/trips/falls meeting SI criteria	11
Treatment delay meeting SI criteria	11
Sub-optimal care of the deteriorating patient meeting SI criteria	6
Surgical/invasive procedure incident meeting SI criteria	5
Confidential information leak/information governance breach meeting SI criteria	3
Abuse/alleged abuse of child patient by third party	1
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	1

Adverse media coverage or public concern about the organisation or the wider NHS	1
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1
Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)	1
Maternity/Obstetric incident meeting SI criteria: mother only	1
Medication incident meeting SI criteria	1
Screening issues meeting SI criteria	1
TOTAL SI'S REPORTED	**167**

Detailed below are some of the improvements the Trust has made as a result of Serious Incidents:

- Revision and implementation of the Consent policy and the provision of an information leaflet (EIDO) handed to the patient pre-operatively for both single and dual procedures.
- Senior Sisters notify the staffing hub when expected staffing levels are impacted at low levels.
- Revision of the Electronic Foetal monitoring policy to include full implementation of NICE guidance.
- Extensive audit programme effected to ensure paediatric patients were appropriately vaccinated
- MDT preparation and management has been incorporated into radiologists workload.
- Standard Operating Procedures for the receipt of internal referrals has been implemented and is utilised by the medical secretaries for outpatient scheduling.
- Reinforcement and adherence to the surgical handbook has been undertaken within the General Surgery specialty.
- Revision of the VTE policy has been updated to reflect current guidelines and VTE has been incorporated into the Vitalpak system
- Task and finish group for Sepsis/Deteriorating patient is scheduled and takes place on a monthly basis.
- Establishment of an error and discrepancy monitoring panel to review Consultant Radiologists activity.
- Consultants" and their respective secretaries now receive red flag imaging notifications
- A live dashboard has been activated to identify patients who should have received follow-up appointments on a daily basis and any outstanding status.
- Development of an acute neurology pathway for AMU
- Standard operating procedures have been implemented in relation to the processes for posting external and confidential mail.
- The processes for transporting patient information within the community have been strengthened

Never Events

Never Events are serious incidents that are wholly preventable as 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.
Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

We have reported 3 Never Events in 2017/18 in the categories listed below. Two investigations have concluded with one in progress during the production of this account.

Never Event Category	Root cause / contributory factors	Principal actions taken
Retained foreign object post procedure (Maternity)	There was a lack of clarity of roles and responsibilities pre and post procedure for perineal trauma; re: the counting and documentation of swabs, needles and instruments.	Removal of all small swabs from Delivery suite with immediate effect. Liaison with BadgerNet lead and IT software providers to review documentation for swabs on electronic system as a priority Review of all equipment packs utilised for delivery suite to ensure appropriate equipment is in place. Immediate safety checklist has been implemented in the interim.
Wrong route administration of medication (Maternity)	a) Lack of physical barrier(s) to prevent the connection of an epidural into the wrong port and identification thereafter. b) Failure to follow Trust guidelines and policies for the establishment and management of epidural analgesia in labour	All clinical staff working within maternity has been provided with information on the incident with a reminder to be vigilant following the siting of epidurals. Currently investigating the equipment used for the use of epidural analgesia and revision of the trust guideline for siting of epidurals.
Wrong site surgery (Gynaecology)	Investigation in progress	Immediate actions to protect patients from harm have been taken while the investigation is in progress.

Prevention of Future Deaths Reports - Section 28 of the Coroner's Act

Coroners have a duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. This includes Hospital Death (Clinical Procedures and medical management) related deaths.

The Black Country Coroner issued the Trust with two Prevention of Future Deaths reports in 2017/18. These are described below along with the actions we have taken. Further details can be found on the Coroner"s website:

Coroner's Concerns	Recommendations	Principal actions taken
A missed opportunity and failure by the Radiologist to assess a scan which would have resulted in further investigation of the "mass" that was identified. Failure to note a fracture from the x-ray during the admission.	In relation to the failure to note the scan results, you may consider re-visiting your procedures and systems to ensure that this is not replicated as part of your internal serious incident investigation of the "mass" that was identified	The red flag system to alert staff to abnormal scan results and the order in which records are presented in the system to Radiologists has been reviewed and staff trained. The system for imaging discrepancy and error rate monitoring has been reviewed to ensure they are in accordance with Royal College guidelines and identify individual training issues which require further support
Failures to properly implement sufficient training for staff during	You may wish to consider further reviewing the systems in	The initial review of patients identified a small number who

the introduction of a new IT system (Lorenzo). This resulted in the premature closing of her access plan and effectively no further review.	place to ensure that all relevant patients identified during the relevant period have been identified and further treatment offered as needed. In addition you may wish to review that this IT system change did not result in any other patients across the Trust having their cases closed prematurely.	were contacted and recalled for review. No significant harm has occurred to them. The wider system issue continues to be explored and will be reported to the Coroner before the May 2018 deadline.

Duty of Candour

The Duty of Candour regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires health service bodies to act in an open and transparent way with people when things go wrong.

Walsall Healthcare NHS Trust has a policy that describes how we will meet the legal Duty of Candour by setting out the responsibilities of staff, a clear process to report and record incidents, templates, advice and support for staff to apologise, review the event, write a report and provide the results to the patient or relative. The report may identify shortfalls in care or that care was provided appropriately. The point is that we must be open and transparent.

We also monitor the initiation of the Duty through the weekly Safety Huddles and Serious Incident meeting and measure compliance with the process by logging when patients are informed and letters and reports are provided to them. We are currently trialling an integrated information form and notification to simplify the process.

The report from the CQC inspection in June 2015 recorded that staff demonstrated a good understanding of the principles of being open and transparent with patients, when it should be applied and the process for doing so, with the exception of Maternity staff. Remedial action has been taken in this service to ensure that staff do understand and apply the process and this is supported by the Division"s weekly Safety Huddle which monitors incidents and the application of the Duty.

Clinical Claims

The Trust in the financial year 2017-2018 reported 59 clinical negligence claims to NHS Resolution (NHSR), an increase of 6 claims on the last financial year. In 2017-18, NHSR, on behalf of the Trust, settled 67 claims.

Further detail on the Trust"s claims history can be obtained via the NHLA (NHS Resolution) website www.resolution.nhs.uk

The Trust adopts a „lessons learned" approach to the handling of clinical negligence claims. During 2017/18, Litigation Forums in Trauma & Orthopaedics, Accident & Emergency, General Surgery and Obstetrics met to analyse trends in claims received, identify areas of potential risk in individual cases and drive improvement work. These forums work on a peer review basis. We have noted that improvement programmes have resulted in a reduction in claims in the following areas:

- Complications associated with bariatric surgery
- Retained products of conception following birth
- Claims associated with consent

- Claims involving delayed diagnosis of fractures

We have also identified areas for improvement during 2018/19:

- Inpatient Falls
- Hand injuries
- Upper limb surgery
- Delay/failure to follow up"

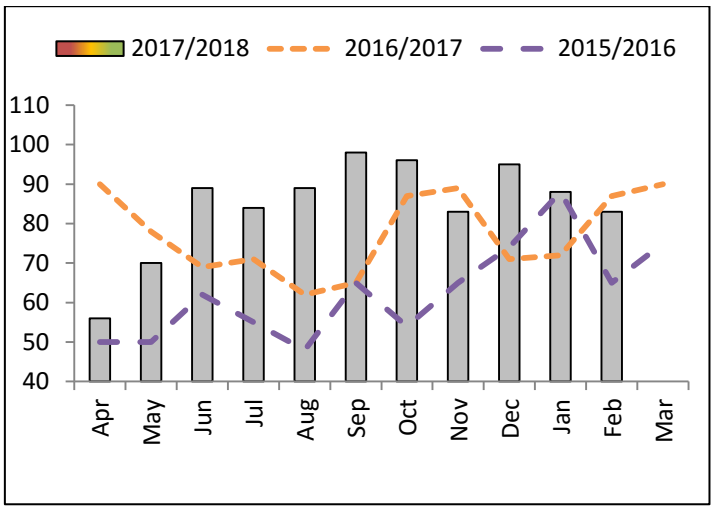
Patient Falls in hospital

Patient falls are the cause of a significant numbers of injuries and death in hospitals. With the exception of a spike in falls recorded in September 2017 Walsall Healthcare has a falls rate which remains consistently lower that the national rate of 6.63 falls for 1000 occupied bed days and so has a lower rate of falls than similar Trusts.

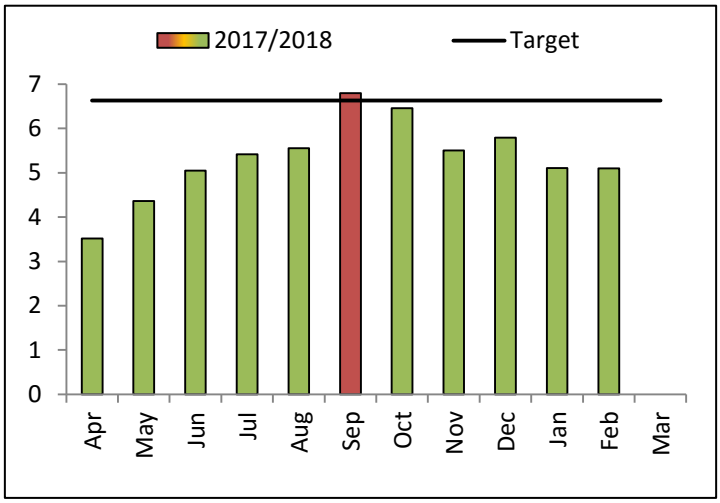
All falls causing injury are investigated and reviewed in the Falls Surveillance Group which includes a member of the Quality Team from Walsall CCG. The Trust has reinvigorated the Falls Steering Group which has representation from both the Acute Hospital and Community Services and has defined workstreams. NICE guidance has been implemented across the Trust which has resulted in a change to how patients are assessed for Falls risk and falls prevention.

	Total Falls Reported			Falls – Rate per 1000 bed days		
Month	**2015/2016**	**2016/2017**	**2017/2018**	**2015/2016**	**2016/2017**	**2017/2018**
April	50	90	56	2.77	5.13	3.52
May	50	78	70	2.88	5.03	4.36
June	62	69	89	3.75	3.87	5.05
July	55	71	84	3.11	4.24	5.42
August	48	62	89	3.15	3.63	5.55
September	65	65	98	3.87	4.12	6.80
October	54	87	96	3.06	5.11	6.46
November	65	89	83	3.77	5.42	5.50
December	74	71	95	4.08	3.94	5.79
January	88	72	88	5.02	4.19	5.11
February	65	87	83	3.72	5.41	5.10
March	75	90		4.33	5.28	

Patient falls in hospital 2017/18



Falls – Rate per 1000 bed days 2017/18



Pressure ulcers

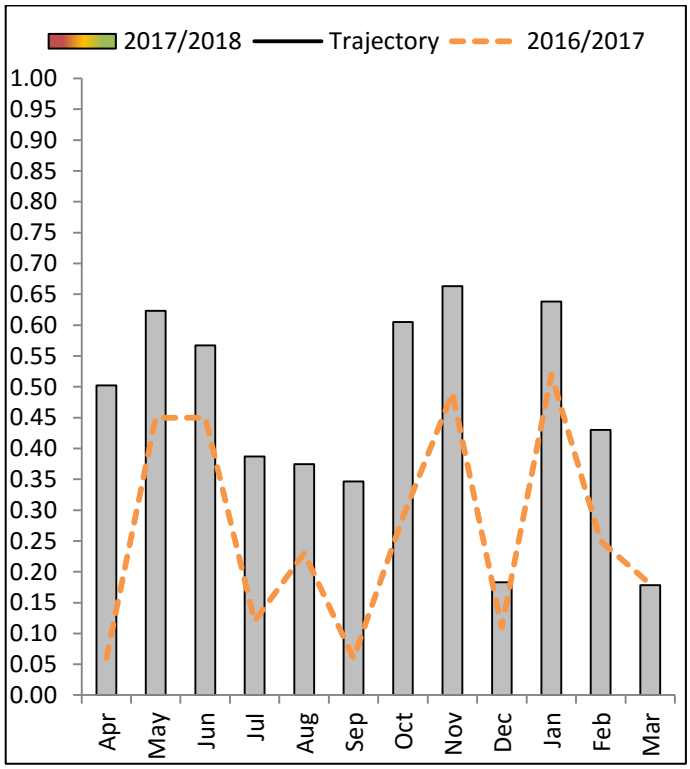
Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time. They're most common on bony parts of the body, such as the heels, elbows, hips and base of the spine. They often develop gradually, but can sometimes form in a few hours

The prevention of patients developing pressure ulcers remain high on the agenda with reduction remaining a Trust aim. Pressure ulcers that are acquired whilst patients are under the care of the Trust are closely monitored and there is a clear process in place to monitor and investigate incidents of pressure ulcer development.

An investigation is completed for all serious pressure ulcers (category 2, 3 and 4 and unstageable wounds) that have occurred within the trust. The investigations identifies if there are lessons that can be learned to prevent further incidents. Grouped together the investigations also help to identify any trends in good practice as well as those that need improvement.

- Following the review of hospital mattresses in 2016/17 the Trust has invested in new higher specification base mattresses which has resulted in the development of a new process for the ordering of air mattresses.
- Competencies have now been agreed and Tissue Viability are progressing with assessment of community wound care link nurses
- The Nursing Admission document & comfort rounds are undergoing alteration and plan to include the new proposed SKIN bundle form. The Pressure Ulcer Prevention pack will incorporate Waterlow/ SKIN bundle and patient information in one document, which will form part of the admission document.

	Pressure Ulcers - Avoidable Rate per 1000 bed days (cat 2, 3, 4 & Unstageable)	
Month	**2016/2017**	**2017/2018**
April	0.06	0.5
May	0.45	0.62
June	0.45	0.57
July	0.12	0.39
August	0.23	0.37
September	0.06	0.35
October	0.29	0.61
November	0.49	0.66
December	0.11	0.18
January	0.52	0.64
February	0.25	0.43
March	0.18	0.18

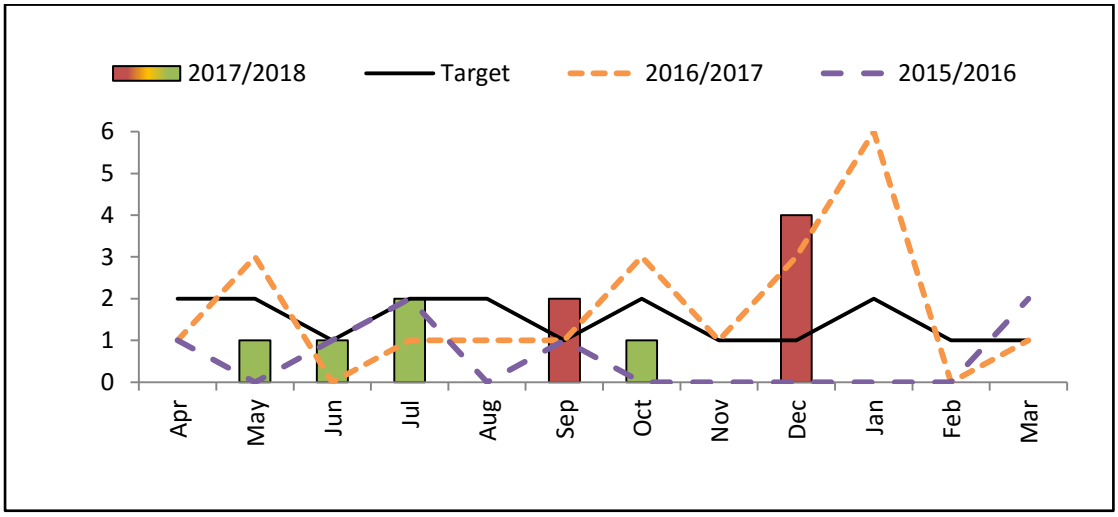


The Trust"s Infection Control Team covers both Acute and Community services and works with the Clinical Commissioning Group to extend the service to care homes, GPs and dentists across Walsall.

c. Difficile

C. Diff rates per 100,000 bed-days				
	2014-15	**2015-16**	**2016-17**	**2017-18**
Trust attributed	16	7	21	11
Total bed days	169384	169544	167564	159179
Rate per 100,000 bed days for specimens taken from patients aged two years and over	9.4	4.1	12.5	6.9
National Average	15	15	13 * (National published figures published before Q4 16/17 available hence used Q4 15/16 as a proxy)	Not available

In 2017/18 the number of cases of patients with C.Diff reduced to 11, against a target of 18 for the year. Every case has been reviewed. We found that 5 cases that were deemed unavoidable. This means that the care that the person received during their stay could not have prevented this infection, nor would different care have changed that.



The Infection Control Team initiated a daily review of our admissions areas in 2016/17 to identify patients who present with an increased risk of infection and take earlier action to treat patients at risk. This has led to early intervention and helped to reduce the number of cases this year. An important factor is staff following the basics of infection control so continuing education and audit of practice remains a priority.

MRSA Bacteramias

We have not had any cases of MRSA bacteraemia (blood stream infections) assigned to the Trust in 2017/18, making it over two years since our last case.

There was one case in the wider community in Walsall and this was deemed unavoidable due to the patients underlying condition.

The maintenance and improvement of infection control practice to prevent cases continues and includes screening all our admitted patients for MRSA carriage on admission and the safe use of devices such as cannulas and urinary catheters.

Cleanliness / reports

Jane Longden / Alison Potts to provide

Safeguarding – Adults and Children

The Trust has a statutory duty under both Section 11 of the Children Act 2004 and the legal framework created within the Care Act 2014 to ensure that arrangements are in place to ensure that the Trust, and all staff working within it, have regard to the need to safeguard and promote the welfare of children, young people and adults at risk. The Trust reports to both the Walsall Safeguarding Children"s Board and Walsall Safeguarding Adults Board. The Trust continues to have representation on all sub-groups of both Adult and Children Safeguarding Boards.

The Trust also has responsibility for monitoring the health of Looked After Children within Walsall and provides support and Health Assessments to our population of children who are in care. The Trust continues to provide the Health representation within the Multi-Agency Safeguarding Hub (MASH) where we work together with our partners to make decisions to ensure the safety of children in Walsall. The success of the MASH has seen a significant rise in the number of appropriate referrals it receives.

Safeguarding Adult and Children training has been challenging for the organisation, the Trust has ensured that there are enough training spaces to ensure staff are compliant and have developed a system of automatically booking staff onto sessions to ensure they remain green for compliance. PREVENT training continues and whilst there has been a marked improvement the Trust is still not 85% compliant as per NHS England"s trajectory.

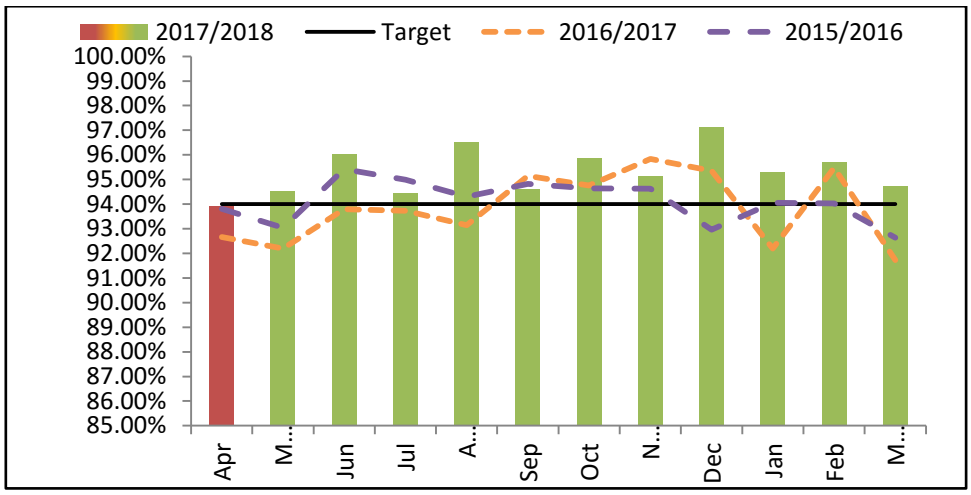
Safety Thermometer

The Safety Thermometer consists of data collection carried out on a predetermined date each month for all inpatients and community service contacts, with certain exclusions, in four particular areas. These are:

- Pressure ulcers,
- Falls
- VTE (Venous Thromboembolism)
- Urinary tract infection in patients with a catheter.

An internal target of 94% Harm Free Care was set which has continually been achieved since May 2017

Graph showing Safety Thermometer performance for the last three years



Venous Thromboembolism (VTE)

Venous thromboembolism (VTE) is a blood clot that starts in a vein. There are two types:

- Deep vein thrombosis (DVT) is a clot in a deep vein, usually in the leg, but sometimes in the arm or other veins.
- Pulmonary embolism (PE) occurs when a DVT clot breaks free from a vein wall, travels to the lungs and blocks some or all of the blood supply. Blood clots in the thigh are more likely to break off and travel to the lungs than blood clots in the lower leg or other parts of the body.

VTE is preventable and patients at risk should be assessed when they are admitted and treatment provided to reduce the likelihood of a VTE occurring. The target is to assess 95% of the patients at risk. When a VTE occurs, the patient is treated; the VTE is then reported and investigated to determine the cause.

The VTE indicator was qualified in the 2017/18 Quality Account as our external auditors found that the indicator reporting the percentage of patient"s risk assessed for VTE did not meet the accuracy, validity and reliability dimensions of data quality set out in the Audit Guidance. An action plan was subsequently developed to address these issues raised.

The Trust aims to achieve as a minimum, the national quality requirement of assessing 95% of patients who were admitted to hospital for the risk of VTE. The trust has previously struggled to meet the requirement but did so in March 2017/18 and we intend to maintain this performance.

To improve measurement and support an improved performance, the Trust has developed two IT systems for assessing and recording VTE assessment: the Vitalpac system in all adult wards and Badgernet within maternity services. A single process has now been implemented for the collection and reporting of data through the IT systems negating the need for scrutiny of the patient record.

To support this transition the VTE policy was also reviewed, robust training was implemented, revised patient information leaflets were developed and revised reporting governance was implemented.

During the period April 2017 to March 2018 the overall Trust performance has improved from 80.34% to 93.53%.

We have acknowledged the concerns raised in the CQC inspection report and the CCG Performance Contract Notice relating to Standard SC22 regarding the continued failure to achieve the quality performance indicator.

The action plan has been developed further to mitigate any risk to patients and assure future performance. This includes the following:

- Performance monitoring - The provision of VTE assessment performance reports to senior clinical managers on a daily basis and weekly to Clinical Directors, Consultants and Ward Sisters for them to manage performance.
- Accountability - Improved accountability by including VTE performance in the divisional quarterly reviews as part of the Divisional Accountability Framework
- Training - The provision of training on the VTE assessment and IT systems for new medical staff and others to ensure the process is understood and recorded accurately
- Provision of a dedicated resource of a senior nurse to embed SOP, identify and resolve barriers in system and process
- Responding to thrombosis - Implement a more robust process for monitoring, recording and reviewing reported hospital acquired thrombosis.
- Audit - Undertake biannual audits to assure appropriate prophylaxis is prescribed and administered

The Trust has stated that the national standard will be achieved and sustained by the end of June 2018.

Freedom to Speak Up Guardians

The Francis reviews into care at Mid Staffordshire Hospitals made a number of recommendations to deliver a more consistent approach to whistleblowing and freedom for staff to speak up across the NHS and the report identified the Freedom to Speak Up Guardian as an important role. All NHS trusts and NHS foundation Trusts are required by the NHS contract (2016/17) to nominate a Freedom to Speak Up Guardian.

We appointed three members of staff to undertake this local guardian role. A Transparency and Openness Steering group was created to assist the Guardians and a set of actions developed. An early review of the 95 concerns raised with the Guardians between November 2016 and May 2017 showed that the 45% of the concerns were related to patient safety with 28% related to attitudes and behaviours of colleagues, which can have a detrimental effect on morale and the safety culture.

One year on from their appointment, the role of the Freedom to Speak Up Guardians is being reviewed to learn from experience and improve the service provided.

Sign up to Safety

In 2014, Sign up to Safety was launched to bring organisations together behind a common purpose; to create the conditions for making care safer. Led by the Divisional Quality Governance Teams, the Trust has been an active participant in the campaign helping to improve our patient safety culture.

In addition to the work to improve care described in this report, including, preventing patient falls and pressure ulcers, the avoidance of venous thrombosis (VTE) detecting and quickly treating patients whose condition is deteriorating, including from sepsis. Further improvements involved improving the way in which we consent patients for treatment to better describe the risks, benefits and options available so a better informed choice can be made. We continue to reach out to colleagues to improve the understanding of how to learn to improve safety and encourage local action to do so. During 2017/18 the following have been in place:

- Risk Roadshows – The Divisional Quality Governance Teams visit wards and departments to have a conversation about incidents, actions, the Duty of Candour and learning from other incidents
- Patient Safety Kitchen Table events – where else would you feel safe and have truly open and honest conversation without judgement? The teams hold several events a year to have an open discussion about patient safety with clinical colleagues
- Divisional Safety Huddles - Led by the Divisional Directors, new incidents are reviewed every week so that immediate actions can be taken to prevent further harm, previous actions are followed up and learning from investigations is shared.
- Sharing the results of incident investigations at ward level to improve local engagement and learning
- Risk Register Reviews - building on the foundations set out when we the risk register was transferred from paper documents to electronic database. The Divisional Governance Teams continue to actively work at department, Care Group and Divisional levels with check & challenges to test risk management and advise on when to escalate risks for higher level management.

2.4 - Clinical Effectiveness

Mortality Review

To learn from a review of the care of patients who have died, the Trust uses the standardised method for reviewing patient records, introduced by the National Mortality Case Record Review Programme in conjunction with the Royal College of Physicians (RCP). A senior clinician has been identified as the lead for mortality and specialty leads have been nominated. The RCP training programme for clinicians reviewing patient records using this tool has commenced.

Learning from deaths

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards “from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals”. This was further reinforced In December 2016 when the Care Quality Commission published its review Learning Candour and Accountability. A review of the way NHS trusts review and investigate deaths of patients in England. In response, the Secretary of State accepted the reports‟ recommendations and made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die.

In March 2017 the National Quality Board, NQB, released National Guidance on Learning from Deaths as a national endeavour to initiate a standard response.

This Trust is committed to responding to the guidelines and In response to the national guidelines the trust developed the Learning from Deaths Policy as per the guidelines in October 2017.The policy sets out the approach and standards the Trust will implement to align to the national recommendations to ensure deaths are reviewed in a structured manner. This policy also describes how relatives and carers are involved in reviews appropriately, problems in care or process that may have contributed to a death are identified, lessons are learnt actions are taken, shared learning takes place and systems, practices and processes are changed to reduce the risk of premature death. Findings from the reviews of deaths, lessons learnt and actions taken will be shared at public forums to demonstrate appropriate governance, transparency, acknowledgement and action for issues that may have contributed to a patient death.

During the period 2017 - 2018 the Trust commenced a programme of work to implement the NQB guidelines to include a governance process, reviewing deaths, identifying lessons learnt, developing action plans and reporting performance and finding internally and externally to the organisation. The processes have incorporated the national safeguard framework to ensure duty of candour and appropriate serious incident and root cause analysis process have been utilised.

The processes and systems currently in place strive to review all deaths using the Royal College of Physicians, RCP, Structured Judgement Review, SJR, process for a cohort of patients each month determined by using a set of triggers identified from the NQB guidelines. This process was launched in June 2017 and further developed during the year following a group of clinicians undertaking the RCP training in the use of the SJR approach and the launch of the Trust learning from death policy. The deaths are reviewed by the clinical teams to determine any issues in care or process that may have contributed to the patient death. Any issues that are identified as contributing to poor care are reported via the

Trust"s incident reporting system and managed to determine cause, lessons learnt and actions.

Similarly, in addition to the learning from death process any deaths reported to the Coroner are managed via the serious incident reporting system and acknowledge coronial recommendations and the development of action plans to address preventing future death notifications.

We will continue to develop and embed governance and learning processes in respect of being owned and driven by the clinical teams. We will also continue to develop processes to strengthen the bereavement services available for relatives and 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.

The mandatory statement required by NHS England on learning from deaths is provided in the appendix.

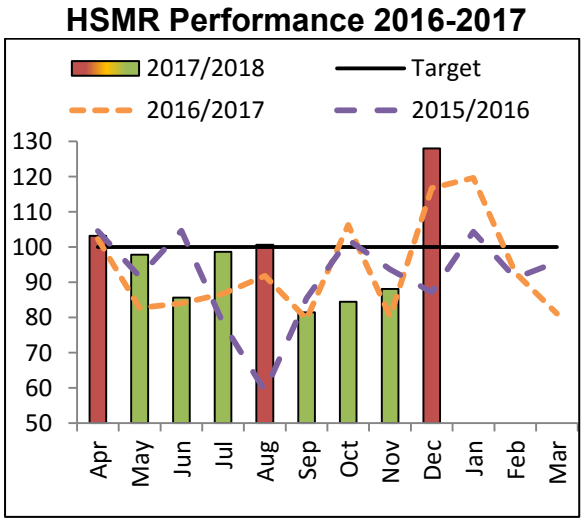
Mortality rates - HSMR and SHMI

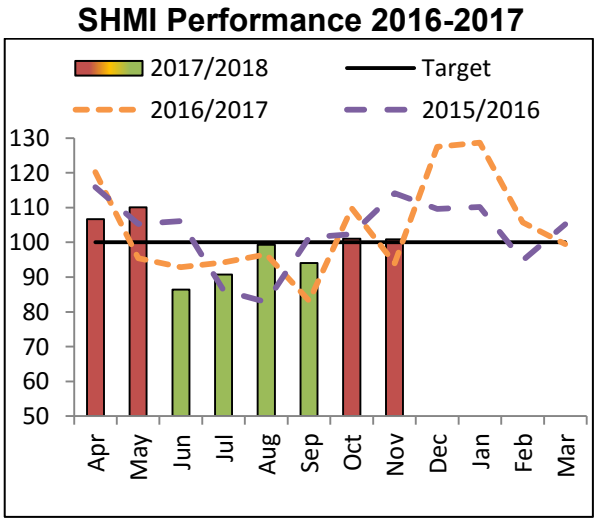
The Hospital Standardised Mortality Ratio (HSMR) is a ratio of the number of in-hospital deaths to the expected number of in-hospital deaths. The performance of the trust is referenced against a national ratio of 100.

The Summary Hospital-level Mortality Indicator (SHMI) is similar but includes patients who die up to 30 days after being discharged from the Trust
For both measures, a number less than 100 indicated that there have been fewer deaths than expected.
The Trust performance against the two key national indicators for mortality Hospital Standardised Mortality Rate and Standardised Hospital Mortality Index has been variable during the year 2017/18.

The latest available figures show that for the year to date

- HSMR October 2017 92.68
- SHMI September 2017 97.22





NICE Guidance

Every piece of guidance published by the National Institute for Health and Care Excellence (NICE) is assessed for its potential relevance to this Trust and senior clinicians asked to determine whether the Trust is compliant, the guidance does not apply or we are not compliant and so need to take action to do so.

Our overall response rate of from clinicians for their reviews of compliance is 100% for 2017/18.

Technology appraisals (TA) must be implemented within three months of publication. The majority of TAs relate to the use of drugs. Our commissioners assist in the funding of these drugs in advance of the TA being published and the drug is made available within the three month period so the legal requirement is met.

The results simply show the clinician"s response, which we aim to improve in 2018/19 by creating Clinical Effective Leads in each of our Care Groups, overseen by the Clinical Effectiveness Committee and responsible for the management of the review and response for NICE guidance and the Clinical Audit Programme which is used to test the ongoing compliance with a selection of NICE guidance each year.

7 day services – progress

The NHS England paper “Everyone Counts” was published in December 2012. The Seven Day Service Forum was established in response and focussed in the first stage of its work on the variations in outcomes for patient admitted as emergencies over weekends and particularly, mortality, length of stay in hospital, readmissions to hospital and patient experience. Ten clinical standards were developed to describe the standards of emergency care that patients should expect to receive 7 days per week.
Four of these clinical standards are considered to have the greatest impact on the quality of care patients receive.

2. Time to first consultant review
5. Availability of diagnostics
6. Consultant led interventions
8. 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 Trust participated in the NHSE 7 Day survey in 2017 relating specifically to Standard 2.

The table below shows progress for standards 2 and 8.

	Survey		
	September 2016	**March 2017**	**September 2017**
2. Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	62%	79%	79%
8. Proportion of patients seen every 24 hours		88%	

A further self-assessment of all 4 standards will be undertaken during March and April 2018.

We have assessed the results to understand what we need to do to achieve these standards. The delivery of 7 day services does not stand on its own, it is integral to service strategies such as stroke care and will require some reconfiguration and redesign of the way in which we, and the wider health community, deliver care. This will include supporting ongoing consultant review in medical wards outside the Acute Medical Unit, direct admissions to Cardiology and the “Walsall Together” initiative which integrates community based services.

2.5 Patient Experience

During 2017-2018 the Trust has received feedback directly from patients, families and carers through our Friends and Family Test (FFT), National and Local Surveys. Overall most of our services were rated as providing a positive experience however the feedback also highlighted areas which require improvement.

Friends and Family Test

We aim to offer all patients the opportunity to respond to the FFT question and to have the opportunity to tell us about anything else we could have done to improve their experience.

The Friends and Family Test (FFT) asks patients:

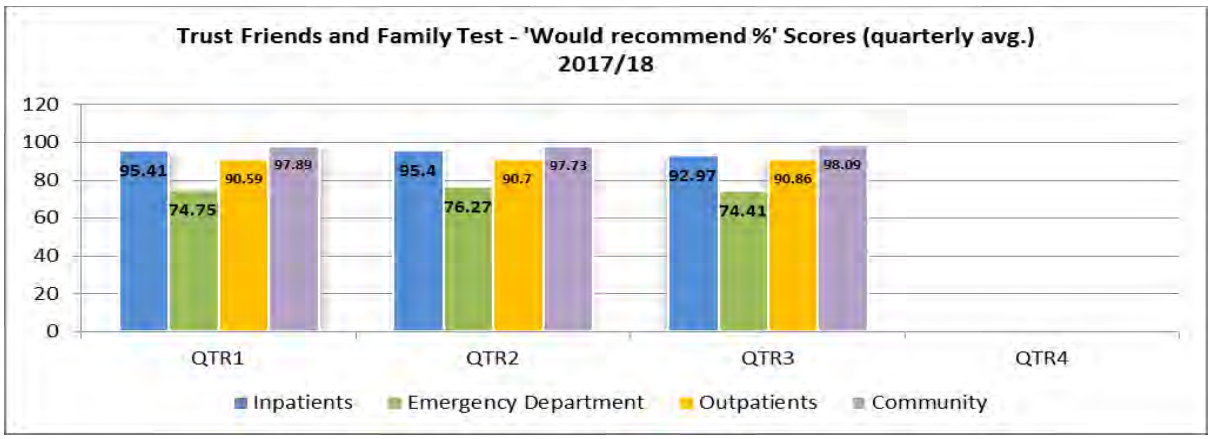
"How likely are you to recommend our wards/emergency department/services to friends and family if they needed similar care and treatment".

Responses to the FFT for inpatients/day cases, accident and emergency, outpatient and maternity are reported monthly to NHS England for publication on their website and NHS Choices website. We continually monitor the proportion of patients who **would/would not recommend** our services and identify key themes from the comments made to continually improve our services.

Inpatients, Emergency Department, Outpatients and Community Services FFT 2017-2018

During 2017-2018 the Trust received **??** FFT responses from patients about their experience of access care and treatment across acute and community services.

The charts below show FFT results for positive recommendation percentages for the FFT for inpatients, A&E, outpatients and community services in 2017-2018:



The **Community Service** recommendation score of 98% (quarter avg.) was ranked high nationally. Currently, most of the Trust's Community services conduct FFT only once a

month using paper surveys. Use of „Badgernet" devices for online FFT surveys has been agreed in principle with phased roll out proposed from April 2018. This will facilitate wider coverage and real time feedback collection/reporting.

Benchmark comparisons

The table below show benchmark comparison for the positive recommendation percentage for the FFT for inpatients, emergency department, and outpatients for Walsall Healthcare NHS Trust and national averages.

The emergency department recommendation scores continue to trail the national average by about 10%.

FFT Recommendations Score Comparison with National Data		
Clinical Area	National Average	Walsall Healthcare Trust
Inpatients	96%	95%
Emergency Department	86%	76%
Outpatients	94%	91%

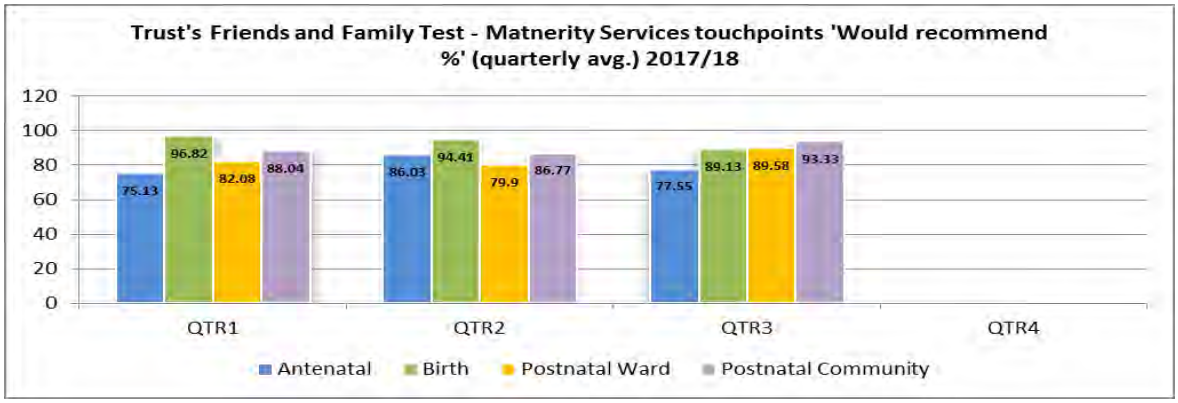
Improvement Actions:

- All wards and departments display their FFT results on a weekly basis.
- The inpatients response rates (receiving feedback) has been consistently high compared to national average.
- IPAD pilot on four wards was successful in significantly increasing the response rate on the inpatient wards. Other wards are actively exploring funding options to roll this out on their areas.
- All Divisions have action plans aimed at improving both FFT response rates and positive recommendation scores through responding to patient feedback from the FFT.
- Awareness of the Quiet Protocol was promoted across the Trust in response to feedback relating to reducing noise at night. A wider campaign was agreed and implementation is planned for May/June 2018.
- Volunteer support has increased across the wards to assist with mealtimes, patient visiting and dementia tea parties.
- Joined the National Always Events® Programme which aims to optimise positive patient experience and improved outcomes for every patient every time.
- Piloted the Observe & Act Tool which paves the way for using lay members to identify and co-produce service improvements.

FFT Maternity Services

The chart below show FFT results for positive recommendation percentages for the FFT for maternity services in 2017-2018.

All maternity touchpoints which includes antenatal, birth, postnatal ward and postnatal community improved their recommendation score over the year. Response rates still remain low.



Maternity FFT Recommendations Score Comparison with National Data		
Clinical Area	National Average	Walsall Healthcare Trust
Antenatal	97%	83%
Birth	97%	95%
Postnatal ward	95%	91%
Postnatal community	98%	97%

In relation to national comparisons the antenatal FFT trails behind the national average by more than 15% while the FFT for birth trails behind by about 6%. **(update when end of year data in)**

Improvement Actions:

- Whose Shoes event held where a number of pledges have been made by a range of staff to continue to improve the patient experience.
- Proactive Maternity Voices Partnership Group

Patient Surveys

The results of the national surveys are included in the Patient Care Improvement Plans for individual service areas and reported divisionally and at Trust Quality Executive and Trust Patient Experience Group. The performance of Walsall Healthcare NHS Trust in relation to the National Patient Surveys published in 2017 are outlined below.

National Emergency Department Survey 2016 (CQC reports published in October 2017)

The CQC 2016 National Emergency Department Survey covered patients seen in September 2016. The results were published in October 2017.

A total of 1250 questionnaires were sent and 293 completed surveys were returned, giving the Trust a response rate of 24%. The overall national response rate was 27%.

33 questions showed no significant change in score since the 2014 survey.

The questions where the Trust was in the „worse" than most other NHS Trusts category related to patients:

- Feeling they had enough time to discuss their health or medical problem with a doctor or nurse
- Feeling that the doctor or nurse explained their condition and treatment in a way they could understand
- Feeling that the doctor or nurse listened to what they had to say
- Feeling that the doctor or nurse discussed any anxieties or fears they had about their condition or treatment
- Feeling that staff explained the reasons for tests in a way they could understand
- Describing the emergency department as clean
- Being able to access suitable food and drink if they wanted to
- Being treated with respect and dignity

National Emergency Department Survey 2016	Compared with other trusts
N/A	Better
• Time to talk for feeling hey had enough time to discuss their health or medical problem with a doctor or nurse • Clear explanations for feeling the doctor or nurse explained their condition and treatment in a way they could understand • Being listened to for feeling the doctor or nurse listened to what they had to say • Discussing anxieties or fears for feeling the doctor or nurse discussed any anxieties or fears they had about their condition or treatment • Information for being given the right amount of information about their condition or treatment • Privacy for being given enough privacy during examinations and treatment • Explanations about tests for feeling that staff explained the reasons for tests in a way they could understand • Cleanliness for describing the emergency department as clean • Access to food and drink for being able to access suitable food and drink, if they wanted to • Information about resuming usual activities for staff explaining when they could resume their usual activities • Contact information for being told who to contact if they were worries about their condition or treatment after leaving • Respect and dignity • For being treated with respect and dignity	Worse
All other questions	About the same

2017 National Maternity Survey Results (CQC reports published in January 2018)

Mothers who gave birth at Walsall Healthcare NHS Trust during January and February 2017 took part in the 2017 CQC Maternity Survey to give feedback about their experiences of care and treatment they received. A total of 300 surveys were posted and there was a 31% response rate (92 responses). The results were published in January 2018.

Generally, the results showed that the Trust performed „about the same" on most of the questions when benchmarked against other Trusts nationally. The only question that put us as „worse" in the comparisons were related to skin to skin contact with the baby shortly after the birth..

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

2017 National Maternity Survey Results	Compared with other trusts
N/A	Better
• Skin to skin contact Having skin to skin contact with the baby shortly after birth	Worse
All other questions	About the same

National Children & Young People Survey Results 2016 (CQC reports published in November 2017

This CQC National Children and Young Peoples Inpatient/Daycase Survey 2016 covered patients who were discharged during November and December 2016. The results were published in November 2017.

There were three version of the questionnaire:

- For children aged 0-7yr olds (answered by parents/carers of children only)
- The other two being questionnaires 8-12yrs and 12-15 yrs (both answered by parents/carers and children).

With 147 completed surveys returned, the Trust had a response rate of 21%.

Compared with the Trust's 2014 survey, the 2016 survey showed no change in overall scores for 40 questions. There were no questions with significantly better or worse scores. The Trust did score better than most Trusts for parents and carers being able to access hot drinks when in hospital.

- The Paediatric healthcare app, co-produced with patients, parents/guardians and staff members, was launched to improve experience of patients and their families when using hospital services. This app won a national award for innovative use of technology at the Patient Experience National Awards.

National Children and Young Peoples Inpatient/Daycase Survey 2016	Compared with other trusts
• Access to hot drinks for parents and carers being able to access hot drinks when in hospital	Better

N/A	Worse
All other questions	About the same

National Cancer Survey Results 2016 (CQC reports published in July 2017)

The responses received for the survey was 250 completed responses from an adjusted sample of 378. This is a 66% response rate (comparing favourable against a national response rate of 67%. The results were published in July 2017.

There were no statistically significant changes (either improvement or deterioration) for any questions between 2015 and 2016.

Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.5

- 1 Question continues to score above expected range
- 8 Questions score below expected range
- 43 Questions score within expected range:
  5 questions score above national average
- 5 questions equal to national average
- 33 questions below national average

Areas for further consideration and potential improvement include:

- Staff Attitude and Communication Skills
- Information giving, especially related to test results and efficacy of treatment
- Keeping patients updated and management of patient expectations
- Time keeping and organisation of clinics and day case treatment
- Support for patients during and after treatment; including Living with and beyond Cancer programmes (Survivorship)+

National Cancer Survey Results 2016	Compared with other trusts
• Hospital staff gave information on getting financial help	Better
• Given complete explanation of test results in understandable way • Patient had confidence and trust in all ward nurses • Hospital staff definitely did everything to help control pain • Doctor had the right notes and other documentation with them • Beforehand patient had all information needed about radiotherapy treatment • Beforehand patient had all information needed about chemotherapy treatment • Patient definitely given enough support from health or social services after treatment • Patient's average rating of care scored from very poor to very good	Worse
All other questions	About the same

National Inpatient Survey Results 2017 - 2017

NOTE:

- This survey is currently with the CQC and will be published in early June 2018.
- The results will be included in the final version of the Quality Account.

- The information given below is taken from the Trust‟s own results compared with the previous year‟s survey but NOT benchmarked with other trusts – the CQC report will provide this.

[Include screenshot of the survey results from the website.]

With 476 completed surveys returned, the Trust had a response rate of 39.4%.
The Trust scored an average score of 70% which is the same as in 2016. The Trust was banded in the „worse‟ category on national comparison for 13 questions in the 2016 Inpatients survey.

Compared with the 2016 survey, on our current results the Trust showed a 5% or greater improvement on 5 question scores and a 5% or greater reduction in score on no questions.
The „significantly better‟ scoring questions were:

- If you brought your own medication with you to hospital, were you able to take it when you needed to?
- Beforehand, were you told how you could expect to feel after you had the operation or procedure?
- After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?
- Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Our Strengths

- Reduced noise at night from staff
- There have been some improvements in staff information giving since 2016.

Areas for Improvement

The Trust scored low on 45 out of 55 questions which cover core areas of:

- Waiting times
- Staff information giving and communication including – consistency, providing explanations about condition, operations or treatment and medicines information.
- Care including – practical and emotional support, pain management , respect and dignity
- Discharge planning and aftercare
- Hospital environment and facilities including – single sex accommodation and privacy.

Patient Experience Initiatives undertaken in 2017-2018.

Some of the initiative undertaken in 2017-2018 to improve patient experience are outlined below.

- The patient experience dashboard has been developed as part of the Trust's Accountability and Performance Framework which informs services about the feedback performance trends.
- A new feature was created by the Patient Experience Team for all the FFT touch point to celebrate the positive comments from the FFT (Friends and Family Test). Every month, one „Star Comment" which shone the spotlight on the excellent experience and care being provided by ward/department teams is picked and sent to the area leaders who then use it as positive recognition to add value to our their interactions with their teams.
- „Soundbites" audio recordings are now used at all Patient Experience Group meetings and its use is being encouraged at divisional and care group meetings.
- The User Information Reading Panel is composed of volunteers who review and comment on the non-clinical information produced by staff members. They give suggestions on the what information should be included, how to make it user-friendly and easy to understand, and general format of leaflets and posters. Uptake of the panel's services is increasing as staff are getting more aware of co-producing information for patients and service users.
- Following an audit of „noise at night" undertaken by volunteers and staff members a „Quiet Protocol" was developed and implemented
- Maternity Services organised an „Whose Shoes" event with support from the national team and was attended by a wide range of staff and service users and are developing an action plan following this event.
- Introduction of the „Observe and Act Programme" as an approach to look at a person's total experience of a service from their perspective. Through observations good practice and areas for improvement are highlighted and action plans agreed with local teams
- Development of „You and I" patient experience sessions on the wards which have increased the awareness and the importance of gaining patient feedback. Improvement actions are agreed with teams and support is provided by the Patient Experience Team to make this happen

Patient Experience Initiatives 2018-2019

The following Patient Experience initiatives are planned for 2018-2019:

- Work with NHSI in relation to the introduction of the patient experience „Always Events" The Patient Experience Team has identified an area to pilot the „Always Events" which focuses on those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health care system. On completion of the pilot the programme will be rolled out to other areas/teams.
- Co-production approach used in the development of the Paediatric Healthcare mobile phone app.

Patient Opinion/NHS Choices/CQC

Since April 2017 there have been 68 comments made about the Trust via the NHS Choices/Patient Care Opinion website, this includes 22 Compliments. The key category types reported on the website include Clinical Care, Assessment and Treatment,

appointment queries, communication and attitude. This mirrors the feedback received via all categories of complaint and concern.

Feedback posted on the NHS Choice/Patient Opinion website is acknowledged with a request to contact the Trust to discuss the situation further offered. In terms of CQC we have 9 patient concerns logged. Some of these were also received as formal complaints and were investigated accordingly; where no contact was made with the Trust directly, feedback was provided directly to the CQC following investigation for contact to be made with the person raising the complaint.

Compliments, Concerns and Complaints

Walsall Healthcare NHS Trust remains committed to improving the experience of all patients, their families and carers who access services both within the hospital and community, and learning from their feedback to improve the care we provide to ensure we deliver+ the best care possible to our patients.

Complaints, Concerns and Complements
A formal complaint is one in which the patient or relative asks for an investigation and a written response. Where possible, the Divisions work with the complaints team to resolve issues without a full investigation. For example, concerns about appointments can often be resolved quickly by the local teams.

During **2017/2018** a total of **3661** contacts were received by the Patient Relations Team which included a total of 284 written complaints, 25 informal to formal complaints and 8 MP letters (in total a reduction of 9 complaints overall for the year compared to 2016-2017).

Complaint Type	2015-2016	2016-2017	2017-2018
Formal Complaint	370	284	280
Informal to formal complaint	29	32	25
Informal concern	2418	2091	2164
Formal to informal	29	20	8
Compliment	441	635	734
Comments/suggestion/referred on	123	297	455
MP letter	6	6	8
Total	3416	3109	3674

The Division of Medicine and Long Term Conditions continues to receive the largest number of complaints accounting for 52% of all the complaints received. The main theme emerging from formal complaints was „clinical care, assessment and treatment", accounting for 58% of all complaint categories. Other themes included communication, appointments, diagnosis and issues associated with discharge from hospital.

In 2017-2018 the number of complaints versus patient activity was 8.6%. This is worked out as the number of complaints divided by-elective, non-elective and emergency patients (36315) and multiplied by 1000.

A number of interventions throughout 2017-2018 such as Divisional huddles and focused feedback to complaints investigating officers have seen an significant improvement in

response times, with 85% of all complaints responded to within the timeframe agreed, compared to 51% in 2016-2017.

In addition to complaints, the complaints team received 2164 informal contacts. The main theme of concerns raised are regarding appointments which have increased this year, clinical care, assessment and treatment, communication and information request and issues related to staff attitudes.

Patients unhappy with the outcome of our complaints processes can ask for their complaint to be reviewed by the Parliamentary and Health Service Ombudsman (PHSO). In 2017-2018 a total of 8 cases were referred to the PHSO. In the last year 3 were not upheld and 4 partially upheld with the outcome being an apology and an action plan to rectify any failures that were identified, in the remaining case the outcome is yet to be determined.

Some of the lessons learned from investigated complaints include:

- Following a patient complaint about their surgical stocking being too tight after an operation which caused wounds which required redressing regularly the surgical wards developed a checklist for all patients regarding the use and monitoring of surgical stockings, ensuring that a patient"s stockings are checked regularly, and that any changes and actions taken are documented. This checklist is now in every patient folder.
- Following a complaint about a nurse failing to escalate an abnormal blood sugar to the medical team the ward have developed a NEWS escalation stamp that can be used to document escalation in the patient case notes
- Following complaints about confusing signage regarding the escalators in the Hospital main atrium this was changed to make this clearer for visitors

Complaints Monitoring Panel

The Complaints Monitoring Panel, set up in October 2015 with the purpose of the panel to assist the Trust in improving complaints handling procedures and help to improve standards in decision making has continued to meet throughout 2017-2018. The panel has undertaken the following work during this year:

- Completed Complaints Investigation Masterclass training

- Reviewed PHSO cases to gain a better understanding how complaints are investigated at that level

- Led a workshop that reviewed a sample of complaint responses, response satisfaction survey findings and equality monitoring data

- Contributed to the development of a revised complaints information leaflet, and supported and reviewed a draft unreasonable behaviour guideline

Complaint Satisfaction Questionnaire

Our Trust feedback survey is provided to all complainants to enable them to provide feedback on their experience of the complaints process at the Trust. Feedback received is outlined as follows based on 15% return rate (49 responses):

- Making a complaint was straight forward : 86%

- I knew I had the right to complain: 89%
- I knew that my care would not be compromised by making a complaint: 92%
- The staff who spoke to me regarding my complaint were polite and helpful: 86%
- My complaint was acknowledged within 3 working days: 79%
- I was informed about the complaints process: 91%
- I was informed of any delays and updated on the progress: 83%
- I received a resolution in a time period that was relevant to my particular case and complaint: 91%
- I am happy with my overall response time to my complaint: 85%
- I feel the Trust has taken my comments on board and have made changes to improve the things that I was unhappy with: 74%
- I would complain again if I felt the need to: 100%

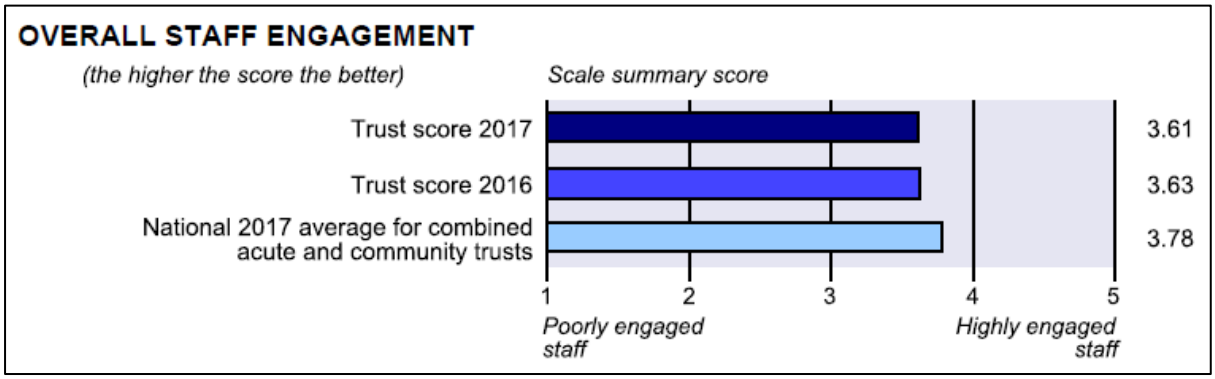
2.6 - What our staff say

Every year the NHS ask an independent company to survey the opinions of staff about working in the organisation where they are employed. The survey results are published on the internet through NHS England. The survey looks at 32 factors and compares information from the previous year as well as how the organisation measures against other NHS organisations. Some of the factors the survey asks questions about are for instance: staffing levels, support for learning, and their experience of violence or bullying and incidents.

The 2017 questionnaire was sent to all colleagues in the Trust and 1536 responded, a response rate of 36% compared with the response rate for all combined acute and community trusts in England of 40.4%.

Following the 2016 Staff Survey results we employed a Staff Engagement lead to better understand what lay behind the disappointing results and to lead the engagement with staff and improve both the staff experience at work and the level of satisfaction felt.

Summary of 2017 results:



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

Some clear movement has been observed for specific questions:

Improved:

- 5% more people say they are involved in deciding on changes introduced
- 7% more people feel that the organisation would treat them fairly if involved in an issue

- 5% more people say they are given feedback about changes in response to reported errors, near misses and incidents
- 4% less people state they have received training, learning or development in the past 12 months
- 4% more people state that where they did receive development it helped them be more effective
- 8% more people agree they receive regular updates on patient experience in their areas
- 9% more people agreed feedback received from patients is used to make informed decisions
- 4% more staff stated that the last time they experienced physical violence they did not report it

Worsened:

- 3% more people say they have suffered work-related stress compared with 2016
- 4% more people say they are dissatisfied with their level of pay compared with 2016
- 4% more people stated communications between senior management and staff is effective

Our response:
The Staff Engagement Lead is building on the work done in 2017 and coordinating additional work to continue to improve staff satisfaction. This work includes:

- The Staff Engagement Lead has reviewed all the topics with the Trust Executive members as well as senior leaders and agreed 5 key topics to focus on first, which are more likely to have the strongest positive impact.
- agreeing a template for divisional areas to identify 5 areas that require their focus. HR will have oversight of these plans and Divisional areas will have ownership and accountability for delivery of them.
- Two groups have been established to support the engagement work - the 55 „Engagents" and the Passionate for Engagement Group (PEG)
- Values have been revised and established and will be launched early in 2018/19
- Feedback has been provided to some colleagues, as a result of the focus groups, to assist their future performance.
- Manager feedback sessions have been run to share best practice in delivering feedback
- 360 feedback is currently being piloted by Board, Exec through to Teams of Three Managers and their equivalents
- A pledge from the Board is being developed relating to a zero-tolerance towards bullying and harassment

2.11 Equality, Diversity and Inclusion

Getting equality, diversity and inclusion right for our staff, patients, carers, patients, families and communities will support the delivery of strategic objectives to deliver integrated health and social care services that best meet the patient's needs.

To be added

2.8 - Overall Activity Levels and Performance against Core Operating Standards

The Trust records every time a person is provided with advice, assessment, tests and treatment. This is called activity. Nationally there are a number of areas that are set to be able to compare one Trust with another.

Emergency activity is any activity which is not planned through a booked appointment. This may be a person attending the Emergency department or by an urgent admission following a call from a family doctor or from a planned visit to outpatients resulting in the need for a person to be admitted on that day

Activity				
	2014-15	**2015-16**	**2016-17**	**2017-18**
Emergency Activity	35,056	38,420	35,154	31,847
Day Case	22,281	21,864	21,515	22,253
Elective	3,968	3,749	3,422	3,725
Outpatient	262,038	263,380	248,452	230,583
A & E	66,777	64,806	64,686	74,003
Community	340,158	329,939	344,377	36,1113
Total	730,278	722,158	717,606	723,524

Performance against standards

Measure	Actual 14 - 15	Target 15-16	Actual 15-16	Target 16-17	Actual 16-17	Actual 17-18
Total Time in A & E 4 Hour wait	89.1%	95%	87.90%	95%	84.10%	82.67%
C. Diff Cases	16	18	7	18	21	11
MRSA Cases	0	0	1	0	0	0
% of patients whose operations were cancelled for non-clinical reasons		0.75%	0.47%	n/a	0.65%	0.45%
Cancer 2 week wait	91.7%	93%	90.80%	93%	96.4%	**95.2%
Cancer 2 week wait Breast Symptoms	91.7%	93%	90.80%	93%	96.2%	**96.0%
Cancer 31 day diagnosis to treatment	98.9%	96%	99%	96%	99.2%	**99.3%
Cancer 31 day wait surgery	99.2%	94%	97.30%	94%	99.0%	**98.8%
Cancer 31 day wait drug	99.6%	98%	99.50%	98%	100.0%	**100.0%
Cancer 62 day wait all cancer	76.7%	85%	79.80%	85%	87.0%	**88.1%
Cancer 62 day wait screening	96.4%	90%	100%	90%	95.9%	**97.7%
Cancer 62 day wait consultant upgrade	90.5%	92.10%	91%	91%	92.2%	**86.1%

**Cancer performance – latest year to date performance as at February 2018. Checking comments with the COO

There are some waiting times and that the Department of Health has set targets for Trusts to meet. These are written into the NHS Contract. These are the measures that are often reported by newspapers nationally and locally.

In Walsall there are some of these that we have managed to achieve every year for some time. We are pleased to be able to report that …. What?

Others targets we have not achieved. We have taken steps to change the way we work in order to reach the standards. In particular we have been working at the way we manage our waiting lists this year

2.9 CQUIN

A set of Commissioning for Quality and Innovation (CQUIN) goals were agreed with our commissioners for 2016/17. The table below shows the progress made in achieving these goals.

NOTE: Final performance will be available mid-May - 2 schemes to be submitted for Q4 (Sepsis & Proactive & Safe Discharge). Q3 expected to be agreed week of May 14th

CQUIN SCHEME	Type	Potential Monies Available	% Achieved
support engagement with STP's	National STP	£914,168	100%
STP's risk reserve	National STP	£914,168	100%
NHS Staff & Wellbeing	National CCG's	£460,151	Final outcome not yet available
Proactive & Safe Discharge	National CCG's	£460,151	Final outcome not yet available
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	National CCG's	£257,685	Final outcome not yet available
Improving services for people with mental health needs who present to A&E	National CCG's	£257,685	Final outcome not yet available
e-Referrals	National CCG's	£257,685	Final outcome not yet available
Wound Care - Community	National CCG's	£257,685	100%
Preventing ill health by risky behaviours – alcohol and tobacco	National CCG's	£276,091	Final outcome not yet available
Personalised Care / support planning - Community	National CCG's	£257,685	100%
Offering Advice & Guidance	National CCG's	£257,685	Final outcome not yet available
Non - PICU	NHS England Specialised	£37,878	100%
Medicine Optimisation	NHS England Specialised	£76,427	Final outcome not yet available
Neonatal Outreach	NHS England Specialised	£37,878	100%
Dental	NHS England Public Health	£34,962	100%
Totals		£4,757,984	

Section 3 - Priorities for improvement 2018/19

	**Safe**	**1 Implement best Practice around resuscitation, acting on deterioration and utilisation of the sepsis bundle**
	**Effective**	**2 Ensuring the Patient receives the right care, in the right place, at the right** **3 DRAFT – To maintain a secure, accurate, complete and contemporaneous record for each patient**
	**Caring**	**4 Complete the assessment of the Trust's compliance with Equality and Diversity System 2.**

The Quality Commitment on page XX shows the extent of the work being undertaken to improve the quality and safety of care we provide. This includes:

Safe:

Effective:

Caring:

This will be revised for 2018/19 to reflect on the progress made, learning from the CQC inspection and from our wider quality improvement work that supports us getting to good and beyond – work in progress with the Divisions and supported by our improvement Director.

3.1 Priorities for improvement 2018/19

Priority 2: Implement best Practice around resuscitation, acting on deterioration and utilisation of the sepsis bundle

Lead

Medical Director – Divisional Medical Director MLTC

Plan

With regards to deterioration and sepsis, training will continue for all clinical staff in the form of bespoke sessions and on the mandatory clinical update sessions. The Chief Executive officer from the Sepsis Trust will be attending the Trust on May 18th 2017 to give a Sepsis Seminar. The Quality Facilitator takes a key role in working with wards to improve detection of deterioration and sepsis by working alongside them in their day to day activities.

How will we measure this?

Both deterioration and sepsis are audited monthly. Sepsis is a national CQUIN and audited in line with national guidance which involves the auditing of records of 50 patients within A&E and 50 in patients with regards to Sepsis screening, antibiotic usage and review of antibiotics is also reviewed. Deterioration is audited by reviewing all patients, in 1 week, who on their observations (pulse, blood pressure, temperature, respirations etc.) scored 5 or above on the early warning score which highlights the need for a clinical review. Key elements such as timing of observations, escalations to medical staff and documentation of clinical review are audited.

Where and when will we report the progress

The Results of both audits will be reported to the Resuscitation Committee and Trust Quality Executive

How we will make sure that the standard achieve will remain high.

Once achieved improvement will be maintained by continuous audit and training.

Priority 2: Ensuring the Patient receives the right care, in the right place, at the right

Lead

Medical Director/Chief Operating Officer and Director of Nursing

Plan

This priority aims to improve the effectiveness, quality and safety of patient care by ensuring that the patient receives the right care and expertise, at the right time, and in the right place. We know from our own performance targets and from patient feedback that we do not always provide care in a timely way, and consistently complete all assessments and evaluations of care. The aim is to improve the overall patient experience of care by ensuring that key activities take place consistently for each and every patient regardless of the care setting.

This work draws together activities undertaken across the patient journey to improve the effectiveness of care and will incorporate some of the initiatives already underway including the implementation and embedding of Safer and Red to Green, development of ward based multidisciplinary leadership (with the ward manager and a designated named consultant jointly taking accountability for ward processes and performance) and a visible leadership programme with non-clinical manager engagement at ward level

How will we measure this?

Multi-disciplinary team audits undertaken monthly on a cohort of patients to review key metrics of care across the patient"s care episode including for example: ED performance (e.g. time to triage, Length of time in ED), referral time and transfer times to specialities, wait times for investigations, assessments (including VTE, Falls, MUST, Pressure Ulcers, Medicines reconciliation, timely recording of observations and other safety checks), discharge planning and EDD versus actual DD.

Where and when will we report the progress

The Trust Management Board

How we will make sure that the standard achieve will remain high.

By embedding ownership and accountability within clinical areas and at ward level for these key metrics of effectiveness and quality

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Priority 3: Draft – To maintain a secure, accurate, complete and contemporaneous record for each patient

Lead

Director of Strategy, Director of Nursing, Medical Director

Plan

To maintain securely an accurate, complete and contemporaneous record in respect of each patient, including a record of care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided.

The strategic direction is to move to a fully digitised patient record, this includes scanning the paper based record and preventing further paper records being produced by introducing electronic forms (eForms).

How will we measure this?

- The number of records available for an patient-out patient appointment or planned surgery.
- Monitoring of the risks relating to Health Records recorded on the trusts risk management system.
- A business case is created for the implementation of Electronic Document Management Solution (EDM).
- A business case is created for the implementation of an electronic forms solution.

Where and when will we report the progress

The Health Records Committee will provide oversight
The Trust Management Board will monitor progress

How we will make sure that the standard achieve will remain high.

Quality audit check of the patient record after an inpatient episode or an Outpatient appointment, this includes both paper based record and the digital based record in our EPR

Priority 4: Complete the assessment of the Trust's compliance with Equality and Diversity System 2.

Lead

Director of Nursing, Director of Organisational Development and Human Resources

Plan

Completion of EDS2 and grading assessment remains a key and urgent priority.

The Trust has already agreed to engage with patients and colleagues, utilising our internal data sources to identify a schedule of departments to „deep dive". There will be a key balance between identifying areas that require support and areas where we can learn from excellence. Progressing this work on was delayed due to the workforce lead leaving the Trust. However in December, we attended by invite the West Midlands Ambulance Service (WMAS) EDS2 Grading event. WMAS is ranked as one of the leading NHS providers – outstanding in all fields for implementing and learning from EDS2. In attending the grading event WMAS has agreed to support the process here at Walsall in order for us to progress and complete this well overdue action.

Plan:

1. The Trust will take place in the Equality, Diversity and Human Rights Week. 14-18 May utilising this opportunity to promote activity and gather evidence to support the „deep dive" exercise
2. Lead Directors to request information for grading assessment from the areas identified for the „deep dive" exercise.
    - School Nursing – Rated Outstanding in the Pulse Check
    - Speech and Language - Rated Outstanding in the Pulse Check
    - T&O – Worst Performing Area in the Pulse Check
    - Pharmacy - Worst Performing Area in the Pulse Check
    - Learning Disabilities – as a standalone service due to it being a protected characteristic.
3. Information collated will allow initial grading assessment to take place and then a final, lay assessment grading event will be arranged.

How will we measure this?

The agreement to a fixed term part time equalities post has enabled the Trust to start to make progress on a number of priorities and benefit from work undertaken across the Organisation. The main focus of this work has been to support the development of patient/service elements of equality work. This should enable us to evidence better engagement with those groups and establish key areas to improve service delivery; supporting a robust equality impact process and agree actions; and improve data collection on patients using our services. We have further agreed to bring the patient and staff approaches together and plan to appoint to a 6 month secondment post commencing in July 2018 to assist the work already begun.

Where and when will we report the progress

- Equality Diversity and Inclusion Committee - Quarterly
- People and Organisational Development Committee – Bi-Monthly
- Patient Experience Group – Bi-Monthly

How we will make sure that the standard achieve will remain high.

- Ongoing monitoring of actions undertaken
- Review the EDS2 assessment annually and extending this to other areas
- Engage with the NHS Employers Equality and Diversity Partners Programme

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3.2 CQUIN for 2018/19

A set of Commissioning for Quality and Innovation (CQUIN) goals has been agreed with our commissioners for 2018/19

CQUIN Ref.	CQUIN Scheme Name	17/18 CQUIN Value	Exc Lead
	STP Support engagement	**£914,168**	DoF
	STP risk reserve	**£914,168**	DoF
WCCG			
1	Improving staff health and wellbeing	**£460,151**	OPD & HR
2	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	**£257,685**	MD
3	Improving services for people with mental health needs who present to A&E	**£257,685**	COO
4	Offering advice and Guidance (A&G)	**£257,685**	D of S&T
5	NHS e-Referrals (Year 1 only)	**£257,685**	D of S&T
6	Supporting Proactive and Safe Discharge – Acute Providers (inc ECDS)	**£460,151**	COO (D of S&T)
7	Preventing ill health by risky behaviours – alcohol and tobacco	**£276,091**	DoN
8	Improving the Assessment of Wounds	**£257,685**	DoN
9	Personalised Care and Support Planning	**£257,685**	DoN
WCCG		**£2,742,503**	
NHS E Specialised Commissioners			
1	Medicines Optimisation	£76,427	MD
2	Paediatrics - non PICU	£37,878	COO
3	Neonatal Outreach	£37,878	DoN
NHS E Totals		**£152,183**	
NHE E Public Health (Shropshire LAT and Bham and BC LAT)			

1	Dental – audit of Daycase activity	**£34,962**	**COO**

Further details of the agreed goals for 2017/18 and for the following 12 month period are available on request from the Director of Finance

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3.3 Who has been involved in setting our improvement priorities

Text to be added

Appendices:

1. **Assurance Statements by the Trust**
   - Review of Services
   - National Confidential Enquiry and Clinical Audit participation
   - Research and Development
   - Registration with the Care Quality Commission
   - Quality of Data
   - Learning from Deaths
   - Mandatory Indicators and National Targets

2. **Statements**
   - Healthwatch
   - Overview & Scrutiny Committee
   - Clinical Commissioning Groups

3. **Statement of Director's responsibilities in respect of the Quality Account**

4. **Independent Assurance Report**

Appendix 1

Assurance Statements by the Trust

Review of services

During 2017/18 the Walsall Healthcare NHS Trust provided and/ or sub-contracted 88 NHS services. Walsall Healthcare NHS Trust has reviewed all the data available to them on the quality of care in 88 of these NHS services. The income generated by the NHS services reviewed in 2016 - 17 represents 100 per cent of the total income generated from the provision of NHS services by the Walsall Healthcare NHS Trust for 2016 - 17

Care Quality Commission (CQC)

Walsall Healthcare NHS Trust is required to register with the Care Quality commission and its current registration status is Registered (without any compliance conditions and licensed to provide services.

Walsall Healthcare NHS Trust has the following conditions on registration: No additional conditions to those imposed by registration

The current inspection ratings for the Trust following the Chief Inspector of Hospital"s inspection in June 2017 are provided below:

Overall Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Walsall Manor Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good

Community Health Services

The Care Quality Commission has taken enforcement action against Walsall Healthcare NHS Trust during 2017-18.

- The Trust received a Section 29a warning notice following the inspection in June 2017
    - Monitoring, recording and escalation of concerns for Cardiotocography (CTG) requires significant improvement
    - There are insufficient midwives with HDU training to ensure that women in HDU are cared for by staff with the appropriate skills.
    - Safeguarding training is insufficient to protect women and babies on the unit who may be at risk.
    - There are insufficient numbers of suitably qualified staff in the delivery suite and on the maternity wards
- The final inspection report also listed „enforcement" notices. These were:
    - Regulation 18 (1) The registered provider did not ensure there were adequately qualified staff across maternity services to meet the needs of woman and their babies to protect them from abuse and avoidable harm.
    - Regulation 12 (2)(b) The registered provider did not Monitor, record and escalate concerns for Cardiotocography (CTG) to protect women and their babies from abuse and avoidable harm
    - Regulation 13(2): Safeguarding - Safeguarding training across maternity services was insufficient to protect women and babies on the unit who may be at risk.

Walsall Healthcare intends to take the following action to address the conclusions or requirements reported by the CQC:

- In response to the report the Trust has developed a Patient Care Improvement Plan to manage the must and should do actions listed in the report. The work and progress will

be regularly reported to the Board, Further work is being undertaken to plan to achieve higher ratings and develop the actions to achieve this. A broader Integrated Improvement Programme will be developed to encompass both these aspirational elements and the response to the must and should do actions identified in the report.

- The Maternity service continues to hold the Maternity Oversight Committee which oversees and monitors progress with the detailed Maternity improvement plan that encompasses the findings of the 2017 inspection report and the section 29a notice

Walsall Healthcare has made the following progress by 31st March 2018 in taking such action:

- The PCIP has been developed and reviewed at its first cycle
- Maternity have continued with the details Maternity Improvement Plan and in relation to the Section 29a notice have undertaken the following:
    - Staffing - the maternity service has closely monitored the staffing levels on Delivery Suite and the maternity wards and provided a weekly report to CQC detailing, both the numbers of midwives available each shift and also the corresponding acuity within delivery suite. The acuity is measured using the BirthRate plus intrapartum tool, endorsed by NICE. Improvements continue to be made. In March 2018 the incidence of midwifery staffing numbers below optimum for Delivery Suite was 14% and for the wards was 2%
    - Safeguarding training – Consultant training has met the required target. Only level 3 training targets for midwives have not yet been met (84% against a target of 90%)
    - Midwives with HDU training - Each shift now has a HDU competent midwife allocated when the roster is created. The requirement for a HDU competent midwife has been added into the R-roster template to ensure at least 1 x trained HDU midwife is rostered on every shift. In addition the printed roster also highlights who this midwife is and all off duty swaps must be appropriate and agreed by the DS manager or matron to maintain HDU cover each shift. The safety huddle conducted 3 times per day monitors whether a woman requiring HDU care is being cared for by a non HDU competent midwife. There were 4 shifts in March 2018 which did not have HDU cover available. There were no reported incidents or adverse outcomes during these shifts and support is available from the Critical Care Outreach Team and also the Anaesthetic team if required.

Walsall Healthcare NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2017/18:
Review of health services for Children Looked After and Safeguarding in Walsall

Walsall Healthcare NHS Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- An action plan is to be submitted to the CQC in response to recommendations made around a range of issues and services. These include
    - Robust risk assessments for vulnerability in Maternity
    - Communication on Safeguarding risks and Concerns in ED
    - Quality of Health Records and the provision of Electronic Health records
    - Health representation in the Multi-agency Safeguarding Hub (MASH)
    - Capacity within the Health Looked after Children service

Walsall Healthcare NHS Trust has made the following progress by 31 March 2018 in taking such action:].

- Although the report was published post 31st March 2018 many of the recommendations were already being implemented.

- Establishment of specialist midwife for Vulnerable Families
- Redesign of both the Adult and Child Causality Card documentation to ensure Safeguarding considered
- An alternative solution for Electronic records following the decommission of the previous electronic child health system
- Review and Refresh of the Children Safeguarding Team within Walsall Healthcare Trust had commenced. Which included health representation in MASH and capacity within the Looked after Children service

Participation in Clinical Audits

During 2017/18, 34 national clinical audits programmes and national confidential enquiries covered NHS services that Walsall Healthcare provides.

During that period Walsall Healthcare participated in 91%% of the national clinical audits programmes and national confidential enquiries which it was eligible to participate in.
The reports of 19 national clinical audits were reviewed during 2017/18 and the Trust intends to take the following actions to improve the quality of the healthcare we provide.

The national clinical audits and national confidential enquiries that Walsall Healthcare was eligible to participate in during 2017/18 are below.

National Audit Title	Trust Participation	% of the No of cases Submitted	Actions / Comments
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	Data Submission in progress	Results have been shared with the Care group and included in the Divisional report On-going - Assurance of care standards all within expected ranges full report and action plan will be developed as soon as received in the Trust.
Adult Cardiac Surgery	x	-	Not applicable at Walsall Healthcare NHS Trust
Bowel Cancer (NBOCAP)	✓	90%	Data upload successful awaiting report.
Cardiac Rhythm Management	✓	100%	On-going
ICNARC - Case Mix Programme	✓	100%	On-going
Child Health Clinical Outcome Review Programme	✓	100%	On-going
Chronic Kidney Disease in primary care	x	-	Not applicable at Walsall Healthcare NHS Trust
Congenital Heart Disease (CHD)	x	-	Not applicable at Walsall Healthcare NHS Trust
Coronary Angioplasty / National Audit of Percutaneous Coronary	x		Submitted as part of the Paired hospital – New Cross Hospitals NHS Trust.

Interventions (PCI)			
Diabetes (Paediatric) NPDA	✓	100%	On-going
Elective Surgery (National PROMs Programme)	✓	100%	On-going
Endocrine and Thyroid National Audit	x	-	Not applicable at Walsall Healthcare NHS Trust
Falls and Fragility Fractures Audit Programme	Partial	100%	Results have been shared with the Care group and included in the Divisional report Partial compliance in the programme, Walsall Healthcare Actively participated in National Hip Fracture but did not participate in Fracture Liaison Service – the National reports recommends that the Trust actions this section going forward
Head and Neck Cancer Audit	x	-	Not applicable at Walsall Healthcare NHS Trust
Inflammatory Bowel Disease Programme Register	x	0%	Capacity pressures – unable to support Risk on risk register to support
Learning Disability Mortality Review Programme	✓	100%	
Major Trauma Audit	✓	91%	Results have been shared with the Care group and included in the Divisional report • A slight reduction in case attainment was noted from 96.8% last year to 68.6% this fiscal year. • 1 Of the core standards has improved relating to length of stay for ISS patients. • Rehabilitation standards remained consistent with previous yeas data. • Of the 5 core standards measured 3 have decreased compliance and are below the expected Trauma unit average.
Maternal, Newborn and Infant Clinical Outcome Review Programme	✓	100%	Results have been shared with the Care group and included in the Divisional report Key outcomes of the MRACE noted of the 4,865 babies born within the Trust in 2015: • The stabilised & adjusted mortality rates for the Trust were lower than those seen across similar Trusts and Health Boards. This had been noted /reported on in the CQC report. • The proportion of mothers under 25 years of age was considerably higher than that of the UK as a whole: 28.1% versus 19.0%. Work streams are continuing in this area.
Medical and Surgical Clinical Outcome Review Programme	✓	60%	On-going

NCEPOD			
Mental Health Clinical Review Programme	✓		Not applicable at Walsall Healthcare NHS Trust
National Cardiac Arrest Audit	✓	48%	Results have been shared with the Care group and included in the Divisional report A new carbonised cardiac arrest form has been introduced to improve documentation and increase data completeness and included in the patient record.
National Chronic Obstructive Pulmonary Disease Programme	✓	100%	Results have been shared with the Care group and included in the Divisional report Majority of standards fell within the national average, variance with staffing number with Walsall falling lower than the national average; early post discharge for this cohort of patients with a diagnosis of acute exasperation of COPD a business case is in development to enable an improvement to discharges and meeting the BPT quality outcomes.
National Comparative Audit of Blood Transfusion	✓	100%	Awaiting the report
National Diabetes Audit – Adults	✓	100%	Results have been shared with the Care group and included in the Divisional report • Fully participated in the years programme • Care group dashboards continue to incorporate divisional audit results. • Training continues to evolve on the intranet to provide educational support. • Successful bid for increased specialist nursing support submitted to improve the practice for patients with diabetes.
National Emergency Laparotomy Audit	✓	85%	Results have been shared with the Care group and included in the Divisional report • Data upload successful awaiting report. • Actions taken to improve the booking form pre operatively to include the P Possum risk scoring algorithm. • Surgery improvement project is proposed to review options to improve Elderly care input.
National Heart Failure Audit	✓	90%	Results have been shared with the Care group and included in the Divisional report • The introduction/participation in the BPT was successful following the results of heart failure audit. • Additional data support was provided within the division to improve data capture. • Pathway awareness raising sessions from the audit and sharing of the outcome/pathway with the emergency team.
National Joint Registry	✓	100%	On-going

National Lung Cancer Audit	✓	100%	On-going
National Neurosurgery Audit Programme	x	-	Not applicable at Walsall Healthcare NHS Trust
National Ophthalmology Audit	x	-	Not applicable at Walsall Healthcare NHS Trust
National Prostate Cancer Audit	✓	90%	On-going
National Vascular Registry	x	-	Not applicable at Walsall Healthcare NHS Trust
National Neonatal Audit Programme	✓	100%	On-going
Nephrectomy Audit BAUS	✓	TBC	On-going
Oesophago-gastric Cancer Audit	✓	TBC	On-going
Paediatric Intensive Care	x	-	Not applicable at Walsall Healthcare NHS Trust
Percutaneous Nephrolithotomy BAUS	x	-	Not applicable at Walsall Healthcare NHS Trust Not carried out at Walsall however hope to participate nest year.
Prescribing Observatory for Mental Health	x	-	Not applicable at Walsall Healthcare NHS Trust
Radical Prostatectomy audit	x	-	Not applicable at Walsall Healthcare NHS Trust
Sentinel Stroke National Audit Programme	✓	100%	The reports were discussed at the care group / and the speciality management group. A business case was proposed the merge services to improve patient care and provide a specialised service to patients in the borough. As a result the outcome of the audits have been feed into producing a sustainable specialised service managed from New Cross with community support for Stoke rehab being offered as post discharge support, which will look into hand over and improvement in support stoke patients in the region.
Specialist rehabilitation for patients with complex needs	x	-	Not applicable at Walsall Healthcare NHS Trust
Stress Urinary Incontinence Audit	x	-	Not applicable at Walsall Healthcare NHS Trust
BAUS Urology Audits: Cystectomy	x		Not applicable at Walsall Healthcare NHS Trust
BAUS Urology Audits: Nephrectomy	✓	TBC	On going
BAUS Urology Audits: Urethroplasty	x	-	Care group decision not to participate this year risk assessment completed.
Fractured Neck of Femur CEM	✓	100%	Complete

National Audit of Breast Cancer in Older Patients	✓	100%	Data upload successful awaiting report
National Audit of Intermediate Care	✓	TBC	Completed restoration open for 2018 - Report Requested
National Audit of Psychosis	x	-	Not Applicable to Walsall NHS Trust Mental Health led audit
National Audit of Seizures and Epilepsies in Children and Young People	✓	TBC	Didn't run in 2017/2018 time frame
National Bariatric Surgery Registry	✓	100%	Data upload successful awaiting report
National Maternity and Perinatal Audit	✓	TBC	On going
Pain in Children CEM	✓	100%	Awaiting report for national comparators
Procedural Sedation in Adults (care in emergency departments)	x	-	Not Applicable to Walsall NHS Trust
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	✓	100%	Awaiting report for national comparators
UK Parkinson's Audit	✓	100%	Results have been shared with the Care group and included in the Divisional report • All patients were reviewed by a specialist with the last year – on Parr with the national averages, and all medical reviews were completed with 12 months with the majority completed in the 6/12 months criteria. • 4 people received the appropriate oral and written communication in line with the national standards 16 was noted to be not applicable. • Standard C 100% of people with Parkinson's who have sudden onset of sleep should be advised not to drive and to consider any occupational hazards - Achieved • 100% of patients on dopamine agonists are monitored for impulse control disorders including dopamine dysregulation syndrome (Parkinson's NICE R 54) Achieved • Standard E: If an ergot-derived dopamine agonist is used, 100% of patients should have a minimum of renal function tests, erythrocyte sedimentation rate (ESR) and chest radiograph (CXR) performed before starting treatment, and annually thereafter (Parkinson's NICE R30 and

			40) Achieved • For 100% of people with Parkinson"s end-of-life care requirements should be considered throughout all phases of the disease. Limited documented evidence however this standard was poor nationally. • 100% of people with Parkinson"s and their carers should be given the opportunity to discuss end-of-life issues with appropriate healthcare professionals. Evidence in - 50% of the cases.

The reports of 31 local clinical audits were reviewed by the provider in 2017/18 and Walsall Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided (see below)

Title	Outcome	Action
Sepsis CQUIN	Sepsis Audit – The screening patients using the appropriate Screening and Action Tool across the Trust was not always optimised.	The Trust Implemented a universal Sepsis Screening and training workshops and safety events were held across the organisation. • A revised screening tool was launched in the emergency department. • Deteriorating patient and sepsis training was trialled on the 20 February to raise awareness. • Trust wide support of national sepsis day to raise awareness.
Deteriorating Patents	Reviewed a number of cases and identified a number of issues linked to documentation.	A number of quality work streams commenced to improve the issues noted that includes the new Transfer of Care Policy and the amended SBAR tool that improves communication by ensuring concise focused information of the care needed.
Paediatric Sleep Study	Identified a number of blockages and communication barriers for the patient journey.	New process to improve the patient journey were devised that will reduce time spent waiting for clinics to occur and expedited results.
Handover Audit - Re-Audit on Current Practice	Handover issues were identified	A joined approach was introduced to reduce time and improve communication between teams.
NNU outpatient appointments	The audit identified that follow up appointments were only attended by 25% of patients and DNA of patients were high in high risk preterm babies.	A text reminding system was introduced that sought to remind patients of appointments a review is to be undertaken in 2018 programme to demonstrate improvement.
VTE Performance Paediatric – Learning from Audit – Sepsis	The use of the paediatric sepsis 6 bundle had improved from the previous study. Nursing staff feel more empowered using the bundle and the escalation was	Continue and improved display of posters/ pathways in all relevant clinical areas, and work between A&E and Paediatric team needs to

Re-Audit outcome	expedited. There were indications of a timely review by senior doctors. All patients had their antibiotics reviewed within 72 hrs, and there was a better patient outcome and no retrievals	remain collaborative.
Spot audit of non-technical skills and clinical quality carried out on wards 10 and 11	100% completion of introduction to patient, giving clear instructions, maintaining privacy and dignity and legible documentation in the notes reflect good communication skills within the teams. The results demonstrate good practice with >80% compliance with team working elements of non-technical skills. Of concern is the 78% compliance with hand hygiene between patients, the 39% discussion re IV fluids and NBM status and 17% amber care /DNAR assessment. Improvements could also be made in reviewing analgesia/VTE etc Some of these are more relevant to the day 1 post take ward round, rather than those who have been an in-patient for a while	Incident report equipment failures • Continuous education to all by Seniors with regards to standards required for ward round • Regular peer audits to be undertaken and fed back to Care Group
An Audit of Pre-Operative Administration of Prophylactic Antibiotics	46% of patients who did not receive antibiotics may have benefitted from doing so 91% of patients who received prophylactic antibiotics may not have required them or required an alternative agent	The Trust brought together a MDT to bring together formal guidance and clinical preference A project reviewing all medical guidance and formalising the governance process around these is underway..
Laparoscopic management of ectopic pregnancy	Good compliance was noted overall	Improve the process of communication for negative laparoscopy results to enhance the patient experience.

Participation in Research – to be provided

The number of patients receiving relevant health services provided or sub-contracted by Walsall Healthcare NHS Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 374.

The number of patients recruited in 2016/17 was 494 and in 2015/16 was 502. Although there is a decrease in number of patients recruited this year in clinical research, we are opening more complex research studies and this demonstrates Walsall healthcare"s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. This year, we recruited the most number of patients in a commercial

Dermatology study and Sexual Health clinical research studies in UK. We were also the first in West Midlands to recruit plus completed the full allocated number of patients for a National Sexual Health study this year.

Walsall Healthcare was involved in conducting 41 clinical research studies, 39 non-commercial and 2 commercial studies. Walsall Healthcare completed 80% of these studies as designed within the agreed time and to the agreed recruitment target. 20% of these studies are still on going. Walsall Healthcare used national systems to manage the studies in proportion to risk. Of the 12 studies given permission to start, 80% were given permission by an authorised person less than 30 days from receipt of a valid complete application. 100% of the studies were established and managed under national model agreements and 25% of the 12 eligible research involved used a Research Passport or letter of access to run the studies. In 2017-18 the National Institute for Health Research (NIHR) supported 3 of these studies through its research networks, using NIHR CRN research staff support.

In the last three years, 2 publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.

Goals agreed with commissioners

CQUIN Performance - A proportion of Walsall Healthcare NHS Trust income in 2016 – 17 was conditional on achieving quality improvement and innovation goals agreed between Walsall Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

The table showing the achievement of these 2017/18 goals is on page *XXX*

Data Quality

Walsall Healthcare NHS Trust submitted records during 2016 – 17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

– which included the patient"s valid NHS number was:
99.84% for admitted patient care
99.84% for outpatient care
99.30% for accident and emergency care

"– which included the patient"s valid General Medical Practice
Code was:
100% for admitted patient care
100% for outpatient care
100% for accident and emergency care

Good quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made. Walsall Healthcare NHS Trust

submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The Trust can confirm that it submitted data during the reporting period to both SUS and HES systems for national reporting purposes.

Information Governance Toolkit

Information governance (IG) in about the proper management of information that an organisation has collected and is storing. The IG Toolkit is a system that allows NHS organisations and partners to assess themselves against national standards. Results are published on 1 April each year.

Walsall Healthcare NHS Trust score for 2017/18 for Information Quality and Records Management, assessed using the Information Governance Toolkit was
72% (green)

The Trust continues to have a satisfactory rating (organisations are rated either satisfactory or unsatisfactory).

Clinical Coding

Walsall Healthcare was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

A similar requirement is now covered by the Information Governance Toolkit.

Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct
93.50%	96.73%	99.23%	91.81%

Learning from Deaths

Mandatory Statement

During the reporting period 2017-2018 the Trust has implemented the SJR approach to deaths occurring in the trust falling into 16 key cohorts

1. All deaths where bereaved families and carers or staff have raised a significant concern about the quality of care provision
2. All patients with a learning disability

3. All patients with a mental health illness
4. All maternal deaths
5. All children and young people up to 19 years of age
6. All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work
7. All 0-1 day LOS who are not receiving specialist palliative care
8. All patients admitted out of hours who die within 5 days, excluding those receiving specialist palliative care
9. All elective surgical patients
10. All none elective surgical patients
11. All unexpected deaths/ coroner reported
12. All Deaths in critical care
13. A random selection of 20% of those other than listed above
14. 20 patients per month to be reviewed by the palliative care team to review EOL care
15. All patients readmitted within 30 days
16. Those patient with 4 or more inpatient admissions within a 12 month period

Utilising this methodology the number of deaths to be reviewed each month is as follows

June 2017		July 2017	
Total Number of Deaths	80	Total Number of Deaths	81
Total Number to be Reviewed	62	Total Number to be Reviewed	62
August 2017		September 2017	
Total Number of Deaths	88	Total Number of Deaths	62
Total Number to be Reviewed	52	Total Number to be Reviewed	35
October 2017		November 2017	
Total Number of Deaths	86	Total Number of Deaths	80
Total Number to be Reviewed	68	Total Number to be Reviewed	51
December 2017		January2018	
Total Number of Deaths	133	Total Number of Deaths	139
Total Number to be Reviewed	103	Total Number to be Reviewed	88
February 2018		March 2018	
Total Number of Deaths	109	Total Number of Deaths	113
Total Number to be Reviewed	71	Total Number to be Reviewed	71

The number of cases reviewed to date per quarter of deaths that occurred in the reporting period are:

Quarter	Number of Case Reviews Completed
Q1	212
Q2	101
Q3	146
Q4	121

During the reporting period the trust has reported 1166 deaths.

For this period the Trust has recorded 4 deaths which were judged as being as a result of a problem in care or system, 0.3%. 2 occurred in Q1 and 2 in Q3.

Key themes identified from these deaths were

- Timely recognition and response to the deteriorating patient
- Maintaining professional standards in relation to record keeping internally and in communication with other care providers
- Timely and effective Consultant to Consultant referral
- Human errors in imaging interpretation
- Failure to use red flag notification to a clinician on identification of an imaging anomaly
- Patient lost to follow up following an original review and plan for review

In response to these findings the trust via the root cause analysis process clearly identified care and system issues, lessons learnt and developed concise action plans

Key actions taken to address these issues have been

- External review by WMQRS of the sepsis and deteriorating patient systems and processes
- Launch of FEVERED initiative as a trigger for staff
- Additional training led by Sepsis UK
- A trust wide multi professional documentation audit of the patient record. To be owned by each specialty and accountability to be managed by the specialty teams
- Review of the provision , quality and timeliness of patient electronic discharge summaries to GPs
- Development and implementation of an inpatient referral standard operating procedure
- Ensure the system for imaging discrepancy and error rate monitoring is robust to assure that individual errors in reporting are monitored to ensure they are in accordance with Royal College guidelines and identify individual training issues which require further support.
- Review PACS and CRIS interoperability issue to ensure all colleagues are supported in completing imaging reporting accurately.
- Ensure that all colleagues are fully aware of the requirement to utilise the urgent red flag where it is required regardless of referrer or modality.
- Share learning amongst all radiologists to ensure learning.
- Discuss with individual image reporters relating to identified errors and practice issue for consideration within their on-going professional reflection and development.
- Ensure clinicians across the Trust are reminded of their professional responsibility to review and act on all requested investigations regardless of if they are identified as being urgent.
- Review the process for managing complaints and incidents identified via them to assure incidents and serious incidents are identified at the earliest opportunity to support learning and maintaining patient safety
- Review of all patients who have open access plans and have exceeded their guaranteed access date. This work is being led by the trust access team in conjunction with clinical leads across the trust for all specialties.

It is envisaged that the impact of these actions will reduce the risk of future deaths occurring due to those issues in care or process that have been identified.

During the previous reporting period 2016- 2017 the trust identified 3 deaths identifying issues in care or process that were more likely than not to have been due to a problem in care.

Mandatory Indicators

NHS Outcomes Framework Mandatory Indicators

All trusts are required by the Department of Health to provide a core set of indicators relevant to the services they provide using a standardised statement.

The eight indicators relevant to Walsall Healthcare NHS Trust are provided below using information from the Health & Social Care Information Centre and cover the last two reporting periods where the data is available. They are set out under the NHS Outcomes Framework domains.

See presentation guidance

(Some data will not be available until June – Performance Team to provide)

NHS Outcomes Framework Domain 1

Title	Indicator	2016/17	2017/18	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Summary Hospital Mortality Indicator (SHMI)	a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period;	April 16 – 120.23 May 16 – 95.42 June 16 – 92.83 July 16 – 94.24 August 16 – 96.57 September 16 – 83.21 October 16 – 109.84 November 16 – 93.95 December 16 – 127.45 January 17 – 128.67 February 17 – 105.75 March 17 – 99.49	April 17 – 106.68 May 17 - 110.10 June 17 – 86.40 July 17 – 90.69 August 17 – 99.28 September 17 – 94.05 October 17 – 101.03 November 17 – 100.88 December 17 – n/a January 18- n/a February 18 – n/a March 18 – n/a	1.00	Latest position – Mar18 Issue (Oct 16 – Sept 17) Highest Performing Trust – The Whittington Hospital NHS Trust (0.73) Lowest Performing Trust – Wye Valley NHS Trust (1.25%)
	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	Performance team to provide	Performance team to provide	Performance team to provide	Performance team to provide
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The data reported represents the trusts performance against the national benchmarks. The data represents deaths occurring across primary and secondary care. Variances in performance represent the health demographics of the population, seasonal trends in keeping with the national picture. The trust has not reported any CUSUM alerts for this period.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		See section 2.4		

NHS Outcomes Framework Domain 3

Title	Indicator PROMs case mix-adjusted scores	TRUST 2016/17 Adjusted average health gain	2017/18	National Average 2016/17 (provisional data -) Adjusted average health gain	Upper and Lower 95% control limit for the Trust (provisional data –) Health Gain
Patient Recorded Outcome Measures **(PROMS)**	(i) groin hernia surgery	No longer measured	No longer measured	N/A	N/A
	(ii) varicose vein surgery	No longer measured	No longer measured	N/A	N/A
	(iii) hip replacement surgery	Published Feb 18 **EQ5D 0.373 (95% CL)** **EQVAS 11.459** **OHS 17.360 (99.8%CL)**	Provisional data for April 2017-Dec 2017 will be available in June 2018 The Full 2017/18 data will not be available until August 2018	Published Feb 18 EQ5D 0.437 EQVAS 13.1 OHS 21.4	EQ5D 0.382-0.492 EQ VAS 8.849-17.376 OHS 19.483 - 23.276
	(iv) knee replacement surgery	Published Feb 18 **EQ5D 0.308** **EQVAS 8.253** **OKS 16.7**	Provisional data for April 2017-Dec 2017 will be available in June 2018 The Full 2017/18 data will not be available until August 2018	Published Feb 18 EQ5D 0.323 EQVAS 6.9 OKS 16.4	EQ5D 0.274-0.371 EQ VAS 3.120- 10.580 OKS 14.694 -18.093
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		Oxford Hip Score (OHS) is a validated tool for the measurement of pain and function related to hips before and after replacement surgery. The lower the score the worst outcome perceived by the patient. (Worst pain and function 0 – 48 Best pain and function). We would expect a low score post op to increase overtime as this indicates an improvement in pain and function (6 months and 1 year). Over the last 3 years we have an increasing score (15.194, 15.789, 17.36). The OHS is affected by patient with long standing Lower back problems as the Hip replacement Surgery does not relieve these symptoms. It also affected by the overall health state of the patient and as the general population in Walsall has high levels of deprivation this is reflected in the EQ5D measurement. This is also improving over the last 3 years (0.317, 0.302, 0.373)		
	Walsall Healthcare NHS Trust has taken the		• New Patient Information Booklets that include up-to-date information		

	following actions to improve this number, and so the quality of its services, by:	regarding why PROMs is collected and Why it is important to the patient and the Trust. • Joint School recommenced November 2017. Joint School presentation mirrors the Patient Information Booklet regarding PROMs participation • Pre-operative Assessment Clinics are collecting, monitoring and submitting both the HIP & Knee Booklets to the performance Department for entry onto the database • We are planning a Poster campaign in Pre-operative Assessment Clinic to back up our drive for patients to participate • We communicate with the National Proms team to discuss ways of improving PROMs participation rates. Interpreter facilities are now available via the National PROMs team hotline. Information Leaflets in different languages are available via the PROMS Website and link given to the Pre-operative Services. • We attend the Yearly National PROMS summit to learn from other Trust Experience • Orthopaedic Consultants are to do NJR / PROMS Peer Audit where they present their own NJR data to each other to provide professional challenge • Professor Briggs GIRFT review due 31st July 2018 regarding Hip & Knee replacement Walsall overall outcomes for NJR / PROMS / SSSI. • The MSK Care Group is working in partnership with GP Colleagues to ensure we operate on the patients in most need for the surgery. Patients who are medically fit, meet the BMI of 35 or below, and fully understand why they are having a major operation. We therefore hope to ensure that we meet/exceed the patients expectation for having the surgery thereby improving patient satisfaction and thus improving the PROMS. Research has shown that patient who have a higher BMI than 35 do not have such good outcome in the long term as patient who are below the BMI threshold.

Title	Indicator	2016/17	2017/18	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Readmission rates	The percentage of patients aged (i) 0 to 15; and (ii) 16 or over, Re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	0 – 15 = 8.75% 16 or over = 9.72%	0 – 15 = 8.71% 16 or over = 10.67%	Not Available	Not Available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	The figures provided above are based on 28 days but the Trust locally reports this metric as patients who are readmitted within 30 days of a previous discharge.			
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	To add			

NHS Outcomes Framework Domain 4

Title	Indicator	2016/17	2017/18	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patient Survey – Responsiveness to patient's needs	The trust's responsiveness to the personal needs of its patients during the reporting period		Q32: Were you involved as much as you wanted to be in decisions about your care and treatment? **6.6/10** Q35: Did you find someone on the hospital staff to talk to about your worries and fears? **5.1/10** Q37: Were you given enough privacy when discussing your condition or treatment? **8.3/10** Q57: Did a member of staff tell you about medication side effects to watch for when you went home? **3.9/10** Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? **6.9/10**	Trust score worse than national score Trust score about the same as national score Trust score about the same as national score Trust score about the same as national score Trust score about the same as national score	N/A
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The Trust follows the National Survey programme for implementing the CQC surveys. The data collated is processed by National Survey Co-ordination Centre and published by CQC via their public website.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		• An Ipad pilot on four wards was successful in increasing accessibility and involvement of patients with feedback activity on the inpatient wards. • Awareness of the Quiet Protocol was promoted across the Trust in response to feedback relating to reducing noise at night, full protocol implementation is scheduled for quarter 1 of this year. • The Trust has joined the National Always Events® Programme which aims to optimise positive patient experience and improved outcomes for every patient every time.		

Title	Indicator	2016/17	2017/18	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Staff recommending the trust as a provider of care	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	48%	48%	69% (2017/2018 for Combined Acute & Community Trusts))	N/A
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The data provided is from question 21d in the National NHS Staff Surveys 2016 and 2017 respectively. The results of this were surprising as did not reflect the much better results of the Staff F&F Test for the same question and Key Finding 1 (which this forms part of) was the only Key Finding where the Trust saw a drop with 28 staying the same and 3 improving against a national average where 22 worsened (according to NHS Employers Edition published 22/3/18) so the results for this were not in keeping with what we expected nor our improved CQC rating.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		The questionnaire was sent to all colleagues and 1536 responded, equating to a 36% response rate. This was lower than the national average response rate of 43% for all combined acute and community trusts in England. Since the survey was launched there has been a significant amount of work in understanding staff opinion and the main factor we have been focusing attention on in culture, recognising this needs to improve. Focused actions have been implemented and staff continue to have the opportunity to contribute towards change and an improved culture through a number of new and existing channels. Targeted divisional action plans are being introduced as we all as a Trust-wide approach to improve this result for the 2018 Staff Survey. We would expect to see more staff recommending the Trust as a place for treatment to their friends and family in line with the Staff Friends and Family Test improvement scores we have seen.		

(There is not a statutory requirement to report this indicator)

Title	Indicator	2016/17	2017/18	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patients who would recommend the Trust to their family or friends		March 2017 (% Recommended) Inpatients – 90% ED – 78% Outpatients – 89% Community – Not Reported Antenatal – 80% Birth – 95% Postnatal Ward – 77% Postnatal Comm – 100%	March 2018 (% Recommended) Inpatients – 94% ED – 76% Outpatients – 92% Community – 97% Antenatal – 81% Birth – 100% Postnatal Ward – 96% Postnatal Comm – 98%	Inpatients: 96% Outpatients: 94% A&E: 86% Community Services: 95% Antenatal (Maternity): 96% Birth (Maternity): 97% Postnatal Ward(Maternity): 95% Postnatal Community(Maternity): 98% Note: No national data for November 2017.	N/A
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The Trust follows The nationally mandated process for implementing The FFT programme. - Data collated is submitted monthly to NHS England via UNIFY2 submissions - FFT results are published NHS England on their public websites		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		• All wards and departments display their FFT results on a weekly basis for patients, visitors and staff members. • An Ipads pilot on four wards was successful in increasing accessibility and involvement of patients with feedback activity on the inpatient wards. • Awareness of the Quiet Protocol was promoted across the Trust in response to feedback relating to reducing noise at night, full protocol implementation is scheduled for quarter 1 of this year. • Volunteer support has been increased across the wards and A&E to assist with activities like mealtimes, patient visiting, dementia tea parties and waiting area support. • The Trust has joined the National Always Events® Programme which aims to optimise positive patient experience and improved outcomes for every patient every time. • Observe & Act Tool was piloted which paves the way for using lay members to identify and co-produce service improvements.		

NHS Outcomes Framework Domain 5

Title	Indicator	2016/17	2017/18	England Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Venous thromboembolism Risk assessments	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	Apr 16 = 96.88% May 16 = 95.05% Jun 16 = 96.06% Jul 16 = 97.17% Aug 16 = 96.74% Sep 16 = 94.49% Oct 16 = 87.85% Nov 16 = 88.61% Dec 16 = 86.33% Jan 17 = 86.23% Feb 17 = 82.23% Mar 17 = 82.49%	Apr 17 = 80.34% May 17 = 87.73% Jun 17 = 81.91% Jul 17 = 79.28% Aug 17 = 88.30% Sep 17 = 90.75% Oct 17 = 90.45% Nov 17 = 89.95% Dec 17 = 93.45% Jan 18 = 91.30% Feb 18 = 93.18% Mar 18 = 95.49%	Latest position - Quarter 3 17/18 = 91.17% (based on 132 Acute Trusts)
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		This data is reflective of the trust performance for VTE assessment of all appropriate admissions as determined by the use of a robust methodology for determining the performance developed and embedded since March 2017. The improved performance represents the use of a single electronic data sources for adult and maternity services and strategies supported by senior clinical and nursing team members to embed a revised system and process.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		See section 2.3 for a description of the actions taken		

Title	Indicator	2016/17	2017/18	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
C. difficile infection	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	12.5	6.9	13 * (National published figures published before Q4 16/17 available hence used Q4 15/16 as a proxy)	Not available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		- The Trust has a process in place for collating data on C Difficile cases - data collated internally and submitted monthly to Public Health England		
	Walsall Healthcare NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:		Please refer to section 2.6		

Title	Indicator	2016/17	2017/18 Latest available data to September 2017	National Average (April – Sep 2017) The latest data available	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Incidents	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period,	10,667 incidents reported and equating to 63.66 incidents per 1,000 bed days	5,868 incidents reported and equating to 76.2 incidents per 1,000 bed days	5,226 incidents reported and equating to 42.84 incidents per 1,000 bed days	10,016 incidents reported by Croydon Health Services NHS Trust and equating to 111.69 incidents per 1,000 bed days. 1,133 incidents reported by South Tyneside NHS Foundation Trust and equating to 23.47 incidents per 1,000 bed days
	the number and percentage of such patient safety incidents that resulted in severe harm or death	60 0.6%	20 0.3%	18 0.3%	13 incidents (0.1%) – Croydon Health Services NHS Trust 0 incidents (0%) – South Tyneside NHS Foundation Trust
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	• The data is provided by the National Reporting and Learning System (NRLS)			
	Walsall Healthcare NHS Trust has taken the following actions to improve this rate (for incident reporting) and number (of incidents that result in severe harm or death) and so the quality of its services, by	• Continuing to promote incident reporting through patient safety workshops and by providing feedback to staff on incidents reported and action taken as a result.. This is reflective in the increased number of incidents reported per 1,000 bed days compared to the previous Quality Account			

Appendix 2 - Statements

Healthwatch Walsall Quality Account Response 2017/18

Healthwatch Walsall welcomes the opportunity to both reflect and comment upon the Draft Quality (QA) Account for Walsall Healthcare NHS Trust.

Whilst the Trust has made progress around a number of the priorities highlighted by the CQC inspection, it is evident that further work is needed to bring some of its services for the people of Walsall up to a consistently good standard.

In relation to patient experience we feel there is considerable dependency by the Trust on Friends & Family Test (FFT) feedback and the complaints processes in determining patient experience indicators. It is important to incorporate other qualitative data from mechanisms such as patient stories, co-design, the National Always Events and the use of the Observe and Act tool as promoted in the report.

Patient and staff surveys highlight room for improvement. We recommend further communication with patients and the public about how service changes are being made and timescales for this. We also believe there needs to be a „sign up" or commitment by all staff around the Integrated Improvement Programme for Quality Improvement.

It is clear that financial pressures are being faced across NHS nationally, however tackling the financial challenges locally must still ensure patient quality and choice in all aspects of care.

It is pleasing that work has progressed to improve pathways between the Emergency Department (ED) and rapid response services as evidenced by the CQC no longer rating the service inadequate. However, FFT feedback for most of the year tell us that only 75% of patients are likely to recommend the service.. We have consistently raised issues around the physical limitations of the ED and Urgent Care service and lack of effective signposting and routes. We urge the Trust and NHS partners to prioritise the capital build programme to improve safety, quality and experience for patients.

In 2017 Healthwatch Walsall undertook a consultation with patients and relatives using A&E at Walsall Manor hospital. As a result of this work a number of recommendations were made in relation to patient experiences, triage and communication. We welcome the hospitals approach to incorporating these recommendations into the ED patient experience action plan.

We congratulate the work and national recognition around the reduction in High Flyers and it is positive to see such „High Flyers" accessing the most appropriate care but also the positive impact in the reduction in hospital resources.

Maternity and gynaecology departments remain a concern for the people of Walsall and we are concerned to note the service is still rated inadequate by CQC for over 2 years. Urgent and sustained improvement is paramount to securing patient confidence. This is reflected by FFT feedback which remains poor when compared to national averages
FFT feedback is still poor when viewed against national averages:

- Antenatal: 80% (national: 97%)
- Birth: 94% (national: 97%)
- Postnatal: 84% (national: 95%)
- Postnatal (Community): 89% (national: 98%)

Initiatives such as the „Whose Shoes „events are a welcome opportunity to help inform service improvements based on patients‟ experiences. Healthwatch wish to see services developed jointly by mothers, families, midwives, staff and doctors working together to improve the experience. Recognising diversity, disability and ethnicity should be an important part of this process. This example of public involvement forms part of the Trust‟s key objectives and we look forward to monitoring and supporting this in 2018/19.

It is encouraging to see that the promotion of Listening into Action has enabled staff to gain a more direct input into maternity practice. The dashboard has shown some positive improvements from Sep 17 - Feb 18 such as a reduction in both emergency and overall C-section rates by 7.8% and 1.3% respectively and work around ensuring CTG monitoring. However, the Trust should not lose sight of the necessity to increase the provision of adequately trained midwives whilst acknowledging the national challenges in this area. Healthwatch recognises the Trust‟s commitment to improving maternity services and we will continue to monitor this.

The Trust is a leading partner in the emerging place-based model to integrate primary, community & social health and care services, known local as Walsall Together. Now that the outline business case has been approved by all partners, we look forward to seeing extensive activity to engage the public and patients in the design, delivery improvement and governance of integrated local services.

Healthwatch Walsall acknowledges that the Trust has made significant progress following its 2015 CQC rating of „inadequate‟ to the rating of „requiring improvement‟ last year. All local health and social care partners should redouble efforts and ambition to shift the rating towards good.

Healthwatch understands the challenging climate in which the Trust‟s health and community services operate. In the year that celebrates the 70th anniversary of the NHS we look forward to working alongside the Trust to maximise the patient voice.

Overview and Scrutiny Committee

It has not been possible for the Walsall Social Care Scrutiny and Overview Committee to receive and comment on the Trust‟s quality account due to a high workload and the timescales involved. Unfortunately, quality accounts are not usually available until after the last Committee meeting, which makes a meaningful commentary that has been agreed by all Members of the Committee difficult to produce. However the Committee has worked and will continue to work with the Trust as a critical friend in their journey of improvement.

Walsall Clinical Commissioning Group

NHS Walsall Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

Walsall Clinical Commissioning Group (CCG) welcomes the opportunity to comment on Walsall Healthcare NHS Trust Quality Account 2017/18. The CCG notes that the year has been challenging for the Trust and that there has been a lack of senior clinical engagement and leadership which has impacted on the quality and development of services.

The CCG is pleased to note the work undertaken by the Trust to achieve the improved CQC rating of *Requires Improvement* and congratulates the Trust on achieving an overall rating of *Outstanding* for the Community Services. It is encouraging that the Trust recognises that to improve their CQC rating further a changed and improved approach to quality improvement is required and that the Trust has plans to achieve this through the development of an Integrated Improvement Programme. The establishment of the Quality Improvement Faculty and the use of Learning from Excellence to improve quality is to be commended.

The CCG is disappointed that Maternity Services have been rated as *inadequate* since 2015 and that a Section 29a Notice was issued by the CQC following their inspection in 2017. We acknowledge some progress and improvements made by the Maternity Department in response to the findings of the inspection; however these are yet to be sustained. The CCG requires assurance that the service adequately serves the needs of the population of Walsall and we continue to attend the Maternity Oversight Board chaired by the Trust Chief Executive to gain assurance of progress and improvement within the services.

The Trust has found it a challenge to achieve Accident and Emergency four hour waits targets, however the CCG recognise that this as a challenge for the majority of acute trusts nationally. The Trust's aim to improve and maintain Accident and Emergency performance during 2018/19 is positive and we are encouraged by the partnership working being undertaken by the Trust with stakeholders. The CCG will continue to work collaboratively with all stakeholders to support the achievement of the target. We are pleased to note the positive impact on admissions made by the High Flyers Project and that this is being acknowledged nationally.

The CCG is also pleased to note that the Trust is committed to partnership working across the Black Country STP with plans for pathology and maternity services and the successful centralisation of stroke services at the Royal Wolverhampton NHS Trust.

Walsall Together is an ambitious and exciting programme to transform the health and social care in Walsall. The CCG notes the Trust engagement with the initiative to achieve service development and redesign, including the achievement of 7 day services.

The CCG acknowledges the awards received by the Trust with the Patient Experience Network National Award and the Baby Friendly Initiative within health visiting and also on being shortlisted

for a Patient Safety Award. The Trust needs to work towards achieving Baby Friendly Initiative within the hospital to promote breastfeeding and the associated health benefits for the population of Walsall.

The CCG acknowledges that there has been progress made with two of the Quality Improvement Priorities identified in 2017/18, Medicines Safety and Care of the Deteriorating Patient. It is disappointing that the Trust has not progressed with the third priority; Compliance with Equality and Diversity. However it is encouraging that all three priorities will be continued in 2018/19 with an addition of Record Keeping.

The CCG commends the Trust for their achievement of zero MRSA bacteraemia cases for two years. There is further work required by the Trust to improve compliance with VIP scores within ward areas.

The CCG notes the improvement in VTE assessment and the work undertaken to achieve. This now needs to be sustained and embedded into practice.

The CCG acknowledges that the Trust has undertaken work to implement new national guidance for mortality reviews to ensure that lessons are learned and that work will continue to further develop this process in 2018/19.

The CCG is disappointed that the Staff Survey results did not demonstrate the expected significant improvements despite the initiatives introduced by the Trust in 2016/17. We recognise that the Trust has plans to build further on the work undertaken in 2017 to improve staff satisfaction and anticipate improved results in 2018/19.

Results of patient surveys are also disappointing but the CCG recognises that the Trust is taking action to improve FFT response rates and scores and look forward to an improvement in 2018/19.

The CCG notes that Safeguarding Adult and Children training and PREVENT training has been a challenge for the Trust and that further work is required to ensure compliance with NHSE trajectories. The CCG will continue to monitor and support the Trust to achieve compliance; however this will require senior clinical commitment and leadership from the Trust to be successful.

In conclusion, we recognise that the Trust has a new leadership and executive team and anticipate that this will impact on progress in improving the quality of care provided by a responsive, visionary and resilient approach to making changes in the delivery of care. We support the priorities identified by the Trust for 2017/18 to further improve the quality, safety and experience for the population of Walsall. We will continue to support the Trust in achieving these priorities.

Signed:

Title: Chief Officer

Date: 25.05.18

Signed:

Title: Chief Nursing Officer/Director of Quality

Date: 26.05.18

Appendix 3

Statement of Director's responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

- The Quality Account presents a balanced picture of the trust"s performance over the reporting period
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice
- The data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with any Department of Health guidance

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chair

Chief Executive

Appendix 4

Independent Assurance Report

[Ernst & Young]

To be provided before Board approval

Glossary to be revised before publication

This section provides a definition of the terms and acronyms used in this report.

A&E	Accident and Emergency
C. Difficile	Clostridium difficile
CCG	Care Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
FF&T	Friends and Family Text
GP	General Practitioner
HRG	Health Resource Group - a grouping consisting of patient events that have been judged to consume a similar level of resource.
HSMR	The Dr Foster Hospital Standardised Mortality Ratio
MRSA	Meticillin resistant Staphylococcus aureus
MRSA BSI	Meticillin resistant Staphylococcus aureus blood stream infections
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
R&D	Research and development
SHMI	Standardised Hospital Mortality Indicator – this looks at the relative risk of death of all patients managed by the Trust and includes the period up to 30 after discharge.
SI	Serious Incidents
WHO	World Health Organisation
WMAHSN	West Midlands Academic Health Science Network

Walsall Healthcare NHS
NHS Trust

Quality Account 2017/18

If you require this publication in an alternative format and or language please contact the Patient Relations Service on 01922 656463 to discuss your needs.

MEETING OF THE PUBLIC TRUST BOARD – 7th June 2018					
Quality and Safety Highlight Report					**AGENDA ITEM: 12**
Report Author and Job Title:	Kara Blackwell Acting Director of Nursing		**Responsible Director:**	Professor Russell Beale Non-Executive Director	
Action Required	**Approval**	**Decision**	**Assurance and Information**		
			To receive and discuss X	**To receive**	
Recommendation	The Trust Board are asked to note the information contained in this report, and the increased number of C. Difficile cases reported year to date.				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Link to Board Assurance Framework Risk Statement No.1 'That the quality and safety of care we provide across the Trust does not improve in line with our commitment in the Patient Care Improvement Plan'				
Resource implications	The funding required for the equipment replacement programme were raised as part of the Quality and Safety Committee				
Legal and Equality and Diversity implications	Compliance with Trust Standing Orders				
Trust Strategy	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme			X	
	Develop the culture of the organisation to ensure mature decision making and clinical leadership			X	
	Improve our financial health through our robust improvement programme				
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts				

Executive Summary

The report provides a highlight of the key issues discussed at the most recent Quality & Safety Committee meeting held on the 31st May 2018 together with the confirmed minutes of the meeting held on 26th April 2018 (appendix 1).

Key items discussed at the meeting were:

- The increased number of C. Difficile cases reported year to date
- The plans to report monthly on the PCIP progress going forward
- The nursing work-stream and pending NHS Improvement report from their review of nurse staffing at the Trust

The meeting held on the 31st May 2018 was quorate and chaired by Professor Beale.

1.0 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.

2.0 Key Issues from Meeting held on 31st May 2018

The Committee was quorate and discussed a number of items. Minutes will be provided to the Trust Board in July 2018. The highlights for the Trust Board to be aware of are as follows:

3.0 ECIP Update

The ECIP lead for the Trust joined the meeting to discuss the current work being undertaken with the Trust in relation to patient flow, and ward processes including embedding the Safer bundle and the principles of Red to Green across the Trust. The Trust has already started these work-streams and will be working closely with ECIP. The ECIP lead will attend future Quality and Safety meetings.

4.0 Performance and Quality Report

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

- Infection Prevention and Control – There had been 5 cases of CDiff year to date. Two cases were reported on Ward 15, following a RCA both cases were deemed unavoidable. A further case was reported on Ward 17. In May 2 cases have been reported on ASU, representing a period of increased incidence, both cases will undergo RCA, and the ward is relocating to enable a deep clean of the area to take place. There are concerns that the target for 2018-2019 will be exceeded if the number of cases continues. One MRSA bacteraemia was reported in Critical Care in April, RCA deemed this to be unavoidable as patient.
- There had been a deterioration in completion of the Electronic Discharge Summaries (EDS). A multidisciplinary audit on documentation is planned to be undertaken across the Trust with specific actions to address improvement following this. There are also plans to allocate an accountable consultant for each ward to work with the ward manager and team to oversee all aspects of ward performance and improvements.
- Safeguarding training below Trust target, this is now being managed weekly, with a revised target agreed with the CCG for this training. The capacity issue

within the children's child safeguarding team were noted and the business case currently awaiting a decision from the CCG.

5.0 Patient Experience Report

The Quarter 4 report was presented and the following noted:

- The Friends and Family Test (FFT) response rates improved for Q4 for Outpatients and ED
- ED 'would recommend' scores trial behind the national results and an action plan overseen by the ED matron is in place aimed at improving patient experience in the Department
- Response rates in maternity remain low but the 'would recommend scores increased in Q4 and the 'would not recommend' reduced significantly
- There was an overall increase in the number of complaints and concerns received in Q4, the themes around complaints do not change and include clinical care/assessment, attitude, waiting times and communications.

There needed to be an increased emphasis on the lessons learnt from complaints and the actions being taken to address the persistent themes.

6.0 Mortality Report

The following key points were noted in relation to the Mortality Report:

- Advice notification in relation to deaths due to electrolyte disturbance, these were small numbers and may have been related to coding
- A review of certain groups of deaths was being undertaken, this related to the poorer performing specialties including respiratory and acute medicine.
- The Trust was looking at implementing a medical examiner role, to review all deaths and refer the ones that need more analysis, death certification etc. There has been good feedback from other trusts that have implemented the role, the business case for this is being developed.
- The feedback on learning from mortality reviews are discussed at the mortality surveillance group to consider wider trends. The key themes around death in the 0-1 day length of stay group have been reviewed and the majority of patients should not have been brought into hospital in the first place. The actions to address this are being addressed with community colleagues and the wider health economy to identify these patients and ensure advanced care planning in place. The A&E delivery board had agreed that the avoidable admissions workstream should be looking at these groups of patients to avoid admission to hospital for patients in the last months of life/ at the end of life.

The report provided assurance that learning was being embedded from the mortality review process. The Mortality indicators are monitored against a moving average which reflects national acuity changes in winter and the data for the Trust now needed to be triangulated to understand the trusts position.

7.0 Trust Quality Executive

The key points discussed in relation to the Trust Quality Executive (TQE) highlight report were:

- The concerns expressed about ESR and accurate recording of the training data. It was agreed that ESR needs to be the one system for recording all training but it was identified that managers need to be able to record training for their staff on the ESR system as currently locally held records and the paper copies of training completed that are collated by the Learning and Development team led to error. The committee recommended that the People and Organisational Development Committee oversee a process run by the HR team to ensure an amnesty is undertaken to get ESR up to date.
- Requirements to improve compliance with environmental audits and set a trajectory for improvement
- Concerns highlighted about the equipment replacement programme and the funding available for this

The current PCIP is being used to measure progress against the key issues and will remain in place until the integrated improvement programme has been developed and implemented. The Divisions are currently updating the progress against the 'must' and 'should' do actions, the corporate actions against the regulatory breaches are also being updated. The PCIP needs to receive increased scrutiny monthly via the newly formed Trust Management Board and the Quality and Safety Committee, which should receive a monthly PCIP update report.

8.0 Maternity Oversight Committee

The update on the Section 29A warning notice was provided alongside an update on the maternity PCIP. The sustained improvements in the Maternity Care Group were noted alongside the on-going culture work being undertaken with Edgcumbe and the RCM and the plans to bring the work with both the midwives and medical staff together in the final phase of this culture work.

9.0 Monthly Staffing Report

The following key points were noted and discussed:

- The overall fill rates for April 2018 exceeded the 90% target set for both day and night shifts. Exception reports for individual areas where this target was not achieved did not report any incidents /omissions in care linked to staffing
- The Care Hours per Patient Day (CHPPD) improved in April 2018 but remained below peers in the Black Country and nationally, this is despite fill rates being >90%. There is a need to review this against our establishments; this work is currently being done as part of the NHSi work
- The NHSi report of the nursing workforce should be provided in June, work is currently underway following initial feedback received.

- The agency and bank hours used in April reduced as beds closed and there is an on-going focus on roster compliance. There is a particular focus now required on the Emergency Department and AMU in relation to this work
- The Board have been focusing on temporary workforce usage recently and the executive team will provide clarity on this in line with the NHS improvement review undertaken. The financial views are being overseen at PFIC, the quality and Safety Committee will look at this work from a quality perspective

10.0 Conclusion/Recommendations

The Board is asked to note the items discussed within this report, and in particularly the increased number of C. Difficile cases seen in April and May and the threats to achieving the Trust target for 2018-2019 if cases continue with this frequency.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD - 7 JUNE 2018					
CQC Preparation Plan				**AGENDA ITEM: 13**	
Report Author and Job Title:	Suzie Loader, Improvement Consultant		**Responsible Director:**	Richard Beeken, Chief Executive	
Action Required	**Approval**	**Decision**	**Assurance and Information X**		
			To receive and discuss X	**To receive**	
Recommendation	Members of the Trust Board are asked to receive the attached report for assurance.				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF No. 11 That our governance remains "inadequate" as assessed under the CQC Well Led standard. Risk Register 1101 – Regulatory intervention in Maternity services based on recent CQC assessment – section 29a				
Resource implications	Issues may be flagged during the preparation phase which require resources to resolve them – these need to be considered alongside other trust commitments and where appropriate prioritised				
Legal and Equality and Diversity implications	CQC compliance				
Operational Objectives 2018/19	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme			X	
	Develop the culture of the organisation to ensure mature decision making and clinical leadership			X	
	Improve our financial health through our robust improvement programme			X	
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts			X	

Walsall Healthcare NHS
NHS Trust

Executive summary

The Trust knows that it needs to prepare for the forth-coming CQC inspection, which will be different to the last inspection, as the CQC have revised their inspection format (CQC, 2017).

At this stage the trust doesn't know what this inspection will entail, but anticipates that as a minimum, the CQC will inspect:

- Maternity
- Critical Care
- Emergency Department'

In addition, the new CQC inspection will include a;

- 'Use of Resources' inspection
- 'Well-Led' inspection

To that end, it is suggested that the trust prepare the whole organisation, so that it is ready for every eventuality, with additional support being given to the 3 clinical areas highlighted above, as we know that they will be inspected.

Attached is a draft CQC preparation plan, which covers the following key areas:

- Governance (Chief Executive)
- Well-Led (Trust Chairman)
- Use of Resources (Director of Finance)
- PIR submission (Director of Nursing)
- Administrative Co-ordination (Director of Nursing)
- Communication Plan (Director of Strategy & Improvement)
- Staff Engagement Plan (chief Executive)
- Peer Review (Director of Nursing)
- Communication Hub & De-brief (Chief Operating Officer)

Walsall Healthcare NHS
NHS Trust

CQC PREPARATION PLAN

1. Introduction

The aim of this plan is to provide a robust and holistic approach to preparing the organisation for its forthcoming CQC inspection, which is anticipated to be in xx 2018. There are 9 key elements to the plan:

- ***Governance*** – Implementation of this plan will be monitored via the *CQC Preparation Steering Group*, which will run weekly on a Tuesday (directly following Trust Management Board (TMB)). It will be chaired by the CEO and have the Executives and Divisional Triumvirates in attendance. The CQC Preparation Steering Group will be accountable to the Trust Management Board.
- ***Well-Led –*** The Trust Board will undertake a self-assessment against the CQC Well-Led Framework, and identify a list of short (to be addressed prior to the well-led inspection) and longer term (more strategic) actions which aim to improve the CQC rating in this area. A series of activities will be undertaken with the board in order to prepare them for the Well-Led inspection
- ***Use of Resources –*** The Trust will identify what actions need to be taken to comply with the CQC 'Use of Resources' framework (using the experience of neighbouring trusts to understand what is required, alongside nationally available information), undertaking those in a timely manner in order to prepare for the 'Use of Resources' inspection.
- ***PIR submission*** – taking on board learning from the previous PIR submission, preparing staff for this submission in relation to their individual responsibilities, ensuring the trust has sufficient robust evidence in place and establishing an appropriate approval process, prior to submission of data
- ***Administrative co-ordination of the inspection*** – in relation to room bookings, arranging interviews, hospitality for the CQC teams, car parking etc.
- Robust ***Communication Plan***
- Robust ***Staff Engagement Plan***
- ***Peer Review*** – a comprehensive peer review using the CQC domains to test out progress made by the organisation, supported by a number of internal audits, particularly focusing on those areas identified as requiring additional support.
- Co-ordination of a '***Communication Hub'*** for the duration of the inspection, which will map the progress of the inspection (through the use of a **WhatsApp group**), support staff who have been or are due to be interviewed and co-ordinate information provided to the CQC.
- Co-ordination of a '***De-brief Session'*** available for any member of staff interviewed by the CQC, but particularly those who spent more than 30 minutes with a CQC inspector

This summary document is supported by a detailed project plan (Gantt chart) identifying the steps required for each aspect of the plan and lead responsibilities. Progress against this project plan will be monitored by the CQC Preparation Steering Group.

2. Details

2.1 The Plan

Details regarding each element of the plan, and the executive lead are summarised below:

Governance – Chief Executive
The CQC Preparation Steering Group will be responsible for monitoring the effective implementation of this plan. It will meet weekly, week commencing 28 May 2018 to ensure that the organisation demonstrates grip and progress. The CQC preparation Steering Group will report into the Trust Management Board (TMB).

In addition to the Trust CQC Preparation Steering Group, weekly Quality Assurance meetings are being established with key clinical areas: maternity, ED & Critical Care in order to provide them with additional support in preparation for the inspection.

The Patient Care Improvement Plan (PCIP) will continue to be monitored via the Trust Quality Executive (TQE), the Divisional Board meetings, Divisional Performance meetings and at Care Group Assurance meetings. However, outcome from the PCIP will be crucial in relation to providing evidence of improvement against the Must and Should Do's identified by the4 CQC 9 +in the last inspection report.

Board Development – Well-Led Inspection - Trust Chairman
The Trust Chairman is responsible for developing the board of directors and for establishing and maintaining an effective board. Demonstrating sound leadership, a clear strategic vision and consistency of message is crucial to the success of the CQC inspection, therefore it is suggested that the following preparation is undertaken:

Commence-ment Date	Action	Frequency	Type of communication
	Develop a clear visibility plan for the whole board, not just the executives leading up to the inspection	TBC	Face-to-face
	Develop a Briefing pack – containing key topic fact sheets (written by the relevant executive) aligned to the CQC domains, pulled together by the executive team for the rest of the board	X 1	Written
	Identify Board Development sessions as follows: • Well-led self-assessment & development of short & longer term actions • Risk: Top risks, BAF, CRR, Risk Appetite & annual update on Risk • PIR Self-Assessment	X 1 X 1 X 1	Face-to-Face Face-to-Face Face-to-Face

Commence-ment Date	Action	Frequency	Type of communication
	• 2 x half day board development sessions focused around the briefing pack	X 2	
	Arrange individual mock interviews for all executives, relevant sub-board committee chair's non-executive directors & all Divisional Triumvirates undertaken by the Improvement Consultant and NHSI	As required	Face-to-Face

Use of Resources Inspection – Director of Finance

The Director of Finance is responsible for developing a plan to ensure compliance against the new 'Use of Resources' framework. It is important that as much information regarding this process is gleaned as possible, so that the trust is prepared. It is suggested that the Director of Finance should:

Commence-ment Date	Action	Frequency	Type of communication
	• Carry out a self-assessment against the Use of Resources Framework	X 1	Written
	• Speak to colleagues in neighbouring trusts who have undergone a Use of Resources inspection to gain insight into the process, quick wins etc.	Ad hoc	Verbal
	• Develop a plan to achieve as much compliance as possible, identifying risks and solutions	X 1	Written
	• Implement that plan, providing regular feedback to the CQC Preparation Steering Group regarding progress, risks & issues.	On-going	Written

PIR Submission – Director of Nursing

The executive lead for the PIR submission is Kara Blackwell, with operational co-ordination provided by Chris Rawlings, Head of Governance.

The PIR format for this inspection will be different to that from the previous inspection, requesting a lot more narrative than previously and the trust will only have 3 weeks to complete and return it to the CQC. Therefore, it is suggested that as much of the required information is collected pro-actively, so that when it's issued by the CQC, there will be less information to collect, making the task less onerous. Learning from the last inspection is being used to plan the next PIR submission and will include the following:

Commence-ment Date	Action	Lead	Type of communication
14.05.18	• Review the new PIR template, to understand the differences from the previous PIR request and identify what information can be completed in advance of the PIR officially being sent to the organisation. Arrange for this information to be collated in advance of official notification.	C Rawlings	Written
14.05.18	• Once the data required has been identified, a review of data sent last year against each of the headings will be carried out and any areas where poorer quality data was submitted will be identified, so that the Head of Governance and his team can work with those teams to develop their data set in readiness for submission	C Rawlings	Written
22.05.18	• Involve grass root staff (not just senior managers from the Divisions) in the self-assessment against the CQC domains. This will need to be ratified by the executive team and if possible the Board, prior to its submission, as part of the PIR (staff, particularly ward sisters / managers may be asked by the CQC if they have been involved in this process).	S Loader	Written
TBC	• Identify & implement an authorisation process for executive sign off of the individual pieces of information / data prior to submission	S Loader	Written
TBC	• Arrange for the executive team as a whole to sign off the PIR prior to submission, sharing the signed off version with the Board.	S Loader	Written

Administration / Co-ordination of the Inspection – Director of Nursing

Executive responsibility for administration of the inspection falls to Zara Blackwell, with operational responsibility falling to Sophie Garner (PA to the Director of Nursing). This will include:

- Room bookings
- Interviews
- Focus groups
- Food & drink requirements
- ID badges for the CQC
- IT access for the CQC
- Parking arrangements
- Computer / WIFI access
- Shredding and Photocopying facilities etc.

Communication Plan – Director of Strategy & Improvement

The Executive lead for the communication plan is Darren Fradgley, operationally supported by the Head of Communications, Jane Ilic. It is vital that the plan is: 'branded', there are clear objectives and a 'map' of key messages are carefully crafted for each of the areas identified within the plan. In addition, to help facilitate board visibility, it is vital that photos of the board and managers from across the organisation are included on as many documents as possible. The communication plan will consist of:

Commence-ment Date	Action	Frequency	Type of communication
	Staff Briefings, 08.30 in the canteen, lasting for 30mins CEO staff briefings, which are filmed and made available on the intranet	Weekly Daily Weekly	Face-to-face Executive Director CEO
	Executive visits to clinical areas at night (during handover period), to help prepare staff, answer questions & allay fears	Weekly	Face-to-Face Executive Directors
	CEO Blog	Weekly	Email / Intranet
	Themed section in 'Daily Dose, re preparation for the CQC inspection	Weekly	Email / Intranet
	Drop in sessions with the executive team (on a rota basis)	Weekly	Face-to-face
	Night staff briefing sessions (2 two weeks prior to the inspection) OR A day of staff briefings from 07.00 – 19.00hrs (whichever is preferable)	Ad hoc	Face-to-Face
	Creation of an intranet page: 'CQC preparation', where key documents and regular updates are posted to inform staff of progress against the PCIP, creating a 'go to' area for staff who want to find out more (all the templates/questions we develop for staff can be placed here)	Updated weekly	Intranet

Commence-ment Date	Action	Frequency	Type of communication
	Screen saver appears as various milestones are achieved, with a countdown to the inspection with key messages / themes	Weekly	Intranet
	Executive team to identify individual 'buddy' ward/departments and visit these on a regular basis. This should include non-clinical areas such as: Coding, medical Records, porters, domestics, finance, HR etc.	Weekly	Face-to-face
	Expand Board to Ward walk abouts to enhance board visibility. NEDs to visit one area of the trust each time they come in for a meeting (co-ordinated by the Board Secretary), feeding back to the board secretary via email their findings. Executives to feedback issues identified at weekly CQC Preparation Steering Group meeting and TMB	Weekly	Face-to-face
	Develop a pocket sized 'achievements pocket guide' pull out for all staff	Once	Paper
	Develop a generic information booklet, customised to individual areas, to include information such as: what they are proud of, top 3 risks, key improvements implemented etc.	Once	Paper
	Develop a communication strategy to manage external partners		

Walsall Healthcare NHS
NHS Trust

Staff Engagement – Chief Executive

The Chief Executive will take the lead on staff engagement, supported by the Staff Engagement lead (Simon Johnson) and LiA lead (Tom Johnson).

It is recognised that effective staff engagement is key to achieving a good safety culture within the organisation, which ensures high quality care on a long-term basis. Whilst this plan focus' on preparation for the next CQC inspection, it must be recognised that this will be a fundamental element of the integrated Quality Improvement plan (when developed).

Commence-ment Date	Action	Frequency	Type of communication
	Facilitate quality workshops for staff, using case studies, focusing on developing knowledge around improvement methodology and how it can be used in any area of the trust, ask staff questions the CQC may ask, such as 'what are they proud of' and enhance understanding of some of the language that the CQC might use e.g. cleaning regime – ensure 'buzz words' are incorporated into these. A guide will be developed for these, so that the format is consistent across the organisation. The workshops will be facilitated by: the executive team, their Deputies, the Divisional Directors, the Improvement Academy and staff identified by the leadership team who have the facilitation skills and credibility within certain departments to deliver a consistent, positive, useful message. *(There are xx departments which need to be covered. In order to be able to achieve the xx sessions required, a minimum of xx staff are needed (delivering 7/8 sessions each))*	Weekly	Face-to-Face
	Facilitated workshops for staff who we know will be interviewed by the CQC e.g. Infection Control, triumvirates, senior doctors, managers and nurses etc.	X 4	Face-to-Face

Commence-ment Date	Action	Frequency	Type of communication
	Develop Ward/Manager department audit checklist, encouraging managers to review to ensure they have up to date information covering the areas the CQC may ask about. Include this in the workshop identified below.		Written
	Development of evidence templates for managers, so that they can develop evidence folders, utilising the CQC domains. Use this in the workshop outlined below		Written
	Facilitate workshops specifically for Ward Sisters & front line managers, to help them develop their evidence folders and give them confidence to answer the questions posed by the CQC	X 3	Face-to-Face
	Develop a list of questions the CQC might ask staff (divide by medical staff, Clinical Staff and Non-Clinical staff)		Written (& face-to-face, as used in workshops)
	Presentation to be developed and delivered by a CQC specialist advisor (consultant) who works within the trust, to outline what is expected from a CQC perspective – suggest?	X 3 (MAC, LMC & CEO Briefing Session)	Face-to-Face to; consultants, associate specialists and juniors
	Offer mock interviews for staff who will be interviewed by the CQC	As required	Face-to-face

Peer Review / Spot Inspections – Director of Nursing

It is imperative that there are a series of regular peer review audits undertaken across the trust, together with a one off 'peer review' across the Manor Hospital site, which reminds staff what a CQC inspection feels like, preparing them for the real thing. These reviews will also be used to test out the evidence presented to the Trust Quality Executive (TQE) in practice and to identify if there are any issues that the trust may not be aware of.

Commence-ment Date	Action	Frequency	Type of communication
	In association with the trust senior nursing and medical teams, identify what audits are currently carried out		

Commence-ment Date	Action	Frequency	Type of communication
	across the trust which cover the topics the CQC will be reviewing and tweak these accordingly to ensure they holistically test out key areas against the CQC's KLOE. Identify a peer review implementation programme for the revised audits, ensuring the results are fed back in a timely and co-ordinated way to the clinical areas so that they can take action as appropriate. Ensure that staff are congratulated and held to account regarding audit results at the Trust Quality Executive, the Divisional Board meetings, Care Group Quality Assurance Meetings & Divisional Performance meetings.		
	Plan and implement a large scale Peer Review, co-ordinated by the trust, but with external support from CCG's, Healthwatch, patient panel, NHSI and HEE. OR Commission an external party to undertake this, possibly supported by HealthWatch, CCG etc.	X 1	Face-to-Face
	Spot audits carried out by the board and senior managers with an agreed themed template	Weekly	Face-to-Face
	Follow up smaller 'peer reviews' for those areas identified in the large scale peer review, which require further development.		Face-to-Face

Communication Hub - Emergency Planning Officer

The Emergency Planning Officer will take the lead on planning and implementing both the Communication Hub and the de-brief following the inspection. The communication hub will run for the duration of the inspection (between 09.00hrs – 18.30hrs) (announced or unannounced) and its function will be to:

- Provide a dedicated telephone number that staff / CQC can call if they require help, or have questions/concerns about the inspection
- Provide a dedicated function where access to senior staff can be provided when requested (additional interviews etc.) and (where possible) support to those staff
- Identify where the CQC go within the organisation, mapping this and the emerging themes

- De-brief staff following interviews with the CQC to offer support and to collect intelligence regarding the areas of focus
- Brief wards/departments regarding the themes the CQC are focusing on
- Provide support to staff if they require it
- Provide one central point for information requests made by the CQC, so that these can be audited and formally sent via the CQC hub following authorisation
- Provide an information analysis service for any information requests made, where the trust does not have the information to hand
- Document all actions and decisions made during the inspection, so that if the trust needs to refer back to something, they have a record to pull on (this could include feedback to the CQC regarding behaviour, duplication of information requests etc.)
- To provide summary feedback at the end of each inspection day to members of the executive team
- To learn from the things which need to be improved upon from this inspection, and those which went well

A standard operating procedure will be developed for this function, so that roles and responsibilities are clear. The Communication Hub will be established for both unannounced and announced inspections.

De-brief for staff - Emergency Planning Officer

Evidence has demonstrated that it is supportive and helpful to staff who have been through a traumatic event, such as a major incident etc. to receive a de-brief after the event. This facilitates a reflective review of the event and learning.

It is suggested that a de-brief session is arranged for staff following both the unannounced and announced inspections. This will consist of feedback from the communication hub (i.e. the sort of information which went through the hub, number of people etc.) and an opportunity for staff involved in the inspection to have a discussion around what went well and what could be enhanced for future inspections.

3. Recommendation

The Board are asked to consider the content of this plan, to discuss, challenge and ratify it for implementation.

MEETING OF THE TRUST BOARD – 7 JUNE 2018					
CNST Incentive Scheme				**AGENDA ITEM: 14**	
Report Author and Job Title:	Cheryl Crosby, Deputy Director of Midwifery		**Responsible Director:**	Kara Blackwell Acting Director of Nursing	
Action Required	**Approval X**	**Decision**	**Assurance and Information**		
			To receive and discuss	**To receive**	
Recommendation	The Trust Board are requested to approve this report prior to its submission to NHSI				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report				
Resource implications	There are no resource implications associated with this report.				
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.				
Trust Strategy	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme			X	
	Develop the culture of the organisation to ensure mature decision making and clinical leadership			X	
	Improve our financial health through our robust improvement programme				
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts				

EXECUTIVE SUMMARY

Maternity safety is an important issue and obstetric incidents can be catastrophic and life changing when they occur. In 2015/16 obstetric claims represented 10% of the total claims but 50% of the total value in relation to claims. NHS Resolution and the national maternity safety champions have developed an incentive scheme to support the delivery of safer maternity care.

The CNST incentive scheme identifies ten actions against which individual Trusts will measure their performance. Those Trusts who can evidence compliance with all ten actions will be able to recover 10% of their CNST premium.

Walsall Healthcare NHS Trust is currently able to evidence compliance with six out of the ten actions. One action requires further clarification (action number 10), two actions will be complaint within 1-2 months (action numbers 1&6) and the remaining action will require more work to achieve compliance (action number 8)

The template below details the current position and evidence where available to support this. This information outlined in this report will form the basis of the Trust's submission to NHS.

SECTION A: Evidence of Trust's progress against 10 safety actions:

Safety action –	Evidence of Trust's progress	Action met? (Y/N)
Safety Action 1 Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	The Trust has a working group to implement the use of the PNMRT and data has now been submitted	**NO** In order to be complaint with this action data for Q4 had to be submitted by April 2018 however, the request for data submission was not received until late in Q4 and so data was not submitted by April 2018 due to the short turn around period A multidisciplinary team of obstetricians, midwives and neonatologists have completed the retrospect data input back to January 2018. Moving forward this will be managed as part of the governance process and will feed back to the perinatal mortality meeting on a monthly basis.
Safety Action 2 Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Achieved Oct 2017-Feb 2018 Awaiting March data	**YES**
Safety Action 3 Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the	There is a 4 bedded Transitional Care area on the Post natal ward (Ward 24). Babies from 34 weeks gestation and babies requiring an enhanced level of care (not NNU admission) are cared for in the transitional care unit. The midwives caring for these babies have received additional training and competency assessment in the	**YES**

ATAIN Programme?	provision of Transitional care.	
Safety Action 4 Can you demonstrate an effective system of medical workforce planning?	None of middle grade sessions on labour ward filled by Consultants acting down from other sessions during a period of 4 weeks in March 2018. Enclosed the Royal College of Obstetricians and Gynaecologists Workforce monitoring tool.  Copy of Walsall Manor-cnst-workforc	**YES**
Safety Action 5 Can you demonstrate an effective system of midwifery workforce planning?	The Trust completed the BirthRate plus audit in 2017. The Birthrate intrapartum acuity tool is also used to monitor staffing. The staffing / acuity is reported monthly to the Quality and Safety Committee and Maternity Oversight Committee. The Trust is also a pilot site for the ward acuity tool. There is currently work ongoing with regard to the development of the Maternity Support Worker role to enable a 90:10 skill mix split with Midwives:MSW as per RCM guidance. The draft staffing plan was shared at Taskforce on 17/11/17  ENC 1 Maternity Taskforce meeting 17  Section 29a report May 2018.docx	**YES**
Safety Action 6 Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	All 4 elements are in progress and the Trust will be fully compliant by the end of Quarter 2 2018/19	**NO** Progress is being made against an action plan to ensure compliance by end of Q2. Although we are compliant with the 4 main

	Copy of West Midland Saving Babies Lives Su	themes, further work is required to demonstrate compliance with Intrauterine growth restriction detection management of women with reduced fetal movements.
Safety Action 7 Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	There is a bi-monthly service user led Maternity Voices Partnership. The Trust also ran a 'Whose Shoes' workshop in December 2017 and developed an action plan Maternity Voices Partnership Minutes A Maternity Voices Partnership Minutes A Maternity Voices Partnership Minutes 6	**YES**
Safety Action 8 Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	The Trust is not compliant with this as not all staff groups can evidence 90% attendance and in addition the training day does not currently include CTG training. Attendance at PROMPT - staff group	**NO** CTG training has been included in PROMPT training from May 2018. Maternity services have reviewed the workforce that is required to attend the PROMPT study day and allocated training dates. It is anticipated that 90% compliance will be achieved by end of Q3
Safety Action 9 Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Monthly Taskforce meetings have been held which have both local and board level safety champions in attendance. Safety issues are discussed and escalated where appropriate. The maternity dashboard is reviewed and exceptions reported and actions discussed. Further meetings will include the Saving Babies Lives Care bundle progress each quarter	**YES** Safety champions meet as part of the monthly maternity oversight meeting.

	at the time of submission.	
Safety Action 10 Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?		**Awaiting confirmation** response anticipated by 5th June. This action may be achieved and will then be converted to a Yes prior to submission to NHSi later in June 2018

Further action required:

If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.

Number	*Action*	*Completion date*	
1	Working party set up – monthly meetings planned and data will be submitted regularly going forward		
6	2.5 – this is now 100% complaint as the Perinatal Institute undertake the audit and reporting 2.6 – this will be 100% complaint, the matron and band 7 commenced ongoing case note audit 3.4 – the checklist has been included on triage assessment document and will be used in FAU and triage		
8	Training day to include MDT CTG training. Structured plan to ensure front loading of study days in first 9 months to ensure 90% can be achieved.		
10	System to be devised to ensure Divisional Governance team has oversight of eligible cases		

	and assurance that all have been submitted.		

SECTION C: Sign-off

……..

For and on behalf of the Board of Walsall Healthcare NHS Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: …….

Date: …….

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

TRUST BOARD – 7th June 2018					
FINANCE REPORT MONTH 1				AGENDA ITEM: 16	
Report Author and Job Title:	Tony Kettle Deputy Director of Finance		**Responsible Director:**	Russell Caldicott Director of Finance	
Action Required	**Approval**	**Decision**	**Assurance and Information X**		
			To receive and discuss X	**To receive**	
Recommendation	Members of the Trust Board are asked to receive an update on the financial performance for April 2018, to include risks and actions being taken to address any areas of underperformance.				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF No. 9 That the Trust overspends compared to its agreed plan & is unable to deliver future sustainability. Risk Register 196 – Delivery of the sustainable long term financial plan				
Resource implications	Impact on attainment of the financial plan, largely a consequence of potential overspends driven by temporary workforce and CIP delivery.				
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.				
Operational Objectives 2018/19	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme				
	Develop the culture of the organisation to ensure mature decision making and clinical leadership				
	Improve our financial health through our robust improvement programme				X
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts				

Executive Summary

1. Purpose of the report

To update members on the financial performance for April 2018 with particular focus placed upon risks to delivery of the 2018/19 financial plan, and actions being taken to address any areas of underperformance.

2. Background

The Trust has adopted a financial plan for the 2018/19 financial year that delivers an £18.6m deficit. The key components being for delivery of a £13m Cost Improvement Programme and mitigation of overspends incurred in the 2017/18 financial year (largely associated with use of temporary workforce).

3. Details

The Trust has attained the following financial performance as at April 2018:

- Deficit of £2.4m in month 1 (in line with the plan)
- CIP is behind plan as at month 1 delivering £0.16m (£0.09m non-recurrently)
- Temporary workforce costs totalled £1.9m (£0.5m above that of April 2017) and this contributed to overspends in month in particular within Nursing

The Trust is required to reduce this run rate in order to deliver the planned outturn of £18.6m for the financial year, key risks being:

- CIP delivery of £13m for the year (in excess of £1m per month savings required per month)
- Overspends continue, driven by temporary workforce, if month 1 was extrapolated over the financial year the agency costs would total £9m (Trust's cap set at £6.5m for the year) prior year expenditure totalling £7.5m.

Actions being undertaken:

- The Trust has initiated a full review of temporary workforce, to include review of e-rostering, annual leave and additional capacity areas, with agency reducing in shift usage significantly during May 2018.
- In addition, the Trust has commissioned NHSI to review the ward based workforce and practice employed within the Trust to inform future expenditure forecasts to be presented to the next PFIC meeting.
- The Chair of Performance, Finance & Investment Committee will attend weekly reviews to support Improvement Work stream delivery
- A drive will be initiated with Divisions to assure PFIC of the value of schemes Quality Impact assessed in year, with a focus on bringing forward schemes within the financial year where possible.

The result of the above actions is to be reviewed at the next meeting of the Performance, Finance & Investment Committee.

4. Recommendations

Members are asked to note the reported performance to month 1 and the action being progressed to ensure robust monitoring of delivery of the 2018/19 financial plan.

Report author: Tony Kettle – Deputy Director of Finance

Date of report: 7th June 2018

5. Appendices

Please see attached finance report

Walsall Healthcare NHS
NHS Trust

2018/19 Finance Report
April 2018 (Month 1)

Becoming your partners for first class integrated care

2018/19 Finance Report: April 2018 (Month 1)	Page
• Key Messages	3
• Overall Summary and RAG Assessment	4
• Temporary Staffing Analysis	5-6
• Cost Improvement Target Achievement	7

Key Messages

Financial Month 1 plan.	• The Trust has set a plan to deliver an £18.6m deficit for the financial year. • At month 1 the Trust has a deficit of £2.4m, whilst this is in line with the plan the Trust is required to reduce this run rate significantly to deliver the planned deficit for the year.
CIP	• The Trust's Cost Improvement Target for the year is to deliver £13m of recurrent efficiencies. • In Month 1 total savings of £0.16m were delivered (£0.09m achieved non-recurrently) on a straight line basis the Trust needs to deliver savings in excess of £1m per month.
Bank, Agency & Locum spend	• Spending on temporary workforce is £1.9m for the month (£0.5m higher when compared April of 2017) Nursing budgets overspent as a consequence of temporary worker usage by £0.4m in month, this is not sustainable.
Financial Risks	• CIP Delivery for the year (£13.0m target) requires traction on the 'Improvement Work-streams' • Overspends in month 1 continue, giving a run rate risk and generating overspends
Management of the financial risks	*Temporary workforce* • A full review of the use of Nursing roster system, a review of annual leave and extra capacity open within the Trust is ongoing, alongside the review being completed by NHSI on workforce modelling and practice. • Forward indicators show a significant reduction in use of Nursing temporary workforce in May 2018. • Forecast for the year on temporary workforce is to be presented to PFIC in June 2018 *CIP* • Continued focus upon delivery of Improvement Work-streams (to include productivity & efficiencies) with weekly meetings with the Chair for Performance, Finance and Investment Committee (PFIC) • Enhanced scrutiny in meetings with the Divisions to assure plans are robust and Quality Impact assessed prior to the next PFIC.

Summary Financial Performance to April 2018 (Month 1)

Financial Performance - Period ended 30th April 2018					
Description	**Annual Budget**	**Budget to Date**	**Actual to Date**		**Variance**
	£'000	£'000	£'000		£'000
Income					
NHS Activity Revenue	228,028	18,317	18,403		86
Non NHS Clinical Revenue (RTA Etc)	1,006	84	18		(66)
Education and Training Income	6,842	583	637		54
Other Operating Income (Incl Non Rec)	7,221	607	769		162
Total Income	**243,097**	**19,591**	**19,826**		**236**
Expenditure					
Employee Benefits Expense	(175,959)	(14,696)	(14,694)		2
Drug Expense	(6,347)	(1,586)	(1,632)		(46)
Clinical Supplies	(17,570)	(1,486)	(1,430)		56
Non Clinical Supplies	(15,432)	(1,295)	(1,337)		(42)
PFI Operating Expenses	(5,081)	(461)	(427)		34
Other Operating Expense	(26,988)	(1,243)	(1,400)		(157)
Sub - Total Operating Expenses	**(247,377)**	**(20,767)**	**(20,921)**		**(154)**
Earnings before Interest & Depreciation	**(4,280)**	**(1,176)**	**(1,094)**		**81**
Interest expense on Working Capital	51	4	4		(1)
Interest Expense on Loans and leases	(7,811)	(765)	(794)		(29)
Depreciation and Amortisation	(6,560)	(547)	(501)		45
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(14,320)**	**(1,307)**	**(1,292)**		**15**
Total Expenses	**(261,697)**	**(22,074)**	**(22,212)**		**(139)**
RETAINED SURPLUS/(DEFICIT)	**(18,600)**	**(2,483)**	**(2,386)**		**97**
Adjustment for Gains on Donated Assets			(40)		(40)
Adjusted Financial Performance (Control Total)	**(18,600)**	**(2,483)**	**(2,426)**		**57**

Division	YTD Budget £000's	YTD Actual £000's	Variance £000's	*Narrative*
MLTC	5,010	5,586	(576)	*MLTC is £0.6m overspent year to date as a result of nursing staffing cost overruns (Wards, capacity and specialist areas – £0.4m) and CIP underperformance.*
Surgery	4,127	4,431	(303)	*Surgery is £0.3m overspent due CIP underperformance (£0.25m) for OPD and Theatre work streams needing to be verified.*
WC & CSS	5,574	5,557	18	*WCCSS is marginally underspent in April.*
Estates & Facilities	1,267	1,231	35	*Minor underspends*

Financial Performance

- The total financial position for the Trust at M1 is a deficit of £2,386k. The YTD deficit plan is £2,483k, which results in a favourable YTD variance of £97k.
- The contracted income shows a favourable variance to plan of £86k. The Trust has agreed a contract with Walsall CCG commissioner which provides for financial certainty on Emergency Inpatients, Rehabilitation and contract fines & penalties. The remainder of contracts with commissioners are on a cost & volume basis providing opportunity to deliver efficiencies through increased income.
- Expenditure is overspent £154k YTD. The main area of overspending is non-pay relating to non delivery of CIP in month (shown in Other Operating expense). Pay is breakeven, this despite overspending within Medical (£115k overspend) and Nursing (£440k overspend) to support the additional capacity open in M1 (April) with these overspends offset by underspends in other pay groups and phasing of pay reserves.
- The YTD CIP delivery is £168k, which is £595k behind the YTD plan. The majority of this shortfall is related to income driven efficiencies e.g. outpatients & theatres, the results of which are still to be verified

CIP 2017/18 Delivery

- **The Trust's Annual Cost Improvement Programme requirement is £13m.**
- **The CIP plan for M1 is £763k (5.9% of the target) and actual delivery is £168k (1.3% of target), resulting in an under achievement of £595k YTD. In addition, of this total £91k is delivered non-recurrently, placing increased pressure on future financial sustainability.**

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding is £1.004m.
- The Trust's agreed borrowing for 2018/19 is £18.6m, reflecting the deficit plan. The interest payable on the increased borrowing adds to the future savings requirement. The level of interest currently payable on borrowing to date and to service the current financial plan is circa £2.3m payable in 2018/19.

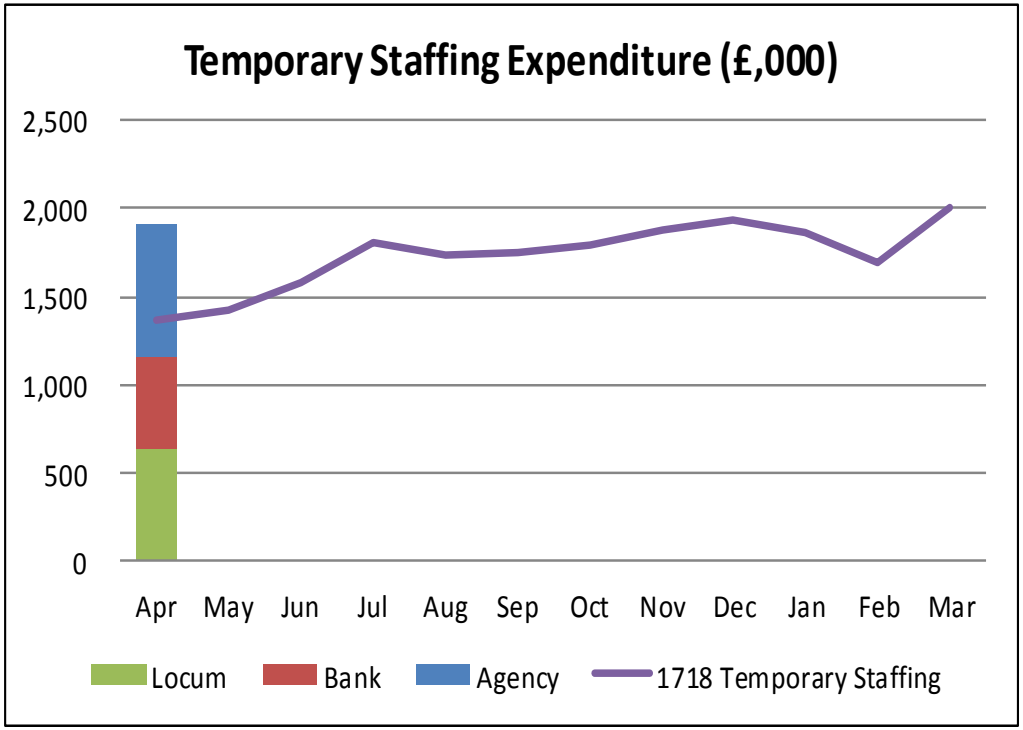
Capital

- The year to date capital expenditure is £0.5m, with the main expenditure relating to ICCU (£0.3m), Estates Lifecycle (£0.07m), Medical Equipment (£0.03m) and Community Mobile technology (£0.05m).

Temporary Workforce

- **Total expenditure on temporary workforce is £1.914m (April 2018) which (although a £91k reduction on the March total) represents an increase over April 2017's expenditure of £0.5m and is a key reason for Divisional overspends in month 1.**

TEMPORARY EXPENDITURE 2018/19

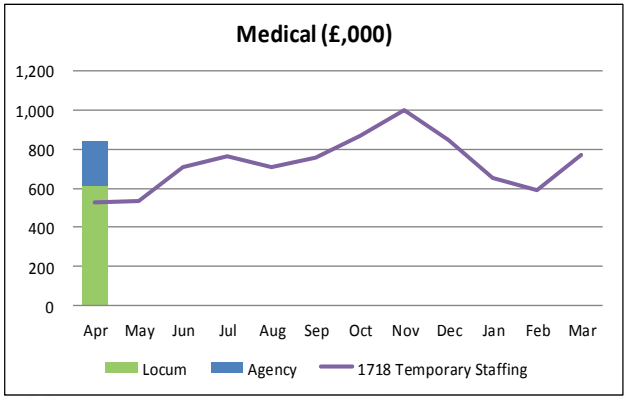


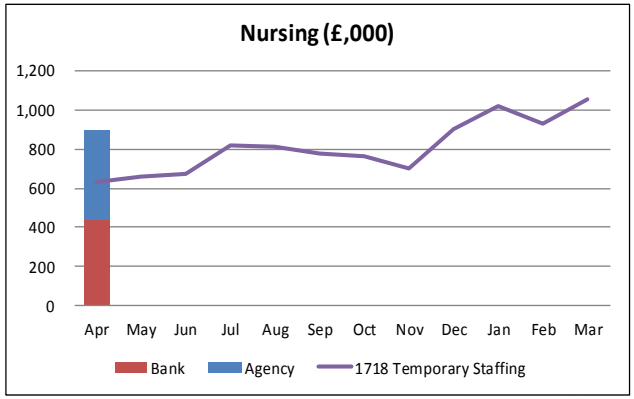
Commentary

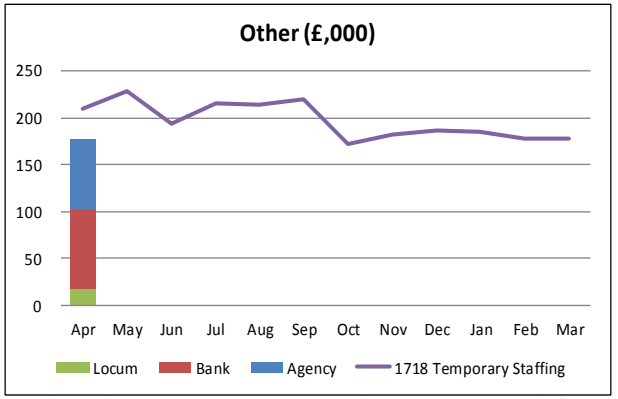
- Temporary staff costs totalled £1.914m in April 2018 (£2.005m March 2018), of which agency is £0.754m.
- The NHS Improvement target for the Trust is to spend no more than £6.5m on agency in 2018/19. This is a £0.5m reduction on 2017/18's target and £1m reduction on 17/18's actual expenditure.
- The Table below shows current expenditure and (if this was extrapolated over the financial year) an annual forecast for temporary workforce spending: -

Description	2018/19		*2017/18*
	Apr £000's	Annual £000's	*Annual £000's*
Temporary worker	1,914	22,599	*20,830*
Agency	754	9,043	*7,503*

- Total spend in April 18 (£1.9m) is significantly higher than the same period last year (£1.4m April 2017).







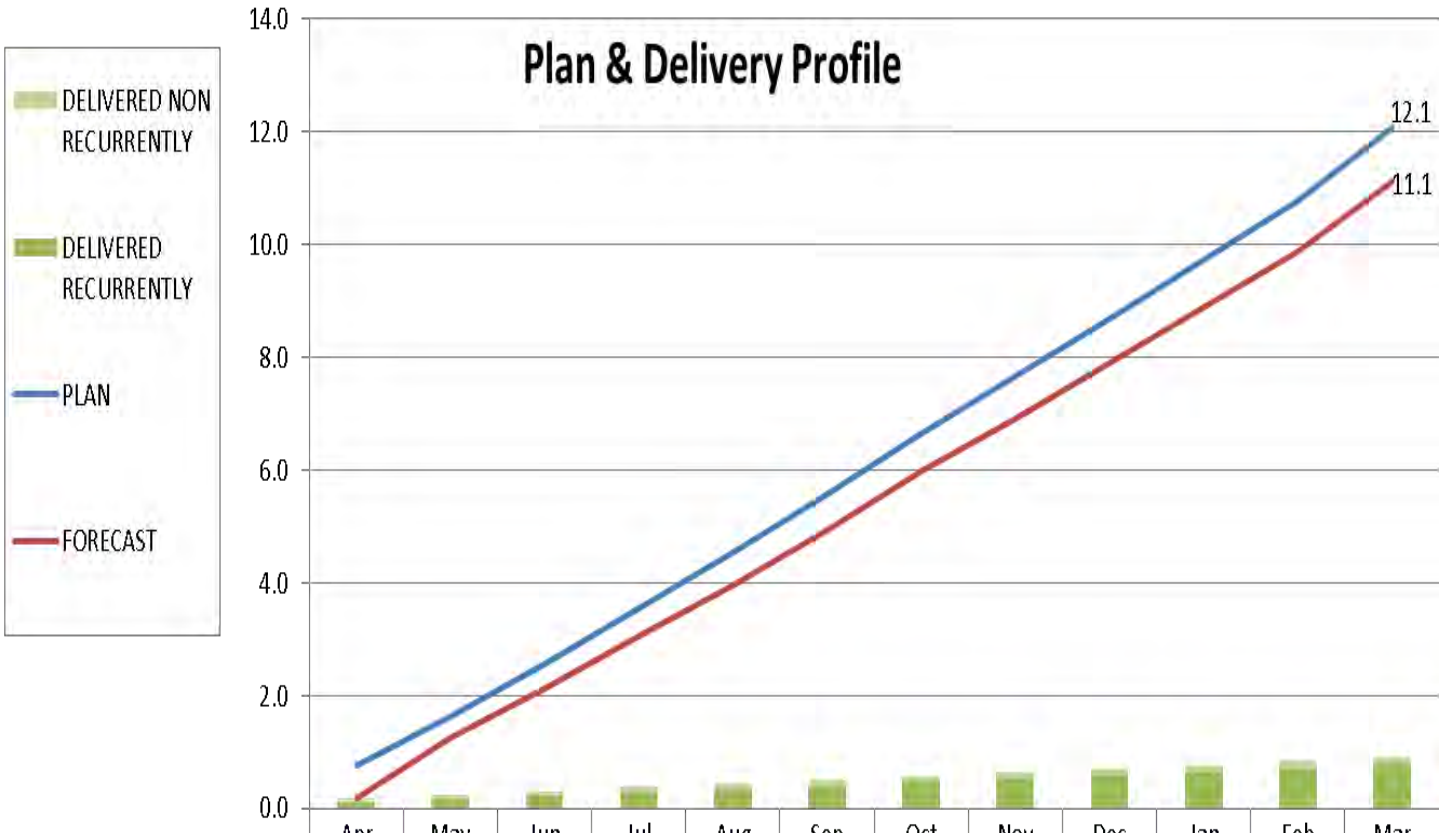
TEMPORARY WORKFORCE EXPENDITURE 2018/19

Agency	17/18													18/19	
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total	Apr	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	114	189	280	213	153	194	174	317	215	169	163	126	2,306	223	223
PTB	6	18	21	19	23	11	15	-6	1	14	14	14	150	12	12
Nursing & Midwifery	247	330	301	332	432	264	367	244	392	555	404	352	4,221	455	455
Other Staff Groups	59	87	59	77	84	83	62	89	78	53	60	36	827	63	63
Agency Total This Year	**426**	**625**	**660**	**641**	**692**	**553**	**618**	**644**	**686**	**791**	**641**	**527**	**7,504**	**754**	**754**
Monthly Movement	(123)	199	35	(19)	51	(139)	65	26	42	105	(149)	(114)		226	

Bank	17/18													18/19	
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total	Apr	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	0	0	0	0	0	0	0	0	0	0			0	0	0
PTB	0	0	0	0	0	0	0	0	0	0			0	0	0
Nursing & Midwifery	386	330	370	489	382	511	393	454	512	467	526	705	5,525	442	442
Other Staff Groups	101	72	79	91	85	104	79	83	93	105	84	107	1,083	84	84
Bank Total This Year	**487**	**402**	**449**	**580**	**466**	**616**	**473**	**537**	**605**	**571**	**610**	**811**	**6,608**	**526**	**526**
Monthly Movement	29	(85)	46	131	(114)	149	(143)	64	68	(34)	39	201		(285)	

Locum	17/18													18/19	
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total	Apr	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	411	348	430	551	553	561	691	683	630	486	425	645	6,414	617	617
PTB	43	51	35	30	22	21	16	17	14	13	20	18	299	15	15
Nursing & Midwifery	0	0	0	0	0	0	0		0				0	0	0
Other Staff Groups	0	0	0	0	0	0	0		0			3	4	2	2
Locum Total This Year	**454**	**399**	**465**	**581**	**575**	**582**	**707**	**700**	**644**	**499**	**446**	**667**	**6,718**	**635**	**635**
Monthly Movement	169	(55)	66	116	(6)	7	125	(7)	(56)	(145)	(53)	221		(32)	
Grand Total	**1,367**	**1,426**	**1,574**	**1,802**	**1,733**	**1,750**	**1,798**	**1,881**	**1,935**	**1,861**	**1,697**	**2,005**	**20,829**	**1,914**	**1,914**
Total Monthly Movement	76	60	147	228	(69)	17	47	83	54	(74)	(163)	308		(109)	

Cost Improvement Target Achievement: April 2018 (Month 1)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
DELIVERED RECURRENTLY	0.1	0.1	0.2	0.3	0.3	0.4	0.5	0.5	0.6	0.6	0.7	0.8
PLAN	0.8	1.6	2.6	3.5	4.5	5.6	6.7	7.7	8.7	9.7	10.8	12.1
FORECAST	0.2	1.2	2.1	3.0	4.0	4.9	6.0	6.9	7.9	8.9	9.9	11.1

Headlines & Commentary

Cost Improvement Programme Target for 2018/19 is £13m.

YTD Delivery

- Year to Date delivery at month 1 totalled £0.17m against a plan of £0.76m, giving an under-delivery of £0.6m
- Of the total savings achieved £0.09m is delivered non-recurrently

Full Year Plan

- The full year delivery forecast totals £11.1m (current shortfall against plan £1.9m) with a number of schemes still remaining as medium to high risk.
- Work continues with the programme to support the delivery of schemes.
- The full year value of the month 1 schemes is £0.9m, of which £.08m is delivered recurrently.

MEETING OF TRUST BOARD – 7th June 2018					
Performance and Quality Report				**AGENDA ITEM: 17**	
Report Author and Job Title:	Alison Phipps - Head of Performance & Strategic Intelligence		**Responsible Director:**	Russell Caldicott – Director of Finance & Performance	
Action	**Approval**	**Decision**	**Assurance and Information**		
			To receive and discuss X	**To receive**	
Recommendation	Members of the Trust Board are asked to note the content of the paper and discuss any areas of concern.				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report provides performance results for the Trust against a range indicators (performance, quality, safety and finance)and the key message summary pages contained within it have been to each of the sub committees (PFIC, Quality & Safety, POD). Lead executives have had an opportunity to incorporate comments on the key message pages and have also debated the content of the report at the relevant subcommittee.				
Resource implications outline	There are no resource implications associated with this report				
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.				
Operational Objectives 2018/19	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme			X	
	Develop the culture of the organisation to ensure mature decision making and clinical leadership			X	
	Improve our financial health through our robust improvement programme			X	
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts			X	

EXECUTIVE SUMMARY

Areas of particular note applicable to Trust Board in respect of the Performance and Quality report attached are summarised in section 3 below.

Performance & Quality Report

1. PURPOSE OF REPORT

The purpose of this report is to provide a summary overview of performance against key metrics aligned to this committee and also detail CQUIN schemes achievement and forecast. More detailed exception pages are included for metrics which have failed to achieve.

2. BACKGROUND

The report provides summary dashboards containing detail of performance against key metrics aligned to the organisational strategic objectives. A page summarising key messages for each subcommittee (Performance, Finance and Investment Committee, Quality and Safety Committee, People and Organisational Development) is contained within this report and discussed prior to receipt at Trust Board.

3. DETAILS

Areas of note are:

- **A&E: Time Spent in A&E (within 4 hours): Target 95%:** Performance improved to 87.22% compared to 81.23% in March. April's performance exceeded the trajectory of 83%.
- **Ambulance Handover:** The number of delayed ambulance handovers significantly improved in April to a total of 43 which is a reduction of 110 compared to March. The number delayed by more than 1 hour reduced to 1 from 9 in March.
- **Cancer** – All 8 cancer metrics achieved in March. Unvalidated results for April show non-achievement against 62 day referral to treatment of all cancers.
- **18 Weeks Referral to Treatment Incomplete: Target 92%:** April's performance further improved to 85.89%.
- **Diagnostic waits:** Performance recovered and the 99% target was achieved (99.05%).
- **HSMR (HED) & SHMI -** February HSMR rate was 102.55. December SHMI changed to 127.25 from 103.66 in November. 90 deaths were recorded in April
- **Infection Control** – There were three reported cases of C Difficile and one case of MRSA, the first since November 2015.
- **Pressure Ulcers – (category 2, 3 & 4's) – Avoidable per 1000 beddays** – The rate for February was 0.55. March and April are pending RCA's.
- **Falls** - The rate of falls per 1000 bed days declined to 5.32 from 5.64 in March and was within the target of 6.63. There were four falls resulting in serious injury.
- **Safeguarding and Prevent Training** – Compliance rates have not been achieved. Trajectories have been established to achieve by end of Q1.
- **Open Contract Performance Notices** – Seven contract performance notices remain open.
- **CQUINS** – Work continues on schemes for 2017-19. A forecast summary is included

4. RECOMMENDATIONS

Members of the Board are asked to note the content of the paper and discuss areas of concern.

Report Author: Alison Phipps - Head of Performance & Strategic Intelligence
Date of report: 31st May 2018

APPENDICES
Performance & Quality Report

Walsall Healthcare NHS
NHS Trust

Performance & Quality Report

Trust Board

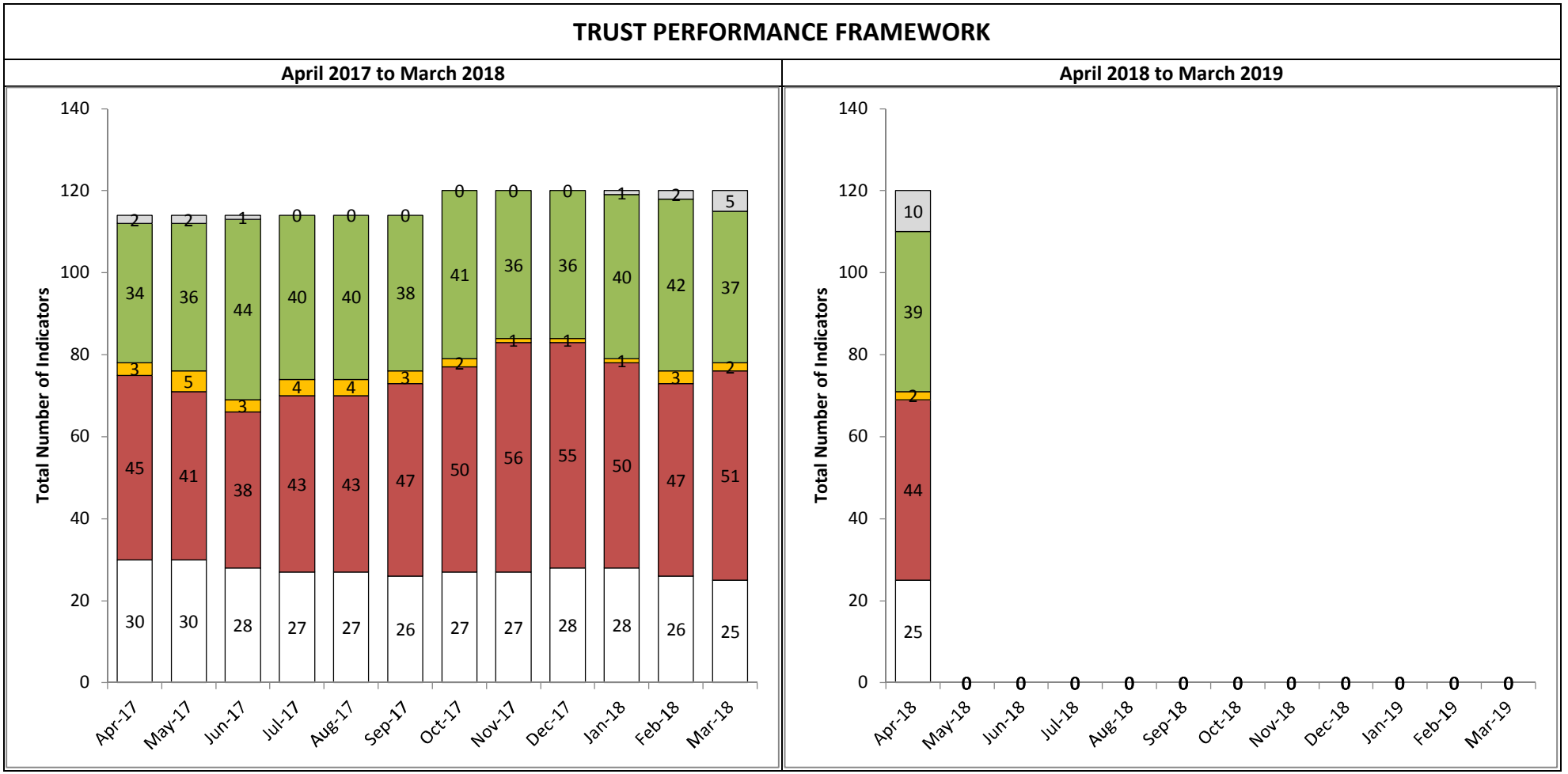
May 2018
(April 2018 Results)

Author: Alison Phipps – Head of Performance and Strategic Intelligence
Lead Director: Russell Caldicott – Director of Finance and Performance

Becoming your partners for first class integrated care

Contents

TRUST PERFORMANCE FRAMEWORK



Indicators with No Targets

Failing to meet Target or Major Variance from Plan

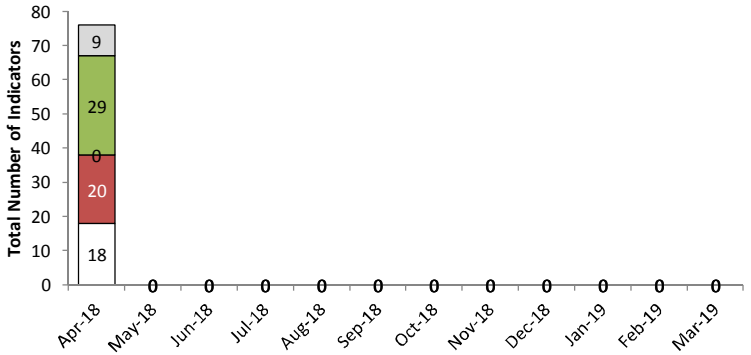
Minor Variance from Plan

Achieving Target or On Plan

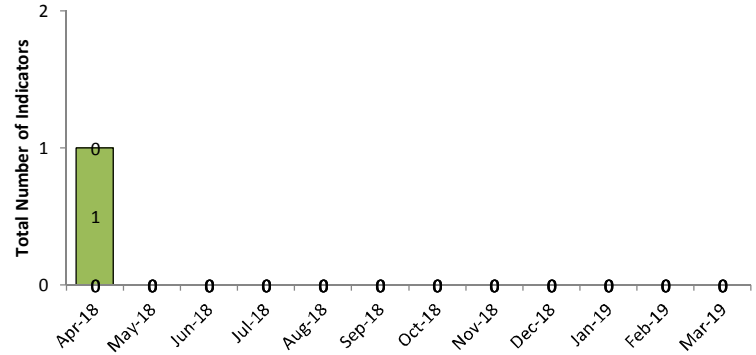
Indicators reported in Arrears or not yet available in Month

TRUST STRATEGIC VALUES FRAMEWORK

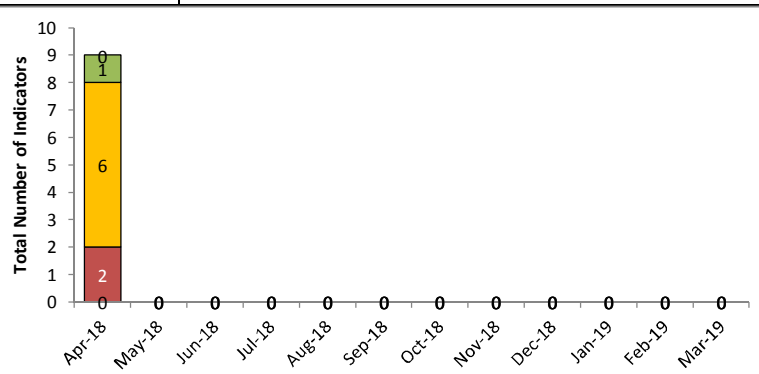
Provide Safe, High Quality Care Across All Our Services



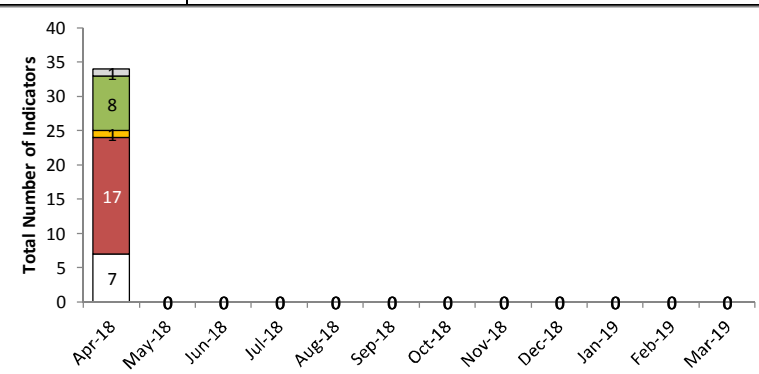
Care For Patients At Home Whenever We Can



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



Use Resources Well To Ensure We Are Sustainable



Indicators with No Targets

Failing to meet Target or Major Variance from Plan

Minor Variance from Plan

Achieving Target or On Plan

Indicators reported in Arrears or not yet available in Month

Walsall Healthcare NHS
NHS Trust

Quality and Safety Committee

Becoming your partners for first class integrated care

Quality & Safety Committee – Key Messages

Please refer to dashboard and exception pages for further detail

Quality & Safety Committee

PERFORMANCE ACHIEVED – OF NOTE:. VTE performance exceeded the agreed trajectory and the national target for the second consecutive month reporting performance of 96.34% . C-Section rates improved in April reporting 27.06% which is within the 30% target. Instrumental Delivery reported performance of 9.48% which is within the 10% target introduced from April 2018. FFT for inpatients improved in April achieving the 96%.

PERFORMANCE NOT ACHIEVED: There was a further improvement in the number of mixed sex accommodation breaches in April from 8 to 3. HSMR improved to 102.55 in February from 113.00 in January. There was 1 reported case of MRSA in April, the first since November 2015. There were 3 cases of C Difficile in April which exceeds the trajectory of 2. There were 9 avoidable pressure ulcers reported for February. March and April figures are provisional. There were 4 falls reported resulting in severe injury. Midwife to Birth Ratio did not achieve at 1:29.8. One to one care in established labour failed to achieve the 100% target with performance of 99.06%. Emergency Readmissions within 30 days did not achieve in March with performance of 10.26%. EDS compliance further declined in April to 83.45%. Dementia improved to 78.26% in March, against a target of 90%, however methodology to determine performance of this metric is still under review. 3 FFT areas (Antenatal, Outpatients & ED) failed to achieve in April. None of the Safeguarding metrics achieved in April and a contract performance notice has been received from Walsall CCG. Trajectories to achieve by the end of Quarter One have been established however, the safe guarding compliance target is under discussion.

TO NOTE:
The number of deaths reduced in April to 90. There were 14 Hospital & 8 Community serious incidents in April.

NONE APPLICABLE
There are no specific Care at Home metrics identified for inclusion within the dashboard for this committee.

NONE APPLICABLE
There are no specific Value Colleagues metrics identified for inclusion within the dashboard for this committee.

PERFORMANCE NOT ACHIEVED – OF NOTE: The number of births increased in April compared to previous month.

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE 2018-2019

	SAFE, HIGH QUALITY CARE	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
no	Sleeping Accommodation Breaches	6	9	3	2	8	3	3	0	66	N
no..	HSMR (HED)	88.09	131.87	115.45	102.55				100.00		N
no..	SHMI (HED)	103.66	127.25						100.00		BP
no	Number of Deaths in Hospital	80	137	139	112	113	90	90		1166	BP
%..	% of patients who achieve their chosen place of death	73.81%	46.30%	63.04%	57.78%	57.69%	54.05%	54.05%			
no	MRSA - No. of Cases	0	0	0	0	0	1	1	0	0	N
no	Clostridium Difficile - No. of cases	0	4	0	0	0	3	3	17	11	N
%..	% of patients screened for Sepsis (CQUIN audit)	92.19%	95.00%	92.00%	95.16%	95.74%			90.00%	93.82%	
no..	Pressure Ulcers - (category 2, 3 & 4's) - Avoidable per 1000 beddays	0.66	0.18	0.70	0.55	0.42	0.24	0.24			BP
no	Pressure Ulcers - No. of Avoidable (category 2, 3 & 4's) - Trust	10	3	12	9	7	4	4	0		BP
no	Pressure Ulcers - (category 2, 3 & 4's) - Hospital	12	11	15	17	20	27	27			
no	Pressure Ulcers - (category 2, 3 & 4's) - Community	15	9	17	14	14	14	14			
no	Falls - Total reported	83	95	88	83	95	89	89		1026	BP
no..	Falls - Rate per 1000 Beddays	5.50	5.79	5.11	5.10	5.64	5.32	5.32	6.63		BP
no	Falls - No. of falls resulting in severe injury or death	2	1	1	0	0	4	4	0	8	BP
no	Falls - Avoidable Falls resulting in severe harm or injury	2	1	1	0						BP
no	Falls - Unavoidable Falls resulting in severe harm or injury	0	0	0	0						BP
%..	VTE Risk Assessment	89.95%	93.45%	91.30%	93.18%	95.49%	96.34%	96.34%	95.00%	88.49%	N
no	National Never Events	1	0	0	0	1	0	0	0	3	N
no	Local Avoidable Events	0	0	0	0	0	0	0	0	0	L
no	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	16	9	9	13	12	14	14		123	L
no	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	5	4	8	4	5	8	8		77	L
no	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	31	28	22	24	18	28	28		262	L
no	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	4	2	16	4	8	6	6		89	L
%..	% of incidents resulting in moderate, severe harm or death as a % of total incidents	3.27%	3.09%	3.31%	2.89%	2.33%	3.17%	3.17%		2.78%	L

Walsall Healthcare NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE 2018-2019

		Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
%..	Deteriorating patients: Percentage of observations rechecked within time	90.16%	88.19%	88.72%	90.27%	90.52%	91.20%	91.20%	85.00%		
%..	Medication Storage Compliance (one month in arrears)	95.00%	93.00%	89.00%	89.00%	91.00%					
%..	Controlled Drug Compliance (quarterly audit)		78.00%					0.00%			
%..	% of Pharmacy Interventions made based on charts reviewed	20.00%	26.56%	22.62%	22.49%	13.00%	14.00%	14.00%			
%..	Trust-wide Safety Index - % of medication incidents resulting in harm (one month in arrears)	23.71%	34.48%	30.59%	20.00%	17.54%			12.00%		BP
no	No. of reported medication incidents level 3, 4 or 5 (reported one month in arrears)	0	5	1	1	3			0		
no..	Midwife to Birth Ratio	1:25.4	1:25.4	1:24.8	1:22.4	1:26.3	1:29.8		1:28	1:26.3	N
%..	One to One Care in Established Labour	98.96%	98.91%	98.98%	99.43%	99.48%	99.06%	99.06%	100.00%		N
%..	C-Section Rates	28.62%	33.09%	27.34%	26.61%	31.80%	27.06%	27.06%	30.00%		
%..	Instrumental Delivery	11.47%	8.93%	14.36%	9.09%	10.03%	9.48%	9.48%	10.00%		
%..	Induction of Labour	33.33%	33.45%	32.01%	31.85%	30.39%	32.01%	32.01%			
%..	NHS Safety Thermometer - Maternity - Women's Perception of Safety	64.30%	91.30%	82.60%	100.00%	94.30%	100.00%		92.00%		
%..	NHS Safety Thermometer - % Harm Free	95.14%	97.12%	95.29%	95.70%	94.75%	95.93%		94.00%		BP
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	10.35%	11.44%	10.44%	10.18%	10.26%			10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	85.38%	89.73%	91.63%	91.84%	89.51%	83.45%	83.45%	100.00%	89.33%	N/L
%..	Dementia Screening 75+ (Hospital) (Internal audit Dec17 onwards)	44.47%	80.79%	79.55%	72.12%	78.26%			90.00%		N
%..	Compliance with MCA 2 Stage Tracking			71.00%	77.00%	77.00%	55.00%				
no	Complaints - Total Received	15	13	24	23	33	26	26		291	BP
%..	Complaints - Percentage responded to within the agreed timescales	92.00%	100.00%	100.00%	100.00%	90.32%	87.50%	87.50%	70.00%		BP
no	Clinical Claims (New claims received by Organisation)	9	10	10	14	8	9	9		131	L
no	No urgent op to be cancelled for a second time	0	0	0	0	0	0	0	0	0	N
%..	% of RN staffing Vacancies	8.85%	9.78%	9.96%	9.20%	9.13%	9.79%				
%..	Friends and Family Test - Inpatient (% Recommended)	92.00%	91.00%	93.00%	97.00%	94.00%	96.00%		96.00%		N
%..	Friends and Family Test - Outpatient (% Recommended)	90.00%	91.00%	91.00%	91.00%	92.00%	92.00%		96.00%		N
%..	Friends and Family Test - ED (% Recommended)	76.00%	77.00%	75.00%	79.00%	76.00%	79.00%		85.00%		N
%..	Friends and Family Test - Community (% Recommended)	99.00%	99.00%	97.00%	99.00%	97.00%	97.00%		97.00%		N

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE 2018-2019

		Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
%..	Friends and Family Test - Maternity - Antenatal (% Recommended)	82.00%	80.00%	97.00%	0.00%	81.00%	90.00%		95.00%		N
%..	Friends and Family Test - Maternity - Birth (% Recommended)	94.00%	83.00%	100.00%	100.00%	100.00%	100.00%		96.00%		N
%..	Friends and Family Test - Maternity - Postnatal (% Recommended)	79.00%	85.00%	97.00%	100.00%	96.00%	97.00%		92.00%		N
%..	Friends and Family Test - Maternity - Postnatal Community (% Recommended)	100.00%	100.00%	99.00%	100.00%	98.00%	100.00%		97.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	99.28%	99.61%	98.84%	98.80%	96.56%	98.59%		95.00%		L
%..	PREVENT Training - Level 3 Compliance	62.89%	63.93%	69.07%	70.90%	75.97%	76.07%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	57.67%	59.50%	63.80%	66.37%	70.09%	74.57%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	63.19%	62.05%	71.85%	74.09%	77.64%	78.06%		85.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	71.66%	73.16%	74.03%	73.84%	73.25%	75.49%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	62.09%	66.32%	68.87%	67.48%	71.07%	73.72%		85.00%		L
	RESOURCES										
no	Total Births	279	280	280	253	289	306	306		3603	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

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 March and provisional figures for April show achievement of all except 62 day referral to treatment. Diagnostics waits achieved the 99% target with 99.05%.
PERFORMANCE NOT ACHIEVED: The ED 4 hour performance improved significantly to 87.22%. ED median waiting time also improved in April. The number of delayed ambulance handovers reduced by over a 100 to a total of 43 compared to 153 in March. Within this the number delayed by more than 1 hour reduced to 1 from 9. Incomplete 18 weeks RTT for March improved to 85.89%. The number of open contract notices remains at 7.

TO NOTE: Applying the national cancer breach allocation guidance to the 62 day cancer targets for the validated March 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.
There are no specific Value Colleagues metrics identified for inclusion within the dashboard for this committee.

PERFORMANCE ACHIEVED – OF NOTE:
The Theatres Touch Time Utilisation exceeded the target range of 75-85% reporting a performance of 80.91%.

PERFORMANCE NOT ACHIEVED: DNA Rates for Acute and Community continued to improve in April with performance of 10.47% . Average length of stay failed to achieve the 7.01 target reporting 8.24 days. DTOC did not achieve but has shown an improvement compared to the previous month.

FINANCE: Please refer to Finance report.

TO NOTE: There are 4 new metrics relating to medically fit patients being introduced.

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)	82.03%	83.38%	82.68%	82.81%	81.23%	87.22%	87.22%	95.00%	82.67%	N
no	Total time spent in ED - No. of Trolley waits over 12 hours	0	0	0	0	0	0	0	0	3	N
no	Median Waiting Time in ED Metric (average in mins)	171	179	181	178	187	167		120		
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	70.04%	58.42%	59.73%	71.31%	70.36%	80.95%	80.95%	100.00%	65.80%	BP
no	Ambulance Handover - No. of Handovers completed between 30-60mins	122	246	259	108	144	42	42	0	1836	N
no	Ambulance Handover - No. of Handovers completed over 60mins	8	35	37	21	9	1	1	0	236	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	99.73%	97.42%	95.16%	96.61%	97.90%	93.19%	93.19%	93.00%	95.45%	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	96.88%	100.00%	94.12%	96.55%	100.00%	94.00%	94.00%	93.00%	96.55%	N
%..	Cancer - 31 day second or subsequent treatment (surgery)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.00%	98.92%	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%	98.82%	100.00%	100.00%	100.00%	100.00%	96.00%	99.39%	N
%..	Cancer - 62 day referral to treatment from screening	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.00%	98.03%	N
%..	Cancer - 62 day referral to treatment of all cancers	85.51%	90.12%	87.36%	85.71%	87.69%	83.47%	83.47%	85.00%	88.05%	N
%..	Cancer - 62 day referral to treatment from consultant upgrade	87.84%	85.71%	90.91%	79.52%	86.89%	88.73%	88.73%	85.00%	86.20%	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	83.57%	80.99%	82.48%	83.69%	84.74%	85.89%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	1	1	1	0	0	0	0	0		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Admitted	1	0	1	0	1	1	1	0		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Not Admitted	1	0	0	1	0	0	0	0		N
%..	Diagnostic Waits - % waiting under 6 weeks	99.53%	99.15%	99.54%	99.66%	98.06%	99.05%	99.05%	99.00%	99.06%	N
%..	Elective Cancellations - No. of last minute cancellations on day of operation or after patient admission	0.58%	0.51%	0.19%	0.35%	0.39%	0.09%	0.09%	0.75%	0.45%	N
no	Elective Cancellations - No. of last minute cancellations not rebooked within 28 days	0	0	0	0	0	0	0	0	0	N
no	No urgent op to be cancelled for a second time	0	0	0	0	0	0	0	0	0	N
no	Rapid Response Team - Avoidable admissions (one month in arrears)	237	248	326	225	258					

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
%..	% of RN staffing Vacancies	8.85%	9.78%	9.96%	9.20%	9.13%	9.79%				
no	No. of Open Contract Performance Notices	6	6	6	6	7	7	7	0	7	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	6.50%	7.00%	6.71%	6.18%	6.87%	6.80%	6.80%	7.00%	6.76%	BP
	RESOURCES										
%..	Booking Utilisation (booked as a percentage of capacity)	92.15%	91.14%	90.13%	90.41%	92.87%	93.17%	93.17%	90.00%	89.90%	L
%..	Outpatient DNA Rate (Hospital and Community)	11.77%	14.36%	12.11%	11.27%	10.73%	10.47%	10.47%	8.00%	12.16%	
no..	New to follow up ratio - WHT	1.93	2.03	2.04	2.01	2.04	2.09	2.09	2.14	1.99	BP
%..	Theatre Utilisation - Touch Time Utilisation (%)	61.11%	66.31%	58.16%	63.60%	70.73%	80.91%	80.91%	75.00%		
no..	Length of Stay	7.06	7.51	7.50	7.59	7.59	8.24	8.24	7.01	7.22	BP
%..	Delayed transfers of care (one month in arrears)	3.27%	2.16%	3.11%	3.44%	3.63%	2.97%	2.97%	2.50%	2.56%	L
no	Average Number of Medically Fit Patients										0
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only										0
no	Average Number of Medically Fit Patients relating to Social Care - Trust										0
no..	Average LoS for Medically Fit Patients (from point they become Medically Fit)										0
no	Hospital beds open at month end	468	483	532	514	519	488	488			L
%..	Day case rates	90.32%	88.82%	90.32%	88.44%	86.78%	88.31%	88.31%		88.14%	BP
%..	Bank & Locum expenditure as % of Paybill	8.48%	8.53%	7.29%	7.42%	10.31%	7.93%	7.93%	6.30%	7.67%	L
%..	Agency expenditure as % of Paybill	4.41%	4.69%	5.39%	4.51%	3.68%	5.15%	5.15%	2.75%	4.32%	L
£	Surplus or Deficit (year to date) (000's)	-£16,976	-£20,342	-£20,395	-£23,257	-£23,267	-£2,386	-£2,386		-£23,267	L
£	Variance from plan (year to date) (000's)	-£3,093	-£3,991	-£3,622	-£4,238	-£2,511	-£2,483	-£2,483		-£2,511	L
£	CIP (£) (000's)	£5,924	£6,620	£7,213	£7,826	£10,900	£168	£168		£10,900	L
%..	CIP % delivered (year to date)	68.00%	71.00%	72.30%	74.80%	99.10%	6.90%	6.90%	100.00%	99.10%	L
£	Income variance from plan (year to date) (000's)	£653	£464	£640	-£927	-£2,306	£236	£236	£0	-£2,306	L
£	Expenditure - Variance from Plan (year to date) (000's)	£2,245	£4,271	£3,991	-£3,389	-£222	-£154	-£154	£0	-£222	L
£	Cash Against Plan (variance) (000's)	£858	£526	£73	£121	£128	£1,004	£1,004		£128	L
£	Capital spend YTD (000's)	£4,818	£5,663	£6,674	£7,438	£9,662	£506	£506		£9,662	L

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
no	Monitor Risk Rating (Actual YTD)	1	1	1	1	1	1	1	3	1	BP
no	Total Referrals (Contracted)	7699	6419	8730	8712	9073					BP
no	Total Elective Activity (Contracted)	275	218	250	250	322	265	265		3725	L
no	Total Non Elective Activity (Contracted)	53	138	61	62	39	57	57		578	L
no	Total Outpatient attendances (Contracted)	20830	15371	15932	18388	20094	19165	19165		230583	L
no	Total Day Case Activity (Contracted)	2147	1500	2089	1812	1847	1800	1800		22253	L
no	Total Emergencies Activity (Contracted)	2747	2689	2815	2551	2682	2465	2465		31847	L
no	Total ED Attendances Type 1 Pbr (Excl Badger) (Contracted)	6417	6577	6551	5984	6606	6148	6148		74003	L
no	Total AHP Activity (Contracted)	2145	1337	1811	1866	1799	1661	1661		21600	L
no	Total Critical Care Days (Contracted)	863	1232	990	895	829	1002	1002		11242	L
no	Total Unbundled Chemo Delivery Activity (Contracted)	359	241	323	318	353	307	307		3975	L
no	Total Maternity Pathway	894	720	881	766	801	905	905		11712	L
no	Total Community Contacts (Contracted)	20614	13823	23589	27787	27787	29198	29198		361113	L
no	Total Births	279	280	280	253	289	306	306		3603	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
There are no specific Care at Home metrics identified for inclusion within the dashboard for this committee

PERFORMANCE NOT ACHIEVED: Sickness absence improved from 5.65% in March to 5.06% in April. PDR's compliance improved in April to 80.55% , as did mandatory training which reported 76.99% compliance. Compliance against Safeguarding and Prevent Training has been included in this report with effect from this month. None are currently achieving and a contract performance notice has been received from Walsall CCG. Trajectories to achieve by the end of Quarter One have been established however, the safe guarding compliance target of 95% is under discussion.

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

Walsall Healthcare NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 2018-2019

		Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	% of RN staffing Vacancies	8.85%	9.78%	9.96%	9.20%	9.13%	9.79%				
	VALUE COLLEAGUES										
%..	Sickness Absence	5.55%	5.81%	6.23%	5.00%	5.65%	5.06%	5.06%	3.39%	5.30%	L
%..	PDRs	76.25%	75.90%	78.24%	79.47%	78.17%	80.55%	80.55%	90.00%	78.17%	L
%..	Mandatory Training Compliance	78.69%	79.65%	78.14%	77.61%	76.61%	76.99%	76.99%	90.00%	76.61%	L
%..	PREVENT Training - Level 1 & 2 Compliance	99.28%	99.61%	98.84%	98.80%	96.56%	98.59%		95.00%		L
%..	PREVENT Training - Level 3 Compliance	62.89%	63.93%	69.07%	70.90%	75.97%	76.07%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	57.67%	59.50%	63.80%	66.37%	70.09%	74.57%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	63.19%	62.05%	71.85%	74.09%	77.64%	78.06%		85.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	71.66%	73.16%	74.03%	73.84%	73.25%	75.49%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	62.09%	66.32%	68.87%	67.48%	71.07%	73.72%		85.00%		L
	RESOURCES										
%..	Bank & Locum expenditure as % of Paybill	8.48%	8.53%	7.29%	7.42%	10.31%	7.93%	7.93%	6.30%	7.67%	L
%..	Agency expenditure as % of Paybill	4.41%	4.69%	5.39%	4.51%	3.68%	5.15%	5.15%	2.75%	4.32%	L
no	Staff in post (Budgeted Establishment FTE)	4073	4100	4100	4116	4095	4125	4125			L
%..	Turnover	8.89%	8.93%	8.77%	8.89%	9.13%	9.83%	9.83%	11.00%	9.13%	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

Exception Pages

	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
Total time spent in ED - % within 4 hours - Overall (Type 1, 3 and WiC)	95.00%	83.00%	87.22%	87.22%	▲	
Ambulance Handover - Percentage of handovers completed within 15mins of arrival	100.00%		80.95%	80.95%	▲	

What is driving the reported underperformance?

ED Overall		Feb-18	Mar-18	Apr-18
Type 1 Attenders		5986	6607	6193
Type 3 Attenders		3147	3271	3323
WiC Attenders		3164	3358	3329
Breaches (Type 1)		2101	2471	1640
Trolley Waits >12Hours		0	0	0
Median Wait		178	187	167
Ambulance Handover	<15mins	1814	1956	2090
	15-30	601	671	449
	30-60	108	144	42
	>60	21	9	1
	No Time	60	68	31
	Total	2604	2848	2613

- Average attendances per day were 206 compared to 213 (Mar)
- Average breaches per day were 55 compared to 80 (Mar)
- Average number of ambulance arrivals to ED per day was 87, compared to 92 in March.
- There were over 90 ambulance arrivals to the department on 14 days during the month, a decrease compared to March (17) and 1 day where the Trust saw over a 100 ambulances to ED which is a decrease compared to March (7).

Benchmarking

ED 4 Hour - (April 2018)

National position = 79/133 Trusts & Regional position = 6/14 Trusts.

Ambulance - (April 2018)

Regional position = 1/14 Trusts.

Contractual Status

ED 4 Hour - CQN/First Exception report remains open. Monthly penalties will be applied by WCCG £120 per breach based on the agreed trajectories. Fines for April equate to £0.

Ambulance - 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 April a fine of £9,400 will be incurred.

What actions have we taken to improve performance?

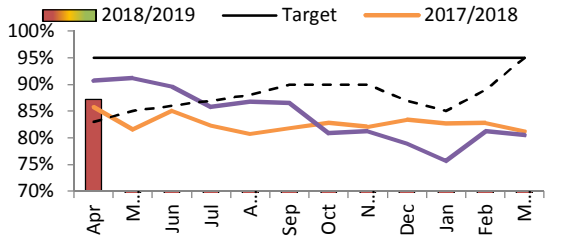
New Actions:

- The Emergency & Acute Improvement Group have agreed terms of Reference for their group and have commenced their meetings. the group are in the process of agreeing measures to monitor success fc increased AEC activity, Improved Internal Professional Standards in ED, Increased direct referrals to specialities and reduced conversion rates through workforce changes.
- The group to improve ward processes have also agreed objectives for their group. The Divisional Director of Nursing for MLTC as clinical lead is developing SAFER and Red to Green on the Wards by embedding principles and standards as a consistant approach to ward processes.
- The Frailty Team have recently joined the National Frailty Network. With Director of Strategy as their Executive Lead, bi-weekly meetinç for this team are also in place and commenced end of April.
- ED Nurse Team have developed their shift allocations within the department. The changes ensure that there is a 2nd Triage Nurse and additional Ambulance Handover Nurse in place robustly.
- The ED team have also updated their escalation protocols. With th use of the ED Trigger Tool, actions have been updated to manage pressures within ED and approaches to "cohorting" stable patients are being safely trialled and tested with the team.

Continuing Actions:

- Ward Managers continue to attend Capacity Meetings throughout the day with the newly established Discharge Plans that are produced.
- General Managers continue to carry out daily rounds to the wards to support discharge planning and 7 day LOS review with clinicians.
- The Discharge Lounge continues to open from 9am (weekdays) to enable patients to move from wards earlier.
- Regular escalations continue with Health & Social Care to review tl Medically Fit lists and continue to remove and reduce delays to discharge.
- Transformation Managers continue to support the Patient Flow Meeting which is in place weekly.

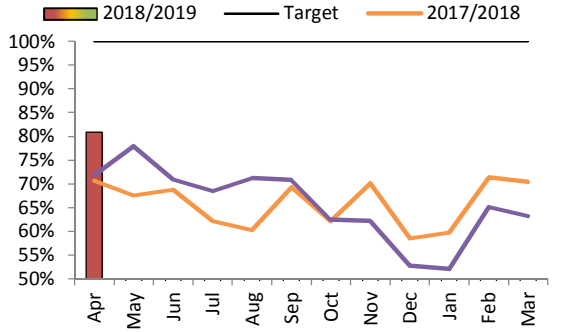
Contractual Financial Penalties (LCA)	YTD £	
	ED	£0
	Amb	£9,400



Trajectory - ED 4 Hour

Apr	May	Jun	Jul	Aug	Sept
83.00%	85.00%	86.00%	87.00%	88.00%	90.00%
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
90.00%	90.00%	87.00%	85.00%	89.00%	95.00%

Ambulance Handover



Expected date to meet standard	ED 4 Hour - achieved trajectory Ambulance - to be agreed
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

18 weeks Referral to Treatment - % within 18 weeks - Incomplete

Walsall Healthcare NHS Trust

18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Year Standard	Monthly Trajectory	Mar-18	YTD	Change on last month	Year End Forecast
	92.00%	89.10%	84.74%		▲	

What is driving the reported underperformance?

Performance results (Validated March 2018):

The Trust achieved 84.74%, which is an improvement compared to 83.69% in February. The number of patients waiting over 18 weeks has reduced again by 165 compared to February. All divisions improved their performance.

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

		Jan-18	Feb-18	Mar-18
PTL Size		14889	14755	14693
No. over 18 Weeks		2608	2407	2242
No. over 52 Weeks		1	0	0
Clock Stops	Total	6757	5749	5977
	Admitted	915	906	893
	Not Admitted	5842	4843	5084
Specialties achieving 92%		8	7	8

Performance of Divisions (target 92%):
- MLTC achieved 86.80% compared to 85.68% in February.
- Surgery achieved 81.24% compared to 80.19% in February.
- WCCSS achieved 96.09% compared to 94.53% in February.

Benchmarking:

For March, the Trust ranked 90th out of 127 Acute Trusts nationally who submitted information and 9th out of 14 Trusts regionally. 73 Acute Trusts reported breaches of over 52 week waits in March.

Contractual status:

Contract Query Notices remain open with Walsall Clinical Commissioning Group (WCCG) and NHS England (NHSE). National monthly penalties of £300 per service user apply where the number of service users waiting more than 18 weeks at the end of the month exceeds the tolerance permitted by the 92% threshold. The £5000 fine for any patient waiting more than 52 weeks remains in place.

What actions have we taken to improve performance?

Data Quality:

- Robotic software in place and simple closure of access plans for follow up backlog pre 2017 complete. Lettering process underway (Urology completed), All specialities to be completed 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 10,000 from the original 53,000.
- 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 during clinics continues. The number of incomplete outcome forms have reduced this month.

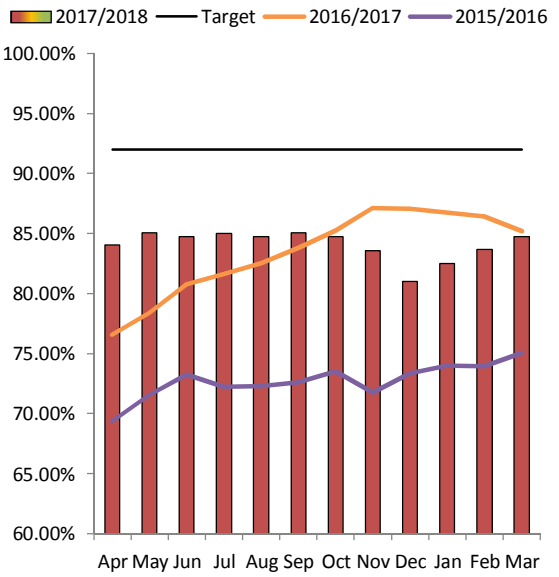
Capacity Improvements:

- WLI clinics in place to support cancer delivery and long waiters in RTT.
- Figures for outpatients has shown an increase in forward booking for central & service areas. Attendance utilisation continues to improve delivering 88.11% in March.
- Focus of the outpatient workstream is to maximise booking opportunities and reduce DNA rates. DNA percentage reduced to 10.73% in March. Surgery achieved < 10% for the first time.
- Partial booking for follow up patients commenced roll out in April. It is anticipated this will reduce cancellation and DNA numbers.

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 £** £5,205,800



Proposed Trajectory

Apr	May	Jun	Jul	Aug	Sept
84.00%	84.60%	85.10%	86.20%	86.20%	86.20%
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
86.20%	86.20%	86.20%	87.00%	88.20%	89.10%

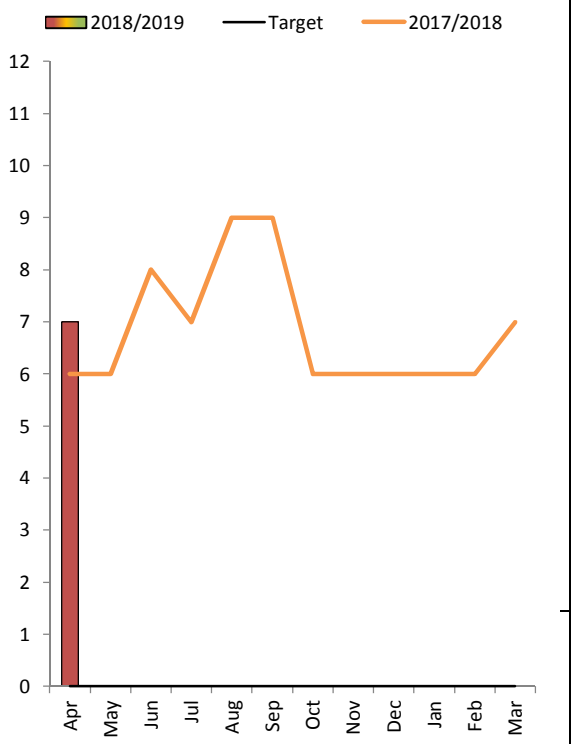
Expected date to meet standard	Achieve trajectory 84.2% for April.
Lead Director	Chief Operating Officer

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	Apr-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 30th April 2018, there are 7 formal contract notices outstanding. 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

	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
Outpatient DNA Rates	8.00%	9.00%	10.47%	10.47%	▲	
Booking Utilisation (booked as a percentage of capacity)	90.00%		93.17%	93.17%	▲	

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

Performance Results

Outpatient DNA rates are the number of outpatient appointments where the patient 'Did Not Attend' against the total number of outpatient appointments.
The Trust failed to achieve the internal trajectory of 9% with performance of 10.47%, however the trend of improvement has continued since December.
Divisional performance is as below:-
MLTC - 10.51% (Apr) (compared to 10.73% in Mar)
SURG - 8.87% (Apr) (compared to 9.83% in Mar)
WCCSS - 12.10% (Apr) (compared to 11.67% in Mar)

Booking utilisation measures the number of routine acute clinics (excluding emergency) appointment slots booked as a percentage of the total available to book.
The Trust exceeded the internal target of 90%
Divisional performance is as below:-
MLTC - 96.61% (Apr) (compared to 92.41% in Mar)
SURG - 93.16% (Apr) (compared to 92.67% in Mar)
WCCSS - 90.54% (Apr) (compared to 93.67% in Mar)

Benchmarking

DNAs - Currently being scoped
Clinic Utilisation - No formal national reports

Contractual Status

Both metrics are not contracted but are core metrics utilised by the Trust to monitor efficient use of resources.

Continuing 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 remaining specialities is scheduled following the successful implementation of the pilot.

- 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 are in place to introduce two more specialities during May.

- A standard report is in place to enable Care Groups to interrogate DNA rates, drilling down to booking methods and previous cancellations. An organisational DNA trajectory has been agreed. In addition, divisions have been requested to develop trajectories to address specialities with specific challenges for high DNA rates, ensuring that all of the generic strategies for reduction are also reflected and incorporated within these.

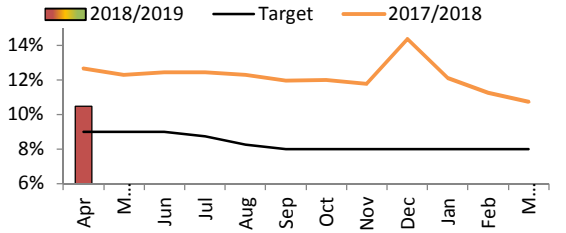
- Roll out plan for direct booking via ERS is in place for all new patients, in line with the National Paper Free Project.

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

- 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.

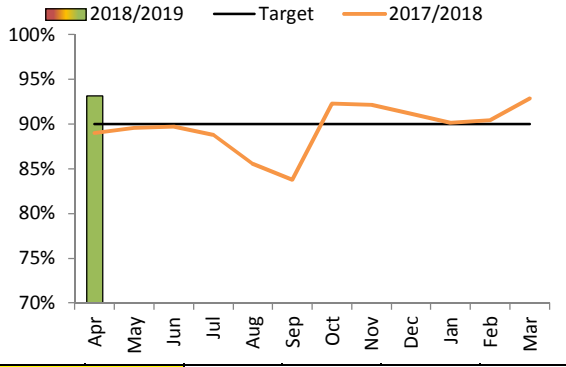
- Care Groups continue to validate patients to reduce DNAs which also acts as a further caller reminder.



Trajectory - Outpatient DNAs

Apr	May	Jun	Jul	Aug	Sept
9.00%	9.00%	9.00%	8.75%	8.25%	8.00%
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
8.00%	8.00%	8.00%	8.00%	8.00%	8.00%

Booking Utilisation



Expected date to meet standard	Outpatient DNAs - June 2018 Booking Utilisation - Currently meeting standard
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	Apr-18	YTD	Change on last month	Year End Forecast
	7.01		8.24	8.24	▼	

What is driving the reported underperformance?

Performance results:
Overall performance for LoS in April was 8.24 days. This is an increase compared to 7.59 days reported in March. 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 Mar	Ave LoS Apr	% LoS <72hr	% LoS of "0"
MLTC	9.03	9.99	54.53%	27.11%
SURG	6.25	6.16	63.64%	25.93%
WCCSS	3.31	3.21	91.72%	65.88%

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

Rehabilitation patients demonstrated some of the longest lengths of stay during April.

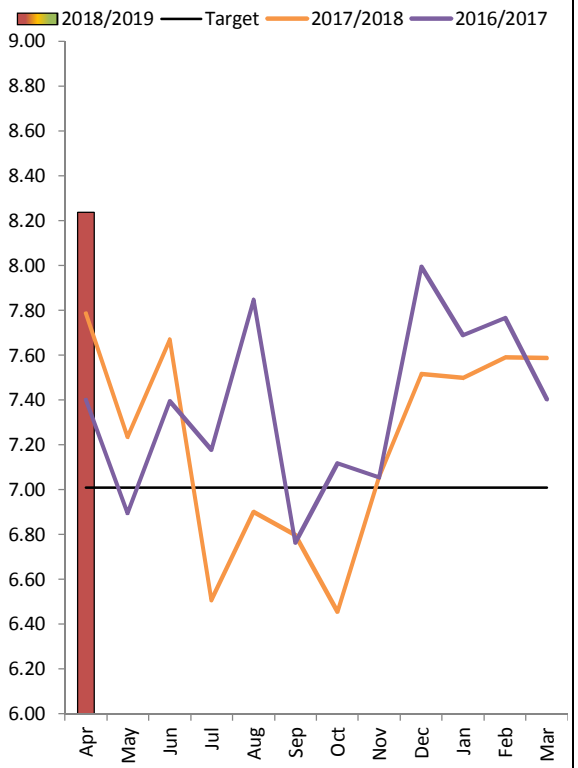
Benchmarking:
No formal national reports.

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	Mar-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%		3.63%	2.56%	▼	

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 March with performance of 3.63%. This is a decline in performance compared to 3.44% reported in February.

The DTOC reporting changed from 1st October 2017. Now every medically fit patient is reviewed daily and all 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.

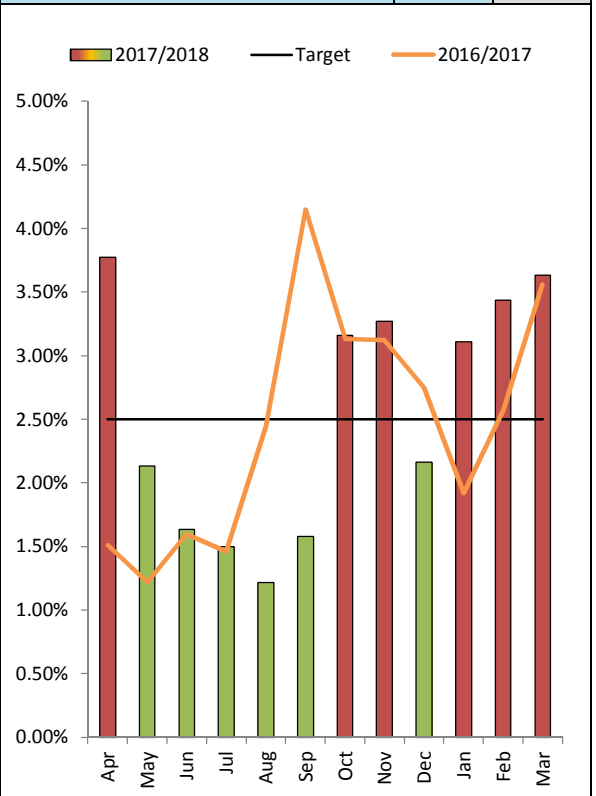
Benchmarking:
Benchmarking for this measure is based on the number of bed days impacted from delayed transfers every month.

Latest benchmarking shows, 535 bed days were impacted in March 2018 from delayed transfers taken at the snapshot position. This ranks the Trust 56th out of 133 Trusts nationally and 3rd out of 14 Trusts regionally.

Contractual status:
There is no financial penalty against the Trust for this metric.

Continuing 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	Apr-18	YTD	Change on last month	Year End Forecast
	0	0	3	3	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties (LCA)	YTD £	£0

Performance results:

There were 3 patient breaches reported within the Trust during Apri This is an improvement in performance compared to 8 reported in March. A trajectory for 2018/19 is to be agreed.

For the 3 patient breaches reported in April the length of breach incurred for each patient was one day. The patients breached on 16th and 17th April. There was 1 patient from Walsall CCG, 1 patient from NHS South East Staffs and Seisdon Pennisular CCG and 1 patient from NHS Birmingham CrossCity 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.

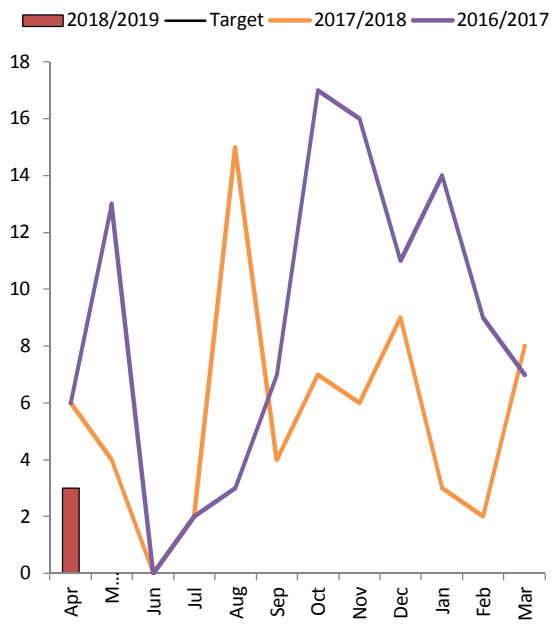
Contractual status:

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
Oct	Nov	Dec	Jan	Feb	Mar

Expected date to meet standard	Due to limitations with Estates and capacity pressures, on occasion breaches may be unavoidable
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

HSMR (HED) SHMI (HED)	Year Standard	Monthly Trajectory	Feb-18	YTD	Change on last month	Year End Forecast
	100		102.55	100.41	▲	
	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 102.55 for February 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 was 1 more 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.

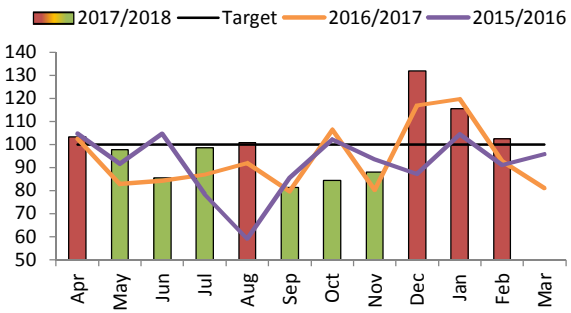
New actions:

- A review of deaths recorded in Feb/March is to be undertaken with the results to be shared in June.
- Align the actions to address poor documentation to the CQC PCIP work relating to documentation.
- Ensure mortality reviews are a standing agenda item at care group quality meetings and actions are developed and monitored through the divisional quality teams.

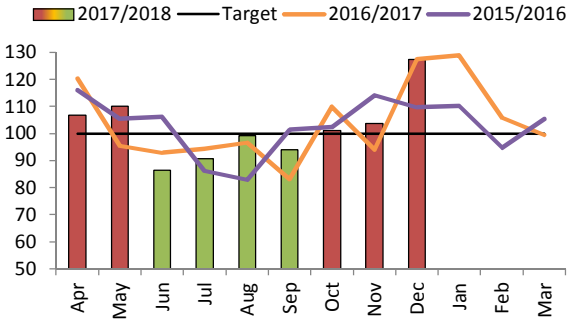
Continuing actions:

- 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.

HSMR (HED)



SHMI (HED)



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	Apr-18	YTD	Change on last month	Year End Forecast
CDiff - Total number of cases of Clostridium Difficile recorded in the Trust	18	2	3	3	▼	
MRSA - total number of cases of MRSA recorded in the Trust	0		1	1	▼	

Contractual Financial Penalties	YTD £
CDiff	
MRSA	£10,000

What is driving the reported underperformance?

Performance results:

CDiff:

There were 3 reported cases of C.Difficile attributed to Walsall Healthcare NHS Trust during April 2018. This has exceeded the monthly trajectory of 2. The cases were reported on ward 15 (2) and ward 17 (1).

There was 1 case of MRSA bacteraemia attributed to Walsall Healthcare NHS Trust during April 2018. This case was reported on ward 19 (ITU).

Benchmarking:

CDiff:

Data published one month in arrears by Health Protection England confirms that for March 2018, there were 0 cases of hospital attributable C.Difficile toxin at Walsall Healthcare. This compares to 2 cases at Dudley and 0 cases at Wolverhampton.

MRSA:

Data published one month in arrears shows there were no cases of MRSA recorded regionally for March 2018.

Contractual status:

CDiff:

The contract for 2018/19 invokes financial penalties if the number of avoidable cases during the year exceeds 18.

MRSA:

The national contract for 2018/2019 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 - There were 3 C.Difficile cases reported in April 2018.
A serious incident for investigation of period of increased incidence of c.diff toxin on ward 15 in progress.
RCA's on both cases have been completed and both cases from ward 15 were deemed avoidable the cause of the PII was error in specimen procedure (specimen sent on one patient was from another patient), issue with basic infection control practice was also highlighted. The RCA for the patient on ward 17 has been completed and deemed unavoidable.

MRSA - There was 1 MRSA case reported in April 2018.
MRSA case review has been completed, no omissions in care were identified and the case was deemed unavoidable.

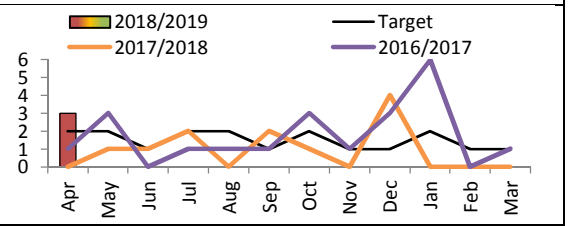
- Deep cleans have been completed on ward 16 and 17 and ward 11 is due to be completed on 25/5/18. Ward 15 was completed first however there were issues regarding equipment availability therefore will be completed again at the end of the plan.

Continuing actions:

CDiff - Infection Control continue to monitor Matrons monthly environmental audits and carry out an audit a month for assurance.
- Infection Control are involved, from the beginning, in meetings and discussions relating to new wards and decant facilities.
- C.Difficile actions are monitored at Infection Control Committee.
- 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.

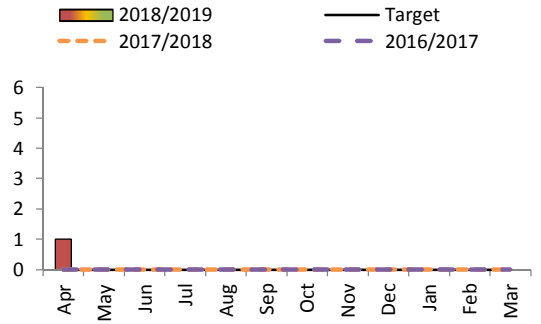
MRSA - improvement work for care of peripheral vascular devices continues throughout the Trust.
- Work continues with the Continence and Urology services to improve the care of urinary catheters. This will be monitored via the NHS Safety Thermometer.
- The Infection Control nurses continue to follow up all positive MRSA results and re-screen at 28 days post admission.

CDIFF



Trajectory					
Apr	May	Jun	Jul	Aug	Sept
2	2	1	2	2	1
Oct	Nov	Dec	Jan	Feb	Mar
2	1	1	1	1	1

MRSA



Expected date to meet standard	May 2018
Lead Director	Medical Director

National Contract		Local Contract		Best Practice		CQUIN	
	X		X				

Walsall Healthcare NHS Trust

Pressure Ulcers - (category 2, 3 & 4's) - Avoidable per 1000 beddays	Year Standard	Monthly Trajectory	Feb-18	YTD	Change on last month	Year End Forecast
Figures based on all avoidable pressure ulcers acquired within the Trust			0.55		▲	

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	*Avoid*	Total	*Avoid*
Feb-18	Cat 2	12	*5*	10	*1*
	Cat 3	1	*0*	0	*0*
	Cat 4	0	*0*	0	*0*
	Unstage	4	*1*	4	*2*
*Mar-18	Cat 2	16	*4*	8	*0*
	Cat 3	0	*0*	0	*0*
	Cat 4	0	*0*	0	*0*
	Unstage	4	*0*	6	*3*
*Apr-18	Cat 2	20	*4*	6	*0*
	Cat 3	2	*0*	1	*0*
	Cat 4	0	*0*	0	*0*
	Unstage	5	*0*	7	*0*

Rate per 1000 Beddays					
Feb-18	0.55	*Mar-18	0.42	*Apr-18	0.24

*Figures for these months are still being validated - please note there are 3 PU's for February still awaiting final validation but initial discussions have already taken place with the wards involved.
There were 31 PU related incidents reported in February.
The highest reported area of prevalence continues to be on patients heels. There have been 9 incidents confirmed as avoidable in February.

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:

1 hospital incident identified no body map and delay in reporting with the rest were relating to upgrades of equipment (2 community 1 hospital)

Education

Short education sessions have been provided to staff in A&E AMU and Theatres. Other core sessions are planned for the rest of the year.
Competencies have now been agreed and Tissue Viability are progressing with assessment of community wound care link nurses

Equipment

All new foam mattresses now in place and process for ordering air mattresses in place. TV attended Nursing Forum on 12th April in response to concerns about PU numbers and process. Group were reassured and advised of further education events (now completed with 37 attendees)
Continues to be some teething problems, TV is working with porters and mattress company with recommendation still in place for equipment coordinator to support in sustaining changes
Work has recommenced to look at options for seating and heel protection.

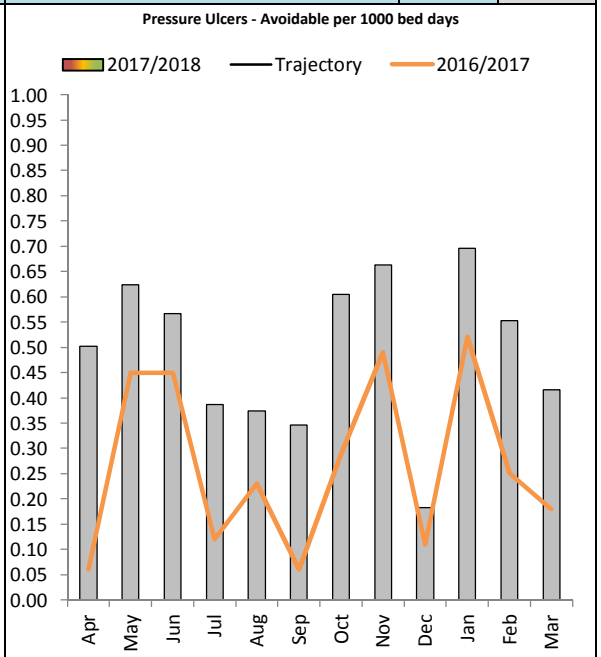
Documentation

Draft skin bundle submitted to form part of the admission document. Comfort chart has been revised once the new document is in place to prevent duplication. Patient information reviewed for PU, leg ulcers and general wound care. Process agreed for translation / possibly to be ready to print or requested adhoc.

Wound Care Formulary Group

The wound care formulary group continue to meet monthly.
Pilot to streamline products and reduce silver in hospital completed over 4 wards with annual cost saving of 4K. Plans in place to roll out to rest of hospital.
Trust wide swaps agreed for tapes, adhesive remover, film dressings
Evaluations ongoing in maternity and orthopadics to look at options for alternative surgical type dressings.

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

	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
Falls - Number of Falls reported			89	89	▲	
Falls - Rate per 1000 Bed Days	6.63		5.32		▲	

What is driving the reported underperformance?

Performance results:

There were 89 falls reported during April 2018, equating to a rate of 5.32 falls per 1000 beddays for the month which is an improvement compared to 5.64 in February and achieves the Trust target of 6.63.

Based on Calendar Month		Feb-18	Mar-18	Apr-18
Count of Falls	Total	83	95	89
	MLTC	66	80	72
	Surgery	16	14	15
	WCCSS	1	1	0
	Comm / Corporate	0	0	2
	Other	0	0	0
Rate per 1000 beddays - All Falls		5.10	5.64	5.32
Rate per 1000 beddays - Moderate & Severe Falls		0.06	0.00	0.24

There were 17 reported incidents of patients falling more than once in April which is more than in March (15). In total these patients had 39 falls. The highest no.of falls were reported on Swift Discharge (13 falls), Ward 01 (10 falls), Ward 29 (9 falls) & Acute Surgical Unit (9 falls).

There were 4 falls resulting in moderate or severe harm(on Ward 14, Swift Discharge, Ward 09 & Ward 16 - patients suffered injuries to hips and arms).

NHS Safety Thermometer results for April show performance of 0.00% of Falls resulting in harm (this is based on the number of falls reported on a one day audit completed each month).

Benchmarking:

National benchmarking is via the National Inpatient Falls Audit 2015 which is endorsed by the RCP. National figures for falls are 6.63 per 1000 occupied bed days. Serious & Moderate Harm caused by falls is 0.19 per 1000 occupied bed days.

Contractual status:

No contractual requirements apply.

What actions have we taken to improve performance?

New actions:

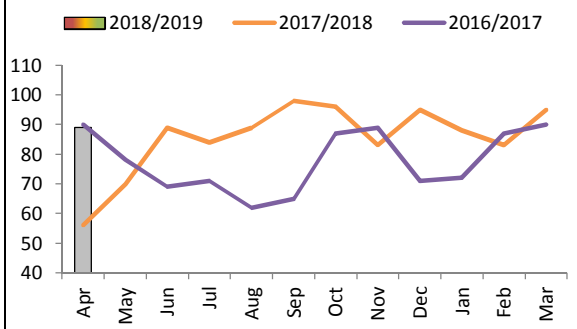
- New training programme has begun with face to face training at ward level this includes the use of bedrails. This training is evaluating well.
- The Trust has been accepted and is working collaboratively with NHSI regarding enhanced care.

Continuing actions:

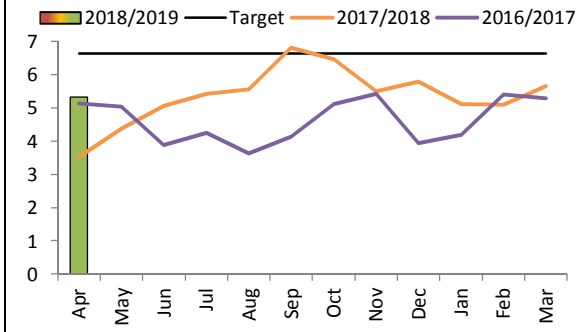
- Monthly falls audits continue.
- Falls dashboard is shared with all wards and is monitored via the ward review process.
- All incidents relating to falls are recorded within the Safeguard system.
- Safety huddles on wards continue.
– Moving and handling training includes Falls scenarios and includes 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.
- 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.

No Contractual Financial Penalties | **YTD £**

Number of Falls reported



Rate per 1000 Bed Days



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

National Contract		Local Contract	X	Best Practice		CQUIN	

Emergency Readmissions Within 30 Days

Walsall Healthcare NHS Trust

% of Emergency Readmissions within 30 Days of a discharge from hospital	Year Standard	Monthly Trajectory	Mar-18	YTD	Change on last month	Year End Forecast
	10.00%		10.26%		▼	

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

Performance results:

The percentage of emergency readmissions within 30 days of a discharge from hospital is reported one month in arrears.

This metric measures the percentage of patients who were an emergency readmission within 30 days of a previous inpatient stay (either elective or emergency). The criteria excludes Well Babies, Obstetrics and patients referred to the Early Pregnancy Assessment Unit. Performance is reported a month in arrears.
The performance for March was 10.26% which is a decline compare to 10.18% in February 2018 and narrowly misses the internal target 10%.

There were 548 emergency readmissions in March, of which, 55 wer related to GAU cohort.

Of the patients who were re-admitted in March:-
- Approximately 24% of the readmissions were aged under 30 (a decrease compared to 28% in February).
- Approximately 33% of the readmissions were aged over 70 (an increase compared to 28% in February).

The average number of days between the original admission and the re-admission is 9 which is comparable with February.

For those patients discharged in the month who were an emergency readmission within 30 days, the average length of stay of the readmission was 4.8 which is an increase compared to 3.9 in February.

Benchmarking:

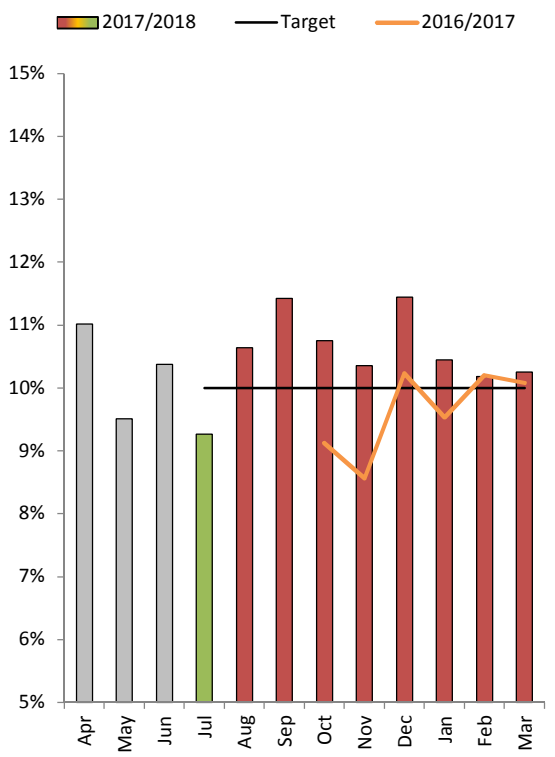
There are no formal national reports published for this metric.

Contractual status:

No contractual target, however performance is reported monthly to commissioners.

Continuing 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.
- The community services review all frequent admissions known to their caseloads and have demonstrated a reduction in admissions over the past year. Following a revised methodology to determine the performance for readmissions a robust piece of work will be undertaken in Month 6 to analyse trends and determine strands of work to be undertaken to review causation for key cohorts of patients.
- In line with this, work will be developed to link the work currently being done in the community around frequent admissions to those who are readmitting within 30 days to aid a better understanding of why these patients are frequently being admitted.



Expected date to meet standard	To be agreed.
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Electronic Discharges Summaries (EDS) completed within 48 hrs

Walsall Healthcare NHS Trust

Electronic Discharges Summaries (EDS) completed within 48 hrs	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
Number of EDS completed within 48 hrs of the point of patient discharge	100.00%		83.45%	83.45%	▼	

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 April to 83.45% compared to 89.51% in March, below the locally agreed target of 95%.

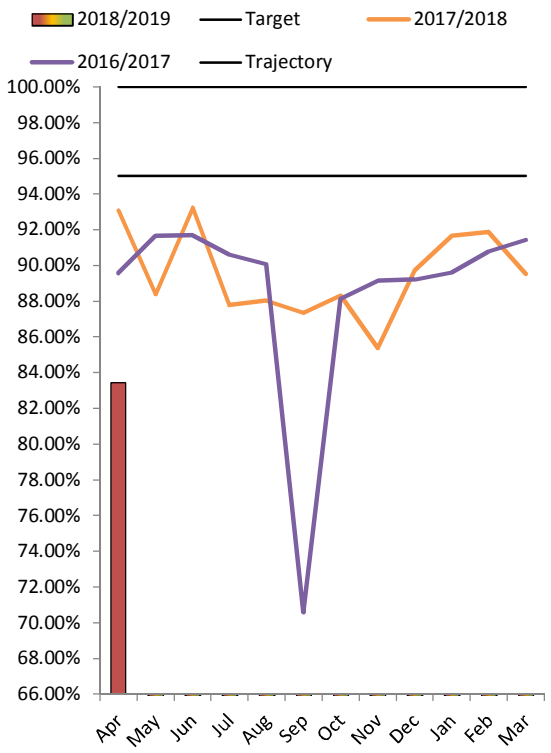
Divisional performance for April 2018 was as follows:-
- Surgery: 84.68% (89.88% in March)
- MLTC: 74.81% (90.43% in March)
- WCCSS: 92.80% (88.03% in March)

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:
- A programme of work is due to commence, led by the Medical Director & the Director of Nursing, which will cover monitoring and accountability for key quality metrics. Working alongside the Performance & Information department, a process will be set up to ensure compliance against the key metrics is shared with with each clinical area on a monthly basis.

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.



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	Mar-18	YTD	Change on last month	Year End Forecast
	90.00%		78.26%	59.54%	▲	

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 March 2018 the Trust failed to achieve the 90% screening target for patients aged 75 years and over with performance of 78.26%. This is an improvement compared to the reported result in February 2018 (72.12%).

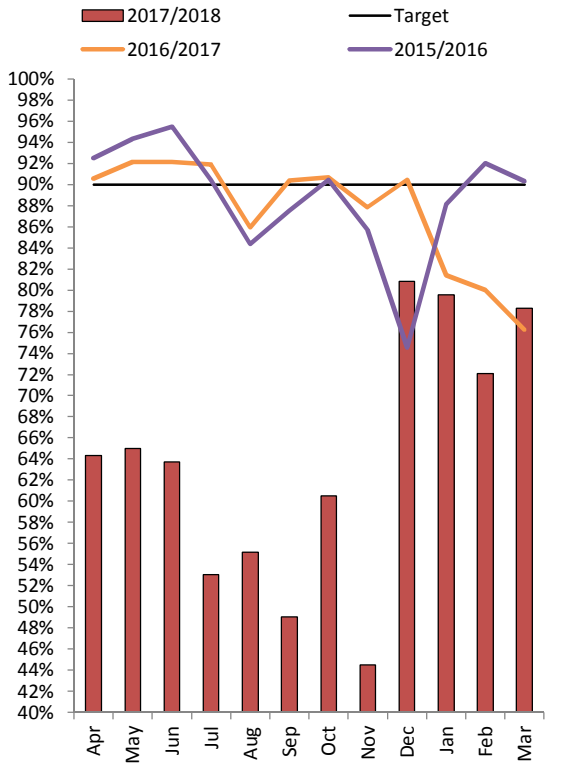
In agreement with WCCG and the Trusts executive lead, the reporting methodology has changed to utlising an audit approach rather than against the full cohort as it was not possible to capture the assessments for all applicable patients due to electronic system limitations.

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, however NHSI are aware of the situation and are investigating the apparent anomolies which exist between the methodologies applied when calculating performance achievement for national submission.

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 (All Services)

Walsall Healthcare NHS Trust

Friends & Family Test - ED (% Recommended) Friends & Family Test - Inpatient (% Recommended)	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
	85.00%		79.00%		▲	
	96.00%		96.00%		▲	

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	Mar	Apr
Inpatient	96%	94%	96%
Outpatient	96%	92%	92%
ED	85%	76%	79%
Community	97%	97%	99%
Maternity-Antenatal	95%	81%	90%
Maternity-Birth	96%	100%	100%
Maternity-Postnatal Ward	92%	96%	97%
Maternity-Postnatal Community	97%	98%	100%

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

Benchmarking:

For ED, the latest benchmarking (March) ranks the Trust 121st out of 132.

For Inpatients, the latest benchmarking (March) ranks the Trust 101st 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. Requests pending with Trust Charities group.
- The national award-winning Walsall Healthcare Paediatric app has clocked over 10,000 views and is an additional easy to use option for completing the FFT.
- Always Event® programme progressing well on AMU, intial feedback exercise to identify improvement opportunties with patients and carers has been completed. Next stage includes a staff feedback and focus group.

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 are being encouraged to increase use of ipads for improving quality of feedback and promoting accessiblity.

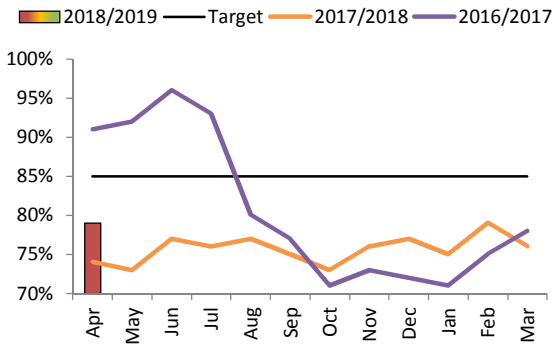
Community:

- Maintaining current level of support with Community Teams.

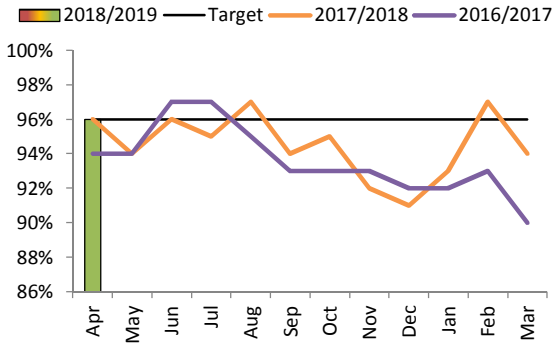
Continuing actions:

- 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 key staff online and via printed weekly reports.

Friends & Family Test - ED (% Recommended)



Friends & Family Test - Inpatient (% Recommended)



Expected date to meet standard	To be agreed
Lead Director	Director of Nursing

National Contract	X	Local Contract		Best Practice		CQUIN	

Walsall Healthcare NHS Trust

	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
Adult Safeguarding Training - Level 3 Compliance	85-90%		78.06%		▲	
Children Safeguarding Training - Level 3 Compliance	85-90%		73.72%		▲	

What is driving the reported underperformance?

Performance results:

There is a mandatory requirement for 95% of staff employed by the Trust to routinely undertake Safeguarding Training Levels 2 and 3 (Adults and Children). This is not currently being achieved.

Based on Calendar Month	Target	Mar-18	Apr-18
PREVENT Level 1 & 2	95%	96.56%	98.59%
PREVENT Level 3	95%	75.97%	76.07%
Adult Safeguarding Level 2	85-90%*	70.09%	74.57%
Adult Safeguarding Level 3	85-90%*	77.64%	78.06%
Children Safeguarding Level 2	85-90%*	73.25%	75.49%
Children Safeguarding Level 3	85-90%*	71.07%	73.72%

***Please Note we are waiting agreement with the CCG regarding training compliance targets for Safeguarding Adult & Children Level 2 & 3**

Reasons for underperformance include:
- a high volume of staff requiring training across the same period of time which brings pressures in terms of releasing staff from their duties to attend/complete training at a time when the hospital is under significant pressures
- a review of staff competencies in summer 2017 resulted in a number of staff changing levels of competency which adversely impacted upon the compliance rates.

Benchmarking:

No benchmarking data is available for these metrics.

Contractual status:

A Contract Performance Notice (CPN) was issued by Walsall CCG in April 2018.

What actions have we taken to improve performance?

New actions:

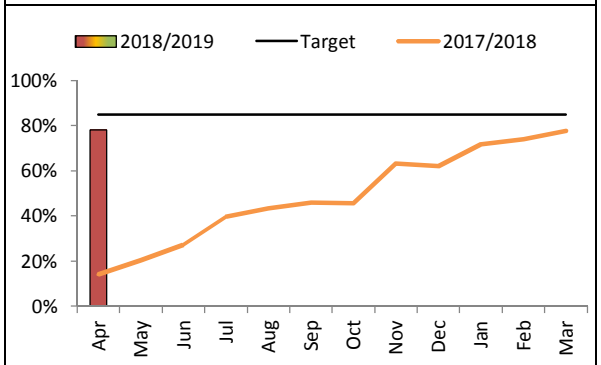
- Compliance against all metrics has been added to the performance and quality report to improve visibility with effect from April 2018.
- Corporate Senior Nurse receives and reviews a report regarding staff that may have DNA'd the training sessions on multiple occasions, for specific target and raising with their line managers.
- Face to face sessions arranged for Level 2 so that staff have a choice of training methodology.
- Staff requiring Level 3 training (face to face) automatically booked onto a training session and notified by MLCC.

Continuing actions:

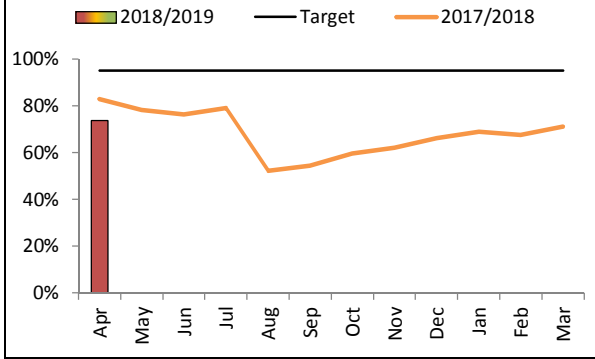
- Continual monitoring of training spaces to ensure adequate number of spaces for staff needing face to face training.
- Low compliance rates are recorded on the Corporate Risk Register and therefore reviewed on a regular basis.
- Compliance levels for Safeguarding and Prevent Training are regularly reviewed and discussed at the monthly Clinical Quality Review Meeting.

Contractual Financial Penalties | **YTD £**

Adults Safeguarding Level 3 Compliance



Childrens Safeguarding Level 3 Compliance



Expected date to meet standard	To be agreed
Lead Director	Director of Nursing

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Sickness Absence	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
	3.39%		5.06%	5.06%	▲	

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

Performance status:
Sickness levels improved in April with performance of 5.06% compared to 5.65% in March 2018 but did not achieve the target of 3.39%. This represents a rise of 0.56% compared to same period 2017/18.

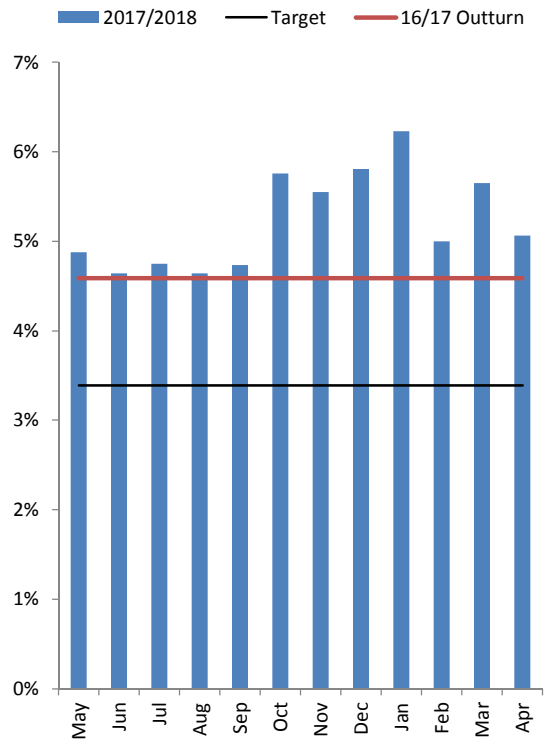
Monthly short-term sickness during April 2018 totalled an estimated cost of £160k and long-term sickness totalled an estimated cost of £281k.

There were 156 long-term episodes of sickness during April 2018 and 15 LTS cases extend to 6 months or more.
The largest cause of absence during April 2018 was Anxiety/stress/depression/other psychiatric illnesses - 1382 FTE Days across 85 episode(s) including 47 long-term.
The second largest cause of short-term absence was Other musculoskeletal problems - 692 FTE Days across 60 episode(s) including 22 long-term.
The sickness absence during the past 12 months stands at 5.32%, 1.93% above the Trust target.

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

Contractual status:
No contractual requirements apply.

Continuing Actions:
- HR identified a delay with managers closing down episodes of sickness absence, which can contribute to apparent increases in absence.
- The HR Op's team are continuing to work with managers to alleviate this.
- In respect to Mental Health the OH department offers weekly Stress Management groups for staff. Walsall & Dudley Mental Health Trust have put on 1 training session to date, with 2 pending; offering managers training 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; something which will be promoted during the May 18 Mental Health week.
- The Health & Well-being hub continues to roll out schemes and embed/promote heathy lifestyle benefits.
- The HR Team continue 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 Trust

PDR Compliance	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
	90.00%		80.55%	80.55%	▲	

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 April 2018 was 80.55%, an increase on March's 78.17%. This represents a rise of 2.38% month on month.

Compliance amongst directors & board members was 17% and 119 Band 7 & above colleagues required an annual appraisal at the end of April 2018, resulting in a 79% compliance rate for this group.

The majority of divisions experienced a rise in compliance levels over the past month, of between 1% and 12%.

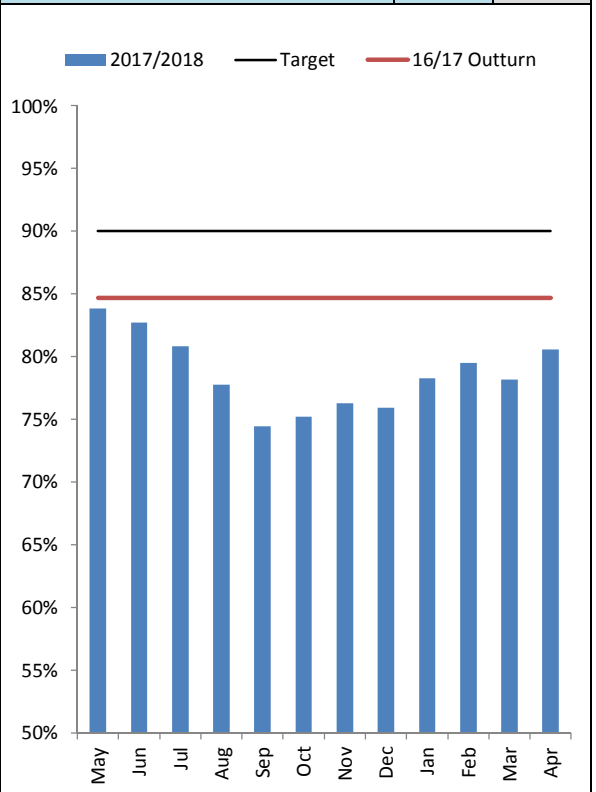
The Women's, Children's & Clinical Support Services division has the highest level of compliance at 88.63%.

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

Contractual status:
No contractual requirements apply.

New Actions:
- Training sessions for Appraisers were rolled out during Feb/Mar 18 and are on-going.
- An Appraisal themed Listening into Action event took place during March 2018, which fed into a review of the IPDR policy and accompanying paperwork.
- The appraisal paperwork will be redesigned and linked to the new Trust Values & Behavioural Framework.

Continuing Actions:
- The publication of HR KPI league tables, with the performance of services ranked in a meaningful and engaging way, is being tabled for Q2 18/19.
- 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 Trust

Mandatory Training Compliance	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
	90.00%		76.99%	76.99%	▲	

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 April have improved to 76.99% compared to 76.61% reported in March. A rise of 0.38% month on month. This represents a fall of 2.66% since the end of Q3 17/18 and a fall of 3.77% compared to the same period last year.

4 of the 8 core mandatory competences saw compliance increase by up to 2% month on month.

The largest improvement owed to Information Governance, whereby compliance rose by 2.26% 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.

New Actions:
- Learning & Development plan to produce guides on how to access e-learning; improving the experience of users and also taking note of new facility to complete training remotely via the myESR mobile phone app or website.

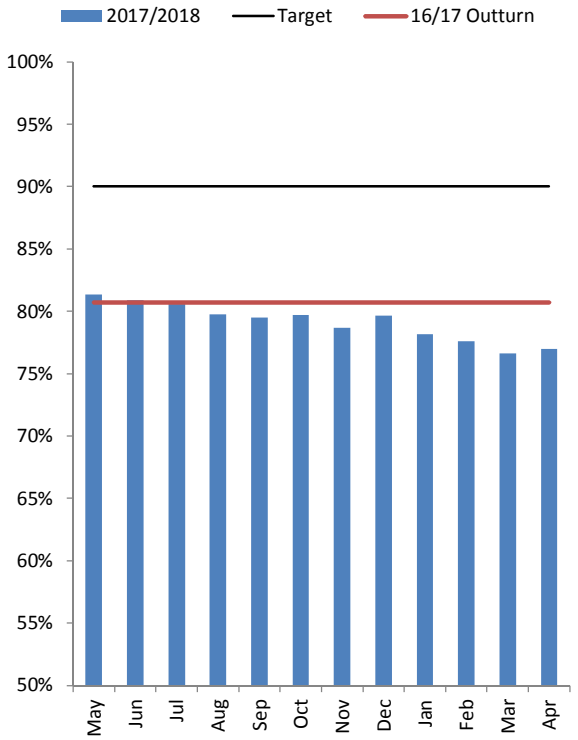
- Facilitated E-Learning workshops have been held, offering 1-1 advice for any colleagues struggling to access training.

- Further to this, Learning & Development colleagues have been visiting departments to give training and advice.

- Colleagues are being 'auto enrolled' onto classroom courses; giving them and managers 6 weeks' notice to plan attendance.

- The number of classroom sessions has been increased.

- Paper assessments are still available for any colleagues having difficulty with computer access.



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.)
Final achievement pending Commissioners confirmation

	Total year 1	Q1 - Confirmed	Q2 - Confirmed	Q3 - Confirmed / (Expected)	Q4 - Confirmed / 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 for March 2018 reduced to 0.272 however did not achieve the 0.04 national target.
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 **Confirmed by WCCG 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: Confirmed by WCCG Achieved.** There were 8 patients who scored zero who now require personalised care plans.
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% Achieved 97%**
			£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%. Achieved 88%.**
			£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%. Achieved 88%**
			£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%. Achieved 91%.**
			£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 & Q3Confirmed Achieved by WCCG. Q4 target 85%. Achieved 100%.**
Sub totals	£276,091	£69,023	£69,023	£69,023	£69,023	

Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) MD	£257,685	£8,053	£8,053	£8,053	£8,053	**Timely identification of sepsis in emergency departments** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis The indicator applies to adults and child patients arriving in hospital as emergency admissions A minimum of 50 records per month after exclusions for ED. 90% Target. Sliding scale 50-89% = 10%. **Status:** The audit methodology of NEWs scores continues not to identify the full required number of patients and continues to be time consuming. A centralised database is being created during Q3 to support the audit process. Risk: **Q1 achieved 95.33%. Q2 achieved 94.85% Q3: 95.77% Achieved. Q4 achieved 93.59%**
		£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 achieved 90.48%.
		£3,221 £4,832	£3,221 £4,832	£3,221 £4,832	£8,053	**Timely treatment for sepsis in emergency departments** The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour. Applies to adults and child patients arriving in hospital as emergency admissions. 90% Target. Sliding scale 50-89% = 10% **Status:** Actions taken; additional teaching, grand round presentation, raising awareness through care groups, wards and mandatory training. **Risk:** Q1 86.21% partial achievement 10%. Q2 88.57% partial achievement 10%. **Q3: 89.34% partial achievement 10%.** Q4 achieved 96.43%
		£3,221 £4,832	£3,221 £4,832	£3,221 £4,832	£3,221 £4,832	**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 partial achievement 67.31%
		£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 submitted to PHE via an online submission portal. Q4 =
					£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:** All data has been submitted to PHE, awaiting validation
					£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**: All data has been submitted to PHE, awaiting validation
					£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:**All data has been submitted to PHE, awaiting validation
Sub totals	£257,685	£48,317	£48,317	£48,317	£112,738	
Supporting Proactive and Safe Discharge – Acute Providers COO (a&c) D of S&T (b)	£460,151		£184,060			Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories **Q2:** i) Map and streamline existing discharge pathways across acute, community and NHS-care home providers, and roll-out protocols in partnership across local whole-systems. ii) Develop and agree with commissioner a plan, baseline and trajectories which reflect expected impact of implementation of local initiatives to deliver the part b indicator for year 1 and year 2. As part of this agree what proportion of the part b indicator for each year will be delivered by the acute provider and what proportion will be delivered by the community provider. Achievement of part b will require collaboration between acute and community providers **Status**: **Confirmed by WCCG Achieved.**
		£69,023				Emergency Care Data Set (ECDS) To have demonstrable and credible planning by the end of Quarter 1, in order to commence timely submission of data from 1st October 2017 Q1: Type 1 or 2 A&E provider has demonstrable and credible planning in place to make the required preparations (e.g. by upgrading IT systems and training staff) so that the Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017. **Status:** plan submitted pending WCCG decision on payment. **Risk:** Confirmed by WCCG Achieved.
				Q3 moved into Q4 as agreed with WCCG	£11,504	Q3: Go live with ECDS. **Status:** Due to the delay with the Lorenzo upgrade by the system provider it was not possible to achieve the Q3 requirements , following our request WCCG have agreed to move the CQUIN requirements from Q3 into Q4. project plan is progressing, initial data flows have commenced, 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. Extension granted by WCCG for this submission to obtain further information.
Sub totals	£460,151	£69,023	£184,060	£0	£207,068	
Sub Total WCCG	£2,742,503	£340,973	£726,580	£310,603	£1,364,350	

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 **Confirmed by NHS E achieved.**
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 confirmed by NHS E achieved.
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

MEETING OF THE PUBLIC TRUST BOARD – 7 June 2018					
Performance Finance and Investment Committee Highlight Report				**AGENDA ITEM: 18**	
Report Author and Job Title:	John Dunn, Committee Chair		**Responsible Director:**	Russell Caldicott, Director of Finance & Performance	
Action Required	**Approval**	**Decision**	**Assurance and Information**		
			To receive and discuss X	**To receive**	
Recommendation	Members of the Trust Board are asked to receive the report for information and discuss any key information provided.				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline					
Resource implications	There is no resource implications associated with this report.				
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.				
2018/19 Objectives	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme			X	
	Develop the culture of the organisation to ensure mature decision making and clinical leadership			X	
	Improve our financial health through our robust improvement programme			X	
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts			X	

Walsall Healthcare NHS
NHS Trust

Finance, Performance and Investment Committee Highlight Report

1. PURPOSE OF REPORT

The purpose of the report is to highlight the key issues from the meeting held on the 30 May 2018 together with the approved minutes of the meeting held on the 21 February 2018 and an extra ordinary meeting held on 8 March 2018.

2. BACKGROUND

The Committee reports to the Trust Board each month following its meeting. The Board receives the approved minutes from the previous Committee meeting and a highlight report on the key issues raised at the most recent meeting.

3. DETAILS

The meeting was quorate, and the following items were discussed:

Divisional Presentation – Surgery
A comprehensive presentation covering 2017/8 outturn and the finance and operational plan for 2018.

The plan was well structured and demonstrated a clear linkage to the improvement work stream initiated last year within the FIP programme. Weekly performance was reviewed and an early results show improvement. Further work is on-going to refine the process statistics and to understand the weekly variance in performance. Lots of work to be done to fully underpin the plan and budget but a really first rate start to the year.

April 2018 Financial performance
Performance was adverse to plan mainly due to temporary staffing spend. Work is currently underway to refine the financial plan with a clear focus on reducing the overall run-rate to bring performance back to plan. Details will be available for the June committee meeting and will cover: Bed utilisation, use of agency and bank usage.

Cost Improvement Programme
The current status of the plan was discussed in detail, whilst month 1 saw a disappointing delivery, the plan to deliver the £13 m target was looking more robust with assured plans for £6m with ideas and initiatives bring the total to £12m. Work was continuing to convert the list of initiatives into firm plans.

Budget Control Target Proposal
A review was underway looking at the implications and practicality of delivering the revised budget. Whilst the work has not yet been finalised, it does offer some tangible benefits to the Trust.

Temporary Staffing
Nursing agency and bank usage was adverse to plan for month 1, May position has improved, and it was agreed to update the committee on further actions to address the position in June.

Constitutional standards operational report
A strong performance for the month highlights:

- Cancer standards met
- A&E performance in advance of plan
- Medically fit list is reducing facilitating improved patient flow
- RTT performance on plan

4. RECOMMENDATIONS

The Board is recommended to DISCUSS the content of the report and raise any questions in relation to the assurance provided.

Report Author: John Dunn, Committee Chair PFIC
Date of report: 31 May 2018

APPENDICES
Minutes

Walsall Healthcare NHS
NHS Trust

MINUTES OF THE PERFORMANCE FINANCE AND INVESTMENT COMMITTEE HELD ON MONDAY 21st FEBRUARY 2018 AT 2.00 P.M. IN MEETING ROOM 10, MLCC

Present:	Mr J Dunn	Non-executive Director (Chair of Committee)
	Mr S Heer	Non-executive Director
	Mr R Kirby	Chief Executive
	Mr R Caldicott	Director of Finance and Performance
	Mr A Khan	Medical Director
	Mrs L Ludgrove	Interim Director of Human Resources and Organisational Development
	Mrs B Beal	Interim Nurse Director (up to Item 175/17)
	Mrs L Storey	Trust Secretary
	Mr P Thomas-Hands	Chief Operating Officer
In Attendance:	Mr C O'Toole	KPMG (Item 171/17 & 172/17 only)
	Ms B Fenton	KPMG (Item 171/17 & 172/17 only)
	Dr K Gnanaolivu	KPMG (Item 171/17 & 172/17 only)
	Mrs C Dawes	Executive Assistant (Minutes)
Apologies:	Mr D Fradgley	Director of Strategy & Improvement

The Chair welcomed everyone and opened the meeting. Apologies were noted and the meeting was declared quorate.

168/17 Declarations of Interest **ACTION**

There were no declarations of interest.

169/17 Minutes of the Meeting held on 24th January 2018

Resolution:
The minutes of the meeting held on 24th January 2018 were approved as an accurate record.

170/17 Matters Arising and Action Sheet

The Committee received the status of the actions.

The Director of Finance and Performance advised the position of the Carter Benchmarking had not changed since he presented the report in August 2017. The Carter data had since been refreshed and confirmed the Carter Lead for the Trust was the Director of Strategy & Improvement who would present future quarterly reports.

Resolution:
The Committee received and noted the status on the actions.
Noted future Carter Benchmarking reports would be presented by the Director of Strategy & Improvement.

Mr O'Toole, Ms Fenton and Dr Gnanaolivu joined the meeting at this point.

171/17 Forecast Outturn 2017/2018

The Director of Finance and Performance outlined the 2017/2018 Forecast Outturn position and highlighted the following:

- The Trust had a £20.5m deficit target for 2017/18. Key reporting of performance on a monthly basis had shown:
  - An increasing adverse variance to financial plan (month on month).
  - Corporate Risk Register (high risk to delivery).
  - Board Assurance Framework (high risk to delivery).
  - Commissioned KPMG as FIP (2) partner to support delivery.

- Previous reports had indicated high financial risk to attainment of the outturn, endorsing a recovery plan for ensuring attainment of the 2017/18 outturn

- The Trust was now reporting a £3.6m adverse variance to plan as at month 10.

- The key risks and mitigations in delivery of the financial plan have been identified.

- The unmitigated outturn was £27.7m resulting in a shortfall of £4.6m.

- Incremental changes anticipated to improvements in Divisional positions and Workstreams for Theatres, Outpatients and Temporary Workforce had deteriorated.

- Financial adjustments were anticipated due to asset sales, winter allocation, balance sheet and the Apprenticeship Levy.

- The remaining gap would be £2.5m if all of the above actions were delivered.

  Key drivers were prioritisation of ED over elective activity and temporary workforce premiums. In nursing a change of practice around risk resulted in attempts to resource RN vacant shifts with RN's (practice of using CSW posts deemed not appropriate by the Director of Nursing) due to a change in view on risk. A further review on medical workforce was required to secure the benefits originally anticipated.

- As a result of the worsening position at month 10, the Trust was now reporting a likely deficit of £24.6m for the 2017/18 financial year.

- If the Trust was allowed to retain CQUIN 2017/18 finances and Winter Tranche 1, the deficit would be restated to £23.0m.

<u>Questions and Comments</u>

The Chair noted the worsening position and commented on the serious

issue that the organisation appeared to have lost traction and wanted to understand the reasons behind this as the Financial Plan of £20.5 had been signed off by the divisional teams and Trust Board.

There was a discussion on the timeframe required to complete the asset sales to enable them to be included in the current financial position. The Director of Finance & Performance advised he was awaiting a response from the External Auditors.

The Chair requested a paper outlining the financial position the Trust would accept to enable to Trust Board to make a decision. Where plans were considered not fit for purpose the committee needed to know what the issues were. **RC**

Resolution:
The Committee:

- **Received and noted the content of the Financial Outturn 2017/2018.**
- **Noted the deterioration in the financial position at month 10**
- **To receive an updated Financial Plan for approval by the Trust Board at its meeting on the 8th March.**

172/17 Financial Recovery Plan Update

The Chair opened by asking KPMG to affirm the plans were attainable and the recovery programme deliverable, with all officers signed up to delivering the service and financial benefits outlined in the Financial Recovery Plan.

Mr O'Toole gave assurance the targeted improvements were attainable, the plans owned by the Trust officers and assured through the work of the teams on site for KPMG. Mr O'Toole then presented the Financial Recovery Plan Update and the following points were highlighted:

- A weekly financial tracker was provided indicating progress week by week against plan for each of the Workstreams

- A daily escalation policy had been agreed at the Performance & Finance Executive (PFE) meeting

- Slippage time to make decisions had been approximately 2-3 weeks (but should be made in days). Some actions were now 3 weeks old.

The following updates were noted for the workstreams:
Outpatients:

- There had been slippage in Q3 as the workstream had struggled to get traction (turnaround time was 2-3 weeks rather than days).

- Delays in communications going out had been escalated to the Chief Operating Officer and PFE. The divisions of Medicine and WCCSS committed to book patient appointments this week/DD for Surgery on leave – Mr Khan agreed to progress and get traction.

- Clinic late starts – no progress on action agreed at PFE over 3 weeks

ago – face to face meetings with clinicians required

Theatres:

- There had been improvement week on week but had dipped from Christmas. Last week was the highest effort but was still off track.
- Clinical practices – there was resistance to change in some specialties
- Bookings for a richer case mix which attracts higher income

Patient Flow

- Some extra capacity beds had now closed (Endoscopy and Starling)
- Plans had been agreed for the closure of other additional capacity areas by the end of March

Procurement

- Good engagement with clinical teams and progress was being made with rationalisation of products
- Contracts had been tendered and savings identified

Grip and Control

- Good engagement from the divisions
- Need to start monitoring to ensure compliance

Temporary Workforce - Medical

- Additional Medics were covering extra capacity for winter period and could be removed if bed base reduced and covered by medics from other wards

Temporary Workforce - Nursing

- Additional capacity remained open requiring additional temporary staff
- The risk profile for filling of RN & CSW shifts had been changed resulting in significantly more shifts being used in agency and bank, this was raised as a key concern, why was the Trust Board unaware of this stance and the Director of Nursing was asked to attend the next meeting of PFIC to understand the change and impact on this and next financial year. **BB**
- Roster clinics had been established to ensure that all rosters are quality assured in relation to skill mix and signed off 42 days in advance and all known gaps released to bank at 42 days

<u>Questions and Comments</u>

The committee noted the content of the report and the updates provided

and raised concern that traction had slipped within the workstreams, together with the capacity and capability to sustain the efforts when support from KPMG had ended.

Members raised concerns that the commission for the phase 4 work from KPMG had not delivered the benefits articulated within the Financial Recovery Plan and the Trust is still to see the benefits associated with the work-streams for productivity and temporary workforce controls (specific areas associated with the KPMG FIP (2) commission). **RC**

Mr O'Toole indicated the delays in implementation of actions and Mrs Gnanaolivu referred to an issues list, citing traction within the operational teams as a reason for delayed realisation of the benefits from the work-streams.

The Chair challenged the basis for commissioning Phase 4 (referring to KPMG being with the Trust for the previous phases) as being to deliver the outturn of £20.5m for the year and exit the year at the right run rate.

Ms Fenton stated that the plan was not able to be delivered owing to capability and capacity of the internal Operational and Improvement teams, and their ownership of the plan with their being pulled in different directions through having competing priorities.

The Chair and Executives challenged this stance, the Chair referring to his opening statement and the assurance provided by Mr O'Toole as evidence the plan was owned and deliverable, supported through KPMG.

Mr O'Toole assured members the plan was deliverable and the Chair requested a handover plan from KPMG to officers of the Trust be presented at the next meeting of the Committee.

Resolution:

The Committee:

- **Received and noted the content of the updated Financial Recovery Plan**
- **Requested an extraordinary meeting of members to assess the ability to deliver the outturn prior to adoption of a revised forecast by Trust Board** **RC**
- **Noted the risk to outturn and the areas current underperforming in regards to the FRP**
- **Requested KPMG present on the handover plan to the next Committee meeting** **KPMG**
- **Requested Director of Nursing attend to affirm the rationale for practice changes and mitigation of impact on 2018/19** **BB**

Mr O'Toole, Ms Fenton and Dr Gnanaolivu left the meeting at this point.

173/17 Temporary Staffing

The reports on Nurse Rostering and Annual Leave Planning/ Forecast Outturn for Nursing, Medical and Others were taken as read and not discussed at the meeting.

Resolution:

The Committee:

- **Received and noted the content of the reports on Nurse Rostering and Annual Leave Planning and the Forecast Outturn for Nursing, Medical and Others**

174/17 Internal Audit Reports

The Internal Audit Reports for Temporary Staffing Nursing and Temporary Staffing Non-Nursing/Non-Medical were not discussed at the meeting.

Resolution:

Agreed the Committee would receive the Internal Reports for Temporary Staffing Nursing and Temporary Staffing Non-Nursing/Non-Medical at another meeting

175/17 Updated Financial Plan 2018/2019

The Director of Finance & Performance gave an update to the Financial Plan 2018/2019 presented at the previous meeting advising the NHSI Guidance and the Control Total had been issued and the key messages were noted:

National Constitutional Standards

- ED 90% by September 2018, 95% by March 2019
- RTT expectation is that the waiting list at 31st March 2019 will be no more than that at 31st March 2018 (with over 52 week waiters halving)
- Cancer, no change

Additional resources

- STF increases from £1.8m to £2.45m (£645m increase) but only can be received if Trusts accept their control totals
- CCG allocations increase by £600m and freedom given to commit the previously held CQUIN resource (£370m)

The national contracting and planning timetable for 2018/19

- Draft Organisational Operational Plans – 8th March
- Signing of contract variations & contracts – 23rd March
- Final Board approved Operating Plans – 30th April

- The Trust had developed a financial plan that indicates an £18m deficit upon delivery of a £13m CIP (with only 1% allocated to cost pressures and developments) though a £1m contingency was also included

- The Trust had received its control total which was a £5.465m deficit (with STF at £9.939m this would result in a £4.474m surplus plan for the financial year).

- The Trust would require a CIP delivery of £25.635m (the £13m plan increasing by £12.635m). This represents a CIP target of in excess of 10% for the financial year and would give rise to serious concerns on the Trust's ability to deliver safe patient care within this envelope of funds.

Questions and Comments

The committee noted the content of the updated Financial Plan and raised concern about the delivery following earlier conversations within the meeting.

There was a discussion about the capacity and capability to deliver the 2018/19 Plan after KPMG support had ended. The Director of Finance & Performance advised support for managers moving forward would be discussed with the Executive Team and the next Performance & Executive meeting.

Committee discussed the need to be honest over a three year time horizon and what was deliverable within the time period afforded to the Trust. The three year plan overlaid with strategy information as to what the Trust will do moving forward in redevelopment of the services to assure financial sustainability.

The Chair requested a further version of the draft plan submission be reviewed prior to Trust Board adoption of the initial submission next week and agreement reached to form an extra-ordinary meeting of PFIC prior to Private Trust Board.

Mrs Beal left at this point in the meeting.

Resolution:
The Committee:

- **Received and noted the content of the Updated Financial Plan 2018/2019 and requested formal presentation at an extra-ordinary meeting of members prior to Trust Board**

176/17 Service Line Reporting

The Service Line Reporting paper was taken as read.

The Medical Director queried how long the non-elective medicine and specialist medicine groups had been separated, The Director of Finance & Performance agreed to check and respond.

The committee commented that it was easier to get a connection with the data when presented in that way.

Resolution:
The Committee:

- **Received and noted the content of the Service Line Reporting report**

177/17 Constitutional Standards Operational Update

The Chief Operating Officer gave an overview of the Constitutional Standards relating to Emergency Department, Elective Access and Cancer. The key messages were highlighted as:

Emergency/Urgent Care:

- January performance had decreased to 82.38% compared to 83.38% in December.

- Focus continued on SAFER, Red to Green, ED processes, ward reconfiguration and Medically Fit for Discharge (MFFD).

- January saw continued high levels of ambulances to ED (90+ ambulance arrivals on 18.

- Admissions per day had increased from 93 in December to 95 in January.

- The trajectory for four hour performance was to achieve 90% in September with a dip in December performance and an improvement back to trajectory in February and March 2018. It was expected that the Trust would achieve an actual performance in the late 80%'s by the end of October.

- Acuity of patients had decreased in January.

- Infection Control ward closures had impacted on patient flow but the closures had been successful and pragmatic.

- There were no 12 hour breaches.

Elective Access:

- Performance in January was 82.38%, which was an improvement compared to December.

- The resubmitted forecast was to achieve just below 92% at the end of March 2018. NHS Improvement had been in agreement with the trajectory, further work had been requested by the commissioners and a response was awaited from NHS England.

- The outpatient clinic utilisation had increased in January with almost 30,000 attendances (overall total of 90.47%).

- The focus was to reduce WLI sessions and focus on improving the core utilisation in outpatients. Work was on-going with support from KPMG with both outpatient and theatre work streams.

- The trajectory assumed delivery without WLI activity.

Cancer:

- All national cancer measures achieved in December with the exception of 62 day consultant upgrade. Initial un-validated performance for January shows achievement of all cancer measures.

- There was one 52 week breach in December.

Diagnostics:
January performance was 99.54% thus achieving the 99% target.

Winter Plan Update

- Wards 10 and 14 were open in January with medical patients to maintain flow out of ED

- Starling Unit had been used throughout January

- On occasion Endoscopy Unit was used overnight to reduce ED waits with no delays to endoscopy treatments.

- Activity was reduced to allow for rising demand and increased LoS

- No 12 hour breaches over the winter period

- Bays had been closed for observation for 48 hours where patients identified positive for Flu. There had been no evidence of cross inflection from positive patients to other patients in the bay.

- The MFFD list in January had reached 115 patients. Pilot integration of organisational teams implemented on 20th November with a trajectory of 90 patients by end of November and 80 patients before Christmas had not been achieved finishing at 89 before Christmas.

- A full review would be undertaken at the end of the winter period.

Next steps:

- To mitigate the financial loss incurred by focussing on the outpatient, theatre and patient flow workstreams

- To design an ECIP work programme to identify key system improvements to deliver a sustainable service

Questions and comments:

The Chair summarised by noting the good results given the challenges teams dealt with over the winter period and to concentrate now on improving performance to increase income.

The Chief Executive expressed his thanks to the operational teams for managing over a difficult and challenging period.

Resolution:
The Committee:

- **Received and noted the content of the Constitutional Standards Operational Update.**
- **Noted the high level of activity and improved performance and noted the Update on the Winter Plan**

178/17 Performance and Quality Report by Exception

The Performance and Quality Report was taken as read.

The Director of Finance highlighted that Walsall CCG were looking at an Information Breach regarding VTE and also that the Midwife to Birth ratio was improving.

Resolution:

The Committee:

- **Received and noted the content of the report.**
- **Further work needed to increase births to cap**
- **Further assurance sought on delivery of the VTE national standard**

179/17 Annual Objectives Performance Update

The Trust Secretary presented the Annual Objectives Performance Update highlighting the RAG ratings showed improvement in all but finances.

Resolution:

The Committee:

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

180/17 Gastroenterology Business Case

The Chief Operating Officer gave an overview of the Gastroenterology Business Case advising there were three phases to the case and he was requesting approval for phase 1 which was around the pre-assessment for JAG Accreditation. The committee asked if the case was supported by the Director of Finance who confirmed support of phase 1 to obtain JAG accreditation. However, Phases 2 and 3 would require further work before they could be presented to the committee for recommendation to the Trust Board.

The Chair asked members if they were happy to endorse Phase 1 of the Business Case if an amended version was submitted specifically requesting support only included in Phase 1 of the draft by the COO. Members were in agreement and the Chief Operating Officer was requested to submit an amended paper for endorsement by the Chair ahead of recommending to the Trust Board in March.

Resolution:

The Committee:

- **Received and noted the content of the Gastroenterology Business Case**
- **Agreed to endorse an amended version of Phase 1 for JAG accreditation** **PTH**

181/17 Award of Contracts

The Director of Finance and Performance gave an overview of the Award of Contracts for arthroscopy consumables, wheelchair approved repairer, laundry/linen and special laundry confirming tender exercises had been undertaken, the contracts would save on costs and the details had been endorsed through the medical teams. The Committee received and noted the reports and agreed to recommend the contract awards to the Trust Board for approval.

Resolution:

The Committee:

- **Received and noted the content of the Award of Contract for arthroscopy consumables, wheelchair approved repairer, laundry/linen and special laundry**
- **Agreed to recommend the contract awards to the Trust Board for**

approval.

18217 ANY OTHER BUSINESS

PTS Contract

The Director of Finance & Performance gave a verbal update on the contract for Patient Transport advising further discussions had taken place with WMAS who had agreed to extend their current contract. A further meeting had been agreed to discuss their proposal moving forward into the next financial year.

Farewell to the Chief Executive

The Chair expressed thanks and best wishes on behalf of the Committee to Mr Kirby who was leaving to take up his new roles as Chief Executive of Birmingham Community Healthcare and interim Chief Executive of the Black Country Partnership Trust.

Resolution:

The Committee:

- **Received and noted the update on the PTS contract**
- **Expressed thanks and best wishes to the Chief Executive**

183/17 Date of Next Meeting

The next meeting of the Committee would be held on of **Wednesday, 28th March 2018 at 2p.m.** in Room 10, Manor Learning and Conference Centre, Walsall Manor Hospital.

Walsall Healthcare NHS
NHS Trust

MINUTES OF THE EXTRAORDINARY PERFORMANCE FINANCE AND INVESTMENT COMMITTEE HELD ON THURSDAY 8TH MARCH 2018 AT 8.00 A.M. IN MEETING ROOM 10, MLCC

Present:	Mr J Dunn	Non-executive Director (Chair of Committee)
	Mr S Heer	Non-executive Director
	Ms D Oum	Trust Chair
	Mr R Beeken	Chief Executive
	Mr R Caldicott	Director of Finance and Performance
	Mr D Fradgley	Director of Strategy & Improvement
	Mrs L Ludgrove	Interim Director of Human Resources and Organisational Development
	Mrs B Beal	Interim Director of Nursing
	Mrs L Storey	Trust Secretary
In Attendance:	Mr R Beale	Non-Executive Director
	Mrs C Dawes	Executive Assistant (Minutes)
Apologies:	Mr A Khan	Medical Director
	Mr P Thomas-Hands	Chief Operating Officer

The Chair welcomed everyone and opened the meeting. Apologies were noted and the meeting was declared quorate.

The Chair advised the Financial Outturn position had been reviewed at the Performance, Finance & Investment Committee last month and had been disappointed that the financial plan would not be delivered. The extraordinary meeting had been arranged to understand what the anticipated year-end position would be and what assurance would be given to the Trust Board moving forward.

184/17 Declarations of Interest

ACTION

There were no declarations of interest.

185/17 Year End Outturn 2017/2018

The Director of Finance and Performance gave an overview of the 2017/2018 Forecast Outturn and highlighted the following:

- The Trust had a £20.5m deficit target for 2017/18. Key reporting of performance on a monthly basis had shown:
  - An increasing adverse variance to financial plan (month on month).
  - Corporate Risk Register (high risk to delivery).
  - Board Assurance Framework (high risk to delivery).
  - Commissioned KPMG as FIP (2) partner to support delivery.

- Previous reports had indicated high financial risk to attainment of the outturn, endorsing a recovery plan for ensuring attainment of the 2017/18 outturn

- The likely outturn for 2017/18 was stated as being a £23m deficit following the increased use of Nursing temporary workforce within the Trust following a change in practice and delays in generation of productivity gains from the outpatients and theatre improvement programmes. The Director of Finance noted it was disappointing for the financial recovery plan to not have delivered the benefits required, and more so that the financial overspends were located within the areas supported by KPMG phase 4 of FIP (2)

- A further review was ongoing to ascertain if the position could improve from a £23m deficit, by delivering more of the planned benefits from the work programmes identified in the latest recovery plan.

- The work KPMG was to undertake would be key to delivery, noting the Trust had agreed to phase 4 of the KPMG commission on the basis of their supporting delivery of the required improvements.

- NHSI representatives had indicated to the Trust that the revised forecast should reference reliance upon retention of the CQUIN and winter tranche 1 but not show the impact of losing this resource within the revised forecast outturn.

Questions and Comments

The Chair noted the worsening position and commented on the serious issue that the organisation appeared to have lost traction over recent months and wanted to understand the reasons behind this as the Financial Plan of £20.5 had been signed off by the divisional teams and Trust Board.

There was a discussion on the outpatients' workstream that was beginning to show improvements and it was noted that further work was being undertaken on forward bookings.

There was a discussion about holding people to account for not delivering the plans, the increasing expenditure and delays in getting traction within the outpatients, theatres and workforce workstreams. The committee questioned the organisations urgency and willingness to change the culture and processes moving forward into 2018/19 and to apply sanctions when the accountable people do not deliver. It was agreed discussion would be taken offline on the meaning of accountability and define what accountability means to the organisation. Mr Dunn offered his time to meet weekly with the Director of Finance & Performance and Chief Operating Officer to develop an accountability framework. **JD/RC/ PTH**

The committee raised concern that the KPMG support was coming to an end and a handover plan had not been shared. Also, as raised in previous meetings, details of how the resource gaps would be addressed moving forward have not been confirmed. The Chief Executive responded advising he and the Director of Finance & Performance had received the first cut of the handover plan and further work was required to assess the risk of implementation from 1st April 2018. The Director of Finance highlighted the need for KPMG to share the plan to gain management **KPMG**

agreement and it was noted the final handover plan would be received at the next full committee meeting.

Concern was raised about the protocol, process and governance of the nursing temporary workforce as the paper received at the previous committee meeting had not addressed who had agreed the changes to the nursing workforce and requested details of what the KPI parameters were before and after the changes had been agreed.

The Interim Director of Nursing responded advising she had taken the decision to seek to fill RN's to funded establishment levels and took full responsibility for the decision. The Director of Nursing asked for the minutes to record that she was not made aware of the agreement to manage RN gaps in rotas owing to vacancies and to service additional capacity with CSWs by the previous Director of Nursing. As the responsible officer she was not prepared to take the professional responsibility and took the view that nurse staffing was not safe or appropriate and took action to ensure wards were made safe within the agreed establishment numbers.

The Director of Nursing confirmed plans had been agreed to pull out of using Thornbury nurses from 1st April 2018 except in Critical Care. The Trust Chair clarified the Trust Board understood that risks regarding nursing with vacant RN posts was being mitigated through increased CSW use and this was therefore a change in practice that had resulted in costs increasing beyond plan.

The Chair further highlighted concerns over the increasing run rate for temporary nursing giving rise to a potential cost pressure in the 2018/19 financial year of approximately £2m. The Director of Nursing was asked to present at the next PFIC a report on how measures deployed would mitigate these costs and risk to delivery of the 2018/19 plan. **BB**

It was noted the recruitment run rate had improved and the tightening of processes including off duty rostering, expenditure would reduce. The committee requested a report describing how local organisations manage the staffing situations and processes be shared with Trust Board offline by the end of the month to determine our practice and policy.

The Chair summarised discussions by noting the outturn for 2017/18 was likely to be a £23m deficit, which was a£2.5m adverse position (£3.2m when income from tranche 1 was removed) against the plan of £20.5m. The work-streams (whilst KPI's indicate starting to get traction) and show improvements they had not as yet delivered and so members will need to review closely the KPMG handover plan to be shared at the next committee meeting and acknowledged comments from the Chief Executive and Executive Team that further work was required to assess the risk of implementation from 1st April 2018. **BB**

Resolution:
The Committee:

- **Received and noted the content of the Financial Outturn 2017/2018.**
- **Noted the deterioration in the financial position and drivers of the deficit in year, with the areas linked to those supported by KPMG**

in the phase 4 FIP (2) commission

- **Request a report from the Director of Nursing on measures deployed to eradicate the financial risk to 2018/19 from the change in practice at the next PFIC meeting**
- **To recommend the updated Financial Plan for approval by the Trust Board at its meeting on the 8th March**
- **To receive the KPMG Handover Plan at its next meeting**

186/17 2018/2019 Financial Plan

The Financial Plan 2018/2019, NHSI Guidance and Control Total were received. Due to time constraints this was not discussed further.

Resolution:

The Committee:

- **Received and noted the Financial Plan 2018/2019, NHSI Guidance and Control Total**

MEETING OF THE TRUST BOARD – 7th June 2018					
Partnership Update – Public Trust Board				**AGENDA ITEM: 19**	
Report Author and Job Title:	Daren Fradgley – Director of Strategy & Improvement		**Responsible Director:**	Daren Fradgley – Director of Strategy & Improvement	
Action Required	**Approval**	**Decision**	**Assurance and Information X**		
			To receive and discuss	**To receive**	
Recommendation	Members of the Trust Board are asked to: Receive the report and the information within.				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF No. 12 That the overall strategy does not deliver required changes resulting in services that are not affordable to the Local Health Economy. BAF No. 15 If the Trust does not agree a suitable alliance approach with Local Health Economy partners it will be unable to deliver a sustainable integrated care model.				
Resource implications	Resource implications for both Strategic Partnerships will be mapped out clearly in a programme plan for the Trust Board				
Legal and Equality and Diversity implications	To Be confirmed as part of the programme plans				
Operational Objectives 2018/19	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme			X	
	Develop the culture of the organisation to ensure mature decision making and clinical leadership				
	Improve our financial health through our robust improvement programme				
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts			X	

PARTNERSHIP UPDATE

1. PURPOSE OF REPORT

In this month's report I will refer to four pieces of work. Firstly, the progress that is being made with the Multidisciplinary Team Meetings in the Place Based Localities. This update includes both the GP lead MDT's but also the team MDT's where professional groups come together to undertake case management.

Secondly, I can provide an update on a presentation that a made to the St Giles Trustee's Board last month.

Finally, I will provide a progress report on the Walsall Together work and the second pahse of the Case for Change work.

2. MDT Progress

Despite a challenging start, the GP lead MDT's are beginning to take shape with all the pilot MDT's previously reported as still running and beginning to show benefits for patients and their families through the whole Walsall system. Three short outcome studies are provided in the appendix of this report to demonstrate some of the early progress that is being made. The project now has a full time MDT coordinator, who's role it is to ensure that MDT's are happening, and the right attendance and subject matter is being covered. Early results suggest that this is having a positive effect and this focus has increased the pace of delivery.

GP LED MDT UPDATE

Practice Name	Time & Date	Status	Comments
Bentley Med Centre - West 1 Berkley Practice Stroud Practice	**Monthly** Every 3rd Mon at 13:00hrs	Running	This MDT has now been running successfully since Aug 17
Lockfield Surgery - West 2	**Monthly** Every 3rd Tuesday at 11:30hrs	Running	This MDT has been running over that last few months, originally attendance was an issue, but subsequent MDT's have been well attended.
Northgate Practice - East 2	**Monthly** Every 3rd Tues at 12:30hrs	Running	This MDT has been running over that last few months, originally attendance was an issue, but subsequent MDT's have been well attended
Portland Practice - East 2	**Bi-Monthly** Every 3rd Tues at 13:30hrs	Running	This MDT has been running over that last few months, originally attendance was an issue, but subsequent MDT's have been well

			attended Monthly meetings now bi-monthly due to GSF.
Moxley Practice - West 2	**Monthly** Every 3rd Wed at 11:30hrs	Running	This MDT has been running over that last few months, originally attendance was an issue, but subsequent MDT's have been well attended
Bloxwich Practice - North	**Every 6 Weeks** Next meeting confirmed 27th June at 12:15hrs	Running	A promising MDT, GP's keen to repeat. MDT co-ordinator in contact with the practice, attending next meeting and will discuss support available.
Parkside Practice- East 1	**Monthly** Every 1st Wed at 13:00hrs	Planned	First MDT will take place on the 6th June 18.
St Mary's Surgery- North	**Monthly** First meeting Thurs 21st June at 13.30pm	Planned	First meeting Thurs 21st June at 13.30pm, will feedback once meeting has taken place.

In addition to the GP Led MDT's, the Pace Based Teams have started coming together to have wider meetings with more specialities around the table. The following table highlights the breadth of the new meetings and what the next steps are for each of these meetings. It should be noted that these meetings have been running in a simpler form for some time but are now beginning to tackle some of the more complex issues with a wider range of specialties.

PLACE BASED TEAM MDTS			
Place Based Team	**Date**	**Status**	**Comments**
East 1 & 2 Place Based Team	Monthly- 4th Wednesday First meeting booked for Wed 23rd May at 2pm.	Planned	To be at Anchor Meadow Medical Centre. Attendees will include, District Nurses, Community Matrons, Social Services, Older persons Mental Health Nurses, COPD nurses, Continence Nurses, Palliative Care Nurses and Rapid Response- Heart Failure and Younger persons Mental Health have been invited waiting to hear from services. Frequent Hospital Readmission patients will be discussed beforehand to help identify patients for discussion in MDT's. Possibility of utilising this meeting for Virtual MDT with GP's if agreed to reduce demand on other HCP.
North Place Based Team	Monthly – 4th Thursday, 1st meeting was held 16th May.	Running	Held at Pinfold Health Centre. Attendees include, District Nurses, Community Matrons, Social Services, Older persons Mental Health Nurses,

			COPD nurses, Continence Nurses, Palliative Care Nurses and Rapid Response - Heart Failure and Younger persons Mental Health have been invited waiting to hear from services. Meetings have been well attended with some good outcomes. Frequent Hospital Readmission patients are discussed beforehand to help identify patients for discussion in MDT's. Possibility of utilising this meeting for Virtual MDT with GP's if agreed to reduce demand on other HCP. Dr Pan has already showed interest in joining PBT MDT.
South 1 & 2 Place Based Team	Monthly- Varied dates, 1st South 2 meeting was held 25th April.- decision to merge South 1 & 2 MDT's made after this.	Partly Running	The first joint South 1 & 2 meeting will be held at Beechdale Health Centre. South 2 had a separate PBT MDT on 25th April, after this it was decided to merge PBT MDT's in each CCG locality. Attendees included, District Nurses, Community Matrons, Social Services, Older persons Mental Health Nurses, COPD nurses, Continence Nurses, Palliative Care Nurses and Rapid Response - Heart Failure and Younger persons Mental Health have been invited waiting to hear from services. The Meeting was well attended with some good outcomes. Frequent Hospital Readmission patients are discussed beforehand to help identify patients for discussion in MDT's. Possibility of utilising this meeting for Virtual MDT with GP's if agreed to reduce demand on other HCP.
West 1 & 2 Place Based Team	Monthly- Varied dates, 1st meeting was held	Running	Held at Darlaston Health Centre. Attendees include, District Nurses, Community Matrons, Social Services, Older persons Mental Health Nurses, COPD nurses, Continence Nurses Palliative Care Nurses and Rapid Response, - Heart Failure and Younger persons Mental Health have been invited waiting to hear from services. Meetings have been well attended with some good outcomes. Frequent Hospital Readmission patients are discussed beforehand to help identify patients for discussion in MDT's.

			Possibility of utilising this meeting for Virtual MDT with GP's if agreed, to reduce demand on other HCP.

3. ST GILES

I had the opportunity this month to present to St Giles Trustee Board about Walsall Together and the direction of travel. They we very interested in what we are proposing in the case for change and how they can work with us both in terms of their current hospice at home service but also with their impatient beds at Goscote.

A further meeting is planned with their CEO in June to understand what next steps can be taken in understanding how St Giles can fit into our future scope for Walsall Together.

4. CLINICAL NETWORKS

Work continues on the opportunities to work with partners in a wider network to ensure that our clinical services are sustainable for the future not only in Walsall but also across the Black Country. During May there has been work progressing with several events being held. This work has been undertaken with partners from other Trusts.

5. WALSALL TOGETHER

Engagement on this programme has been continuing over May with Provider Partners, CCG, NHSI and NHSE to understand the next steps required in the planned work programme. This has taken longer than expected but it is important that the scope for the services is mapped out in such a way deliver can still happen before March 2019.

The process of developing a business case for the partnership and what models are within are critical if we are to deliver the scale of change that is required for the future. However, with certain types of changes comes increased regulatory scrutiny, therefore the partners have been testing out the model with the regulators and taking external advice from KPMG based on their deployment experience in other areas of the country.

At the time of writing this report, a next steps report was planned for the Walsall Together Partnership Board – 6th June which outlines the next steps required together with a funding proposal and a scope for external support. The Trust has made a provision within its annual plan for the Walsall Together programme and the report that is tabled falls within this provision. I am hopeful that I will be able to provide a full update at the Board on 7th June.

Subject to support for the above, formal work will start immediately on the business case over the summer with the first draft expected by the second week of September. This is two weeks behind schedule and has also made use of some planned contingency time. Any further delays will therefore be critical to delivery dates.

It is planned that the draft case together with the supporting works will go through formal approvals in October and more importantly be captured in commissioning intentions during the same month.

November is currently held as a contingency month in case there are any adjustments in the approvals process with December onwards working on the delivery. A full update on this programme together with a programme plan will be presented to Committees in June 2018 following the Walsall Together Partnership Board report.

To compensate for this delay and increase the level of focus on the integrated working, an advert has been released to appoint an Operations Director to work full time on integration. This post will primarily work on the Integration within the locality teams and the intermediate care services, but it is planned that this will continue to drive the progress forward whilst the business case takes shape.

Finally, an operational workshop is being held in June to bring together Clinicians from all Walsall Together organisations to commence work on the next steps in terms of clinical pathways. Again, these pathways already exist within the borough but have layers of fragmentation and delays which the workshop is hoping to expose and challenge. The product of this work will compliment the material in the business case and the work already being undertaken on integration in the Place Based Teams.

6. RECOMMENDATIONS

The Board is asked to receive the information within this report.

Report Author: Daren Fradgley – Director of Strategy & Improvement
Date of report: 29th May 2018

APPENDICES
Examples of integrated working and how it is benefitting the people we serve.

Positive Case studies of joint working

Pen Picture/what is their story	South 2 patient -Social team had been to see patient on in May following patients discharge from hospital. Patient identified as EOL but had no plan of care in place. Limited communication on discharge.
How long have they been open to Health and Social Care	Known to South 2 DN for Pressure Area Care
Outcomes achieved	Social workers asked District nurses to support as they felt patient was in crisis. District nurses visited patient within an hour of their request. GP reviewed patient who was organising pre-emptive medication. Social care asked to put in 72 hour wrap around care to support family. Palliative care referral made. DNAR in place
Have we avoided a hospital admission	Yes
What have the outcomes been for the person	Patient passed away peacefully at home.
What have the outcomes been for both health and social care	Working together to ensure the patient received the appropriate care and passed away at home in line with their wishes

Pen Picture/what is their story	South 2 patient 2 Social care looking at relocating patient to independent living as been given notice at current care setting.
What were the reasons for them being referred	Known to South 2 DN for diabetic care.
Outcomes achieved	Meeting at south 2 locality to discuss concerns raised by patient. Social care looking at discharging patient to independent living accommodation following shared information between social and health care in the meeting it was decided this would not be suitable for patient.
What have the outcomes been for the person	Patient remains under 24 hour supported care which is appropriate given the presenting condition.
What have the outcomes been for both health and social care	Working together to ensure the patient received the correct care in the community

West 2
Patient visited the wound care clinic for routine leg dressings. Following discussion with the nurse it was highlighted that the leg wounds were being caused by the chair the patient was sitting on. Through the integration with social care the nurse was able to get the occupational therapist to see the patient during the same visit and an assessment was completed. This process would have historically been a lengthy process with a referral being sent. The patient received a new chair which in turn assisted with the healing of her leg wounds.

West 1 & West 2
Due to the full integration of Health and Social care within the West locality teams. The teams are now stating that they don't need to schedule informal integration meetings as they are now working as one team. They are sharing information daily and reducing duplication of work by aligning caseloads. The teams are positive and moving forward they are piloting the joint referral form

MEETING OF THE PUBLIC TRUST BOARD – 7 June 2018				
Annual self-certification (G4 & FT4)				**AGENDA ITEM: 21**
Report Author and Job Title:	Jackie White, Interim Trust Secretary		**Responsible Director:**	Daren Fradgley Director of Strategy & Improvement / SIRO
Action Required	**Approval X**	**Decision**	**Assurance and Information**	
			To receive and discuss	**To receive**
Recommendation	Members of the Trust Board are asked to make a declaration of compliance in regard to condition G6 and FT4.			
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 11 – Governance remains inadequate			
Resource implications	There is no resource implications associated with this report.			
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.			
2018/19 Objectives	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme			X
	Develop the culture of the organisation to ensure mature decision making and clinical leadership			X
	Improve our financial health through our robust improvement programme			X
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts			X

Executive summary

The Trust is required to annually self-certify that they meet the obligations as set out in the NHS Provider License and show they have complied with governance requirements.

The Trust is therefore required to self-certify against the following conditions:

- Condition G6 – The provider has taken all precautions necessary to comply with the license, NHS Acts and constitution (by 31st May 2017 and made public by 30th June 2017).
- Condition FT4 – The provider has complied with required governance procedures (by 30th June 2017)

This report details the structures in place to ensure compliance with NHS Acts and the constitution and confirms therefore that the Trust has confirmed compliance with condition G6 and FT4.

The report recommendations that the Board declare compliance with Condition G6 and FT4.

Annual self-certification (G4 & FT4)

1. PURPOSE OF REPORT

The purpose of the reports is to provide assurance to the Board that the Trust is meeting the conditions set out in the Provider Licence in respect of:

- Condition G6 – The provider has taken all precautions necessary to comply with the licence, NHS Acts and constitution (by 31st May 2017 and made public by 30th June 2017).
- Condition FT4 – The provider has complied with required governance procedures (by 30th June 2017)

And therefore able to make a declaration of compliance in line with the deadlines identified.

2. BACKGROUND

Foundation Trusts were required to annually complete a self-certification and Trusts are now required to complete a self-declaration (though not required to submit this declaration). The self-certifications will be audited for a select few Trusts to ensure compliance.

All Trusts are now required to annually self-certify that they meet the obligations as set out in the NHS Provider Licence and show they have complied with governance requirements.

This report details the structures in place to ensure compliance with NHS Acts and the constitution.

3. DETAILS

The Trust is required no later than two months following the end of the financial year (by 31st May 2017) to self-certificate to the effect that it “confirms” or “Does not confirm” that it had well established and effective processes and systems to identify risks and guard against their occurrence in 2017/18, and, that these are still in place and their implementation and effectiveness is regularly reviewed going forward.

Condition G6 - Evidence of attainment:

- The Board and supporting committees (Audit Committee, Quality & Safety Committee, Performance, Finance and Information Committee and People and Organisation Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance. Examples include Board Assurance reports; Internal and External Assurance reports, Patient and staff survey results, CQC inspection reports, internal finance and performance reports, General Medical Council reports and patient safety and quality information.

- The Trust has a well-established Risk Committee and reports through to Trust Quality Executive and Quality and Safety Committee and Trust Board. The Trust Board regularly reviews Corporate Risks and the Board Assurance Framework.

- The Trust has been rated as requires improvement through a CQC inspection, and has made progress delivering the actions identified in the Patient Care Improvement Programme and evidenced improvements in patient care.

- The Board and subcommittee review of a monthly comprehensive performance dashboard that articulates performance against Quality, Finance, Performance and workforce metrics.

- The Trust Board is held monthly and is open to the public and the development of an enhanced Accountability Framework has been undertaken and is to be implemented within the Trust.

- The Trust has implemented a clinically led model, with meetings scheduled monthly to review key performance metrics and quarterly review meetings are held with the wider executive and chaired by the Chief Executive.

Condition FT4 – see attached report.
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4. RECOMMENDATIONS

Based on the evidence highlighted above and attached, it is recommended to the Board that the condition G6 and FT4 Self-Certification is formally signed off as "Confirmed".

Report Author: Jackie White, Interim Trust Secretary
Date of report: 16 May 2018

APPENDICES
Condition FT4 evidence of attainment

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Annual Governance Statement outlines the main arrangements to ensure the Trust applies the principles systems & standards of good corporate governance. Adoption of model standing orders and is subject to internal & external audit on the robustness of its standards.	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board receives new guidance issued by regulators in reports from CEO' & Trust Secretary. Monthly independent delivery mtg with NHSI reported to Board.	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Board approved Scheme of Delegation, Standing Financial Instructions, Board approved committee structure and terms of reference / annual workplans. Executive portfolios and organisational structure, including clear reporting lines. Regular reporting:Committee to Board & Ward to Board on quality. The AGS sets out developments each year. Director responsibilities in job descriptions & annual objectives reported to Nominations & Remuneration Committee. Establishment of	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	a) Qualified value for money conclusion from external auditors for 2017/18 is mitigated by a Board approved financial plan including efficiency targets monitored monthly by Performance, Finance & Investment Committee & Board. b) Board infrastructure including Committees & operational groups provide assurance that the organisation, decisions & business is monitored effectively. Committees scrutinise key areas of performance: quality, workforce, finance & performance & provide Board assurance by regular highlight reportingp & key recommendations. c) The Quality and Safety Committee & Trust Quality Executive review in detail (monthly) quality issues related to the Trust's Quality Committment. The Trust was rated requires improvement by the CQC in 2017 & reamins in special measures. The Trust has continued to monitor a Patient Care Improvement Plan & report delivery of this to Committee & Trust Board monthly. The 2017/18 Quality Account highlights quality improvements made & outlines 2018/19 priorities. d) Standing Financial Instructions & Scheme of Delegation determine an agreed framework for financial decision making, management & control. Monthly scrutiny at PFIC reported to Trust Board. Internal control systems are internally & externally audited. e) Board & Committee dates set for timely information for scrutiny & assurance. f) Board approved risk management strategy & quarterly Board Assurance Framework & Corporate Risk Register reporting. g) Annual planning process ensures plans developed & supported by appropriate engagement/approvals. h) Governance, risk & control processes ensure legal compliancy	Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	a) The Board has a mix of quality, people & performance expertise to provide effective leadership. There is an effective appraisal process to support Board Members and a Board Development programme is in place. b) There is a robust Quality Impact process in place to support decision making processes and any impact on the quality of care. c) In addition there are specific routine reports providing timely and accurate data on quality of care. Data is compiled from a variety of sources including Friends and Family Test, direct patient feedback and reporting on complaints, concerns and incidents. d) The Quality & Safety Committee meets monthly & considers quality issues in detail. The Committee Chair reports any key decisions and recommendations to the next meeting of the Trust Board. e) All Board members are actively engaged in quality initiatives including monthly Board Walks. The Board also alternates a patient and staff story at the start of each meeting. f) As above and including the appointment of 2 Freedom to Speak Up Guardians. Recently approved Accountability Framework with quality metrics.	Please complete Risks and Mitigating actions

6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board considers its capacity and composition & staffing across the organisation. Executive leadership is supported by the Senior Leadership Team & development of the Clinically Led model. There are a number of tools in place to ensure the Trust has sufficient number and appropriately qualitified staff including a bi annual safer [illegible]	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	Signature
Name	Name

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A		Please Respond

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD – 7 June 2018					
Audit Committee Annual Report				**AGENDA ITEM: 22**	
Report Author and Job Title:	Jayne Ilic, Head of Communications, Engagement and Marketing		**Responsible Director:**	Daren Fradgley, Director of Strategy & Improvement	
Action Required	**Approval X**	**Decision**	**Assurance and Information**		
			To receive and discuss	**To receive**	
Recommendation	Members of the Trust Board are asked to approve the Annual Report in order that it can be submitted in line with year-end deadlines. The Audit Committee has received draft versions of the report at its meeting on 24 May 2018.				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.				
Resource implications	There are no resource implications associated with this report.				
Legal and Equality and Diversity implications	The report support compliance with the following: Department of Health Group Accounting Manual 2016-2017. NHS Improvement Annual Governance Statement Guidance 2016/2017. Audit Committee Terms of Reference.				
Trust Strategy	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme		X		
	Develop the culture of the organisation to ensure mature decision making and clinical leadership		X		
	Improve our financial health through our robust improvement programme		X		
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts		X		

CONTENTS

3. Financial Statements and Notes

Welcome to Walsall Healthcare NHS Trust's Annual Report and Accounts

Our Annual Report provides an ideal opportunity for all of us to take stock of another busy, challenging and rewarding year in the life of Walsall Healthcare NHS Trust.

It has been a year that saw the NHS once again dominating news headlines with reports of the significant impact that winter pressures were having on hospitals and the wider healthcare economy across the country. NHS England took the unprecedented step of allowing hospitals to cancel tens of thousands of planned operations in order to free up beds, given the extra demand for treatment.

In Walsall our staff were under extreme pressure to deliver the safe, high quality care that our patients expect and deserve. We thank those who work in the Manor Hospital and our community services for everything they did during this difficult period.

More recently, the hospital had to deal with an outbreak of norovirus which resulted in large numbers of ward areas being closed. We took the decision to close the hospital to visitors for a period leading up to and during the Easter Bank Holiday and we thank our patients, their families and carers for bearing with us while we took the necessary actions to stop the infection spreading even further.

The hard work of our teams across the Trust to improve services for patients was recognised in the latest inspection report released by the Care Quality Commission (CQC), which showed progress in each service area. The CQC rated the Trust as "Requires Improvement" overall, with a rating of "Good" for the caring domain and a rating of "Outstanding" for our community services. Maternity services remained inadequate though the CQC recognised improvement in the service since 2015.

Further details on the report's findings can be found on page 7 of this Annual Report but it should be noted that the progress the Trust has made since its 2015 inspection, which saw it placed into Special Measures, has been excellent. We need to keep up this momentum and set ourselves four priorities:

1 Improving patient care – by focusing on maternity services and the CQC's recommendations to ensure we can exit Special Measures in 2018.

2 Improving our emergency care pathway – to reduce the risk when we are at our busiest and provide care that keeps people well at home for longer.

3 Delivering our financial recovery plan –improving our finances by around £600,000 a month to deliver our 2017/18 deficit and improve further next year.

4 Accelerating culture change – by using Listening into Action as part of a suite of quality improvement methods which we will deploy through our new Quality Academy. Our revised engagement approach will also include clinical leaders taking an equal seat at our Trust Management Board for critical decision-making.

For the coming year we have set ourselves four priorities:

- **Quality improvement** – Continue our improvement journey on patient safety culture and clinical quality through a comprehensive improvement programme which focuses on outcomes
- **Culture development and clinical leadership** – 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

- **Financial improvement** – Deliver the next stage of our journey of financial improvement, driven by improvements to services' progress and productivity through our improvement programme

- **Clinical strategy through collaboration** – Develop and deliver our clinical services strategy through the implementation of integrated local care (Walsall Together) and increased hospital collaboration to ensure service resilience and sustainability

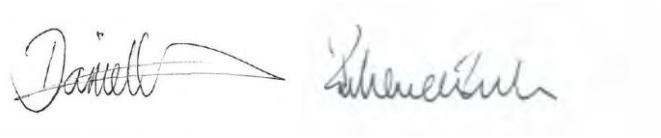
Delivery against these priorities will help us to realise our vision for 2020 of "Becoming your partners for first class integrated care".

Two examples of this new approach to clinical strategy are evidenced within pathology and stroke services in Walsall.

A single Black Country Pathology Service, with a hub at New Cross Hospital in Wolverhampton and essential services laboratories at each of the acute hospitals in the Black Country, is being created. Suspected stroke patients in Walsall will now be taken to the specialist unit at New Cross Hospital, rather than treated in the borough. More details of these important changes to ensure sustainability can be found on page 10 of this Annual Report.

This year the Trust bid farewell to Chief Executive Richard Kirby and welcomed new Chief Executive Richard Beeken.

There is a strategic need to work collaboratively across the whole population if we want to effectively address the future health and care needs of our residents and the work that has been undertaken through Walsall Together set the wheels in motion for doing things differently. The year ahead will see us step this activity up a gear with the continued support and feedback from our colleagues, patients and stakeholders.



SECTION 1: PERFORMANCE REPORT

OVERVIEW

This overview is a short summary that provides readers with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Chief Executive's Statement on Performance

Walsall Healthcare NHS Trust is now two years into its five year ambition to deliver its vision of "Becoming your partners for first class integrated care".

This vision is underpinned by five objectives.

1. Provide Safe, High Quality Care. We will provide care that we would want for our family and friends.
2. Care for Patients at Home. We will keep people well at home, provide alternatives to acute care and return people home safely and quickly after admission.
3. Work Closely with Partners. We cannot do this alone and will work with our partners in Walsall and the Black Country.
4. Value Colleagues. We will be a clinically-led, engaged and empowered organisation.
5. Use Resources Well. We will ensure future sustainability by living within our means.

We have continued to achieve all cancer standards and diagnostic waits against an increasing demand.

After a particularly difficult winter involving flu and norovirus our four- hour waits were challenging. We remain heavily focused on improving our overall ED (Emergency Department) performance and patient experience within urgent care. Working with Walsall Council's Social Care we have developed the Intermediate Care Model – more details of which can be found on page 11.

We are already working with clinicians to prepare for next winter.

We acknowledge that the ED environment is not fit for purpose and have submitted our business case to ensure we can get the residents of Walsall and staff who work there a better and far more appropriate environment to meet demand.

The Trust is also working to co-ordinate with mental health services and social care to ensure that patients who have long term conditions are supported at home, where they want to be, so that they can avoid admission to hospital wherever possible. This agenda is central to the Walsall Together developments we are driving forward in 2018/19.

We are also looking at how we can work with patients' families and carers to improve our management of patients whilst they are in hospital: encouraging them to get up and dressed, mobilise and increase their chances of independent recovery. As a result, the patient's stay will be reduced and beds will be freed up. All of this is being managed through an urgent care improvement plan being led by our Chief Operating Officer.

Our demand and capacity planning manager is working with clinical services to develop their planning capabilities. This is an ongoing process as we build on and develop the demand and capacity capability of the organisation, which will include capacity requirements to improve quality, meet national standards and to reduce dependence on locum and agency staff.

We've also had a real drive to maximise the potential of our Discharge Lounge to ensure early discharges from all wards and free up our Emergency Department. We are getting a daily average of around 25 patients through its doors and will continue to ensure all teams are making the most of this important facility.

Richard Beeken, Chief Executive

Purpose and Activities of Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust is an integrated Trust. The Manor Hospital provides a full range of district general hospital services and community health services for adults and children which are run from more than 60 settings across the borough, including health centres and GP surgeries, while community services also provide support in people's own homes.

Walsall borough is made up of a diverse multi-cultural population of more than 270,000.and suffers from a number of health inequalities.

The 2017 Health Profile published by Public Health England shows that Walsall is one of the 20% most deprived districts/unitary authorities in England and about 30% (17,000) of children live in low income families.

Life expectancy for both men and women is lower than the England average. In Year 6, 25.5% (833) of children are classified as obese, worse than the average for England. Levels of teenage pregnancy, GCSE attainment and breastfeeding initiation are worse than the England average.

In adults, the rate of alcohol-related harm hospital stays and the rate of smoking related deaths is worse than the average for England. Estimated levels of adult excess weight and physical activity are worse than the England average.

In more affluent areas of the borough there is a longer life expectancy and a growth in dependency from frail elderly patients.

We have integrated health and social care with the development of seven Integrated Locality Teams. The teams are co-located Community, Social Care staff and Mental Health staff who provide a 'wrap-around' service to GP Practices. This approach is expected to deliver reduced attendances in ED, reduced re-admission of patients and reduced length of stay which will have an overall positive impact on occupied bed days.

There has been earmarked an overall investment of £50m in healthcare services across the hospital's estate which includes two new, state-of-the-art MRI scanners, the creation of a new Integrated Critical Care Unit and a new Obstetric Theatre and expansion of the Neonatal Unit. The Emergency Department is also being redeveloped.

The Trust has also invested £800,000 in mobile technology for staff working within its community teams, a development which has been universally applauded by those teams.

Walsall Healthcare is an active partner in the Black Country Sustainability and Transformation Partnership which brings together more than 10 healthcare providers, Local Authorities and four CCGs. The STP's vision is to transform health and care in the Black

Country and West Birmingham through the development of place-based care, acute hospital collaboration and tackling the wider determinants of health.

Milestones over the last 12 months

CQC Inspection

The Care Quality Commission's inspection in June 2017 was an important milestone for Walsall Healthcare NHS Trust. Inspectors published their report in December 2017 and it showed that we had made progress in each service area.

The CQC rated the Trust as "Requires Improvement" overall, with a rating of "Good" for the caring domain and a rating of "Outstanding" for its community services. There are only a handful of community services in the country with this rating.

The inspectors told us that the Trust they inspected in 2017 was "a very different Trust" to the one they visited back in 2015 confirming that the improvements we have made are starting to show significant results. The CQC also described our staff as "kind caring and compassionate."

Seventy per cent of the ratings in the report were "good" or "outstanding". The report also emphasised several areas of "outstanding practice" in Urgent and Emergency Services, End of Life Care and Outpatients and Diagnostic Imaging and repeatedly referenced the "kind, compassionate and respectful" care shown to patients.

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A number of examples of significant improvement since the 2015 inspection included:

- Increased staff numbers and dedicated separate paediatric and waiting areas in ED
- The culture in the Outpatients Department has changed considerably for the better with local staff taking responsibility and ownership for their own areas and specialities
- Evidence seen of good multidisciplinary team working where staff worked together to safely discharge patients or plan their future care
- Trust's Frail Elderly Service has helped prevent many unnecessary hospital admissions
- Most staff reported their managers were "visible, supportive and approachable"

Maternity services remain inadequate though the CQC has recognised improvement in the service since 2015.

We know that we still have challenges to address in maternity services where the pace of change was not initially as swift as in other areas of the Trust. The establishment of the new leadership team took longer than anticipated, but there is now consistent delivery against the key indicators of quality care that we want to continue to embed.

The CQC report stated that management is "visible and approachable" in maternity, and we are moving in the right direction and creating a culture where staff are encouraged and supported to raise concerns and make suggestions.

Since the inspection the Trust has recruited new midwives and has also appointed four specialist midwives including a specialist bereavement midwife. The Trust has also worked hard to reduce its midwife to birth ratio from 1:35 in 2015 to around 1:23 currently.

Maternity admissions were limited to 4,200 and this is reviewed regularly with our local partners. The Midwifery-Led Unit was temporarily closed in July 2017 with the activity and staffing relocated to the Delivery Suite within the Manor Hospital.

We must continue to build on the foundations we've laid and to work with partners across the health and social care system to collectively deliver services that meet the needs of the communities we serve. We will be working with our clinical teams to take the action needed to ensure that all of our teams are able to achieve "good" or "outstanding" ratings in the future.

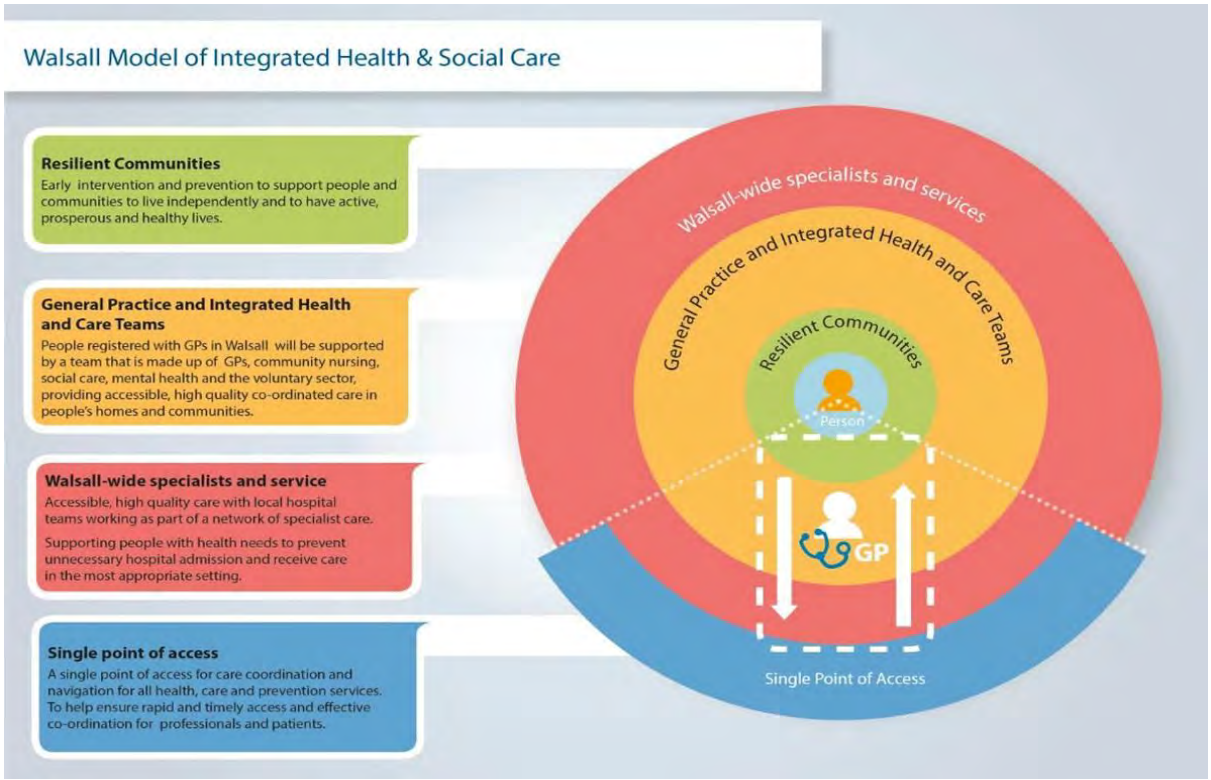
The CQC is due to re-inspect our services in the summer of 2018.

The Trust developed a Patient Care Improvement Plan (PCIP) to tackle the issues identified by the CQC. Executive leadership for quality governance is provided by the Director of Nursing and the Medical Director.

Actions in the PCIP range from safe staffing levels to timely Mental Capacity Act assessments, improved assessment of patients at risk of Venous Thromboembolism (VTE), improvement of fracture clinic environment and reinforcement of professional boundaries between staff and patients.

The majority of these actions are not dependant on finance or additional resources but by us working together to do things differently, complying with best practice and coming up with solutions that we know will make the most impact.

Creating a more integrated health and social care system



The Executive Team has been working closely with partners across the health and care economy to further develop plans for creating a more integrated health and social care system in Walsall. There is a strategic need to work collaboratively across the whole population if we want to effectively address the future health and care needs of residents.

In Walsall, this is set against the challenges of health inequality, a rising elderly population, deprivation driven disease and cultural differences at the same time as our desire to improve pathways of care for our patients.

We know we can't continue to work in the same way as we have been because it simply isn't sustainable. Meanwhile our patients, their families and carers repeatedly tell us that their biggest frustrations are often not being able to access the appropriate support and services

they need as and when they need them, in particular avoiding potentially unnecessary acute hospital admission.

The Walsall Together Case for Change has been produced by the Walsall Together Board as an outline of change - together with a proposal of next steps for the next 12 months to establish a Host Provider Contract with Commissioners by April 2019. The Board has endorsed its statement of intent and work will continue in terms of governance and practical delivery.

Sustainability Reviews

As part of its annual planning process, the Trust has been carrying out a full sustainability review of all of the acute hospital services it provides to gain a strategic understanding of the strengths and weaknesses of its service models.

Following a high level review of each service, co-ordinated through its clinical leadership teams, the Trust is prioritising the required interventions to ensure future sustainability. The process is designed to provide greater insight into the requirements of both its patients and the population of Walsall to help the Trust achieve and sustain high quality services for the future.

The review considers each of the seven domains shown below:

Intermediate Care Model

Walsall's health and social care economy relies too heavily on a bed-based model of post-acute care when national and local evidence shows that a significant proportion of this care could be provided in a home setting with the appropriate clinical or support services.

The Trust consistently fails to meet the 95% waiting target set for patients in ED and patient flow is impacted by a significant proportion of patients who are medically fit for discharge being unable to leave hospital. They may be waiting for something from external partners which adversely affects flow through the hospital and availability of beds for those in ED or the Acute Medical Unit who need admission.

Prolonged hospital stays mean poorer outcomes for patients who can suffer muscles wastage, loss of mobility and a decline in the skills that they need to maintain their independence.
Intermediate Care Services in Walsall have tended to work in isolation, making pathways complex to navigate, delays in handover, and potential duplication of effort.

The Intermediate Care Model, introduced in 2017, is a community-based health and social care single service with responsibility for complex patients who require support to enable them to leave an in-patient hospital bed.

It provides a rapid response to care delivery in the right place at the right time to maximise a patient's independence. This response is appropriate and proportionate to the patient's assessed needs with the focus being concentrated on the patient being able to return home. The service operates seven days per week

£50m investment in our estate

Work is well underway to house two new state-of-the-art MRI scanners at Walsall Manor Hospital as part of the Trust's overall £50 million investment in healthcare services. This investment will also see the creation of our new Integrated Critical Care Unit, a new Obstetric Theatre and expansion of the Neonatal Unit and the redevelopment of the Emergency Department.

In partnership with the InHealth Group which provides the service, the Trust has entered into a 15 year contract which will see the replacement of the current old scanner and installation of a second. This will enable the Trust to make better use of its financial resources.

By doubling our provision we can reduce the length of time patients wait for a scan and increase the number of patients we see which will have a huge impact on their health and wellbeing. Not only will they receive speedier diagnoses but also more timely assessments on how effective previous treatment has been.

A temporary MRI unit was put into place in January 2017 while this vital, six month project progresses.

Work is progressing well on the 18 bedded Integrated Critical Care Unit which is on schedule for Winter 2018 completion.

Creation of Black Country Pathology Service

All four Trust Boards in the Black Country supported the creation of a single Black Country Pathology Service with a hub at Royal Wolverhampton and essential services laboratories at each of the acute hospitals. This will result in one of the largest pathology services in the country and is only the second such collaboration to go live. Detailed work is continuing on all elements of this development including staffing arrangements, how the services work together, the buildings and IT requirements with the date of change being in 2019.

The new service aims to make sure that we maintain and continue to develop high quality pathology services in the Black Country.

Stroke Services centralised

Suspected stroke patients in Walsall are now be treated at New Cross Hospital's specialist unit

Following extensive consultation with patients, their families and clinicians, a decision was made by NHS Walsall Clinical Commissioning Group's (CCG) Governing Body to transfer the Hyper Acute Stroke Unit (HASU) from Walsall Manor Hospital to Royal Wolverhampton NHS Trust (New Cross Hospital) for acute stroke care.

Rehabilitation and community services will continue to be provided in Walsall.

Currently Walsall Manor Hospital cares for 360-400 patients per year, which is rated good overall but the number of stroke cases is insufficient to meet the nationally recognised standards for acute stroke care. To be a viable HASU it is recommended there is a minimum of 600 confirmed stroke patients per year.

All changes in stroke services are subject to NHS England's assurance process. The move is also a result of a six week public consultation that took place last year to hear the views of Walsall residents.

Successful diabetes funding bids

Walsall has the third highest rate of diabetes in the country with 8.8% of its population affected compared to the national average of 6%. And this is expected to rise to 10.9% by 2030 making the need for effective care and support a priority.

Walsall Healthcare secured funding through NHS England's Diabetes Transformation Fund. The Trust worked with colleagues in podiatry, Public Health Walsall, Walsall Clinical Commissioning Group, Diabetes UK and a Consultant from Dudley Group NHS Foundation Trust to develop the successful bid.

Two funding bids made to improve the treatment and care of Walsall patients with diabetes were successful resulting in a £1.2m boost over the next two years.

The Trust will now be able to double its diabetes nurse specialists from two to four and speed up the process for patients who need to be seen by the Multi-Disciplinary Foot Team. This enhanced service will aim to improve patients' experience as well as reduce their length of stay in hospital.

A new Foot Protection Team was launched in November 2017 for Walsall people living with diabetes or at risk from developing the condition in a bid to reduce hospital admissions and amputations. The team, which has been developed following feedback from patients, comprises of specialists who work together across both the community and Walsall Manor Hospital to better meet the needs of people with diabetes across the borough.

Mobile technology for our community teams

Hundreds of our community nurses are now using mobile technology thanks to an £800,000 investment.

All seven of the Trust's locality teams are live with 160 clinicians using tablets to access and input clinical information. The administrative support staff, Clinical Leads and Service Management for each team are using the desktop version of the new Totalmobile system.

The rest of the teams within Phase 1 Community Services will be live by the end of May 2018.

The new Totalmobile system is a switch from a paper-based patient assessments and means that community staff can give patients the results of their blood tests for example, reducing any delay in starting treatment. They can also access details of new patients more quickly and the devices offer greater security for lone workers.

The new system incorporates the capture of referral and contact information, aids the scheduling of appointments and allows visit information to be inputted on to the system .The mobile application works in both online and offline mode, allowing staff to carry on working out in the field, even if there is no Wi-Fi or 4G signal. Staff have all the clinical information that they require at the point of care and a Sepsis alert has also been introduced aiding communication between the community and acute services.

Engaging and empowering our staff

Listening into Action

Staff told CQC inspectors that they had seen many positive improvements since the implementation of the Trust's Listening into Action (LiA) approach which puts staff in the driving seat and empowers them to make sustainable changes. And the third LiA Pulse Check Survey which took place during July 2017 shows a clear improvement in Pulse Check scores since May 2016, with an average 13.9% point increase across the 15 questions, within 14 months.

This includes: 16% up on managers and leaders seeking our views, 15% up on how valued staff feel, 17% up on staff recommending the Trust to family and friends, 15% up on effective communication, and 15% up on being able to prioritise patient care over other work.

In the July 2017 Pulse Check, 7 out of 15 questions scored under 50% positive responses highlighting the opportunities for improvement. The seven areas were:

- Q4 Day-to-day frustrations (33%)
- Q5 Communicating priorities and goals (44%)
- Q8 Recommend Trust to family and friends (49%)
- Q10 Communications between senior management and staff (38%)
- Q13 Structures and processes support staff (40%)
- Q14 Systems and facilities support staff (39%)
- Q15 Organisation supports me to grow (43%).

Listening into Action will no longer work in isolation but will come together with the Trust's newly established Quality Improvement Academy; the importance of a multidisciplinary approach to quality improvement is key with staff-led, on the ground ownership of change ideas.

A Staff Engagement Lead has also been working with the Trust and during summer 2017 carried out 19 focus groups with staff across all levels of the organisation, with some work specifically within Maternity. The conversations and feedback provided helped get a real sense of how it feels to work within the organisation.

The Executive Team has agreed that the following five areas will be focused on as a priority

- Recognition
- Values
- Change and improvements at work
- Bullying, harassment and behaviour
- Appraisal

The Staff Engagement Lead has also been working to refresh the Trust's values so that they represent the true values of staff and what it means to work for Walsall Healthcare NHS Trust. These values, and a subsequent behaviours framework, will be launched at our Trust Leadership Conference in June 2018.

Staff Survey

The 2017 national staff survey results for Walsall Healthcare showed that colleagues are not as satisfied with their experience at work and feeling engaged in the organisation's objectives, as many other Trusts.

Whilst the results have not deteriorated from 2016 they have only marginally improved despite the work we have been doing to:

- Resource clinical staffing better wherever we can, particularly on our inpatient wards
- Enable local service improvement and engagement through a high energy programme (Listening into Action)
- Improve the fundamentals of quality and patient safety at the Trust through our Patient Care Improvement Plan

There are clear signs that staff feel they are listened to compared with last year and have more of a say than previously. But there are also clear signs of the pressure staff are feeling, with more people feeling work-related stress and also feeling less well paid than previously.

These results must motivate the Trust to continue trying to improve the culture of the organisation while accepting that change will take time.

Staff also stated they were less likely to report physical violence if they experienced it. In spring 2017 we launched a new anti-violence and aggression campaign featuring the

hashtag #someonesdaughter or #someonesson in a bid to get people to stop and think how they'd feel if their loved one was subjected to such abuse while trying to do their job.

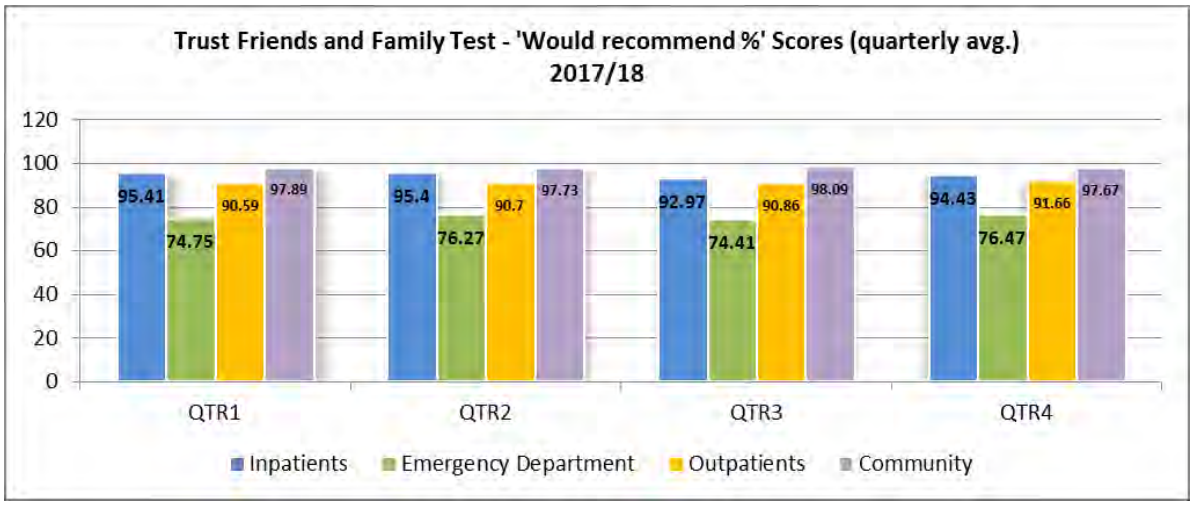
The Trust will continue to support its staff to report these incidents and ensure the perpetrators are dealt with appropriately.

Improving our patients' experience

Over the last year we have continued to implement our patient experience strategy that puts the patient voice at the heart of our services and ensures that the Trust has a co-ordinated approach of 'listening to' and 'learning from' patient feedback.

We saw patients reporting a better experience in our hospital through the Friends and Family Test (FFT), national and local surveys. More than 52,000 patients responded to our feedback surveys and 91% said they would recommend our services.

The chart below shows FFT results for positive recommendation scores (%) for the FFT for inpatients, A&E, outpatients and community services in 2017-2018



Key improvements included the introduction of the Quiet Protocol to help patients sleep well at night, establishing a patients' reading panel, piloting the Always Event® improvement programme and the 'Observe and Act' tool for a better feel of the total experience journey.

We continued with our 'You & I' programme for staff engagement inpatient experience and the Trust's 'Listening into Action' along with the 'Maternity Whose Shoes' approach has further embedded co-production and collaboration with patients, carers and staff members.

Key areas highlighted for improvements in our national surveys included communication, patient involvement in decisions about care and treatment, arrangements around discharge and waiting times.

The Friends and Family Test showed the following themes from patient feedback:

Top 10 Words

+ Positive		− Negative	
1. Staff	14210	1. Time	824
2. Friendly	5647	2. Waiting	795
3. Good	4342	3. Staff	512
4. Helpful	4141	4. Appointment	421
5. Attitude	4111	5. Wait	327
6. Treatment	4032	6. Hours	304
7. Time	3468	7. Doctor	284
8. Care	3052	8. Seen	258
9. Clinical	2662	9. Treatment	215
10. Service	2532	10. Long	193

Top 10 Themes

+ Positive		− Negative	
1. Staff attitude	28040	1. Staff attitude	1455
2. Implementation of care	11880	2. Waiting time	1214
3. Environment	7192	3. Environment	1009
4. Clinical Treatment	6789	4. Communication	786
5. Patient Mood/Feeling	5125	5. Implementation of care	769
6. Communication	4871	6. Clinical Treatment	651
7. Waiting time	4548	7. Patient Mood/Feeling	650
8. Admission	3504	8. Admission	526
9. Staffing levels	1005	9. Staffing levels	258
10. Catering	517	10. Catering	114

The Trust is also extremely grateful to its 308 volunteers who support staff and patients across the hospital, Palliative Care Centre, Chaplaincy and Self Care Management.

Celebrating our staff

Staff in the hospital and community have been putting Walsall on the national map by scooping a host of prestigious awards over the last year.

These include:

Our Clinical Cancer Research Team being judged "Team of the Year" in the National Institute of Health Research Clinical Research Network Division 1 - Cancer AGM.

The team works tirelessly to encourage patient involvement in trials and to support colleagues in their own studies.

Professional lead for the School Nursing Service Sallyann Sutton gaining the Elizabeth Garrett Anderson (EGA) NHS Leadership Award through a programme that works to develop robust, senior healthcare leadership; training the next generation of leaders in healthcare.

An app designed to help young patients and carers have a great experience while in hospital winning the *Patient Experience Network (PEN)* 'Innovative Use of Technology/Social Media' award.

The Walsall Children's Healthcare app was prompted by Dr Hesham Abdalla's experience of shadowing a patient on the hospital's Paediatric Assessment Unit.

Managers and staff from nursing homes throughout Walsall have also been recognised for the improvements they have made in quality, safety and culture over the last year

Awards were presented for Most Improved Care Home, Most Innovative Improvement (Environment and Clinical Care), Most Improved Safety Culture and Care Home Manager of the Year as part of The SPACE – Safer Provision and Caring Excellence – initiative which is being pioneered by the Walsall Quality Improvement Project. This is a partnership between Walsall Healthcare NHS Trust and NHS Walsall Clinical Commissioning Group.

A busy charity year

With a boxing match, fashion show, fun run, Trust's Got Talent, Make A Will Fortnight and bag pack among just some of the events over the last 12 months our Well Wishers charity has had another busy year.

The charity raises money for items above and beyond what the NHS can provide to enhance patients' experience. Success stories include the creation of a quiet/parents room on the children's ward at the Manor Hospital and the creation of a medical tattooing service for women who have had reconstructive surgery following breast cancer.

One of the charity's biggest achievements has been the £15,000 appeal launched last September to improve the sensory room used by children with complex conditions and disabilities at the Shelfield Child Development Centre. The equipment used for group work and one to one sessions is outdated and broken but thanks to a host events including a 100 mile bike ride, cake bakes and raffles and generous donations from the public, the fundraising target looks set to be reached very soon.

See our website www.walsallhealthcare.nhs.uk/charity/home, call the fundraising team on 01922 656643 or email fundraising@walsallhealthcare.nhs.uk

Key issues and risks

During 2016/17, the Trust identified the following key risks to the delivery of its strategic objectives. The major risks identified and monitored through the Board Assurance Framework during the year related to:

1	That the quality & safety of care we provide across the Trust does not improve in line with our commitment in line with our Quality Commitment
2	That we continue to provide inadequate care for patients attending our Emergency Department
3	That we continue to provide "inadequate" care for patients of our maternity & neonatal services
4	Integration of community services fails to deliver the required reduction in acute admissions
5	That our emergency care pathway does not improve resulting in continued delays for patients and poor flow through the hospital
6	Insufficient capacity leads to inability to deliver the elective national constitutional standards resulting in potential harm to patients
7	That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff
8	That we are not successful in our work to establish a clinically led, engaged and

	empowered culture
9	That the Trust overspends compared to its agreed plan and is unable to deliver future financial sustainability
10	That we cannot deliver our planned programme of hospital estate improvement including ITUY, Neonatal Unit, 2nd Maternity Theatre and a plan for the Emergency Department
11	That our governance remains “inadequate” as assessed under the CQC well-led standard
12	That the overall strategy does not deliver required changes resulting in services that are not affordable to the local health economy
13	New entrants into the market will succeed in attracting services resulting in income loss to the Trust
14	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

This process is described in more detail in the Annual Governance Statement section of this Annual Report

Statement of Going Concern

These accounts have been prepared on a going concern basis. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

The Trust has recorded revenue deficits in the three financial years prior to 2017/18. The Board are committed to addressing the current deficit position and the Trust’s five year model shows a planned breakeven in 2020/21. This financial recovery is dependent upon the achievement of cost improvement programmes over the period during which the Trust will also be reliant on financial support from the Department of Health to continue the provision of services.

The Trust recognises there is significant risk associated with the achievement of cost improvements targets included the forthcoming financial years. The Trust has delivered a cost improvement target of £10.9m for 2017/18 and is continuing to develop initiatives to deliver future savings beyond this financial year.

The Board of Directors have therefore given careful consideration to the Going Concern principle when preparing these accounts, and the planned revenue deficit for 2018/19.

In respect of the £18.6m planned revenue deficit for 2018/19 the Trust has access to the Uncommitted Interim Revenue Support Facility and cash supporting loans are agreed monthly with the Department of Health dependent on cash requirements

The Board has concluded that although the financial circumstances represents a material uncertainty that casts significant doubt upon the Trust's ability to continue as a going concern, the Directors have a reasonable expectation that the Trust will have access to sufficient resources, including revenue and capital loan funding, to continue to provide services to patients for the foreseeable future. For this reason the Board has adopted the going concern basis when preparing these accounts.

Performance Summary

The table below show the Trusts Key Clinical Performance Indicators:

Measure	Target 15-16	Actual 15-16	Target 16-17	Actual 16-17	Target 17-18	Actual 17-18
18weeksRTT (Referral to Treatment) Incomplete		Decision taken in Nov 2014 not to submit RTT pathway performance to NHS England for a period of time	92%	85.22%	92%	84.74%
Total Time in A & E 4 Hour wait	95%	87.90%	95%	84.10%	95%	82.67%
C. Diff Cases	18	7	18	21	18	11
MRSA Cases	0	1	0	0	0	0
% of patients whose operations were cancelled for non-clinical reasons	0.75%	0.47%	n/a	0.65%	0.75%	0.45%
Cancer 2 week wait	93%	90.80%	93%	96.1%	93%	95.4%
Cancer 2 week wait Breast Symptoms	93%	90.80%	93%	96.1%	93%	96.5%
Cancer 31 day diagnosis to treatment	96%	99%	96%	99.3%	96%	99.4%
Cancer 31 day wait surgery	94%	97.30%	94%	99.1%	94%	98.9%
Cancer 31 day wait drug	98%	99.50%	98%	100.0%	98%	100.0%
Cancer 62 day wait all cancer	85%	79.80%	85%	87.0%	85%	88.0%
Cancer 62 day wait screening	90%	100%	90%	96.2%	90%	98.0%

Cancer 62 day wait consultant upgrade	92.10%	91%	91%	92.2%	85% (From Jan 18)	86.2%

All 2017/18 figures are based on a full YTD position with the exception of 18 weeks RTT (March 18 position)

The Trust continued to endeavour to meet the requirements placed on it by its regulators and the Government. The figures show how it is performing against these key requirements.

Performance Analysis

The Trust experienced significant emergency pressures combined with a difficult winter which resulted in utilisation of additional capacity to service increased emergency activity and additional sessional work needed to support referral to treatment (RTT).

The Trust reviews and monitors performance against key performance indicators (KPIs) via a number of forums as part of its governance processes. Dependent on the nature of the KPIs, performance is monitored, daily, weekly and monthly using a number of reporting tools and online dashboards. The KPIs are made up of national, local and internally agreed standards.

Performance is reviewed weekly by the operational leads, including executive oversight. Escalation processes are put into place regarding any concerns including actions required to remediate performance and to assess any impact on the delivery of action plans. Performance is also benchmarked against peer providers to show how the Trust compares to similar sized organisations and also against organisations within the local health economy. Monthly reported performance is signed off by both operational and executive leads. It is then reported to the appropriate sub-committees of the Trust Board and to the Trust Board for scrutiny.

In addition to the internal processes, performance against key national indicators is reviewed and scrutinised externally by commissioners via a number of external meetings associated with system resilience. The Trust then works collaboratively with commissioners in agreeing remedial action plans for any recovery required and associated trajectories.

The Trust benchmarks its performance with other Acute Trusts. It provides a monthly report that is available on its Performance Hub and is presented to the Performance, Finance and Investment Committee.

Shown below are some examples of monthly/quarterly positions.

Measures which have Improved (in terms of National Rank)

Cancer 2 Week Waits – 25th (Q4 17/18) compared to 41st (Q3 17/18)

Total Time Spent in ED Overall – 79th (Apr 18) compared to 92nd (Mar 18)

Measures which have Declined (in terms of National Rank)

SHMI* – 110th (Oct16-Sept17) compared to 101st (Jul16-Jun17)

Cancer 62 Day RTT – 38th (Q4 17/18) compared to 28th (Q3 17/18)

* Standardised Hospital Mortality Indicator – this looks at the relative risk of death of all patients managed by the Trust and includes the period up to 30 after discharge.

Measures which are similar to the previous ranking (in terms of National Rank)

18 weeks RTT Incomplete – 90th (Mar 18) compared to 101st (Feb 18)

Cancer 62 Day Screening – 1st (Q4 17/18) compared to 1st (Q3 17/18)

The Trust achieved a deficit of £24.2m for the financial year, (following national adjustment) against a planned £20.5m deficit. This deterioration in performance was due to increased pressure on services requiring additional bed capacity and the associated premium costs of temporary staffing to maintain services. The Trust also received reduced income from obstetric and maternity services due births being significantly lower than planned. The national adjustment was applied for non-achievement of 2016/17 financial target.

The Trust established a target for delivery of £11.0m of cost efficiencies for the year and has delivered £10.9m of this total. Included within this target was an objective to reduce total spending on agency staffing, to £8.2m, with spending outturn at £7.5m, with reductions in medical agency expenditure and other staffing. The Trust introduced initiatives to improve outpatient productivity and theatre efficiency through earlier start times and through reduction in non-attendances. The full benefit of these improvements will result in the ability to see more patients in 2018/19.

The major redevelopment of the hospital's urgent and critical care facilities commenced in year and will complete in 2018/19. The Trust has now agreed the redevelopment of maternity services and work was due to start on site in May 2018. In addition, an Outline Business Case to extend and redevelop emergency services was submitted to NHS Improvement for approval in October 2017.

Following agreed investment from Walsall Clinical Commissioning Group, the Trust has commissioned and implemented a mobile system for recording of activity for community based services. This will result in reducing clinician time on administration and allow better inter clinician communication for improved patient outcomes.

Walsall Healthcare NHS Trust is committed to reducing the level of fraud, bribery and corruption within both the Trust and the wider NHS to an absolute minimum and keeping it at

that level, freeing up public resources for better patient care. The Trust does not tolerate fraud, bribery and corruption and aims to eliminate all such activity as far as possible. This is outlined for staff in the Anti-Fraud , Bribery & Corruption Policy.

The Trust is a significant employer in Walsall and aims to go beyond the requirements of its contracts and contribute to the wider wellbeing of the communities it serves.

In 2017-18 the Trust supported a wide variety of community events. These included support for sexual health within harder to reach communities, older people's mental health, awareness of FGM (Female Genital Mutilation) and a wide range of wellbeing initiatives. Engagement with community representatives from local temples and mosques also continued.

The Trust has an important role to play in protecting human rights through its administration of the Mental Health Act (1983) (MHA) and oversight of the Mental Capacity Act (2005). The Trust issues and maintains a comprehensive set of policies which describe how it protects patients' human rights including Safeguarding and the Depravation of Liberties Act.

Walsall Healthcare is a publicly-funded organisation and does not engage in service provision in order to make a profit. Whilst some services operate on a commercial basis they only generate a modest income and these services are not considered commercial as they do not generate income in excess of £36 million per annum. A statement on the steps the Trust has taken to ensure that slavery and human trafficking is not taking place in the Trust's supply chain or any part of the Trust's business is therefore not required.

The Trust has a continuing commitment to carbon reduction and providing sustainable environments and its Energy Efficiency Committee meets regularly to discuss ideas that improve both operational efficiency and user experience.

To utilise space more efficiently within the hospital, Estates and Facilities have been using 'OccupEye' devices which rely on wireless sensors to capture the presence of people within various areas (without identifying who they are) and note how frequently these areas are occupied. This gives the Trust an opportunity to check that it is utilising space efficiently.

These devices will support the Trust to ensure that it achieves its goal of operating with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied/under-used space by April 2020; ensuring that resources are used in a cost-effective manner.

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Chief Executive

Section 2: Accountability Report

CORPORATE GOVERNANCE REPORT

The Directors Report

Directors of the Trust

The Chair and Chief Executive

Ms Danielle Oum is the Chair of the Trust and took office on 8 April 2016.

Mr Richard Beeken is the Chief Executive of the Trust (Accountable Officer) and was appointed on 26 February 2018, taking over from Mr Richard Kirby who had been Chief Executive since May 2011.

The table below sets out the names of the Chair, Chief Executive and all individuals who were directors of the Trust from April 2017 until the publication date of this Annual Report. The individuals in the table form the composition of the Trust Board and have authority or responsibility for directing or controlling the major activities of the Trust during the year.

TRUST BOARD COMPOSITION

Name	Designation	In Year Start / Leave Dates
Danielle Oum	Chair	-
Professor Russell Beale	Non-executive Director	-
John Dunn	Non-executive Director	-
Victoria Harris	Non-executive Director	-
Sukhbinder Heer	Non-executive Director	-
Dr Jonathan Shapiro	Non-executive Director Senior Independent Director	To 31 October 2017
John Silverwood	Non-executive Director	To 31 January 2018
Deborah Carrington	Associate Non-executive Director (non-voting)	To 2 February 2018
Philip Gayle	Non-executive Director	From 1 November 2017
Paula Furnival	Associate Non-executive Director (non-voting)	-
Richard Kirby	Chief Executive	To 28 February 2018
Russell Caldicott	Director of Finance & Performance	-
Daren Fradgley	Director of Strategy &	-

	Transformation (non-voting)	
Mr Amir Khan	Medical Director	-
Rachel Overfield	Director of Nursing	To 29 October 2017
Mark Sinclair	Director of Organisational Development & Human Resources (non-voting)	To May 2017
Linda Storey	Trust Secretary	To March 2018
Philip Thomas-Hands	Chief Operating Officer	-
Louise Ludgrove	Interim Director of Organisational Development & Human Resources (non-voting)	From 30 May
Barbara Beal	Interim Director of Nursing	From 6 November
Richard Beeken	Chief Executive	From 26 February 2017

Trust Board Member Profiles (with pix)

Danielle Oum

Chair of the Trust Board (Voting Position)

Appointed April 2016

Danielle has more than 10 years' experience of leading public service business improvement and programme management, and has also worked extensively in the private sector, building and leading international teams. Danielle's professional expertise is in stakeholder engagement and transformational change. Her other professional interests are socio-economic inclusion, cross sector partnerships and regeneration. Danielle was previously the Chair of Dudley and Walsall Mental Health Partnership NHS Trust.

Professor Russell Beale

Non-Executive Director (Voting Position)

Chair of Charitable Funds Committee (until October 2017)

Champion for Information and Computer Technology

Appointed June 2016

Professor Russell Beale holds the Chair in Human-Computer Interaction in the School of Computer Science at the University of Birmingham, and is also the founder and Director of the Human-Computer Interaction Research Centre, a cross-University Research Institute. Russell has a broad range of interests across the field of HCI, being particularly interested in the use of artificial intelligence to model and optimise interaction, and in technologically-mediated behaviour change.

His research and development activities are funded through a mix of Government grants, innovation awards, commercial partnerships, EU funding, and venture capital.

Russell has commercial and entrepreneurial experience as well as an academic background. He has founded six high-technology companies, and run four of these; one works on intelligent healthcare apps. He has won awards with websites he has been involved in, and some of the products have an extensive user base. When not researching HCI he can be mostly be found outside with his children, dogs and wife, either sailing, mountain biking, or otherwise trying to be active.

John Dunn

Non-Executive Director (Voting Position)

Chair of Performance, Finance and Investment Committee

Champion for the Emergency Department

Appointed February 2015

John's professional life was spent almost exclusively in the Telecoms sector and he has extensive experience in the field of operations, and customer service. His career includes 20 years' experience at divisional board level in a variety of executive and non-executive roles and his last position with BT was as Managing Director Openreach. As MD, he was responsible for the delivery and repair of customer service and for the provision and maintenance of the local access network for the south of the UK.

Victoria Harris

Non-Executive Director (Voting Position)

Chair of Charitable Funds Committee (from November 2017)

Champion for Maternity and Neonatal Services

Appointed April 2015

Vicky has strong local links, having worked in Walsall for over 12 years and lived most of her life in the Black Country. An honours graduate in psychology, much of her career has been in the public sector in mental healthcare, although it began in the voluntary sector. Vicky has developed numerous projects and partnerships to support local people into employment. For almost a decade she was a non-executive director of the Black Country Partnership NHS Foundation Trust, during which time she saw its transition to achieving FT status, and to acquiring new services across the Black Country under the Transforming Community Services agenda.

Sukhbinder Heer

Non-Executive Director (Voting Position)

Chair of Audit Committee

Champion for Improvement

Appointed September 2016

Sukhbinder has more than 30 years' senior management experience in corporate finance and private equity as well as leading one of the UK's top professional services companies. Over the past few years Sukhbinder has also undertaken a number of non-executive positions in private, public and charity sectors and is currently also Non-Executive Director and Chair of Audit at Birmingham Community Healthcare Foundation Trust (BCHCFT).

Dr Jonathan Shapiro

Non-Executive Director (Voting Position)

Senior Independent Director

Chair of Quality and Safety Committee

Champion for Safeguarding

Appointed October 2013

Left the organisation 31st October 2017

Jonathan's interests have always centred on the 'whole system' of healthcare, and his career reflects this. Originally a GP, he then became a medical manager, before working as a senior academic for many years.

His most recent research explored organisational change in the NHS, and he now applies the lessons of his work in a variety of ways, carrying out consultancy in this area, as well as in broader policy analysis and change; he chairs the charity Education for Health, and

regularly produces journal articles as well as more detailed reports. Other roles have included being Chair of a large Mental Health Trust and Clinical Director for Humana Europe until its move back to the USA.

John Silverwood

Non-Executive Director (Voting Position)

Chair of People and Organisational Development Committee

Appointed February 2015

Left the organisation 31st January 2018

A Chartered Fellow of The Institute of Personnel and Development, John spent most of his career working in the manufacturing sector in textiles and later in soaps and detergents. He was Group HR Director for PZ Cussons plc, working extensively in Africa, Asia and Europe before retiring in 2008. John then became HR Director for the University Hospital of South Manchester NHS Foundation Trust before retiring for a second time in 2012. He hails from Nottingham but has lived in Macclesfield and the Staffordshire Moorlands and now lives in Stafford. In addition to his new position with the Trust, he is a Non-Executive Director of The High Peak Theatre Trust which is responsible for the running of Buxton Opera House.

Deborah Carrington

Associate Non-Executive Director (Non-Voting Position)

Champion for Improvement, Staff Experience (including Duty of Candour,

Freedom to Speak Up, Whistleblowing and Junior Doctors).

Appointed July 2016

Left the organisation 2nd February 2018

Over the past 20 years Deborah has held a number of senior executive roles in both the public and private sector and has a wealth of experience leading organisations through periods of transition and challenge along with an in-depth knowledge of governance and developing strategic partnerships.

Philip Gayle

Associate Non-Executive Director (Non-Voting Position)

Champion for Patient Care, Equality, Diversity and Inclusion

Appointed August 2016

Phil is currently Chief Executive Officer for Connect West Midlands, an organisation that supports those affected by substance misuse. Phil has considerable experience of the health sector and has also worked as a Non-executive Director for Sandwell and West Birmingham NHS Trust. Phil is passionate about contributing to improving services for patients in particular their experience of care at the Trust and has a strong interest in equality, diversity and ethics.

Paula Furnival
Associate Non-Executive Director (non-voting position)

Paula is the Executive Director of Adult Social Care for Walsall Council, and her experience has been gained in working within the NHS and councils who have social care responsibility.

Prior to that Paula was a solicitor working in criminal, youth court and child care law, where she gained a real insight into the social and emotional issues facing many families which led to her gaining her first role in social care in Knowsley on Merseyside, 20 years ago.

She has been a District Director in Staffordshire where she was a commissioner and provider of services across a population of about 150,000, running assessment and care management support for older people, mental health and learning and physical disability services and, care homes, and day services.

In 2010, Paula was part of a small team which helped to form a new provider of community health and social care, the Staffordshire and Stoke on Trent Partnership NHS Trust; the largest single integrated provider of health and care. More recently Paula has worked for NHS England supporting commissioning delivery and transformation developing CCG five year plans, negotiating on Better Care Fund plans and leading programmes of integrated commissioning, prevention and early intervention support.

She describes herself as an advocate of enabling people to live as independently as possible and works to integrate services to best meet the needs of local communities.

Richard Kirby

Chief Executive (Voting Position)

Appointed May 2011

Left the organisation in February 2018

Richard is a graduate of the NHS Management Training Scheme. After undertaking roles in commissioning at both health authority and primary care group level, he was Head of Performance at Birmingham and Black Country Strategic Health Authority, where he ensured that the SHA maintained its position as one of the best performing in the country.

Richard gained board level NHS Trust experience by joining Sandwell and West Birmingham Hospitals NHS Trust initially as Director of Strategy and then as Chief Operating Officer. In these roles he led the development of new models of care working with local partners, delivered service reconfigurations in paediatrics, surgery and pathology, maintained the Trust's track record of delivery on access targets and secured significant improvements in performance across the organisation. Richard was also chosen to take part in the national NHS Top Leaders Programme.

Russell Caldicott

Director of Finance and Performance (Voting Position)

Appointed July 2015

Russell lives locally and has in excess of 20 years' experience of working within the acute sector of the NHS, formerly undertaking roles such as Senior Divisional Accountant, Associate Director of Finance and Deputy Director of Finance. A Qualified Accountant and advocate of continuing professional development, Russell occupies the role of Executive on the Board of the West Midlands Healthcare Financial Management Association, providing support and opportunities for development to the finance teams of Central England.

Daren Fradgley

Director of Strategy and Transformation (Non-Voting Position)

Appointed January 2016

Daren joined the Trust after holding numerous operational and director posts at West Midlands Ambulance Service NHS Foundation Trust (WMAS). A paramedic by background Daren joined WMAS in 1994 on frontline operations initially in the Black Country and then Birmingham before moving to the Emergency Control Rooms in 2005. He then went on to manage the Trust Performance Improvement team including informatics and Business Intelligence team. In 2013 he became the A&E Operations Director before moving to NHS 111.

Daren is responsible for the Trust's transformation and cost improvement programme together with strategic and business development.

Amir Khan

Medical Director and Director of Infection Prevention and Control (Voting Position)

Appointed October 2011

Amir is a General Surgeon with a specialist interest in Vascular and Bariatric Surgery and joined Walsall in 1992 after completing his training. Amir led on the establishment of Walsall as a regional Bariatric Centre and is the lead accountable Director for the Medical workforce. Amir is also the Director of Infection Prevention and Control and the organisations Caldicott Guardian. Patient Safety and quality of care are key priorities for Amir in ensuring that our clinical outcomes for patients are of a high standard.

Rachel Overfield

Director of Nursing (Voting Position)

Appointed June 2016

Left the organisation in October 2017

Rachel joined the Trust in January 2016 as Interim Director of Nursing before becoming Director of Nursing in June 2016. Rachel trained in Worcester and worked in Worcestershire before leaving to become a Macmillan Nurse in Dudley and Wolverhampton, specialising in breast oncology. A spell at the Royal Marsden Hospital in London followed before Rachel returned to Worcestershire to take up a Matron role in head and neck trauma, orthopaedics and outpatients. She went on to the Deputy Director of Nursing role before rapidly becoming transitional director for the new Worcestershire Royal Hospital.

Around five years later she moved to Sandwell and West Birmingham Hospitals Trust as Director of Nursing. From there Rachel moved to Leicestershire as Chief Nurse. Before coming to Walsall, Rachel has also worked at the Trust Development Authority as Head of Quality.

Mark Sinclair

Director of Organisational Development and Human Resources. (Non-voting position).

Left organisation May 2017

Mark's early career included Oil and Gas, the Military and Specialist Chemicals followed by NHS jobs in Norfolk and Norwich and NHS Grampian and Orkney. He spent time working in Higher Education, in research at Glasgow Caledonian University and JHI before becoming Jersey's Director of Public Sector reform and HR. He has a diverse portfolio of Organisational Development, HR, Health and Safety, Estates & Facilities, Communications, Engagement, Procurement and Occupational Health

Linda Storey
Trust Secretary
Appointed June 2015

Left the organisation in March 2017

Linda was previously Trust Secretary at Ipswich Hospital NHS Trust from 2007 – 2014 and joined the NHS in 2003.She is a qualified chartered secretary and an associate member of both the Institute of Chartered Secretaries and Administrators and the Chartered Institute of Personnel and Development.

Responsible for the corporate governance of the Trust, she advises the board of directors about their responsibilities. As well as having worked in the acute hospital sector, Linda has worked within clinical commissioning in London and in the private sector.

Her professional interests include corporate social responsibility and risk.

Philip Thomas-Hands

Chief Operating Officer (Voting Position)

Appointed October 2016

Philip has worked in healthcare since 1985, working across acute hospitals, Mental Health, Primary Care, Medicine, Surgery and Specialised Services across both Gloucestershire and the Midlands.

Philip has also worked for GP fund holders and in the private sector, spending five years as management consultant to the manufacturing and healthcare industries. For the past four years he has been a Non-executive Director for a housing association. His role is to deliver systems, and constantly improve them, to ensure that clinicians can look after as many patients as possible within the resources available. Professional interests include change management, succession planning, task management and a strong focus on patient experience.

Louise Ludgrove

Interim Director of HR

Appointed May 2017 (non-voting position)

Louise joined the Trust in May 2017 as Interim Director of OD & HR. She has worked in the NHS since the early 1990s in provider, integrated and Foundation Trusts. Louise became a Director in 2003 and having worked in permanent roles, became an interim Director in 2011.

Barbara Beal
Interim Director of Nursing (Voting Position)
Appointed November 2017

Approaching 45 years in the NHS, Barbara's career has seen her start out as a cadet nurse before progressing to Head of Midwifery and Executive Director of Nursing & Midwifery, Chief Operating Officer and Deputy Chief Executive as well as a Non-Executive Director.

Her range of skills means she has been able to offer her knowledge as an experienced nurse and midwife, a clinical advisor, and executive/coach mentor in both the NHS and independent healthcare sector;

Barbara is committed to help support the Trust on the next stage of its improvement journey: "To focus on the safety, quality of care and experience of our patients, families, carers and our staff"

When not at work, Barbara enjoys spending time with her family and travelling.

Richard Beeken

Chief Executive (Voting Position)

Appointed February 2018

A graduate of the NHS Management Training Scheme and the NHS Top Leaders Programme, Richard has extensive NHS Leadership experience, including a number of executive roles. As CEO at Wye Valley NHS Trust, Richard led the organisation out of special measures.

He was previously Delivery and Improvement Director for NHS Improvement West Midlands, Interim Chief Executive at Worcestershire Acute Hospitals NHS Trust, and most recently was the Chief Operating Officer for University Hospitals of North Midlands NHS Trust.

Audit Committee

The Trust has an Audit Committee comprised of four Non-executive Director members, one of which is Chair. The members of the Audit Committee are:

Sukhbinder Heer: Non-executive Director and Committee Chair

John Dunn: Non-executive Director

Jonathan Shapiro: Non-executive Director (left October 2017)

Russell Beale: Non-executive Director

John Silverwood: Non-executive Director (left January 2018)

Further information relating to the Audit Committee, including key responsibilities and highlights from the year, can be found in the governance statement section of this annual report.

Company Directorships and Other Significant Interests held by members of the Board

The Board of Directors has a legal obligation to act in the best interests of the organisation in accordance with its governing document and to avoid situations where there may be a potential conflict of interest. As such, there is a requirement for Board Members to register company directorships and other significant interests that they hold that may be perceived as conflicting with their overriding duty as a Board Member.

Name	Designation	In Year Start / Leave Dates	
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.
John Dunn	Non-executive Director	-	No Interests to declare.

Victoria Harris	Non-executive Director	-	Manager at Dudley & Walsall Mental Health Partnership NHS Trust Governor, All Saints CE Primary School Trysull Husband, (Dean Harris) Deputy Director of IT at Sandwell & West Birmingham Hospital from March 2017
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).
Dr Jonathan Shapiro	Non-executive Director Senior Independent Director	To 31st October 2017	Researcher-in-Residence Chair, Education for Health Independent Chair Transformation Herefordshire
John Silverwood	Non-executive Director	To 31st January 2018	Non-executive Director of the High Peak Theatre Trust
Deborah Carrington	Associate Non-executive Director (non-voting)	To 2nd February 2018	No interests to declare.
Philip Gayle	Non-executive Director	From 1 November 2017	Chief Executive Newservol (charitable organisation – services to mental health provision).
Paula Furnival	Associate Non-executive Director (non-voting)	-	Executive Director of Adult Social Care, Walsall Council.
Richard Kirby	Chief Executive	To 28th February 2018	Steward (Trustee) Selly Oak Methodist Church
Russell Caldicott	Director of Finance & Performance	-	Chair and Executive Member of the Branch of the West Midlands Healthcare Financial Management Association
Daren Fradgley	Director of Strategy & Transformation (non-voting)	-	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
Rachel Overfield	Director of Nursing	To 29th October 2017	No interests to declare.
Mark Sinclair	Director of Organisational Development & Human Resources (non-voting)	To 11th May 2017	No interests to declare
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.

Louise Ludgrove	Interim Director of Organisational Development & Human Resources (non-voting)	From 30th May	Director of Ludgrove Consultancy Services Ltd.
Barbara Beal	Interim Director of Nursing	From 6th November	Non-executive Director at University Hospital Coventry and Warwickshire. Managing Director – Griffis-Beal Healthcare Company Ltd. Associate Fine Green Limited
Richard Beeken	Chief Executive	From 26 February 2017	Spouse, Fiona Beeken is a Midwifery Lecturer at Wolverhampton University.

The register is updated as interests are declared and at least annually and is reviewed by the Audit Committee and the Trust Board.

Personal data related incidents reported to the Information Commissioners' Officer

The Trust had a total of 5 reportable serious information governance incidents during 2017/18 related to clinical information being sent to the wrong address, information being sent to the wrong email address, a letter regarding a forthcoming operation sent to a wrong patient, a formal complaint response letter containing sensitive information about inpatient treatment sent to another address and a discharge summary was attached to another patient's letter. These were all reported to the Information Commissioner Office and appropriate action taken.

Summary of serious information governance incidents requiring investigation involving personal data as reported to the Information Commissioner's Office in 2017/18

Incident Date	Nature of Incident	Nature of Data involved	Number of Data Subjects	Notification steps
14 Mar 2018	Disclosed letter in error	Name, address, NHS number, clinical information	1	ICO informed, CCGs informed, data subjects informed by letter.
17 Aug 2017	Referral forms Emailed in error	Name, address, NHS number, GP details and the reason for referral	9	ICO informed, CCGs informed,

26 May 2017	Disclosed letter in error	Name, address, NHS number, clinical information	1	ICO informed, CCGs informed, data subjects informed by letter.
4 May 2017	Disclosed letter in error	Name, address, NHS number, clinical information	1	ICO informed, CCGs informed, data subject's relative informed by letter.
6 Apr 2017	Discharge summary – disclosed in error	Name, address, NHS number, clinical information	1	ICO informed, CCGs informed.

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Chief Executive

Statement of Disclosure to Auditors

Each individual who is, or was, a member of the Trust Board in the year covered by this report confirmed that, as far as they are aware, there is no relevant audit information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer. As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The Annual Report and Accounts as a whole are fair, balanced and understandable and as Accountable Officer I take personal responsibility for the judgments required for determining that they are fair, balanced and understandable.

Signed...  .....Chief Executive

Date.....

Annual Governance Statement 2017/18

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Accountable Officers' Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Walsall Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact, should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Walsall Healthcare NHS Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

The objectives for 2017/18 and the associated principal risks were approved by the Trust Board at its January 2017 meeting. They are shown below at **Table 1**.

Table 1

Approved Objective	Principal Risk(s)
Embed the quality, performance and patient experience improvements that we began in 2016/17	• That the quality & safety of care we provide across the Trust does not improve in line with our commitment in line with our Quality Commitment. • That we continue to provide inadequate care for patients attending our Emergency Department • That we continue to provide "inadequate" care for patients of our maternity & neonatal services.
Embed an engaged, empowered and clinically-led organisational culture	• That we are not successful in our work to establish a clinically-led, engaged and empowered culture
Track our financial position sot that the deficit reduces	• That the Trust overspends compared to its agreed plan & is unable to deliver future financial sustainability. • That the Service Improvement and Cost Improvement Programme does not deliver the financial impact planned resulting in non-delivery of financial plan. • New entrants into the market will succeed in attracting services resulting in income loss to the Trust.
With local partners change models of care to keep hospital activity at nor more than 2016/17 outturn	• Integration of community services fails to deliver the required reduction in acute admissions.
Embed continual service improvement as we do things linked to our Improvement Plan	• That the Service Improvement and Cost Improvement Programmes do not deliver the financial impact planned resulting in non-delivery of financial plan

Ensure our hospital estate is future proof and fit for purpose	• That we cannot deliver our planned programme of hospital estate improvements including ITU, Neonatal Unit, 2nd Maternity Theatre, and plans for a new Emergency Department.
Deliver a sustainability review of all our services to set plans for the next five years.	• That our emergency care pathway does not improve resulting in continue delays for patients and poor • New entrants into the market will succeed in attracting services resulting in income loss to the Trust.

The means by which strategic and operational risks are managed, monitored and reported in the Trust are set out below.

Capacity to handle risk

As Accountable Officer I am accountable for the quality of the services provided by the Trust. I have overall responsibility for risk management within the Trust and this responsibility is incorporated within the Risk Management Strategy. Elements of risk management are delegated to members of my Executive Management Team and designated specialist staff:

Overall Risk Management	Director of Nursing
Clinical Governance	Director of Nursing
Clinical Risk & Medical Leadership	Medical Director
Corporate Governance	Trust Secretary
Board Assurance & Escalation	Trust Secretary
Financial Risk	Director of Finance & Performance
Compliance with NHSI Regulatory Framework	Director of Finance & Performance and Trust Secretary
Compliance with CQC Regulatory Framework	Director of Nursing
Information Risk	Director of Strategy & Improvement (Senior Responsible Officer)

In addition, the Chief Operating Officer is responsible for risks associated with the operational delivery of performance standards and for are ensuring that the Divisions implement the Risk Management Strategy. The Director of Organisational Development and Human Resources is responsible for risks associated with staff engagement and communications and through the Divisional Director for Estates and Facilities risks relating to the management of buildings, catering, transport, decontamination, security, fire and waste management and health and safety risks. Finally the Director of Strategy and Improvement is responsible for managing the Trust's principal risks relating to strategic planning, service transformation and the cost improvement programme.

Staff members have a responsibility for handling the management of clinical and non-clinical risks according to their roles and duties within the Trust.

Sharing the learning through risk related issues, incidents, complaints and claims is an essential component to maintaining the risk management culture within the Trust. Learning is shared through Patient Safety Teams and Specialist Governance Leads who cascade information through many mechanisms which include:

- lessons learned bulletins
- Safety huddles

- Divisional Quality Boards, Quality Executive and Quality & Safety Committee
- team meetings
- Messages on the staff TV
- attendance at Nurse and Junior Doctor forums and inductions
- Listening into Action (LiA)

Training and education are key elements of the development of a positive risk management culture. Risk management forms a fundamental aspect of many training activities throughout the Trust, where staff are provided with the necessary awareness, knowledge and skills to work safely and to minimise risks at all levels. Risk management awareness training is delivered to all members of staff through our induction programme and to existing staff through mandatory training programmes.

The risk and control framework

The Risk Management Strategy provides a framework for managing risks across the Trust and is consistent with best practice and Department of Health guidance. The strategy provides a clear, structured and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation. The strategy sets out the role of the Trust Board and its committees together with the individual responsibilities of the Chief Executive, Executive Directors and all staff, in managing risk.

Risk management by the Trust Board is underpinned by four (4) interlocking systems of internal control:

- The Board Assurance Framework
- Trust Risk Register (informed by Divisions, Care Groups and Teams)
- Audit Committee
- Annual Governance Statement

The *Board Assurance Framework* (BAF) sets out the key risks to the Trust's strategic objectives together with the controls in place to mitigate the risks and the assurance that can be evidenced relating to their control. During 2017/18 the Trust Board has refreshed its Board Assurance Framework. The Trust Board has received and reviewed the Board Assurance Framework three times throughout the year.

The major risks identified and monitored through the Board Assurance Framework during the year related to:

BAF No. 1: That the quality & safety of care we provide across the Trust does not improve in line with our commitment in line with our Quality Commitment.

BAF No. 2: That we continue to provide inadequate care for patients attending our Emergency Department

BAF No. 3: That we continue to provide "inadequate" care for patients of our maternity & neonatal services

BAF No. 4: 'Integration of community services fails to deliver the required reduction in acute admissions'.

BAF No. 5: 'That our emergency care pathway does not improve resulting in continued delays for patients and poor flow through the hospital'.

BAF No. 6: 'Insufficient capacity leads to inability to deliver the elective national constitutional standards resulting in potential harm to patients'.

BAF No. 7: 'That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff'.

BAF No. 8: 'That we are not successful in our work to establish a clinically led, engaged and empowered culture'.

BAF No. 9: 'That the Trust overspends compared to its agreed plan and is unable to deliver future financial sustainability'.

BAF No. 10: 'That we cannot deliver our planned programme of hospital estate improvement including ITUY, Neonatal Unit, 2nd Maternity Theatre and a plan for the Emergency Department'.

BAF No.11: 'That our governance remains "inadequate" as assessed under the CQC well-led standard".

BAF No.12: 'That the overall strategy does not deliver required changes resulting in services that are not affordable to the local health economy'.

BAF No. 13: 'That the Service Improvement and Cost Improvement Programme does not deliver the financial impact planned resulting in non-delivery of financial plan'.

BAF No.14: 'New entrants into the market will succeed in attracting services resulting in income loss to the Trust'.

BAF No. 15: 'If the Trust does not agree a suitable alliance approach with local health economy partners it will be unable to deliver a sustainable integrated care model'.

Following the work undertaken during the year to improve the Board Assurance Framework, Internal Audit has undertaken its annual review and concluded an opinion of 'requires improvement' for 2017/18 which is a decline on the previous year's opinion which was "substantial". The deterioration in the overall opinion is due to a number of recommendations raised last year not being actioned and further weaknesses being identified. The issues highlighted and action being taken is as follows:

The wording of the 2 year objectives are not consistent with published data on the Intranet	The Trust Board have agreed four (4) objectives for 2018/19 and a Board Development session will be held to develop the BAF for 2018/19 to reflect the risks associated with these objectives. The BAF on the intranet will be updated to reflect this
Some putative controls associated with the risks are not actual controls	During the Board Development Session members will discuss what a control is and what assurances are so that this can be reflected in the BAF
Dates are not consistently added to the evidence section in the assurances section of the AF	The BAF format will be reviewed to ensure that all information required is captured appropriately

When amendments are made to the AF these are not clearly highlighted when presented to the Board for challenge	The Board will receive the BAF on a quarterly basis and a report will highlight the changes made to the BAF since the last update to ensure members are able to challenge the recommendations

The Risk Strategy describes a framework that devolves responsibility and accountability throughout the organisation via a tiered *Risk Register* system (Corporate, Divisional, Care Group, Ward and Department) which enables risks to be identified, analysed, prioritised and managed at all levels of the organisation. The method of assessing the severity and likelihood of risk is by the use of the National Patient Safety Association model matrix. This is based on scoring the impact of the Trust of not addressing the risk against the likelihood of its occurrence.

The Audit Committee is responsible for scrutinising the overall systems of internal control (clinical and non-clinical) and for ensuring the provision of effective independent assurance via internal audit, external audit and local anti-fraud services. The Audit Committee reports to the Board via a Highlight Report after every meeting and annually on its work via the Annual Report of the Audit Committee in support of the *Annual Governance Statement*, specifically commenting on the fitness for purpose of the BAF, the completeness and extent to which risk management is embedded in the Trust and the integration of governance arrangements. The Audit Committee also assesses its own effectiveness, what it has accomplished and whether it has fulfilled its responsibilities along with that of the Board sub committees.

The Trust Board and its sub committees have taken an active role in the improvement of risk management processes. This has included the alignment of Board Assurance Framework and Corporate Risks to the Board sub committees and agreed schedules of review of the risks at each.

The Trust Board is comprised of a Chair, six non-executive director members (currently one vacancy) and five executive director members: the Chief Executive, Medical Director, Director of Nursing, Director of Finance and Performance and Chief Operating Officer. Two other executive director members without voting rights attend each Trust Board meeting: the Director of Organisational Development and Human Resources and the Director of Strategy and Improvement. The Chair of the Trust Board has a second and casting vote on any decision making matters. The Trust Secretary also attends all Board Meetings.

The Trust Board saw the departure of three non-executive director members during 2017/18 Dr Jonathan Shapiro and John Silverwood voting members and Deborah Carrington an associate member of the Board. Mr Philip Gayle, who was an associate non-executive director, was made a full voting member in November 2017.

The executive team has undergone a period of change during the year with the departure of four members of the team including Richard Kirby, Chief Executive, Rachel Overfield, Director of Nursing, Mark Sinclair, Director of OD and HR and Linda Story Interim Trust Secretary. Richard Beeken was appointed as Chief Executive in November 2017, Philip Thomas-Hands was appointed as Chief Operating Officer, Louise Ludgrove was appointed as Interim Director of OD and HR and Barbara Beal was appointed as Interim Director of Nursing.

The Trust Board is supported by a framework of sub-committees. The Trust governance structure at **Appendix 1** illustrates the robustness and effectiveness of the risk management

and performance processes via our governance structure. **Appendix 2** illustrates the reporting processes in place for providing assurance through the governance structure.

The Board has overall responsibility for the effectiveness of the governance framework and plans to undertake a review of its own effectiveness in June 2018. The Board also requires that each of its sub-committees has agreed terms of reference which describe their responsibilities, accountabilities and methods of monitoring effectiveness. There are six formally designated sub-committees of the Board all of which are Chaired by a non-executive director:

- Audit Committee, chaired by Sukhbinder Heer, Non-executive Director.
- Quality and Safety Committee, chaired by Professor Russell Beale, Non-executive Director.
- Finance, Performance and Investment Committee, chaired by John Dunn, Non-executive Director from January 2016.
- People and Organisational Development Committee –chaired by Philip Gayle, Non-executive Director.
- Nominations and Remuneration Committee chaired by Danielle Oum, Chair of Trust
- Charitable Funds Committee, chaired by Victoria Harris, Non-executive Director.

The Trust Board is responsible for setting the risk appetite of the organisation as described in the Risk Management Strategy. This is defined as the amount of risk exposure or the potential adverse impact from an events occurrence that the organisation is willing to accept/retain before further action is deemed necessary to reduce it. In January 2018 the Board had an initial discussion regarding its risk appetite which will be reviewed over the next three months in order to clearly define its risk appetite.

The Trust's approach to quality improvement is clear that quality is the responsibility of all staff from 'ward to board'. 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. Reporting processes and mechanisms through Trust Board, it's Committees, Executive Team and through to Divisions and their governance processes reflect this approach. Accountability for quality is clear through the leadership and management arrangements within the Trust. The revised governance and assurance structure implemented in 2015 continues and is aligned with the clinically led management model in the Divisions providing ward to board reporting and assurance. Divisions continue to enable better and more rapid decision-making, as close as possible to the point of care delivery, which, in turn, enables more effective clinical engagement and leadership in service development and delivery as well as providing service users with greater access to decision-making. The Quality Governance Advisors embedded in the three Divisions have delivered expertise in embedding governance structures and processes at a clinical and managerial level and whilst they will continue to do so it is also planned to strengthen this at divisional and care group level so as to ensure we move to high performing clinical leaders from ward to board.

Executive leadership, accountability and responsibility for quality governance is held by the Director of Nursing and the Medical Director. Quality governance oversight and integration with corporate governance is overseen by the Trust Secretary.

The Trust's approach to clinical quality improvement is supported by a new Quality Improvement Faculty which has been established to support colleagues on the improvement journey. This encompasses the existing Listening into Action (LiA) Programme and the

Service Improvement Team. This provides additional innovative, research, and evidence based support to the services and clinicians. The first phase focuses on Human Factors in Maternity and Gynaecology.

The Trust's strategic priorities and combined support service offer aligns clinical services and support functions to deliver the best care possible to those who use Trust services. Trust Board receives regular reports, directly and through the Quality & Safety Committee, on all aspects of clinical quality and safety including management of incidents and complaints, equality and diversity, service user experience, control of infection and research and development. The Quality & Safety Committee provides assurance to Trust Board that issues and risks identified in a number of portfolio areas, such as managing aggression and violence, safeguarding adults and children, infection prevention and control, and information governance, are being addressed. Where Quality & Safety Committee identifies an area of concern which has been raised at a particular time, we scrutinise that on behalf of the Trust Board by receiving regular reports for a period.

The Trust's Quality Strategy, our ''Quality Commitment'' was approved at Trust Board in November 2016 and continued through 2017/18. The priorities are monitored individually via the Trust quality governance framework which is delivered through the governance structure (figure 1) and described in more detail below. 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 three main sections:

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

The actions to implement the Quality Commitment and those included in the Patient Care Improvement Plan developed after the 2015 CQC inspection helped to improve our ratings and the Trust is now rated overall as 'Requires Improvement'. Following the 2017 inspection the PCIP has been updated and approved by the Quality & Safety Committee at its meeting in January 2018.

The Trust's quality governance framework provides the Trust Board with assurance that essential standards of quality and safety are being delivered within the Trust. It provides assurance that the processes for the governance of quality are embedded through the Trust. Performance and Quality reports to Trust Board provide assurance against a range of Key Performance Indicators relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board.

The Board and sub committees receive assurance on compliance with quality and safety through a number of mechanisms including the Performance and Quality Report which is considered at each of the sub committees and Board. It regularly seeks out and reviews staff and patient feedback through the staff survey, pulse survey's, staff forums, leadership meetings, listening into action work streams, complaints and PALS feedback via telephone, email, face to face, Friends & Family Feedback electronic and paper and collected at point of service, National Surveys, Local Surveys, Forums, User Groups and the Membership forum. There is also regular Trust Board to staff engagement undertaken through Board walks. The Trust also uses third party assurances gained through the internal audit function, health watch, volunteers and regulatory inspections to assure itself of compliance.

The *Quality and Safety Committee* is the central driving force for quality governance, regularly reporting to the Trust Board that the essential standards of quality and safety are being delivered. This includes monitoring compliance with the Care Quality Commissions

Fundamental Standards and other statutory compliance through the Performance and Quality Report prior to submission to the Trust Board. The Quality Committee's other duties include:

- promote quality, safety and excellence in patient care;
- identify, prioritise and manage risk arising from clinical care;
- ensure the effective and efficient use of resources through evidence-based
- clinical practice;
- promote and support the duty of candour to provide a culture of shared learning and openness; and
- protect the health and safety of Trust employees.

The Performance, Finance and Investment Committee have delegated authority to monitor and scrutinise:

- Putting the interests of patients at the heart of what the organisation does.
- Financial/Annual planning and monitoring.
- Cost transformation programmes.
- Activity and productivity including operational efficiency and effectiveness.
- Delivery of the Five Year Forward View, NHS Constitution Standards and local contractual obligations.
- Workforce cost.
- Information Management & Technology: seeking assurances about the underlying data to ensure that it is robust, reliable and accurate.
- Public Finance Initiative performance.
- Challenging relevant mangers when controls are not working or data is unreliable.
- Review, approve and evaluate business case investments and requests for capital expenditure within the powers delegated by the Trust Board.

The People and Organisational Development Committee has delegated authority to:

- Review performance data and quality indicators covering key aspects of the Trust-wide workforce matters, identifying areas for action at a corporate and local level, ensuring follow up takes place:
  - Appraisal
  - Mandatory Training
  - Sickness
  - DBS
  - Staff Survey
  - Flu Vaccination
  - Recruitment & Staffing levels
  - CQUINs
  - Staff friends & family test
  - Bank & Agency
  - Volunteers

The Trust has continued to work to embed the enhanced quality governance measures through the accountability framework maintaining a focus on strong governance and leadership across quality, finance and clinical care ensuring that there is clinically led management decision-making, as close as possible to the point of care delivery.

The Trust is commitment to promoting equality and human rights and valuing diversity in all areas of Walsall Healthcare NHS Trust. It does this by ensuring that Equality Impact Assessments are integrated into core business ensuring due regard to the aims of the Equality Act at the point when decisions are made.

The Trust Board development programme sets out the process by which it will assess itself against the NHS Improvement's well led framework as part of the Trust's journey of improvement. In May 2017 the Board conducted a self-assessment review of Well Led and will be further explored in a Board session due to be held in June 2018.

We continue to work with our two key partnerships to support future improvement – Walsall Together and the Black Country Provider Partnership.

The Trust had a total of 5 reportable serious information governance incidents during 2017/18 related to clinical information being sent to the wrong address, information being sent to the wrong email address, a letter regarding a forthcoming operation sent to two wrong patients, a formal complaint response letter containing sensitive information about inpatient treatment sent to another address and a discharge summary was attached to another patient's letter. These were all reported to the Information Commissioner Office and appropriate action taken.

High reporting of incidents is a mark of high reliability organisations and therefore incident reporting is encouraged by the Trust. It is essential that staff receive feedback, there is a focus on learning, frontline staff is engaged, and incident reporting is easy, reporting systems focus on improving safety, not blaming individuals and appropriate actions taken.

In 2017/18, NHS Trusts have been required to make an annual statement of confirmation in relation to compliance with elements of the NHS Provider Licence as follows:

- G6 – Meeting the requirements of the licence and the NHS Constitution, and, having implemented effective arrangements for the management of risk
- FT4 – Relates to corporate governance arrangements covering systems and processes of corporate governance in place and effective; effective Board and Committee arrangements; compliance with healthcare standards; effective financial decision making; sufficient capability and capacity at Trust Board and all levels in the organisation; accountability and reporting lines.

The Trust Board confirmed that it met the above requirements in May 2017 and is expected to confirm this position again, in May 2018.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. In June 2017, the CQC inspected the Trust and improvements were highlighted by the CQC following their last inspection in 2015 for all acute services at Manor Hospital with the exception of maternity and gynaecology services which remained inadequate overall and critical care which remained requires improvement overall. In the community, community health services for adults and children and young people remained at a good rating overall whilst community end of life care improved from good at our last inspection to outstanding overall.

The CQC rated the Trust as requires improvement overall and the Trust remains in special measures which was placed on the Trust in February 2016 following the CQC announced comprehensive inspection and unannounced visits in September 2015. In addition, the Trust was issued with a Section 29a Warning Notice which wholly related to the quality and safety of maternity services.

The Trust has continued to ensure that the PCIP delivers against the recommendations from the December 2017 CQC report and that these actions to the overall improvement direction of the Trust. The Quality & Safety Committee have received regular updates on delivery of the programme.

The key focus of the PCIP going forward is to make it business as usual as the Trust moves from a 'Requires Improvement' status to one of 'Good'.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme's rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that the organisation complies with all relevant equality, diversity and human rights legislation.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The National Data Guardian (NDG) "Review of Data Security, Consent and Opt-Outs" and CQC "Safe Data, Safe Care" publications were published in June and July 2016 and contain a number of recommendations and standards relating to IT security and leadership / governance related elements of information security. The Trust has ensured that these will be included within the new Data Security & Protection Toolkit which the Trust will complete in April 2018. The Trust manages and controls data security through the risk management framework and records it on Safeguard. There is 1 corporate risk (665 rated 12- amber) that pertains to risk to data security. Action is underway to mitigate where possible. There are 2 departmental risks for IT Services (1221 rated 12-Amber & 1138 rated 16 - red). Action is underway to mitigate where possible.

The Trust has assessed itself against the Department of Health and Social Care, NHS England and NHS Improvement set of 10 data and cyber security standards – the 2017/18 Data Security Protection Requirements (2017/18 DSPR) and have deemed to have:

- Fully implemented 5 of the standards
- Partially implement 4 of the standards
- Has not implemented 1 of the standards

Review of economy, efficiency and effectiveness of the use of resources

As Accountable Officer I have responsibility to the Trust Board for the economy, efficiency and effectiveness of the use of resources. This is achieved operationally through good governance and systems of internal control designed to ensure that resources are applied efficiently and effectively.

The effective and efficient use of resources is managed by the following key policies:

Standing Orders

The *Standing Orders* are contained within the Trust's legal and regulatory framework and set out the regulatory processes and proceedings for the Trust Board and its committees and working groups including the Audit Committee, whose role is set out below, thus ensuring the efficient use of resources.

Standing Financial Instructions (SFIs)

The SFIs detail the financial responsibilities, policies and principles adopted by the Trust in relation to financial governance. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

They do this by laying out very clearly who have responsibility for all the key aspects of policy and decision making in relation to the key financial matters. This ensures that there are clear divisions of duties, very transparent policies in relation to competitive procurement processes, effective and equitable recruitment and payroll systems and processes. The budget planning and allocation process is clear and robust and ensures costs are maintained within budget or highlighted for action.

The SFIs are to be used in conjunction with the Trust's *Standing Orders* and the Scheme of Reservation and Delegation and the individual detailed procedures set by directorates.

Scheme of reservation and Delegation

This sets out those matters that are reserved to the Trust Board and the areas of delegated responsibility to committees and individuals. The document sets out who is responsible and the nature and purpose of that responsibility. It assists in the achievement of the efficient and effective resources by ensuring that decisions are taken at an appropriate level within the organisation by those with the experience and oversight relevant to the decision being made. It ensures that the focus and rigor of the decision making processes are aligned with the strategic priorities of the Trust and it ensures that the Trust puts in place best practice in relation to its decision making.

Anti-Fraud, Bribery and Corruption Policy

The Bribery Act which came into force in April 2011 makes it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Failure to take appropriate measures to avoid (or at least minimise) the risk of bribery taking place could lead to the imposition of fines, or imprisonment of the individuals involved and those who failed to act to prevent it. This will help ensure that the taking or receiving of bribes is less likely and improve the integrity and transparency of the Trust's transactions and decisions.

The Trust Board places reliance on the *Audit Committee* to ensure appropriate and sound governance arrangements are in place to deliver the efficient and effective use of resources and the Trust's internal control systems are robust and can be evidenced.

The Audit Committee agrees an annual work programme for the Trust's Internal Auditors and the Counter Fraud Team, and reviews progress on implementation of recommendations following audit and other assurance reports and reviews.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by NHS Counter Fraud Team (formerly NHS Protect), reports from which are reviewed by the Audit Committee. In addition, further assurance on the use of resources is obtained from external agencies, including the external auditors and the Regulators.

The Trust Board also places reliance on the *Performance, Finance and Investment Committee* to provide appropriate scrutiny and review in respect of Trust performance relating to a number of areas including efficient and effective use of resources. The Trust identified a risk to CIP delivery in 2017/18 and entered into the Financial Improvement Programme supported by NHS Improvement. This robust programme was delivered through three phases for sustainability and assurance (1-Diagnosis, 2- Plan for Recovery and 3-Implementation). An outcome of the programme included enhanced governance processes to support the financial improvement efforts, CIP maturity was progressing with a requirement to get existing schemes de-risked and new schemes quality impact assessed, a communication and engagement strategy was developed. The Trust has also entered into a fourth phase of the programme to assure delivery in year and embed the governance recommendations from the work undertaken by the partner organisation.

Information governance

There were five serious incidents requiring investigation during the period from April 2017 to March 2018 these related to a letter containing clinical information was sent to the wrong address, community referral forms were emailed in error, a letter regarding a forthcoming operation was sent two wrong patients, a formal complaint response letter containing sensitive information about inpatient treatment was sent to another address and a discharge summary was attached to another patient's letter. The incidents were reported to the Information Commissioner's Office (ICO).

Information Governance Toolkit

The Trust has consistently sustained Level 2 compliance with the Information Governance Toolkit. The Information Governance Steering Group has met on a regular basis throughout the year. The committee has reported its activities to the Quality and Safety Committee. An internal audit review of the systems of internal control for complying with the Information Governance Toolkit in 2017/18 concluded that there was "substantial" assurance.

Cyber and Data Security

Cyber and data security continues to be an important focus for the Trust. This because evident in light of the events on 12 May 2017 when the NHS was subject to a well-publicised worldwide cyber-attack. As a result of the co-ordinated emergency response to the threat by the Information Communications Technology (ICT) Department, the Trust defended itself against this particular attack and there was no operational impact to the Trust.

The Trust Information Governance Steering Group receives regular reports on plans and actions to maintain and improve cyber-security defences across the Trust. Some of the proactive work undertaken has included a cyber-security awareness campaign.

Each year the Trust undertakes a cyber penetration as part of its internal audit plan. This involves being subjected to a simulated cyber-attack probing both our external and internal networks. The results provide areas for improving including specific recommendations which are implemented to strengthen our cyber security. The overall opinion provided by the 2017/18 test is a split opinion with 1 optimal, 1 substantial and 1 requires improvement and 1 insufficient. The Trust has taken a number of actions to strengthen its ability to respond to cyber security intelligence through its subscription to alerts from NHS Digital Care Computer Emergency Response Team (CARECert). This provides advance alerting, cyber guidance and expertise. The Trust was also accepted as an early adopter for the Care Cert Assure/React programme which has provided additional analysis of our cyber security protection.

The Trust has assessed itself against NHS England's guidance on cyber risk management following the published "10 steps to cyber security" and adopted these principles. In response to NHS England's requirement for all system suppliers to be working towards Cabinet Officer Government certification for the Cyber Essentials Standard, the Trust is to include these standards into the procurements of all new ICT systems and is requesting existing suppliers to provide statements of compliance.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust's Quality Account for 2017/18 provides a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The Report was externally audited. This provided the required limited assurance opinion on the content and consistency of the report, that the content was in line with the Annual Reporting Manual (2016/17) issued by NHS Improvement and consistent with documents reviewed. In terms of the performance indicator testing of two mandatory indicators (Friends and Family and CDIF),

The Draft Quality Account is shared with partner agencies and stakeholders and commissioners for comment. Leadership comes from the Trust Board with clearly devolved responsibility and accountability for individual quality improvement priorities.

The Director of Nursing is responsible for the preparation of the Quality Account and for ensuring that the document presents a balanced view of quality within the Trust. The Quality Account is prepared with contributions from all responsible and accountable leads.

The Quality and Safety Committee is responsible for reviewing the report prior to submission with the Annual Report and Accounts to the Audit Committee and then the Trust Board. The Trust's External Auditor, Ernst and Young LLP carry out a limited review of the arrangements around the data quality and information included in the Quality Account and assess whether a balanced view of quality is presented based on other information.

Progress against the Quality Account priorities for the reporting period, 2017/18, has been reported through the Trust's governance framework via the Annual Business Cycles of the Quality and Safety Committee and the Trust Board receiving routine reports on:

- Medicines safety
- Sepsis and the deteriorating patient

- Equality and diversity

Priorities for 2018/19 are currently being developed for the Quality Account. Robust outcome metrics will be set for each priority and action to identify progress and success in achieving this improvement. The metrics we will use will be meaningful to both staff and patients. Measurement will be used to demonstrate the impact of change and then continued as on-going performance measures following the implementation of successful change, updates will be reported via Quality and Safety Committee to Trust Board.

Elective waiting time data

The Trust has been working during 2017/18 to improve the quality and accuracy relating to planned and elective waiting time data. Validation has been underway to ensure that only patients requiring further treatment or monitoring appointments remain open on the Trust's patient management system. This work has been extremely successful and will continue through 2018/19. In order to ensure this work is concluded as quickly as possible the Trust has procured Robotic software to assist with the routine data quality activities and release validators time to ensure business as usual processes are effective.

The Trust has not achieved the National standard for RTT (92% incomplete pathways waiting no longer than 18 weeks) during the 2017/18 due to capacity pressures, but data quality indicators for the Trust monitoring system for RTT indicates that data quality has been sustained since the return to reporting in October 2016. Reports are regularly reviewed in order to ensure that data quality issues are identified and validated within 48 hours. The Trust adopted the Intensive Support Teams on line training for elective care during 2017/18, with completion of modules by administrative staff whose role is to support elective pathways in the Trust. The plan is to roll this out to more staff groups in 2018/19.

The Trust Access Policy outlines standards of practice with regard to capture of outcomes following inpatient discharge and outpatient attendance. KPIs are in place supporting the standards and there are weekly meetings held where compliance is monitored. There is a monthly meeting where NHSE/NHSI are represented, along with Walsall CCG. The RTT performance and data indicators are reported.

In March 2018 an internal audit of RTT pathways was carried out and the report is currently being formulated.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee, Quality & Safety Committee, Finance, Performance and Investment Committee, People and Organisational Development Committee, Risk Management Committee and Trust Quality Executive and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that had been applied in maintaining and reviewing the effectiveness of the system of internal control, I have set out below some examples of the work undertaken and the roles of the Trust Board and Committees in this process:

The Trust Board has met in public on eleven occasions and each meeting has been both well attended and quorate. The Committees of the Board operate to formal terms of reference that the Board has approved, and carry out a range of Board work at a level of detail and scrutiny that is not possible within the confines of a Trust Board meeting. Each of the Committees provides assurance to the Board in relation to the activities defined within its terms of reference; this is reported to the next meeting of the Board in the form of a highlight report to ensure that necessary issues are highlighted in a timely way. The Board also receives the formal minutes of the meetings of each of the Committees once approved by the Committee as a true record.

The work that has been undertaken by the Committees includes:

- scrutiny and approval of the annual financial statements and annual report, including the Trust's Quality Account;
- receiving all reports prepared by the Trust's Internal and External Auditors and tracking of the agreed management actions arising;
- monitoring the Clinical Audit Programme, serious incidents and never events and ensuring that risk is effectively and efficiently managed and that lessons are learned and shared;
- monitoring of compliance with external regulatory standards including the Care Quality Commission and the Information Governance toolkit;
- monitoring of the Cost Improvement Programme and the delivery of service development;
- ensuring the adequacy of the Trust's Strategic Financial Planning;
- monitoring the implementation of the key strategies that the Board has approved; and, relevant policy approval/ratification.

The internal audit plan which is risk based, is approved by the Audit Committee at the beginning of each year. Progress reports are then presented to the Audit Committee at each meeting with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, quickly escalate any areas of concern to the Trust Board via a Highlight Report and produces an annual report on the work of the Committee and a self-evaluation of its effectiveness. The plan also has the flexibility to change during the year.

The Head of Internal Audit's overall opinion on the effectiveness of the organisation's system of internal control is that "Limited Assurance" can be given as weaknesses in the design, and/or inconsistent application of controls, put the achievement of the organisations objectives at risk in a number of areas reviewed. This is based on a range of work undertaken as part of the annual internal audit plan, including assessment of the Board Assurance Framework and an assessment of the range of individual opinions arising from risk based audit assignments throughout the year.

Internal audit has reported four areas of audit activity as requiring improvement during 2017/18 these include:

- Performance and Operations (Substantial in 2016/17)
- Clinical and Quality (Requires Improvement in 2016/17)
- Governance and Risk (Substantial in 2016/17)
- IT and Information Governance (Substantial in 2016/17).

In order to address the issues highlighted within each of the areas the following action is being taken:

Performance and	Business Continuity	A further review of the draft policy will be undertaken to ensure that it is in line with the NHSE

Operations		recommendations. The Trust will continue to review the Risk register and risk assessments in relation to Business Impact Assessments. The Trust will ensure all staff aware of the wards/ clinical business impact assessments. A review of the BIA template will be undertaken. All Business Continuity Plans will be reviewed annually. Training will continue to be offered to members of staff relevant to their role. Table top exercises have been undertaken. A review of the BCP group will be undertaken.
Clinical and Quality	Safer Bundles	The Trust is replacing the SAFER policies with a SOP as part of the overall Discharge Policy. Medical staff will ensure that they have estimated the dates of discharge then the nurses will transfer this data to the 'EDD' cell on the Nursing Assessment Document. The Trust are currently partnering with Adult Social Care to implement a 'Discharge to Assess' programme. 'Teletracking' or similar electronic bed board system will be considered for implementation by the Trust. Evidence that Board Rounds are being undertaken is being audited daily by the Care Group Managers. Further work to be undertaken on engaging the medical workforce in Safer and with patients and their carers. Progress against planned roll out of SAFER and outputs will be regularly reported to the Trust Management Board.
Clinical and Quality	Anaesthetic Rotas	A number of actions have been agreed to address the weakness identified in this area including: Trust-wide roll out of 'Allocate' for Medical Rotas. All rotas to be available via the Trust intranet and identify all activity including annual leave, protected teaching time and records working patters in order to ensure transparency, will transition to Allocate. Variation from pre-agreed working patters will be recorded, monitored and tracked to ensure compliance with contracted hours. Job plans to be agreed and entered into Allocate supported by the Job Planning Manager with the CD. Training will be provided for all CGM on allocate.
Governance and Risk	Board Assurance Framework	Actions are described above in the Risk and Control Framework section.
Governance and Risk	Conflicts of Interest	The Trust is reviewing the current policy and will ensure it use the model policy (gateway ref. 06649) as the basis for policy

IT and Information Governance	Ransomware	The Trust continues to improve its Cyber Security, in particular addressing the threat of Ransomware. This includes installation of a web filtering software to block malicious websites, email hygiene systems to block malicious emails and updating our patching regime to ensure all of our critical infrastructure has the latest patches installed. In addition the trust has signed up to the national CareCERT program, receiving weekly updates on Cyber Security from NHS digital which our IT Services department review take the appropriate action.

Taking account of national and local context, the strategic direction for the Trust has been reviewed by the Trust Board. Areas key to the delivery of the Trust's business strategy, managed and monitored by the Trust Board and the Committees of the Board includes:

- Review and maintenance of the Annual Plan and Assurance Framework
- Development of partnership working arrangements with Walsall Together and the Black Country Provider Partnership
- Delivery against the Internal Audit programme; and,
- Income, expenditure and activity

The Trust Board recognises the importance of ensuring that it is fit for purpose to lead the Trust and a programme of Board Development activity has taken place during the year through a programme of Board Seminars.

The Audit Committee has responsibility for overseeing systems of internal control and effective governance and receives assurances from the Quality & Safety Committee, Performance, Finance & Investment Committee and People and OD Committee through formal reporting arrangements following each meeting and cross membership by the Chairs of the respective committees. Additionally, assurance is received by regular internal audit reports on delivery of the internal audit programme and monitoring of actions to further strengthen governance arrangements.

The Trust Board is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended in 2011 and 2012) to prepare a Quality Account for each financial year. The Quality Governance and Risk Committee assume a scrutiny role in the development of this account prior to submission to the Trust Board for approval.

The Performance, Finance and Investment Committee has provided a forum for the Trust Board to seek additional assurance in relation to all aspects of financial and general performance, including performance against nationally set and locally agreed targets, monitoring of the Cost Improvement programme, and monitoring of the Service Transformation Programme.

Significant internal controls issues

In 2016/17 the Trust received from its external auditors, Ernst and Young LLP, a qualified Value for Money Conclusion based on the overall CQC rating of "requires improvement", financial resilience and staff survey results for 2016. The Trust continues to view these areas as significant risk areas for 2017/18.

Care Quality Commission
The CQC visited the Trust in 2015 and rated the Trust as 'inadequate'. The Trust was placed in special measures by the Secretary of State for Health in February 2016 following the CQC announced comprehensive inspection and unannounced visits in September 2015.

Following this the CQC served the Trust with a Section 29a Warning Notice of the Health and Social Care Act 2008. The warning notice set out the points of concern and timescales to address this and was wholly related to maternity services.

An announced visit was undertaken by the CQC in June 2017, and at this inspection, improvements were recognised by the CQC for all acute services at Manor Hospital with the exception of maternity and gynaecology services which remained inadequate overall and critical care which remained requires improvement overall. In the community, community health services for adults and children and young people remained at a good rating overall whilst community end of life care improved from good at our last inspection to outstanding overall.

The CQC rated the Trust as requires improvement overall and the Trust remains in special measures.

During 2017/18 the Trust continued to ensure that the Patient Care Improvement Programme (PCIP) delivered against the recommendations from the December 2017 CQC report. NHSI oversight meetings were held to monitor the actions relating to maternity services and progress has been made to address the actions.

The key focus of the PCIP going forward is to make it business as usual as the Trust moves from a 'Requires Improvement' status to one of 'Good'. In preparation for this the Trust is developing a comprehensive CQC preparation plan which will be shared with Executive Directors in May and the Trust Board in June. Monitoring of this plan will be undertaken in a weekly meeting, chaired by the Chief Executive, with Directors, Divisions and Heads of Service in attendance. The Trust is also organising a series of workshops across the Trust to support staff in the preparation for a CQC inspection and undertaking regular audits of compliance including peer review. The Trust is keen to ensure that areas of good practice are highlighted and celebrated and as part of this preparedness will undertake a self-assessment against the key lines of enquiry to give a holistic understanding of the issues and areas of celebration.

Financial position
The Trust has achieved a £24.2m deficit, following national adjustment, against the original planned deficit £20.5m.
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 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

The financial position has been closely scrutinised by the Trust Board and its committees throughout the year. It has been agreed that going forward this will be strengthen with the introduction of weekly oversight meetings reviewing the CIP programme to ensure there is a clear understanding of mitigation around any slippage in the plan. The Trust's Executive Performance and Finance Group will continue to provide oversight and challenge on a monthly basis providing assurance into the Performance, Finance & Investment Committee.

Staff Survey
The overall national average response rate for Combined Acute and Community Trusts for the staff survey was 40.4%. The Trust reached a response rate of 36.0%, a slight reduction from the previous year but which equated to 1,536 responses. The People and Organisational Development Committee reviewed the findings and plans have been identified to address the issues. The Trust Board has considered the feedback and felt that the overall picture for Walsall Healthcare had improved (going from 37th to 35th against other Trusts) and felt that there had been early signs of improvements across the Trust. The key findings compared nationally to the 2016 survey are:

- No change in 28 key findings
- Improvement in 3 key findings
- Worsening in 1 key finding
- The Trust has improved by 2% or more from 2016 results for 42% of the survey (35 questions)
- The Trust has worsened by 2% or more from 2016 survey for 13% of the survey (11 questions)
- The Trust has stayed about the same (within 1%) from 2016 survey for 45% of the survey (37 questions)
- According to Listening into Action we have improved from 37/37 Acute & Community Trusts to 35/37

The Trust has a dedicated Staff Engagement Action Plan to focus attention on what staff see as areas required for improvement and to support that the Trust has also asked for feedback on a number of key areas relating to the survey results asking for suggestions of improvement, which will feed into that plan. In addition all divisions will have their own dedicated action plan, which will be discussed monthly with the Executive Directors.

Conclusion

The Trust has identified three significant control issues (CQC, financial deficit and staff engagement) which have been identified in the body of the AGS.

There are no other significant issues to highlight.

Richard Beeken

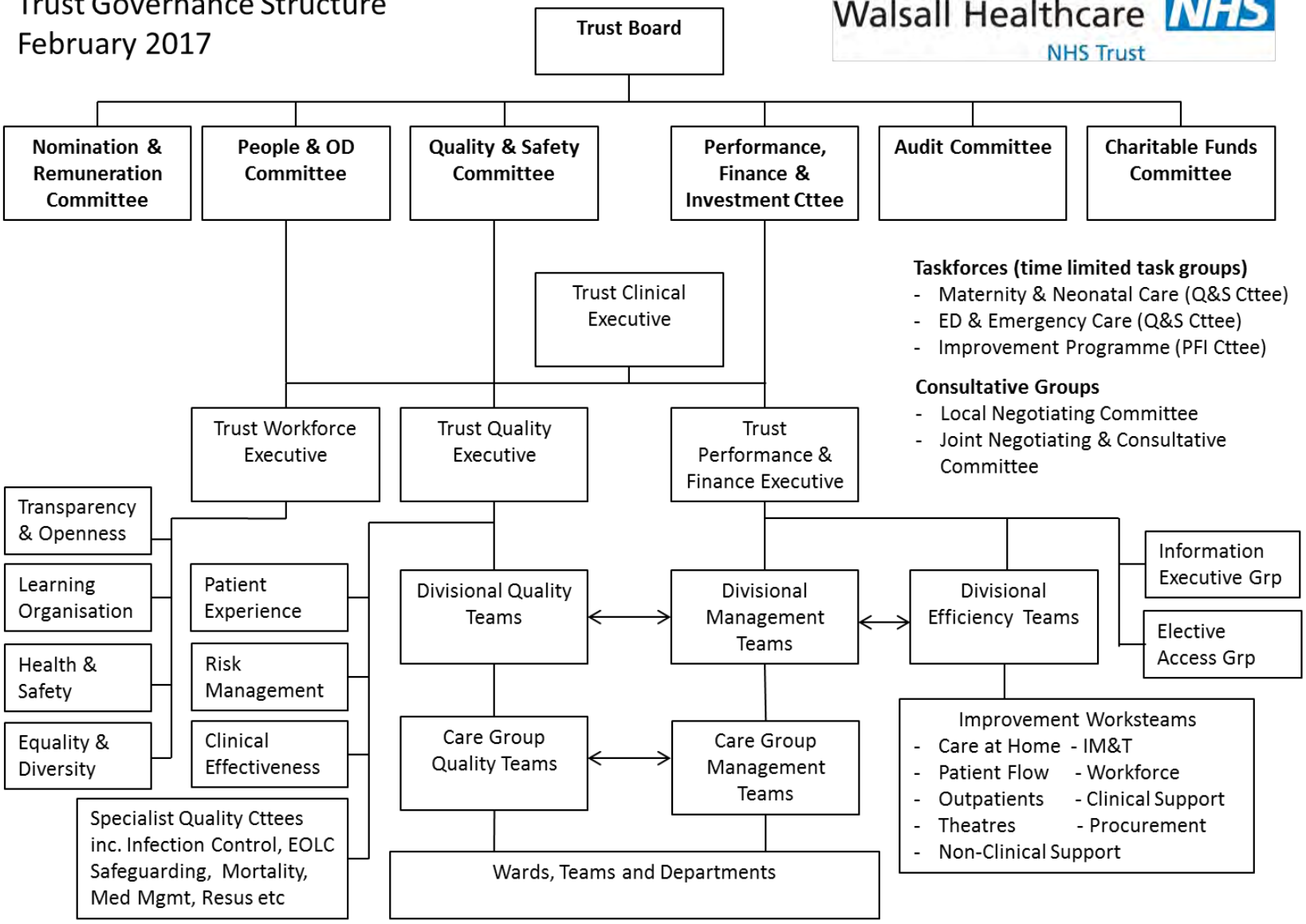
Chief Executive

Date:

Walsall Healthcare NHS
NHS Trust

Appendix 1

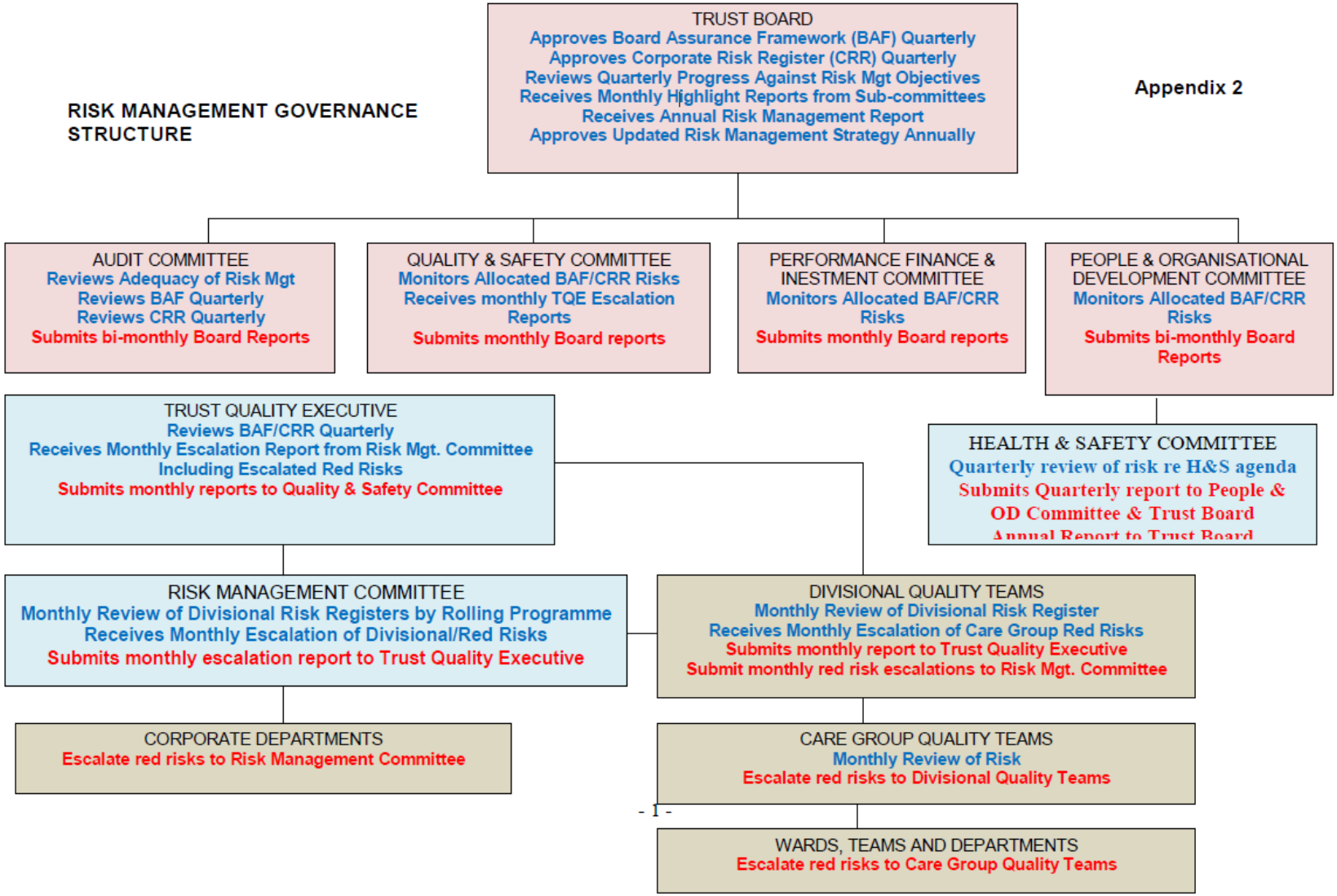
Trust Governance Structure February 2017



Walsall Healthcare NHS
NHS Trust

RISK MANAGEMENT GOVERNANCE STRUCTURE

Appendix 2



Remuneration and Staff Report

Remuneration Policy

The Trust's approach to Remuneration Policy for Directors is ensuring the salary is within the average range for Trusts of a similar size and scope in order that directors' pay remains both competitive and value for money.

The Trust has a Nominations and Remuneration Committee that agrees the remuneration packages for executive directors.

Further information about the committee can be found in the Corporate Governance Report section of this Annual Report.

Fair Pay Disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

In 2017/18, no employees received remuneration in excess of the highest-paid Director (there were 0 in 2016/17).

Remuneration ranged from £15,404 to £200,000 (2016-17 - £15,251 to £198,000).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The Nominations and Remuneration Committee agrees remuneration packages for Executive Directors. The notice period and termination payments are defined within the NHS Agenda for Change payment model as for all employees. No performance bonus payments were made to directors during the financial year.

The information contained within summary financial statements has been subject to external audit scrutiny. In addition, the directors' remuneration tables have been audited for compliance with Statutory Instrument 2008 No 410.

Pay Multiples – Audited

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Walsall Healthcare NHS Trust in the financial year 2017-18 was £200,000 (2016-17, £198,000). This was 7.8 times (2016-17, 8.2) the median remuneration of the workforce, which was £26,000 (2016-17, £24,000). In 2017-18 no employees received remuneration in excess of the highest-paid director.

Name and Title	2017-18						2016-17					
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Long-term Perormance Pay & Bonuses (bands of £5000) £000	Expense Payments (taxable) to the nearest £100	All Pension Related Benefits (bands of £2500) £000	TOTAL (bands of £5000) £000	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Bonus Payments (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	All Pension Related Benefits (bands of £2500) £000	TOTAL (bands of £5000) £000
Ms D.OUM, Chairman (from 8 April 2016)	30-35					30-35	30-35					30-35
Mr R.BEEKEN, Chief Executive (from 26 February 2018)	10-15				7.5-10	20-25						
Mr R.KIRBY, Chief Executive (left 28 February 2018)	140-145				40-42.5	180-185	150-155				37.5-40	190-195
Mr R.CALDICOTT, Director of Finance (from 1 July 2015)	110-115					110-115	110-112.5					110-112.5
Mr P.THOMAS-HANDS, Chief Operating Officer (from 10 December 2016)	120-125				40-42.5	160-165	55-60				50-52.5	110-112.5
Mr S.VAUGHAN, Interim Chief Operating Officer (left 30 September 2016)							150-155					150-155
Mr A.KHAN, Medical Director (from 1 October 2010)	85-90	85-90	30-35			200-205	80-85	80-85	25-30			195-200
Ms B.Beal, Director of Nursing (from 6 November 2017)	35-40					35-40						
Mrs R.Overfield, Director of Nursing (1 June 2016)	70-75					70-75	95-100					95-100
Mr M.SINCLAIR, Director of Strategy (left 11 May 2017)	40-45					40-45	105-110					105-110
Mr D FRADGLEY, Director of Transformation and Strategy (from 1 January 2016)	95-100					95-100	95-100					95-100
Dr J. SHAPIRO, Non-Executive Director (left 31 October 2017)	0-5					0-5	5-10					5-10
Mr J.DUNN, Non-Executive Director (from 1 February 2015)	5-10					5-10	5-10					5-10
Mr J.SILVERWOOD, Non-Executive Director (from 1 February 2015)	5-10					5-10	5-10					5-10
Mrs V.HARRIS, Non-Executive Director (from 1 April 2015)	5-10					5-10	5-10					5-10
Mr R.BEALE, Non-Executive Director (from 1 June 2016)	5-10					5-10	5-10					5-10
Ms D.CARRINGTON, Associate Non-Executive Director (from 1 July 2016)	5-10					5-10	0-5					0-5
Mr P.GAYLE, Associate Non-Executive Director (from 1 August 2016)	5-10					5-10	0-5					0-5
Mr S.HEER, Non-Executive Director (from 15 September 2016)	5-10					5-10	0-5					0-5

**Other Remuneration - This is the salary payment as a Medical Consultant.

The bonus payment for Mr A. Khan is in respect of a National Clinical Excellence Award.

Mr S. VAUGHAN, Interim Chief Operating Officer (from 10 January 2016) his salary represents agency costs.

Mrs R. OVERFIELD, Interim Nurse Director (from 1 November 2015) her salary represents a recharge from the NHS Trust Development Authority (NTDS).

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Name and Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension as pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	in Bands of (£2,500)	in Bands of (£2,500)	in Bands of (£5,000)	in Bands of (£5,000)	£000	£000	£000	£000
Mr R.KIRBY, Chief Executive (left 28 February 2018)	2.5-5	0	45-50	115-120	693	634	48	0
Mr R.BEEKEN, Chief Executive (from 28 February 2018)	0	0	45-50	115-120	742	689	5	0
Mr P.THOMAS-HANDS, Chief Operating Officer (from 10 December 2016)	2.5-5	15.0-17.5	40-45	120-125	845	692	146	0
Mr R.CALDICOTT, Director of Finance (from 1 July 2015)	0	(2.5)-(5)	25-30	65-70	411	386	21	0
Miss R.OVERFIELD, Nurse Director (from 1 June 2016)	0	0	0	0	0	0	0	0
Ms B.BEAL, Nurse Director (from 6 November 2018)	0	0	0	0	0	0	0	0
Mr A.KHAN, Medical Director (from 1 October 2010)	0	0	0	0	0	0	0	0
Mr D FRADGLEY, Director of Transformation and Strategy (1 January 2016)	0-2.5	0	25-30	70-75	409	362	43	0
Mr M.SINCLAIR, Director of Strategy (left 11 May 2017)	0	0	5-10	0	74	34	4	0

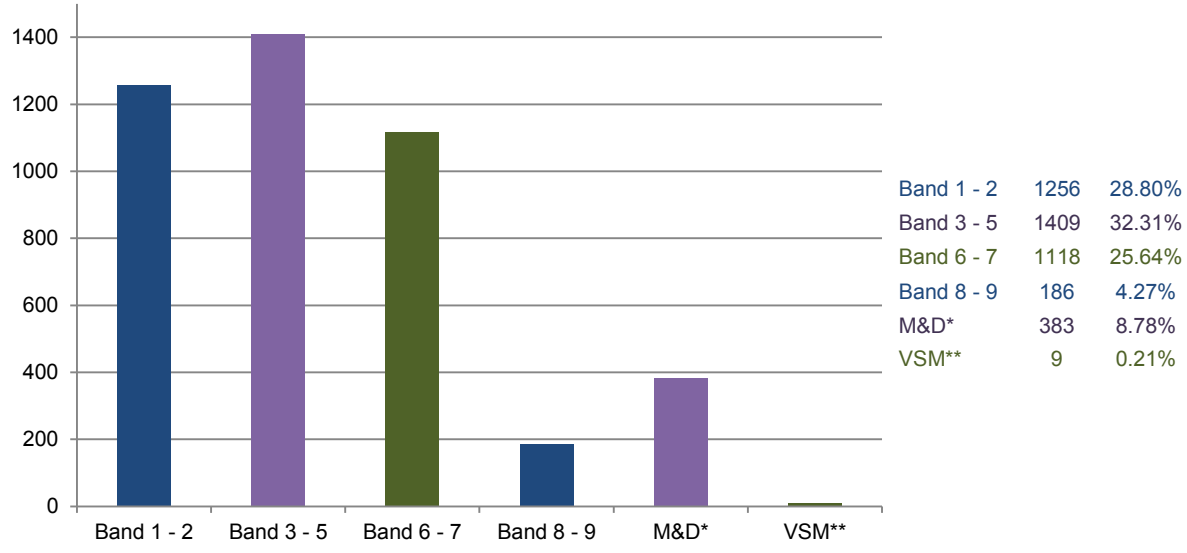
Our organisation and people

As at 31 March 2018, Walsall Healthcare NHS Trust employed 4361 substantive staff. Of these, 4002 colleagues were permanently employed on recurrent, open-ended contracts of employment. A further 359 colleagues were employed on fixed term contracts of employment.

The following table provides a snapshot of the average workforce composition during 17/18:

	Headcount
Additional Clinical Services	800
Additional Professional Scientific and Technical	134
Administrative and Clerical	976
Allied Health Professionals	251
Estates and Ancillary	397
Healthcare Scientists	105
Medical and Dental	390
Nursing and Midwifery Registered	1327
Students	36

All staff by pay band:



**Medical & Dental*
***Very Senior Manager/Director*

Equal Opportunities

All staff by gender

Female	Male
3198	1151
73.3%	26.4%

***Senior Managers* by gender**

Female	Male
80	146
35.4%	64.6%

**For the purposes of this document, "Senior Managers" represent colleagues employed on a Band 8B+, VSM or Medical Consultant contract.*

During the next year, specific actions will be carried out to reduce the gender pay gap, including:

- A review of current recruitment & selection practices to ensure that opportunities are inclusive.
- Establishing what more can be done to improve flexible working.
- Investigating how we can recognise female contributions to the continuous improvement of NHS services by encouraging applications for Clinical Excellence Awards (CEA).

All staff by ethnicity

White	BAME	Unknown
3198	1151	12
73.3%	26.4%	0.3%

Senior Managers* by ethnicity

White	BAME	Unknown
98	127	1
43.4%	56.2%	0.4%

Ninety nine per cent of the substantive workforce has chosen to disclose its ethnic background, with 26% of colleagues declaring themselves to be from a BAME background, representative of the local population and national NHS Workforce. (NHS BAME Workforce population – 18.2%).

BAME (Black, Asian and Minority Ethnic) colleagues account for 73% of the medical consultant workforce, whilst 11% of the Band 8B – Band 9 workforce have identified themselves as being from a BAME background.

The Trust is committed to equality of opportunity and recognises that a renewed Equality, Diversity and Inclusion action plan is required to address the disparity identified in publications such as the Workforce Race Equality Standards review.

Substantive senior staff (or senior managers) by band	**Headcount**
Band 8 - Range B	33
Band 8 - Range C	15
Band 8 - Range D	4
Band 9	1
Senior Manager Grade (Director etc.)	9
Consultant (Medical & Dental)	164
	226

	Female		Male	
All Substantive Colleagues	3566	82%	795	18%
Of which are:				
Directors	4	31%	9	69%
Senior staff	80	35%	146	65%

Our workforce is predominately female (82%), and this is the predominant gender in all of the staff groups except for medical staff and senior managers where the position is the reverse. NHS Employers estimates that the NHS workforce is 77% female and 23% male. Our workforce gender percentage is therefore slightly higher compared to the overall NHS gender percentage in England. As part of the Trust's Equality, Diversity and Inclusion Strategy consideration will be given to the gender distribution and whether targeted intervention is required, particularly at the senior manager level where the gender percentage is lower than average.

While the gender gap for colleagues within Band 1-8a roles falls in line with the overall NHS gender percentage in England, the average number of female colleagues holding more senior positions is 57%. Amongst the medical and dental workforce only 4 out of every 10 positions is held by a female colleague, with men making up 73% of consultant staff. We can use this data to inform our recruitment campaigns to try and rebalance the gender difference at higher bands.

Other Protected Characteristics

The Equality, Diversity and Inclusion strategy and action plan which is currently being reviewed will ensure that all nine protected characteristics identified under Equality Act 2010 are of equal importance.

Our values and behaviours, as well as staff engagement campaigns, are being developed to support an inclusive culture across the Trust, where diversity is embraced.

We will continue our work in building partnerships with local community groups and supporting the establishment of internal network groups for our employees. We will recognise diversity as an important aspect of what makes people unique, allowing individuality and growth to create a positive inclusive environment that encourages respect that will benefit patient care and safety.

The Equality, Diversity and Inclusion Committee will continue to monitor the achievement of agreed actions taken from the plan, as well as agreeing how key milestones will be measured and identify accountable leads across the Trust. It will also challenge where progress has not been achieved within the agreed timescales.

We will continue to organise events to support new and expectant mothers within the community through schemes such as 'Whose Shoes' a national programme with the purpose of improving maternity experiences. We have also created a WREN team (**W**omen **R**equiring **E**xtra **N**urturing) – a new team of midwives committed to supporting vulnerable women throughout pregnancy and beyond into the early postnatal period.

We will also use events such as Equality, Diversity & Human Rights Week to capture feedback about what we can do differently to promote and embed equality and diversity.

The Trust will also continue to collaborate with NHS England to compare the experiences of disabled and non-disabled staff, via the Workforce Disability Equality Standard. This information will be used to develop a local action plan, which promotes and measures progress against the indicators of disability equality and build on our already established practices. These include:

- Ensuring our recruitment and selection practices are inclusive such as additional time, as well as other adjustments to support candidates during the interview process
- Participation in Disability Confident which is a national scheme designed to help us recruit and retain disabled people and people with health conditions based on their skills and talent.
- Working with our local Job Centre to support targeted recruitment of potential employees with disabilities
- Making reasonable adjustments for new and existing disabled employees, including redeployment for existing employees who become disabled during their employment.

Staff Sickness Absence

	2017/18	2016/17
Total Days Absent	42,776	39,391
Total Average Staff	3,791	3,796
Average working Days absent	11	10

The Trust continues to implement measures to support a reduction in sickness absence.

During the past 12 months the Trust has:

- Offered weekly Stress Management groups.
- Collaborated with Walsall & Dudley Mental Health Trust to provide Resilience and Stress Management training sessions for Managers.
- Provided access to a Psychologist, via our Occupational Health service.
- Provided fast-track referrals to a physiotherapist.
- Made Mindfulness training available to all staff.
- Promoted healthy lifestyle benefits via the Health & Well-Being Hub.
- Developed Key Performance Indicators (KPIs) to further support attendance management.
- Supported staff by offering phased returns to work/rehabilitation programmes and redeployment.

During the 2018/19, we will continue to build on the above actions, and we will:

- Review the Attendance Policy to ensure it supports our staff and the effective management of sickness absence.
- Reintroduce training for managers so they feel more able to support staff effectively while they are in work and if they are absent due to illness.
- Review the support given through our Occupational Health and Counselling services.
- Support the effective implementation of a risk assessment process relating to stress management.
- Continue to develop our Health & Wellbeing agenda.

Staff Policies

The Trust has a range of HR policies that support staff and which are widely available on the Intranet.

In respect of disability, the Trust's Recruitment and Selection Policy and Guidelines sets out the Trust's commitment to ensuring that all staff, including those who are disabled are treated fairly and equitably in relation to the appointment processes. The Trust maintains 'Two-Tick's' accreditation, guaranteeing an interview for disabled applicants who meet the person specification and to ensure reasonable adjustments are made.

The Trust has an Equality and Diversity Steering group, which amongst others ensures that disabled persons have equal access to development and support.

The Attendance Policy and Occupational Health Service ensure that staff who become disabled are given appropriate training, support and redeployment opportunities. The Trust monitors its employment and policies to ensure actions are taken to avoid unlawful discrimination whether director or indirect.

The Trust has signed up to the Dying Matters pledge as promoted by Unison.

The full range of Human Resources Policies is available to all Trust employees via the Trust's Intranet.

Consultancy Costs

The Trust paid £2.3m on consultancy costs during 2017/2018.

Off Payroll Arrangements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

TABLE 1 Off-payroll engagements longer than 6 months

For all off payroll engagements as of 31.3.18, for more than £245 per day lasting longer than 6 months	**Number**
Number of existing engagements as of 31.3.2018	**5**
Of which, the number that have existed:	
less than 1 year at the time of time of reporting	4
for between 1 and 2 years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and March 2018, for more than £245 per day and that last for longer than six months

TABLE 2 New Off-payroll engagements

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	4
Of which...	

No. assessed as caught by IR35	4
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	1
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Table 3: Off-payroll board member/senior official engagements

Number of off payroll engagements of 'board members, and/or senior officers with significant financial responsibility' during the year (1)	0
Number of individuals that have been deemed 'board members and/or senior officers' with significant financial responsibility during the year. This figure includes both off payroll and on payroll engagements (2)	12

Note

(1) There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

(2) As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero

In any cases where individuals are included within the first row of this table the department should set out:

- Details of the exceptional circumstances that led to each of these engagements.
- Details of the length of time each of these exceptional engagements lasted.

Exit Packages

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	NUMBER	£'000s	NUMBER	£'000s	NUMBER	£'000s	NUMBER	£'000s
Less than £10,000								
£10,000 - £25,000								
£25,001 - £50,000	1	43			1	43		
£50,001 - £100,000								
>£100,000								
Totals	1	43			1	43		

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Walsall Healthcare NHS Trust has agreed early retirements, the additional costs are met by the Walsall Healthcare NHS Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

A Mutually Agreed Resignation (MAR) Scheme is a scheme whereby organisations may offer a severance payment to an employee to leave their employment voluntarily. The scheme has been developed to assist employers in addressing some of the financial challenges facing the NHS and its key purpose is to create job vacancies for colleagues facing redundancy. The scheme is time limited and has HM Treasury approval. There have been no MARS agreements in the financial year.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period