Walsall Healthcare NHS
NHS Trust

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

For access to Board Reports in alternative accessible formats, please contact the Interim Trust Secretary via 01922 721172 Ext. 6838 or jackie.white@walsallhealthcare.nhs.uk

A G E N D A

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

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
1.	Patient Story	Learning		Verbal	**10.00**
CHAIR'S BUSINESS					
2.	Apologies for Absence	Information	Chair	Verbal	**10.30**
3.	Declarations of Interest	Information	Chair	ENC 1	**10.35**
4.	Minutes of the Board Meeting Held on 7 June 2018	Approval	Chair	ENC 2	**10.40**
5.	Matters Arising and Action Sheet	Review	Chair	ENC 3	**10.45**
6.	Chair's Report	Information	Chair	ENC 4	**10.50**
7.	Chief Executive's Report	Information	Chief Executive	ENC 5	**10.55**
QUALITY IMPROVEMENT					
8.	Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Acting Director of Nursing	ENC 6	**11.00**
9.	CQC Preparedness Update	Information	Chief Executive	ENC 7	**11.10**
10.	Annual Complaints Report	Approval	Acting Director of Nursing	ENC 8	**11.20**
11.	Quality and Safety Committee Highlight Report and Minutes	Information	Committee Chair	ENC 9	**11.30**
STAFF ENGAGEMENT AND DEVELOPMENT OF A CLINICALLY LED ORGANISATION					
12.	Update report on the assessment of the Clinical Leaders Development Programme	Discussion	Interim Director of OD & HR	ENC 10	**11.40**
13.	People & OD Committee Highlight Report and Minutes	Information	Committee Chair	ENC 11	**11.50**

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
BREAK – TEA/COFFEE PROVIDED					**12.00**
FINANCIAL IMPROVEMENT					
14.	Financial Performance Month 2	Discussion	Director of Finance & Performance	ENC 12	**12.10**
15.	Performance and Quality Report Month 2	Discussion	Director of Finance & Performance	ENC 13	**12.20**
16.	Ultrasound business case	Approval	Chief Operating Officer	ENC 14	**12.30**
17.	Performance, Finance & Investment Committee Highlight Report & Minutes	Information	Committee Chair	ENC 15	**12.40**
DEVELOPING OUR CLINICAL SERVICES STRATEGY					
18.	Partnership Update	Information	Director of Strategy & Improvement	ENC 16	**12.50**
19.	Refresh of Trust Vision	Approval	Director of Strategy & Improvement	ENC 17	**13.00**
GOVERNANCE AND COMPLIANCE					
20.	Audit Committee Highlight Report and Minutes	Information	Committee Chair	ENC 18	**13.10**
21.	Charitable Funds Committee Highlight Report	Information	Committee Chair	ENC 19	**13.20**
	Reflections from Meeting - Chair				
22.	**QUESTIONS FROM THE PUBLIC**				
23.	**DATE OF NEXT MEETING** Public meeting on **Thursday 2 August 2018** at 10.00 a.m. at the Manor Learning and Conference Centre, Manor Hospital				
23.	**Exclusion to the Public** – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).				

MEETING OF THE PUBLIC TRUST BOARD – 5th July 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: West Midlands Housing Group
		Board Member: Wrekin Housing
		Chair Healthwatch Birmingham
		Committee Member: Healthwatch England
Professor Russell Beale	Non-executive Director	Director, shareholder: CloudTomo- security company – pre commercial.
		Founder & minority shareholder: BeCrypt – computer security company.
		Director, owner: Azureindigo – health & behaviour change company, working in the health (physical & mental) domains; producer of educational courses for various organisations including in the health domain. .
		Academic, University of Birmingham: research into health & technology – non-commercial.
		Spouse: Dr Tina Newton, is a consultant in Paediatric A&E at Birmingham Children's Hospital & co-director of Azureindigo.
		Journal Editor, Interacting with Computers.
		Governor, Hodnet Primary School.
		Honorary Race Coach, Worcester Schools Sailing Association.
		Non-executive Director for Birmingham and Solihull Mental Health Trust with effect from January 2017.
Mr John Dunn	Non-executive Director	No Interests to declare.
Ms Paula Furnival	Associate Non-executive Director	Executive Director of Adult Social Care, Walsall Council.
		Governing Body Member Walsall Clinical Commissioning Group – in role as Director of Adult Social Care.
		Director of North Staffs Rentals Ltd
		Member of West Midlands Clinical Senate (NHS)
Mrs 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

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.
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.
Ms Kara Blackwell	Acting Director of Nursing	N/A
Ms Jenna Davies	Director of Governance	N/A

Report Author: Jackie White, Interim Trust Secretary
Date of report: 5th July 2018

RECOMMENDATIONS

The Board are asked to note the report

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 7th JUNE 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
Mr S Heer	Non-Executive Director
Mrs V Harris	Non-Executive Director
Professor R Beale	Non-Executive Director
Mr P Gayle	Non-Executive Director
Mr R Beeken	Chief Executive
Mr A Khan	Medical Director
Mr P Thomas-Hands	Chief Operating Officer
Ms K Blackwell	Acting Director of Nursing

In Attendance:

Mrs P Furnival	Associate Non-Executive Director
Mrs L Ludgrove	Interim Director of Organisational Development and Human Resources
Mr D Fradgley	Director of Strategy & Improvement
Ms J Davies	Director of Governance
Mrs J White	Interim Trust Secretary
Mr T Kettle	Deputy Director of Finance
Miss J Wells	Senior Executive PA (Minutes)

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

044/18 Staff Story

Dr Waterhouse Director of Medical Education, attended the meeting with Dr Hirushi Jayasekera and Dr Olivia Cooper, Foundation Year 1 Doctors to share with the board members, their experience of their placements at Walsall Healthcare.

Dr Waterhouse introduced the Junior Doctors and explained that there were currently 100 trainees within the Trust. The Trust strived to provide the best possible training and experience and making it an attractive place to work for trainees selecting their placements, encouraging working more imaginatively to recruit and retain.

Dr Hirushi Jayasekera and Dr Olivia Cooper gave a presentation providing positive feedback and identified areas for improvement from their experience which were;

- Training and teaching

- Palliative Care
- Multi-Disciplinary Team Approach
- Enthusiasm and Teamwork

Opportunities for improvement were reported;

- Incident Reporting
- BLEEP Project
- Electronic System
- Rota Gaps
- Elements of teaching such as SIM real life.

The Junior Doctors also shared a video of other FY1's feedback and why they chose to work at Walsall.

Ms Oum thanked the team for attending and sharing their work with board members. Ms Oum added that the presentation was fascinating and was pleased to hear their experiences.

Questions and Comments

Mr Khan thanked the Doctors for their presentation and the fantastic work they were doing. Mr Khan expressed appreciation that the team not only highlighted problems, but provided solutions, adding that the electronic system was under review for consideration prior to the next intake of trainees.

Mrs Ludgrove was delighted to hear the positive feedback, particularly in relation to the hospital reputation and friendly atmosphere. Mrs Ludgrove queried if the FY1s had been involved in the Human Factors work? In response Dr Waterhouse explained that simulation teaching with all doctors needed to improve and would be included in the development of the curriculum with human factors. Quality improvement was the focus.

Mr Fradgley was encouraged by seeing how the FY1s worked through problems, detailing how to respond and resolve. Mr Fradgley offered support in developing electronic bleeps and would review the practicalities with his teams. **DF**

Mr Fradgley asked what opportunities of continued pathways into place based care were available. Dr Cooper replied that the training pathway and community placements formed part of the FY2's training.

Professor Beale referenced a recurring theme from the Friends and Family Test in relation to communication with patients and asked what training they had received. Dr Cooper replied that there was a heavy communication skills focus at medical school which had put the trainees in good stead, though further development of those skills within the Trust training sessions would be welcomed. Dr Waterhouse agreed that training at medical school had been developed however more could be done within the Trust.

Mr Thomas-Hands gave credit to the teams asked how the

management team linked with junior doctors, in order to make changes and obtain new ideas and experiences in working and planning. Dr Waterhouse advised that the link to management was already being discussed with Mr Beeken.

Dr Waterhouse gave thanks to the team for sharing their story with the board members and requested a Non-Executive Director be aligned with the medical education base in order to embed at board level.

Ms Oum thanked Dr Waterhouse for her input and fresh approach towards education and training. Ms Oum encouraged closer working between the board and the junior doctors, advising that there was a Non-Executive Director vacancy currently under recruitment.

045/18 Apologies for Absence

Apologies were noted from Mr Russell Caldicott, Director of Finance & Performance.

Ms Oum formally introduced Ms Jenna Davies, Director of Governance who joined the Trust at the beginning of the week.

046/18 Declarations of Interest

There were no declarations made.

047/18 Minutes of the Board Meeting Held in Public 3rd May 2018

The minutes of the meeting held on 3rd May 2018 were approved as a correct record.

Resolution

The Board approved the minutes of the meeting held on the 3rd May 2018 as an accurate record.

048/18 Matters Arising and Action Sheet

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

195/17 Performance & Quality Report – A report was completed and reviewed at the last Trust Board meeting. Mr Beeken advised that each Executive Director had been asked to consider changes they would make to reports and to condense the number of indicators reported upon and the new format aligned to a new framework. Though the timeframe may shift, there was a commitment that the revised format and condensed indicators would be in place by mid-July 2018. Mr Dunn requested an early involvement prior to mid-July.

225/17 Patient Care Improvement Plan – Mr Fradgley updated that two meetings had now taken place with a further meeting planned in 2 weeks. Discussion would take place during the Private Trust Board meeting.

035/18 Performance & Quality Report – Ms Blackwell was arranging a

meeting with Mrs Furnival and would be conducting a review of the whole structure.

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

049/18 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.

050/18 Chief Executive's Report
Mr Beeken presented the report, advising that there was an attachment which would form a regular feature, setting out the national guidance instruction requests which were received by the Chief Executive on a monthly basis. Mr Beeken highlighted the following key points;

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

- Yesterday marked the end of an unannounced two day CQC inspection of maternity.
- Reaffirmed discussions were taking place in regards to the Patient Care Improvement Pan that appeared to have slipped somewhat in prominence.

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

- The Pulsecheck Survey was launched on 4th June and closes on 22nd June 2018. Over 400 responses had been received to date which equated to around 10% of the workforce. The target was set at 50%.
- The Leadership Conference would take place on 6th July 2018 with an expected 250 Trust leaders attending the event. The new values framework would be launched at the event and workshops would be held dedicated to quality improvement leadership.

Ms Oum recommended board members attendance the Leadership Conference, utilising the opportunity to engage with a large number of colleagues and input into the workshops.

Questions and Comments

Professor Beale commented that it may not be conducive to receive whole sets of guidelines contained within the report each month and suggested that they were uploaded to the Reading Room.

Mr Heer queried how the Trust could make CQC visits business as usual and sustainable rather than seeking outside help in order to prepare.
Mr Beeken replied that the Trust could only be removed from special measures by ensuring that the fundamentals of care were right.

Compliance and mandatory training was being taken seriously.

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

051/18 Serious Incident Report

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

- A new structured report would be introduced at the next Trust Board meeting.
- There was an increased trend in the number of serious incidents reported, the majority related to pressure ulcers.
- There were two patient falls that involved fractures and two incidents in relation to infection control.

Questions and Comments

Mr Gayle queried the number of tissue viability issues, in particular the increased number of heel ulcers.
Ms Blackwell replied that unstageable ulcers were not previously reported upon. There was a robust Root Cause Analysis process in place which included the CCG, though Ms Blackwell agreed that there needed to be increased pace in identifying incidents that were avoidable. Air mattresses were useful for pressure ulcers but were not effective for heels. Preventative work was underway to encourage keeping heels elevated. An improvement trajectory and on-going training in a number of languages were being introduced.

Ms Oum reiterated that a number of work streams were ongoing to ensure accurate reporting and reassurance. The Quality and Safety Committee were to monitor progress and provide feedback to the board through the highlight report. **Q&S**

Mr Dunn observed that only 14 near misses were reported, highlighting the need to be more proactive. Ms Blackwell replied that near misses within Pharmacy were recorded in-house and would liaise with them in terms of learning. Staff were being encouraged to report near misses.

Mr Heer raised concern in the increase in trends of serious incidents.
Mr Beeken responded that moderate harm incidents had seen a small increase but stated that a large proportion related to pressure ulcers. The number of severe harm incidents remained low; overall the Trust remained within reasonable comparable parameters to other Trusts.

Mr Heer suggested reviewing benchmarking against other NHS organisations. Ms Blackwell replied that a review had taken place and the difference lay within how incidents were reported. The Trust documented two avoidable incidents during April 2018, which was comparable to others. Though it was not easy to obtain a benchmark figure, other peers in the area had been contacted to ascertain their reporting practice.

Ms Oum referenced an incident relating to anticoagulants and asked Ms Blackwell to ensure that learning from a previous similar incident had taken place. Ms Blackwell confirmed that there were two different issues and there had not been a repeat of a previous incident. Mr Khan advised that actions taken had been included in the audit programme of care groups and had been addressed by them. Detailed actions with completion dates would be presented to the Quality and Safety Committee. Mr Khan also confirmed that the incident differed to a previous incident, following which the policy was changed and was not a factor. Ms Oum asked for assurance to be provided to the Quality and Safety Committee. **Q&S**

Resolution

The Board:

- **Received and noted the content of the report.**
- **The Quality and Safety Committee would review actions and assurance.**

052/18 Monthly Nursing and Midwifery Safer Staffing Report

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

- The Trust was compliant with an overall fill rate achieving 90% during April 2018.
- Patient stay figures had improved but remained below in comparison to peers and national reporting.
- Work on e-rostering and e-rostering compliance was ongoing.
- An NHSI report was anticipated to be received during June and would be presented to board members at the July Trust Board meeting.

Questions and Comments

Mr Dunn noted the report contained many green areas but spend was still out of control. Mr Dunn stated that he expected a full report and action plan to address the current spend level.

Mr Beeken advised that there had been difficulties in extracting the report from the NHSI team and had therefore escalated to the national team. Without the report, work on expenditure could not progress. Upon receipt, the paper and recommendation would be reviewed by the Quality and Safety Committee and the Performance, Finance and Investment Committee in June the Trust Board in July.

Mr Dunn expressed concern that actions would not be implemented until Quarter 2 and would have an impact upon the overall sustainability position. Mr Beeken replied that some work streams were continuing following a number of detailed emails.

Mr Heer queried the date of the acuity tool rollout and how effectiveness would be managed. Ms Blackwell replied that the roll out would take place during mid-June and would be used daily with an appropriate accountability structure.

Professor Beale expressed concern in relation to low average care hours per day though staffing levels had risen and what actions were being taken to understand and make improvements.
Ms Blackwell advised that it would form part of the feedback from NHSI.

Ms Oum asked for consideration to making the best use of skills, ability and a realistic pace. Implementation would be during Quarter 2 and would need to be driven forward quickly.

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

053/18 Patient Experience Report

Ms Blackwell presented the report that had been reviewed by the Quality and Safety Committee and highlighted the following points;

- The Friends and Family Test response rates for Outpatients and the Emergency Department had shown signs of improvement. Response rates remained low across maternity services, though there were also slight improvements.
- There was an increase in complaints in Quarter 4 with themes relating to communication, attitude and discharge. Refocus of communications would follow the launch of the new Trust values.

Questions and Comments

Professor Beale referenced that the Friends and Family Test response rates had improved though the feedback in general, though the Emergency Department remained poor.

Ms Oum suggested that a set of actions were reviewed at the Quality and Safety Committee. **Q&S**

Ms Blackwell advised that a communications and attitude pilot had been completed with admin staff and would be rolled out to areas that received a high number of complaints.

Mr Beeken asked whether learning from complaints had been highlighted with the areas concerned. Ms Blackwell replied that discussions had taken place with the complaints team and feedback would be given at divisional reviews.

Ms Oum observed that there was lots of information provided about positive work done but the report did not show a sense of targeted anticipated achievement.

Resolution
The Board:

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

054/18 Quality Account 2017/18

Ms Blackwell presented the Quality Account 2017/18 and sought to delegate authority to the Q&S Committee to approve the completed account at the June meeting prior to the submission deadline date of 30th June 2018.

Questions and Comments

Mr Heer asked for a highlight of work being to be produced in a format that could be used for the population and wider stakeholders.Mr Beeken stated that information from the account would be built into communications.

Mr Fradgley advised that learning had been taken forward from the previous year, informing that communications would be built upon following approval and cascaded with staff and publically.

The board members approved delegation to the Quality and Safety Committee.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Approved delegation of approval to the Quality and Safety Committee.**

055/18 Quality and Safety Committee Highlight Report and Minutes

Professor Beale presented the highlight report from the most recent meeting held on 31st May 2018, together with the approved minutes of the meeting held on 26th April 2018.

Professor Beal advised that steps had been taken to reduce the agenda, adding that presentations from divisions were not routinely necessary.

Questions and Comments

Ms Oum queried the assurance received in light of the rise of c. dificile cases. Mr Khan advised that the cases were unavoidable and there was no pattern. Mr Khan added that there had been a reported case of MRSA. A review was undertaken and established that the case was unavoidable and that the patient was already harbouring the virus. Until this reported case, the Trust had been MRSA free for over 1000 days.

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

056/18 CCG Preparation

Mr Beeken presented the report which was taken as read.

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

057/18 CNST Incentive Scheme Response

Ms Blackwell presented the report, advising that the Trust were

compliant of 6 out of 10 of the initiatives currently. By the end of June, the Trust would be compliant with 8 out of 10. The board members were asked to approve the report prior to submission to NHSI.

Questions and Comments

Mr Heer queried which initiatives were not compliant. Ms Blackwell replied that actions 1, 6, 8 and 10 were not yet compliant. Work was underway for completion by the end of Quarter 2 with a view to training compliance by the end of Quarter 3, due to the scale of the task.

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

058/18 Workforce Update
Mrs Ludgrove advised that a Kings Fund update would be provided at the next Trust Board meeting.

059/18 Financial Performance Month 1
The Financial Performance for month 1 was reviewed and the following key points were highlighted;

- Deficit of £2.4m in month 1, in line with the plan.
- CIP was behind plan in month 1, delivering £0.16m.
- Temporary workforce had reduced in month but remained high against the same period last year.

Questions and Comments

Mr Dunn expressed disappointment to the start of the year. It didn't appear as though lessons had been learnt on profiling the CIP. Mr Dunn stated that trajectory and spend on temporary staffing full year effect was worrying and asked to ensure that the financial recovery plan was reviewed at the Performance, Finance and Investment Committee in June. A plan was required in order to ensure delivery. **PFIC**

Mr Beeken agreed with Mr Dunn's comments and shared concern. Work on temporary workforce was underway and hoped to be alleviated with rota discipline and annual leave reviews being undertaken by Ms Blackwell.

Mr Gayle observed that the Trust appeared to be in the same position as the previous year with temporary staffing. Medical and nursing staffing spikes during March. Mr Gayle queried what plans and assurance could the board receive.

Ms Blackwell replied that the previous report did show a reduction in temporary staffing during April, indicating a downwards trend, though there was further work to do with managing sickness and roster management.

Mr Thomas-Hands stated that the Trust were in a better place in comparison to the previous year and were performing better. Theatres had improved but agreed that they were still not at the point anticipated but gave assurance that issues were being addressed. RTT performance was the highest it had been in two years with more patients being treated quickly. Fewer beds were also utilised in comparison to the same time the previous year.
4 hour performance currently stood at 89%.

Ms Oum observed that clearly a lot of work was underway but acknowledged that the Trust was not in a comfortable position. Ms Oum stated that discipline in preparation for divisional quarterly reviews assisted to pull process back and should be considered again.

Ms Oum recognised the work in progress but expressed concern about progress. Ms Oum asked for Mr Dunn, Mr Heer and Mr Caldicott to discuss and give consideration to the quarterly review and process used previously in terms of financial improvement.

Resolution

The Board:

- **Received and noted the content of the report.**
- **The Performance, Finance and Investment Committee would review the financial recovery plan.** **JD/SH/RC**
- **Mr Dunn, Mr Heer and Mr Caldicott to discuss progress and divisional quarterly reviews.**

060/18 Performance and Quality Report Month 1

Mr Kettle presented the Performance and Quality Report for month 1 and highlighted the following key points:

- A&E Target 4 hour: April had a trajectory of 83% which was exceeded and delivered 86%.
- Cancer: All 8 metrics were achieved during March. Unvalidated performance for April showed non-achievement against 62 day referral to treatment.
- 18 week Referral to Treatment: Performance had improved to 85.89%.
- 3 cases of C. Difficile had been reported and 1 case of MRSA.

Mr Thomas-Hands advised that referral to treatment performance for May was on track to deliver 88%. A&E 4 hour performance had recently stood at 84/85% but had improved recently to 89%. ECIP were undertaking meetings with operational leads. All medical wards will be working to new ward principles from 15th June.

Questions and Comments

Mr Beeken referenced the new breach allocation rules and cut off point of tertiary centre for cancer standards, querying how it was working.

Mr Thomas-Hands advised that it was too early to say. A review would take place. A review with the cancer team would be arranged to mitigate risks as the new rules were open to interpretation. Feedback would be provided to the Performance, Finance and Investment Committee.

Mr Fradgley referred to the ECIP work and frailty pathway, stating that challenges had been experienced that would have an impact upon length of stay in the Emergency Department due to the pathway becoming fragmented. National advice had been sought and renewed links with community teams. The Trust had joined the acute frailty network and were working together with challenging front door figures.

Professor Beale advised that safeguarding training had been discussed at the Quality and Safety Committee in relation to a capacity issue within the Childs Safeguarding Team and was waiting funding from the CCG. Professor Beale queried whether the funding had been approved.

Ms Blackwell advised that there was an issue in terms of the capacity to deliver the multi-agency safeguarding training which was awaiting a response from the CCG.

Ms Oum advised that she had visited the team earlier in the week, who had advised her that there was difficulty experienced with releasing staff to attend training.

Ms Oum observed that the midwife to birth ratio was still reported as red and asked what issues were hindering moving to green. Ms Blackwell replied that a discussion had taken place at the Maternity Oversight meeting. The national target was 100% and the Trust was performing at 99%.

Mr Heer advised that there were still some blanks contained within the balance scorecard. Mr Beeken agreed and advised that he had met with members of the Information Team the previous day and had discussed the need to align the measurable indicators to the organisation priorities and risks.

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

061/18 Performance, Finance & Investment Committee Highlight Report and Minutes

Mr Dunn presented the highlight report of the meeting held on 30th May 2018, together with the approved minutes of the meeting held on 21st February 2018 and the extra-ordinary meeting held on 8th March 2018.

Mr Dunn advised that most of the highlighted points had been discussed during the agenda items covered so far. Mr Dunn reiterated his disappointment in regard to financial performance. The surgery team presented at the committee, which was well structured. Though there was lots of work to be done, there was a marked change.

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

062/18 Partnership Update

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

- Significant progress had been made with MDTs within Walsall. A number of practices were online with the right people. The number represented a 1/5th of practices.
- The project had a full time MDT coordinator and early results suggested that it was having a positive affect and increased pace of delivery.
- There were delays in the progress of the case for change for the Walsall Together business case for delivery in October 2018. There was a shared belief that the issued had been resolved which related to issues outside of the organisation which were complex and revolved around cultural issues and the ability to work together.
- Recognition of the benefits of the integration journey should not be delayed. Executives were looking to create a community division with adult services within the Trust and introducing an Integration Director.

Questions and Comments

Mrs Furnival supported Mr Fradgley's report and update. Item 5 of the paper outlined the structure and framework and assured that all were engaged. Development time with staff was proving successful, with 2 of the 4 localities working as integrated teams and health colleague's involvement. An advert had been released to appoint an Operations Director to work with intermediate care services.

Ms Oum noted the progress made and advised further discussion would take place within the private section of the Trust Board.

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

063/18 Audit Committee Highlight Report

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

- An extraordinary board meeting was held and reviewed the audit accounts following the last Audit Committee meeting.
- Audit received the year end final accounts and the opinion from auditors and the head of internal audit.
- The Extraordinary board committee approved the accounts and submitted prior to 29th May 2018 deadline.

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

064/18 Annual Self certification provider licence

Ms Oum thanked Mrs White for her assistance ensuring that the Trust was compliant. The report was taken as read and approved by the board members.

Resolution

The Board:

- **Received and noted the content of the report.**
- **Approved and declared compliance with condition G6 and FT4.**

065/18 Annual Report 2017/18

Mr Fradgley presented the report, advising that the Audit Committee recommended approval from the Trust Board. The audited report had been approved by internal audit, subject to some minor amendments. The narrative and compliance received approval by auditors.

The board approved the Annual Report 2017/18.

Resolution

The Board:

- **Received and noted the content of the report.**
- **Approved the Annual Report 2017/18.**

066/18 Questions from the Public

Mr Lemord, Staff Representative referenced the financial plans and cautioned board members not make any knee jerk reactions in an effort to get back on track.

Mr Beeken replied that the Trust was in quality special measures which ultimately meant that the Trust could not impose financial constraint that impacted upon safety or experience.

The good use of resources, discipline and better productivity were key focus, though it was a slow burn process. Mr Beeken reiterated that patient safety and clinical effectiveness would not be put in jeopardy.

Mr Lemord advised that staff were under pressure and felt undervalued. Mrs Ludgrove replied that meetings took place regularly with staff representatives to discuss issues and concerns. There was clearly a focus on recovering the financial position and it was clear that there was a consistent and high profile emphasis on quality throughout the organisation and patient care.

Ms Oum thanked Mr Lemord for his comments.

Ms Oum took the opportunity to introduce Ms Suzie Loader who had joined the Trust as Improvement Director and wished farewell to Mrs Sue Holden.

067/18 Date of Next Meeting

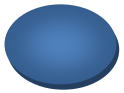
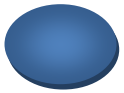
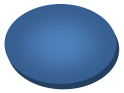
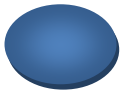
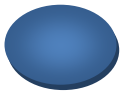
The next meeting of the Trust Board held in public would be on Thursday 5th July 2018 at 10:00a.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

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

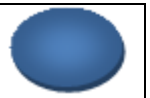
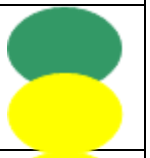
PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
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	02/08/18	**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	02/08/18	**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	
	Review Board Assurance Framework to ensure the right challenges were articulated with a view to there being fewer BAF risks.	Trust Secretary	02/08/18	**Update** The new Director of Governance together with the Trust Secretary is reviewing the BAF and a revised BAF will be presented in August.	
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	02/08/18	**Update** The PCIP is currently under review with a specific focus on aligning the plan to KPIs.	
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 Surveillance Group	

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
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	02/08/2018	**Update** Ms Blackwell and Mrs Furnival have a meeting in place to agree this action	
044/18 Staff Story	Mr Fradgley offered support in developing electronic bleeps issue raised by FY1s and would review the practicalities with his teams.	Director of Strategy & Improvement	02/09/2018	**Update** Meeting took place on the 2nd June 2018.	
059/18 Financial Performance Month 1	Mr Dunn, Mr Heer and Mr Caldicott to discuss and give consideration to the quarterly review and process used previously in terms of financial improvement.	Director of Finance	05/07/2018		

Key to RAG rating

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

MEETING OF THE PUBLIC TRUST BOARD – 5th July 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 met with volunteers at Goscote during Volunteer's Week. I was impressed by their commitment and the assistance they provide for the benefit of patients.

   I am pleased to announced the appointment of 2 new Non-Executive Directors – Anne Baines and Alan Yates who will joining the Board in early July.

2. **Financial improvement**
   I was pleased to chair an Extraordinary Board meeting to approve the Trust's Operational Plan which sets out our ambitions for the coming year.

3. **Improving staff engagement and development of a clinically led organisation**
   Unfortunately, a clinical Non-Executive Director was not appointed during recent interviews. A further advertisement will be made shortly.

   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. More visits are planned over the coming months.

4. **Developing our Clinical Services Strategy through organisational collaboration**
   I met with members of Healthwatch at a Quarterly Review meeting.
   I have met with several candidates ahead of the Medical Director and Director of Nursing Executive Director interviews.

Meetings attended / services visited

Learning Disability Team
Regional Talent Board
Head of Nursing – Surgery
Maternity Oversight Meeting
Medicines Team

RECOMMENDATIONS
The Board are asked to note the report

Danielle Oum

July 2018

<table>
<tr><td colspan="6">MEETING OF THE PUBLIC TRUST BOARD – 5th July 2018</td></tr>
<tr><td colspan="5">Chief Executive's report</td><td>AGENDA ITEM: 7</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 colspan="2">Chief Executive</td></tr>
<tr><td rowspan="2">Action Required</td><td rowspan="2">Approval</td><td rowspan="2">Decision</td><td colspan="3">Assurance and Information X</td></tr>
<tr><td>To receive and discuss</td><td colspan="2">To receive</td></tr>
<tr><td>Recommendation</td><td colspan="5">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="5">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="5">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="5">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="4">Continue our journey on patient safety and clinical quality through a comprehensive improvement programme</td><td>X</td></tr>
<tr><td colspan="4">Develop the culture of the organisation to ensure mature decision making and clinical leadership</td><td>X</td></tr>
<tr><td colspan="4">Improve our financial health through our robust improvement programme</td><td>X</td></tr>
<tr><td colspan="4">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. PROGRESS AGAINST OUR FOUR OBJECTIVES

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

Our preparations for CQC inspection, including the new assessment process for "well-led" and "use of resources" continues at a good pace. Weekly meetings, chaired by myself, with Divisional and corporate leaders, focus on the quick wins we need to resolve (ie. Bed storage, environmental improvements, intensive oversight of our mandatory training compliance improvements) as well as the implementation of a wide ranging and 'three dimensional' quality audit process, which will assess ward and service capability against a wide range of quality indicators and PCIP evidence.

Suzie Loader, Improvement Consultant, is also working with Divisions to ensure that the PCIP, our quality improvement plan, measures outputs and wherever possible, outcomes. Through this process, we will develop a significant proportion of the quality element of our intended new integrated performance report/dashboard. Suzie is also developing the next phase of our Board development work on well-led, and a clear

announcement about next steps will be made shortly on this, once the Chair and myself have agreed the method and content.

Our maternity services received a 2 day unannounced inspection on 5th and 6th June, which colleagues in that service responded to well. The inspection team have now sent us a formal letter to give initial feedback, which was largely positive with regard to progress on the concerns raised in 2015 and 2017 inspections. We are, as yet, unclear about whether the CQC are planning a wider inspection, a focused inspection on key areas of risk or are purely concentrating their scrutiny on maternity services. I recommend that we continue to prepare the organisation to be "inspection ready", whatever final approach taken by the CQC emerges.

Improve our financial health through our robust improvement programme

There are two key developments to report here. Firstly, at our Private Board session last month, we accepted the Provider Sustainability Fund offer from NHSI and will be submitting a plan on 20/6 which reflects the control total we have agreed to. That is to work to a deficit plan of £15.6 million for 2018/19, which, net of a PSF contribution of £5 million, will leave the organisation with a deficit of £10.6 million at year end, assuming full delivery of the plan. I found the Board discussions on this to be both mature and diligent, carefully assessing the risks of the two options available to us. On balance, the capital benefits, fines immunisation and significant step towards financial balance and sustainability, were persuasive factors in our decision. The executive team will now work on the communications approach to the organisation on this, which we agreed at our team meeting on 19/6.

Secondly, the executive team, led by the work of the Chief Operating Officer, continue to work on whether there should be an amendment to our plan submission driven by a change to our approach to managing beds, bed occupancy and activity. Walsall Healthcare has the highest residual bed occupancy in the region, yet, like many Trusts, our ambitious plans for patient flow and length of stay improvement, are part of our financial plan, in the form of seasonal bed closures and savings on the associated staffing costs. Whilst this approach saves money, it necessarily artificially increases bed occupancy, making attainment of the ED improvement trajectory, increasingly difficult. Instead, we are closely examining whether the income associated with additional elective activity, combined with marginal reductions in the negotiated unit cost of supplementary nursing staff, can mitigate the CIP attributed to the bed flexibility plan. If so proven, we will be able to achieve a better balance between safe patient flow, ED standard attainment and financial delivery. I will be able to report on our conclusions with regard to this important consideration, next time.

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

Some strong candidates are coming forward for the key posts of Executive Medical Director and Director of Nursing. I am increasingly confident that we will make appointments to both posts at our recruitment process for each on 3rd and 4th July

respectively. The Medical Director and I continue our discussions with a key individual who could bring clinical leadership experience and new ideas for our MLTC Division, from outside the organisation. In the spirit of our new way of working, we are starting work with the Local Authority on a joint appointment to the Director of Community Services role, an essential precursor to the creation of a community division in the Trust, anticipating the Walsall Together business case conclusions. We are also in discussions with the Local Authority over the appointment of a joint Head of Therapy Services role, another important break from the tradition of managing such appointments purely along organisational lines.

At the time of writing, we continue to chase down responses to the LiA Pulsecheck survey of staff opinion and had, on 19/6, over 1400 responses. The deadline is 22/6. We feel a response rate of over 2000 will represent nearly 50% of the staff in the Trust and will be a statistically significant response, which should help us to tailor our plans on staff engagement and quality improvement, with more certainty.

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

All statutory partners have now agreed to the costs of both leadership team development and business case development, for Walsall Together. As aspirant host provider, we need to continue to push the provider board partners to the next stage in this key work, particularly focusing on engagement of primary care colleagues in the business case development, focusing on practical, patient centred benefits. The next provider board will be crucial, as it should be the first at which both LMC and locality GP representatives attend. It will be a vital litmus test of GP opinion about our methods and intentions.

At STP level, it is important to report back that there is unanimity of view between all STP partners, that the construct of an Integrated Care System in the Black Country should be firmly based on place based developments in care provision within each of the four boroughs. It was unanimously agreed that whilst there was potential for Black Country-wide resilience improvements in mental health, capturing more tertiary/cancer work from Birmingham and some elements of integration of acute hospital services, the biggest benefits would continue to be delivered through health promotion and preventative health and social care actions, within the four boroughs. At the health leaders STP meeting, each acute hospital Trust has committed now to undertaking or completing an acute service sustainability review so that we can be collectively clear about the services which would benefit from collaborative action, before the end of August 2018.

4. DETAILS

Board members are asked to note the report.

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 June, 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.			
	Self-certify this month Trust are required to complete their self-certifying compliance with required governance arrangements under condition FT4 of the NHS provider licence by 30 June.	Action	Director of Governance
	Guide to reducing long hospital stays New guidance on helping trusts deliver the new national ambition to reduce the number of beds occupied by long-stay patients by 25% by December 2018.	Guidance	Chief Operating Officer
	Leadership of allied health professions (AHPs) in trusts Guidance and a self-assessment tool, to help the Trust identify areas for improvement and opportunities for strengthening AHP senior leadership.	Guidance	Director of HR
	Chief executive performance ratings in NHS trusts NHS Improvement's role to oversee all aspects of an NHS trust board's performance on delivering high quality care. As part of this role they are to review the proposed annual performance ratings of Chief Executives. Performance in 2017/8 should have been measured on delivery of organisational performance against NHS Improvement's Single Oversight Framework. Completed templates are due by 5pm Friday 13 July.	Action	Director of OD & HR and Chair
	Information on your analytical services and information teams	Action	Director of Finance & Performance

	NHSI are creating a national database to communicate with those involved in information analysis, activity planning and corporate board and performance reporting. Details are required – see briefing		
	Reducing reliance on medical agency staff: sharing what works New guide highlights common strategies trusts have used to successfully reduce reliance on medical agency spend.	Guidance	Director of Finance & Perofrmance / Medical Director
	Patient experience improvement framework NHSI have published an evidence-based framework centred around Care Quality Commission key themes to enable boards and senior teams to continuously improve the experience of patients.	Guidance	Director of Nursing
	NHS pay deal: trade union ballot result New pay deal is due to be ratified on Wednesday 27 June and NHSI will work with NHS Employers to support trusts as the deal is implemented.	Guidance	Director of OD & HR / Director of Finance & Performance
	Performance of the NHS provider sector 2017/18 Report on operational and financial performance shows despite experiencing the worst winter in a decade, frontline NHS staff and managers rose to the challenge and cared for more patients than ever before. However, this surge in demand affected performance in key areas, such as waiting times and reliance on temporary workers.	Information	All
	Lord Carter's review highlights potential savings Lord Carter's review of the operational productivity of mental health and community health services found the NHS could save £1	Information	All

	billion worth of efficiencies by 2020/21 by reducing unwarranted variations. The report, which was accepted in full by our board last week, has recommendations for national bodies and providers to implement over the next three years.		
	Three new demand and capacity modelling tools NHSI have published three new demand and capacity modelling tools to help Trusts better understand demand, plan capacity across services and improve patient experience by making data-driven decisions.	Information	All
	Prime Minister's speech on NHS funding commitment: 18 June 2018 NHS Providers have issued a briefing which summarises the announcements made by the Prime Minister Theresa May regarding the new five year funding settlement for the NHS, giving the service real terms growth of more than 3 per cent for the next five years.	Information	All
	Health and Social Care Select Committee report - Integrated care: organisations, partnerships and systems NHS Providers have published a briefing from the Health and Social Care Select Committee (the Committee) regarding the inquiry into 'the development of new integrated ways of planning and delivering local health and care services. This timely inquiry focusses on the development of Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs) and Accountable Care Organisations (ACOs). This briefing provides an overview of the Committee's key findings and recommendations.	Information	All

MEETING OF THE TRUST BOARD – 5th July 2018					
Monthly Nurse Staffing Report					**AGENDA ITEM: 8**
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 discuss the information contained in this report, the current performance in relation to the national and local safe staffing and roster KPIs and the ongoing work being undertaken in relation to faciliatating decision making in relation to the deployment of staff via the implementation of a daily acuity tool.				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Objective No. 5: Establish a substantive workforce that reduces our expenditure on agency staff. Corporate Risk No 11 Failure to assure safe nurse staffing levels				
Resource implications	Resources are needed from all teams to focus on efficient scheduling of staff and the prompt action to resolve short staffing where possible. This includes resources from the departments that coordinate the temporary supply of staff.				
Legal and Equality and Diversity implications	None				
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 May 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 Trust performance against key national and local staffing indicators and a comparison to previous months is made. It also outlines the use of temporary registered nursing hours in May 2018 compared to the previous months.

The following key highlights are outlined in the report:

- Overall fill rates of 97% in May 2018
- Care hours per patient day (CHPPD) which have improved from the previous month, but are yet to reach the national average
- Significant reduction in the use of temporary staffing and a 26% reduction in agency cap breaches
- Reduction in informal bed base (boarding patients) and the positive impact this is having on CHPPD and patient safety
- Improved roster efficiency, timeliness of temporary staff requests
- Implementation of a daily acuity tool to aid the clinical decision making in relation to the deployment of staff

1.0 Introduction

The purpose of this report is to present to the board a review of ward nurse staffing level as directed by the National Quality Board (NQB 2016). The NQB has stipulated that; 'Boards must take full responsibility for the quality of care provided to patients, and as a key determinant of quality,take full and collective responsibility for nursing, midwifery and care staffing capacity and capability'. This report provides an overview of staffing for May 2018; it is set out in line with the NQB standards and expectations for safe staffing which includes the *Right Staff, Right Skills, and Right Time and Place* (NQB 2016) to provide 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 Right Staff

2.1 Safe Staffing UNIFY Data

The overall fill rate for registered staff in May 2018 was 97%, for CSW staff the overall fill rate was the same. The target of above 90% fill rate was achieved across both registered and unregistered staffing on both days and nights.

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

Day				**Night**			
RN/Midwives		**Care Staff**		**RN/Midwives**		**Care Staff**	
%Bank	%Agency	%Bank	%Agency	%Bank	%Agency	%Bank	%Agency
32472.5	32383.4	24311	23371.9	26990.5	25687.5	18203	17898.5
Average Fill Rate - RN/Midwives (%)		**Average Fill Rate - Care Staff (%)**		**Average Fill Rate - RN/Midwives (%)**		**Average Fill Rate - Care Staff (%)**	
99.7%		96.1%		95.2%		98.3%	

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 Fill Rate Compliance < 90% by Clinical Area		
Ward	**Fill Rate**	**Exception Report Comments**
Ward 15	89.9 % day	No incidents were reported in which staffing was a factor. The fill rate for CSWs was 116% on nights compensating for some of the gaps in RN shifts
Ward 7	84% day	No incidents were reported in which staffing was a factor.
Ward 9	65.8% night	This ward had use of extra capacity during the month which resulting in demand for higher numbers of RN staff from Bank/Agency which were sometimes unmet.
Ward 21	87.1% night	Paediatric workforce used flexibly based on activity. No incidents reported in which staffing was a factor

CSW Fill Rate Compliance <90% by Clinical Area		
Ward	**Fill Rate**	**Exception Report Comments**
PAU	89.2% day	Paediatric workforce used flexibly based on activity. No incidents reported in which staffing was a factor.
16	89.7% day	No incidents were reported in which staffing was a factor.
18	85.6% day, 57.8% night	The staffing in HDU is applied flexibly to the demand in the area. No incidents were reported in which staffing was a factor.
24/25	74.9% day/77.6% night	No incidents were reported in which staffing was a factor.
Ward 23	79.5% day	Gynaecology ward uses staff from clinic areas to support workforce, this is used flexibly based on activity. No incidents reported in which staffing was a factor.

2.2 Average Care Hours per Patient Day (CHPPD)

Care Hours per Patient Day (CHPDD) continues to be collated on a monthly basis and are reported as part of the Unify data report. The CHPPD for May 2018 was 7.3; this was an improvement on the previous month, although still below the national average, reported via the Model Hospital is 7.6 CHPPD and regional comparison of 7.5. The routine boarding of patients (placing additional patients on the ward, over and above the allocated bed spaces) will directly impact on the Trust CHPPD; there was a decrease in the boarding of patients in May 2018. In addition the Trust has the highest bed occupancy (100%) in the West Midlands and this impacts on the CHPPD reported.

2.3 Safe Staffing, Quality and Safety KPIs

No relationships were identified in May 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.

Key Quality KPIs for those areas with <90% fill rate are outlined below:

Ward	**Hospital Acquired Pressure Ulcer (unvalidated prior to RCA)**	**Falls with Harm**	**SI**	**Complaints**	**FFT Score**
Ward 15	0	3	1	2	94.59%
Ward 7	0	5	0	0	98.21%
Ward 16	3	1	1	1	97.14%
Ward 18	0	0	0	0	100.00%
Ward 9	3	1	1	1	95.45%
Ward 21	0	0	0	0	91.01%
Ward 23	0	0	1	1	98.70%
Ward 24	0	0	0	0	100.00%
Ward 25	0	0	0	0	90.32%

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. Those pressure ulcers reported in May are currently going through the RCA investigation process.

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 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 SNCT audit was undertaken in Febraury 2018, analysis of this showed that the national tool had been modified in some areas which is not recommended. Based on the feedback from the NHSi review the SNCT which was due to be undertaken on June 2018 is commencing on 25th June will no modification from the national tool and the audit is being supported by the Senior Nurse for workforce to ensre the tool is applied equitably across all adult ward areas.

3.0 Right Skills

3.1 RN Recruitment

Current initiatives being undertaken in relation to RN recruitment:

- The Trust continues to advertise on a rolling basis for RN vacancies in the Medicine and Surgical Division
- Ad hoc recruitment events tailored to specialities such as AMU.
- The Trust also has overseas arrivals planned for the remainder of this financial year with an expected conversion to RN registered with the NMC within 6 months. The target for recruitment is 30WTE for this financial year. YTD 4 Overseas nurses have commenced (April/May) against a target of 6 nurses for this time period.

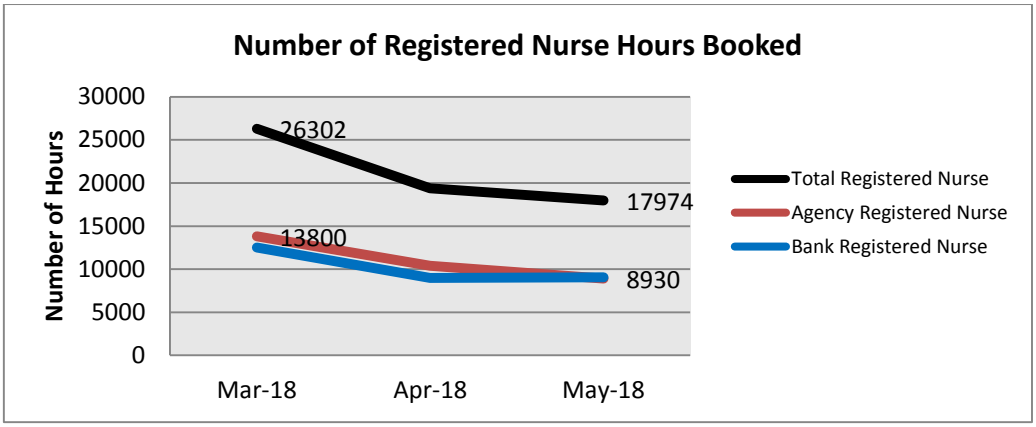
The current vacancies in May 2018 for RNs (excluding Theatres) is 72.83 WTE, in comparison there were 91.67WTE for the same period of May 2017. Comparing RN vacancies to same time period in the last financial year it is evident that the Trust has circa 20WTE less RN vacancies. However, there were an additionl 2 funded wards still open in May 2017 which closed but then re-opened as additional . It is worth noting that at the time of writing this report one ward is still open and if this was funded then the vacacnies would increase and be equivalent to the same time period last year.

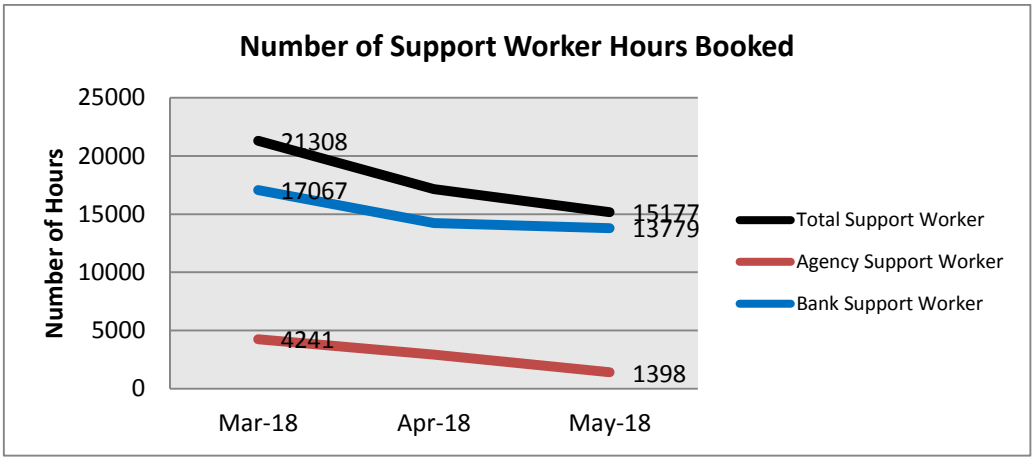
4.0 Right Place and Time

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 and the Divisions and care groups will be held to account through the monthly Divisional Reviews.

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 May 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.





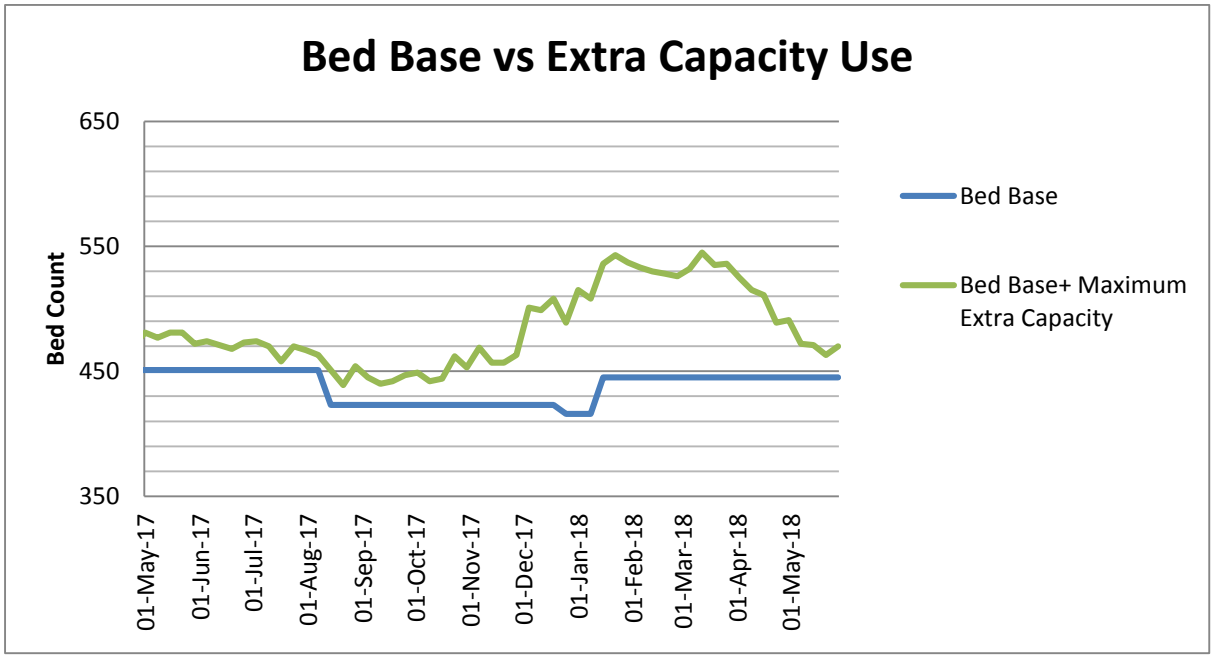
- There were 1408 less registered nurses (RN) temporary staffing hours used in May 2018 compared to April 2018. Overall there are now approx. 55WTE less temporary RNs being used in May than in March 2018.
- There were 1965 less CSW temporary staffing hours used in May 2018 compared to April 2018, this included 1523 less agency CSW hours. Overall there are approx. 40WTE less CSW used in May than in March 2018.

The number of NHSi Cap breaches and the use of Off Framework (Thornbury) also deceased in May 2018, with there being a 26% reduction in Agency Cap breaches decreasing from 347 shifts in April 2018 to 258 in May 2018. There was a significant reduction in the number of off framework shifts being used in May 2018, 5 compared with 26 used during April 18.

A RN HIT team (allocate on arrival) which has been introduced to help achieve a reduction in Tier 3 and off framework registered nursing usage. This commenced on 21st May18 but few shifts have been filled despite an increased rate of pay being offered as staff prefer to undertake bank shfts in their own clinicl areas.

4.2 Additional Capacity

The opening of extra capacity within the trust will impact upon the ability to fill staffing requirements when they are elevated as a result. The graph below shows the trend of extra capacity vs bed base over the last 12 months. The Executive Team are working collaboratively to develop a robust winter plan to plan for this during winter 18/19. At peak there were +90 extra beds in use on the acute hospital site.



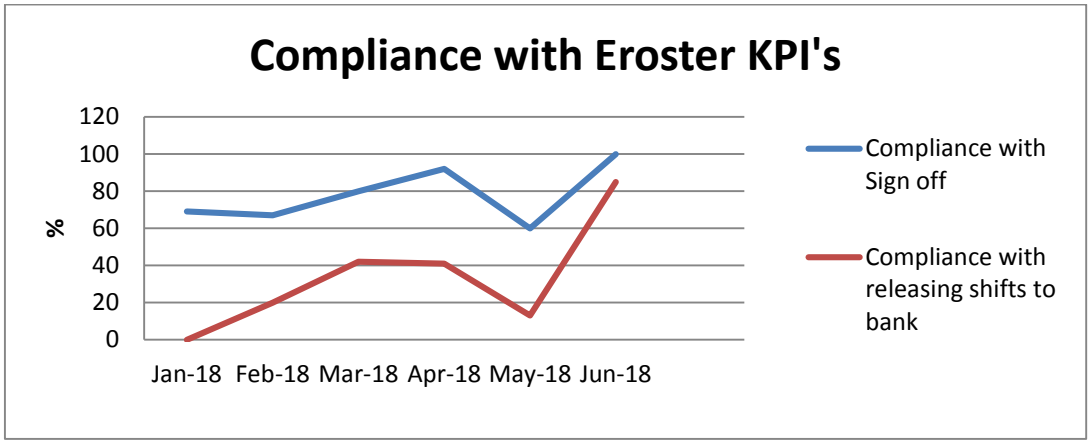
The number of bed days has been compared between April / May 17 and April / May 18. The table below demonstrates the comparative data showing that there were less bed days in May 2018 as a result of Ward 14 closing and other capacity areas being closed, with the exception of Ward 10 which remains open. There were also less bed days and beds open in May 2018 than the same period the previous year.

	April 17	**May 17**	**April 18**	**May 18**
No. Bed Days	15924	16044	16733	15118
Month end Bed count	496	509	488	470

4.2 Productivity Working and Eliminating Waste

Increased focus is now 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 and there is evidence that this is significantly improving roster efficiency (see graph below). Rosters are expected to be signed off 8 weeks in advance and immediately following sign off a request sent to the bank to fill roster gaps in order to optimise the possibility of filling these shifts with bank instead of agency. Any remaining gaps in the rosters are then released to Tier 1 agency at 2 weeks prior to the shift and any remaining gaps are risk assessed 12-24 hours in advance and alternatves to covering the sifts explored.

Eroster Sign-Off Improvements



Compliance with Eroster Sign off has improved with one period of decline aligned to when the roster periods and timescales were amended following the NHSi workforce review and porr attendance at the roster clinics that month. This has now improved with additional review clinics and an increased level of scrutiny by the Director of Nursing who attends the roster clinics.

E-roster Contract Hours utilisation

There have been some improvements in other KPIs which include management of contracted hours and skill mix. An internal assurance audit was undertaken in October 2017 and gave recommendations to improve Eroster KPI performance. A recommendation was made that the amount of contract hours unused on rosters needed to improve. From April to October 2017 the audit found that there were 11,994 nursing hours used used 11,994 nursing hours for which it has paid. In May 2018, on ward based Erosters there were 268 contract hours unused (average of 10 hrs per roster).

4.3 Efficient Deployment and Flexibility

The roll out of a daily acuity tool to all adult inpatient areas will commence on 25th May 2018. This 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 daily at 3pm (as recommended by NHSi). This will 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 Trust Board are asked to note the information contained in this report, the current performance in relation to the national and local safe staffing and roster KPIs and the ongoing work being undertaken in relation to faciliatating decision making in relation to the deployment of staff via the implementation of a daily acuity tool.
The Trust Board are asked to discuss and challenge the content of this report, paying particular attention to the significant improvements in:

- Overall fill rates of 97% in May 2018

- Care hours per patient day (CHPPD) which have improved from the previous month, but are yet to reach the national average
- Significant reduction in the use of temporary staffing and a 26% reduction in agency cap breaches
- Reduction in informal bed base (boarding patients) and the positive impact this is having on CHPPD and patient safety
- Improved roster efficiency, timeliness of temporary staff requests

Quality Committee – 5th July 2018				
Patient Care Improvement Plan (PCIP) Update				**AGENDA ITEM: 9**
Report Author and Job Title:	Shelley Price/Julie Romano Divisional Governance Advisors		**Responsible Director:**	Kara Blackwell Acting Director of Nursing
Action Required	**Approval**	**Decision**	**Assurance and Information**	
			To receive and discuss X	**To receive**
Recommendation	The Trust Board is asked to: • Note the continuing development of the PCIP and the planned introduction of the PCIP dashboard • Consider the progress made to date in completing the actions required to address the Must/Should do actions and regulatory breaches.			
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The risk is that the Trust will not achieve an acceptable rating at the next CQC inspection. Corporate Risk No: 212 Umbrella Divisional Risks in MLTC, WCCSS and Surgery No: 1329, 705 & 1101.			
Resource implications	The PCIP contains many actions, the resource implications of which are expressed in the individual actions			
Legal and Equality and Diversity implications	The PCIP is a response to the Chief Inspector of Hospitals inspection report conducted under the Health Act and CQC regulations and regulatory action is possible should the Trust's ratings worsen or significant failings are exposed at the next inspection.			
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			
	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts			

EXECUTIVE SUMMARY

The Patient Care Improvement Plan (PCIP) was developed following receipt of the Chief Inspector of Hospitals Inspection Report in December 2018. The Must and Should Do actions were assessed and developed by the managers of the core services and lead directors and included in the first cut of the PCIP in January 2018.

The Divisions have been active in managing the actions with their Care Groups but for the reasons stated in the report, it has not been possible to produce a revised version of the PCIP for review at this meeting. It will be available by the next meeting.

The PCIP is being developed further with on-line multiple user access to be made available, mapping of the actions to KPIs and audits taking place to produce a PCIP dashboard and following the workshop at the Trust Clinical Executive meeting, the addition of quick win actions to the PCIP.

A system to record and report on the progress with the actions is in development and this version of the PCIP will be used to populate it. The Improvement Consultant is devising a PCIP dashboard which links the actions to indicators and audits which will show whether the actions are effective in achieving the desired results.

Patient Care Improvement Plan (PCIP)

1. PURPOSE OF REPORT

The purpose of the reports is to inform the committee of the progress made in achieving the must do and should do actions identified in the Chief Inspector of Hospitals Report published in December 2017. Theses have been incorporated into the Patient Care Improvement Plan (PCIP).

2. BACKGROUND

The PCIP was constructed in January / February 2018. The Divisional Management Teams led the work to provide actions which addressed the must and should do actions identified in the CQC report. It also includes the regulatory breaches. The actions related to Maternity were mapped to the Maternity Improvement Plan and any additional issues raised in the report added so there was one plan held by the Care Group. This included the actions taken in response to the Section 29a notice.

As previously reported, while this approach deals with issues identified at the inspection, a different approach needs to be taken to achieve a good or outstanding rating at inspection. As part of this work, the PCIP actions are being mapped to existing indicators and audits to produce a PCIP dashboard which will demonstrate whether the actions are achieving the desired outcome. The Improvement Consultant is leading this work.

A system to record and report on progress with the actions is under construction.

The Divisional Quality Governance Advisors have worked with the Divisional Management Teams to inform this progress report with the June 2018 position. This information will be transferred into the system following this report.

3. DETAILS

The revised PCIP is provided with this report. The summary sheet shows the position for each of the core services and includes the regulatory actions and additional actions.

3.1 Maternity Improvement Plan

The Maternity Improvement Plan is reported separately and is not provided here in detail, the plan also integrates all actions required from National Patient Surveys so that quality, safety and patient experience are managed through one action plan. Progress against this and the Section 29A notice is also reported via the Maternity Oversight Committee. The RAG rating for Maternity Improvement Plan differs from the RAG rating in the PCIP, therefore for clarification of progression.

3.1.1 Section 29A Update

Section 29A Warning Notice	Detail	KPI	Status	Comment
	Monitoring, recording and escalation of concerns for CTG requires significant improvement	100%		Weekly audits on CTG compliance being carried out and reported at Maternity Oversight meeting.
	There are insufficient midwives with HDU training to ensure women in HDU are cared for by staff with the appropriate skills	Plan to have 2 EMC midwives competent in HDU care rostered onto each shift.		There are now enough trained midwives to have 1 on each shift, and there is only the 1-2 shifts where due to sickness this standard has not been met. Plans to have 29 midwives trained by end of June 2018 to enable 2 EMC trained nurses on duty at all times.
	Safeguarding training is insufficient to protect women and babies on the unit who may be at risk	90% compliance by March 2018		SG Children Level 1 – 100% Level 2 – 100% Level 3 93% SG Adult Level 1 – 100% Level 2 – 96% Level 3 – 96%
	There are insufficient numbers of suitably qualified staff in the delivery suite and on the maternity wards	Aim to achieve acuity 85% of the time.		Acuity is monitored x3 daily and discussed at safety huddles, any actions needed are addressed

3.1.2 Summary of Maternity PCIP Progress against Must and Should Do Actions (also includes other actions identified by the Care Group as requiring action also listed)

Theme	Action Complete and assurance gained		Action commenced, some slippage or evidence awaited, expected to complete on time		Action commenced but considerable delay	
	May	June	May	June	May	June
Safe:	26	29	13	10	1	0
Effective	12	15	10	10	3	0
Caring	3	3	3	3	0	0
Responsive	6	6	5	5	0	0
Well Led	3	4	3	3	0	0
Total	50	57	34	31	4	0

3.2 Regulatory Breaches (applicable to all services across the Trust)

Regulatory Breach	Detail	KPI	Status	Comment
Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	Thromboembolism assessments were not carried out for all patients at risk.	95% are assessed on admission March 2018.		Target achieved for last 3 months. On-going work required to embed and sustain this performance as at present PDN still overseeing and chasing compliance
Regulation 18 HSCA (RA) Regulations 2014 Staffing	There were high levels of nursing staff vacancies across acute services. This meant the provider was not providing sufficient numbers of suitably qualified staff to keep patients safe			Current RN vacancy rate is 9.79% (April 18). Model Hospital reports Regional Vacancy rate of 12.5% and National as 10.66% so the Trust is below these. Initiatives Include: -Rolling recruitment to Band 5 posts

				-Guaranteed jobs for Student Nurses with offer made in Year 1 -Ongoing development of new roles, 1st Wave TNAs qualify January 2019 -Retention initiatives including development of PDN roles in Divisions to support staff development Staffing closely monitored via -Monthly reports to Board of Unify Fill Rates and exceptions/Quality KPIs -Model Hospital comparison -Implementation of daily acuity tool - Biannual SNCT audit and recommendations to Board
Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	12 (2)(a) Not all staff were compliant or completed timely assessments for patients- in accordance with the Mental Capacity Act 2005.	Compliance Mandatory training By March 2018 Compliance with MCA when completing DNA CPR decisions by March 2018.		On-going improvements required in training across all disciplines and completion of DNACPR Audit performance has decreased since last CQC Inspection and requires on-going work to address MCA assessment as part of DNACPR process Consent audit being undertaken July 2018 with feedback at MAC and TMB
Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	The critical care environment had only one isolation room. This provision was not meeting the needs of patients so was not sufficient to maintain safe management of infectious patients.	Revised SOP February 2018 New build October 2018.		SOP has been revised and audits to be undertaken to measure compliance to the SOP. New build on target for December 2018 opening.
Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	Staff were not up-to-date with mandatory training. There were a number of modules that had completion rates	90% compliance by 30th June 2018.		All Divisions receiving monthly stats for compliance in their areas. Monitored and challenged as part of Divisional Review process which will be monthly going forward

	significantly lower than the trust's target.			
Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	Blind cords were not secured in all of the rooms at the child development centre	By March 2018. Risk assessment Permanent solution to be implemented. Audit of compliance.		Risk assessment and enquiry with Estates for securing the blinds. Daily checks to be undertaken. Outstanding action to be completed. Compliance reported to Care Quality Group team.
Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment	Safeguarding training completion rates were low for both medical and nursing staff. Not all staff were trained in level 3 safeguarding children, which is a requirement set by the Intercollegiate document (2014).	Achievement of targets for all levels of Children and Adult Safeguarding by end June 2018 Level 1=95% Level 2 & 3=85% PREVENT=85%		As of 18/06/18 Compliance achieved for : Level 1 Children Safeguarding = 99.84% Level 1 Adult Safeguarding =99.92% Level 3 Children's Safeguarding = 88.94% Level 3 Adults Safeguarding = 85.27% However: Level 2 Children's Safeguarding = 77.45% Level 2 Adult Safeguarding =80.36% PREVENT Level 3 =80.44%

Regulation 17 HSCA (RA) Regulations 2014 Good governance	Staff were not consistently completing patient records. There were trust documentation that was not completed. Staff were not always signing entries. There were a number of entries where there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times. Patients' records were taken home by the community children's nursing team when they were not returning to the office. We were not assured of the confidentiality or security of records	Secure accurate, complete contemporaneous records by 1st March 2018. Develop a work stream plan to address the physical condition of the paper records by 31st March 2018 Confirm Trust strategy for EPR by 30th June 2018.		There needs to be further work undertaken as a priority to ensure that documentation is completed in line with Trust Policies and National Professional Regulatory Body Standards Divisions are auditing documentation, but this remains poor although use of stamps is slowly improving Actions being undertaken: -Multidisciplinary documentation audits -DivDON/matron scrutiny at ward level and as part of Ward Review Process -Focus of next Nursing Forum with senior Nurses -PDN/Quality Team daily reviews on ward and support/reminding staff of responsibilities regarding standards of documentation -Revised Nursing Assessment Documentation currently being finalised for launch August 2018

Walsall Healthcare NHS
NHS Trust

3.3 Summary of Divisional Progress against Must and Should Do Actions (other actions identified by the Divisions as requiring action also listed)

	Must				Should				Regulation				Additional			
Core Service																
Children & Young People	0	0	0	1	0	1	3	1	0	1	0	1	0	6	5	2
Community Services - Adults	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0
Community Services - Children	0	0	0	3	0	0	0	3	0	1	0	0	0	1	12	0
Critical Care	0	0	2	0	0	1	2	1	0	0	1	0	0	0	3	0
End of Life Care																
Maternity and Gynaecology	Monitored through Maternity Improvement Plan															
Medical Care	0	2	0	0	0	3	5	0	0	0	0	0	0	0	0	0
Outpatients & Diagnostic Imaging	0	1	2	2	0	0	1	1	0	0	0	0	0	0	0	0
Surgery	0	2	3	0	0	1	5	1	0	0	0	0	0	0	2	1
Urgent & Emergency Services	0	0	0	0	0	2	1	4	0	0	0	0	0	0	0	0
Corporate																
Totals																

Status:

We are using a RAG rating to show whether progress is on track or not. The following definitions will be used to record progress:

= Complete

= Target date missed / actions unachievable

= Target date not met - there is a significant risk of the action not being completed by that date

= Action on target for completion by the expected date

4.0 RECOMMENDATIONS

The Committee is asked to:

- Note the continuing development of the PCIP and the planned introduction of the PCIP dashboard
- Consider the progress made to date in completing the actions required to address the Must/Should do actions and regulatory breaches.

Walsall Healthcare NHS

NHS Trust

Walsall Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD – 5TH JULY 2018				
Annual Complaints Report				**AGENDA ITEM: 10**
Report Author and Job Title:	Garry Perry Head of Patient Relations		**Responsible Director:**	Kara Blackwell Acting Director of Nursing
Action Required	**Approval**	**Decision**	**Assurance and Information**	
			To receive and discuss X	**To receive**
Recommendation	Members of the Trust Board are asked to: 1. To note contents and progress made. 2. To approve service development recommendations			
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			
	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 NHS and Social Care Complaint regulations 2009 require NHS bodies to provide an annual report on complaint handling and consideration, a copy of which must be available to the public. The attached annual report provides details of complaints and concerns received by Walsall Healthcare NHS Trust between 1 April 2017 and 31 March 2018.

During 2017/2018 a total of 3661 contacts were received by the Patient Relations Team which included a total of 313 written complaints (KO14a) about care which were received by the Chief Executive.

The work with divisions and 'profile raising' of the need to negotiate timeframes with the complainant has resulted in a year end position of 85% of all complaints responded to within timeframe agreed with the complainant.

The main themes identified from the concerns raised include: appointments (927) an increase of 21 on the previous year, clinical care, assessment and treatment 690 (an increase of 85), communication (222), information (277) and staff attitude (125).

Planned Initiatives for 2018-2019:

A full action plan for Patient Complaints and Patient Experience is currently being developed, some actions already identified and being worked up /planned include:

- Complete work with the Paediatric department in producing a child friendly leaflet for children and parents in addition to drafting a new Patient Leaflet that better informs complainants of the process
- A customer care pilot using the "hand in hand" approach in partnership with John Lewis has been undertaken. Following the launch of the new Trust Values in July 2018 there will be a planned extension of this programme to address those issues identified from the FFT, complaints and National Surveys around attitude, communication and information**.**

Annual Complaints Report

1.0 Introduction

The NHS and Social Care Complaint regulations 2009 require NHS bodies to provide an annual report on complaint handling and consideration, a copy of which must be available to the public. The attached annual report provides details of complaints and concerns received by Walsall Healthcare NHS Trust between 1 April 2017 and 31 March 2018.

The report identifies both the numbers and themes of formal written complaints reported as KO14a to the HSCIC (Health and Social Care Information Centre).

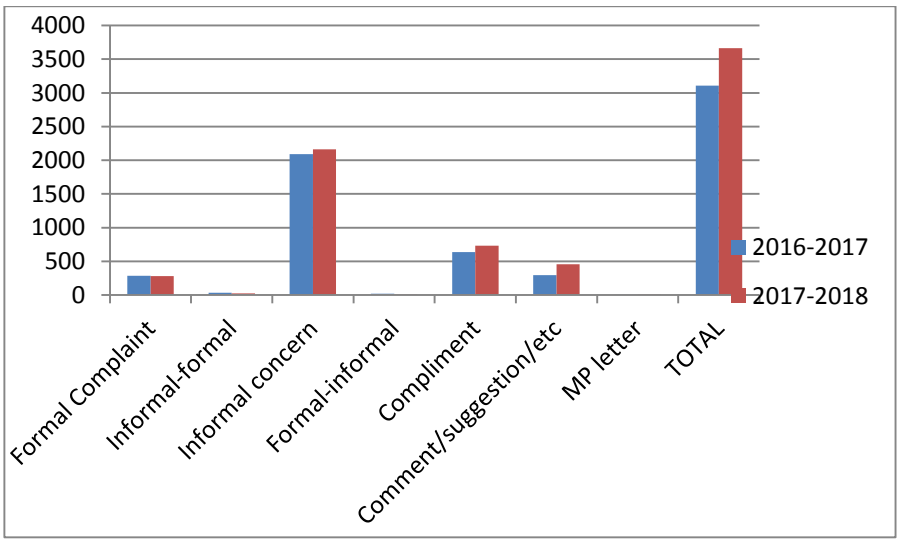
The Patient Relations Team manages complaints, concerns and compliments received on behalf of the Trust. The Team strives to be as responsive and proactive to queries and concerns as possible managing a caseload that averages 14 contacts per working day each year. Working closely with Divisional teams and staff of all levels, the team seeks to maintain an appropriate level of contact with the complainants and where required external agencies; responding in a way that is both 'person centered' and effective in addressing the complainants concerns.

This report provides information on the types of feedback received by the Patient Relations Team in the past year 2017/2018 it highlights some of the actions taken as a lesson learned and looks forward to continuous improvement in the way we respond to patients and their carers when they are often at their most aggrieved.

2.0 Activity

During 2017/2018 a total of 3661 contacts were received by the Patient Relations Team which included a total of 313 written complaints (KO14a) about care which were received by the Chief Executive. This figure includes 280 written complaints, 8 MP letters and 25 informal to formal converted complaints (7 complaints were withdrawn). There has been an overall reduction in 2017/2018 of complaints compared to the previous year. Throughout this report 'K041a' written complaints are referred to as 'complaints' and these are managed through the Trust's complaints process and reported quarterly to the HSCIC (Health and Social Care Information Centre).

Complaints and Patient Relations Team Activity 2017-2018:



3.0 Complaints

This section details Formal Complaints received during 2017/18.

3.1 Complaints by Division

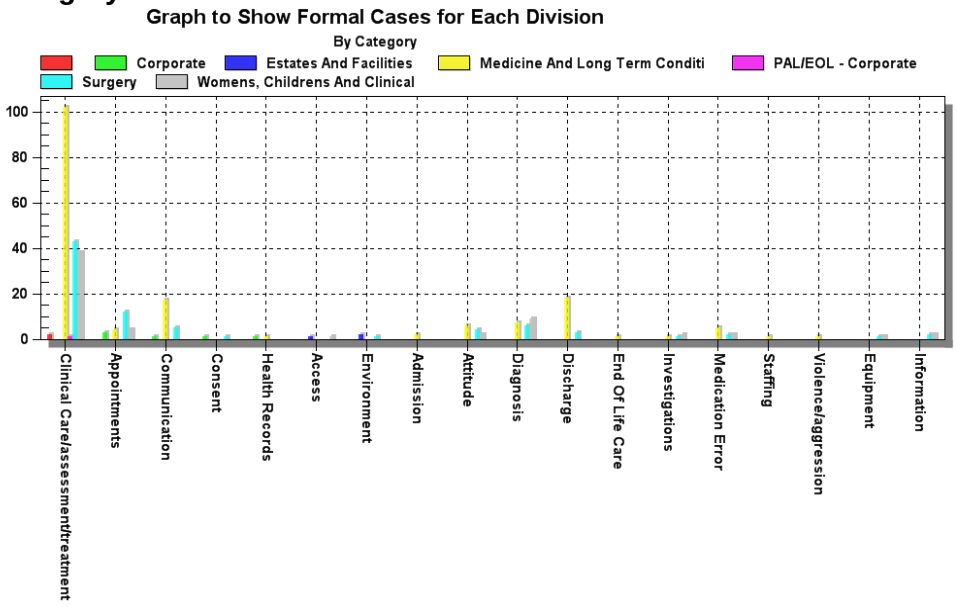
There has been an overall reduction of 9 complaints compared to the previous year 2016/2017.

The Divisions of Medicine and Long Term Conditions (MLTC) and Surgery continue to receive the highest number of complaints generated the greatest number of complaints. Medicine and Long Term Conditions accounts for 52% of all complaints received, with Surgery accounting for 25% and Women's Children's and Clinical Support Services WCCS 19%.

3.2 Complaints by Complaint Category

During 2017/2018, the main themes emerging from the formal complaints received related to clinical care, assessment and treatment, communication/attitude, appointments and discharge.

Complaints by Category:



Category Type																		
	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Corporate	0	3	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Estates And Facilities	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	0	0	0
Medicine And Long Conditi	102	4	17	0	1	0	0	2	6	7	18	1	1	5	1	1	0	0
PAL/EOL - Corporate	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	43	12	5	1	0	0	1	0	4	6	3	0	1	2	0	0	1	2
Womens, Childrens And Clinical	38	4	0	0	0	1	0	0	2	9	0	0	2	2	0	0	1	2

4.0 Formal Complaints and Concerns

4.1 Formal Complaints Response Times and Outcomes

Approval for a new timeframe was agreed with local resolution targets in July 2016 identifying a 10, 30 and 45 working day timeframe based on agreement with the complainant and the level of seriousness afforded.

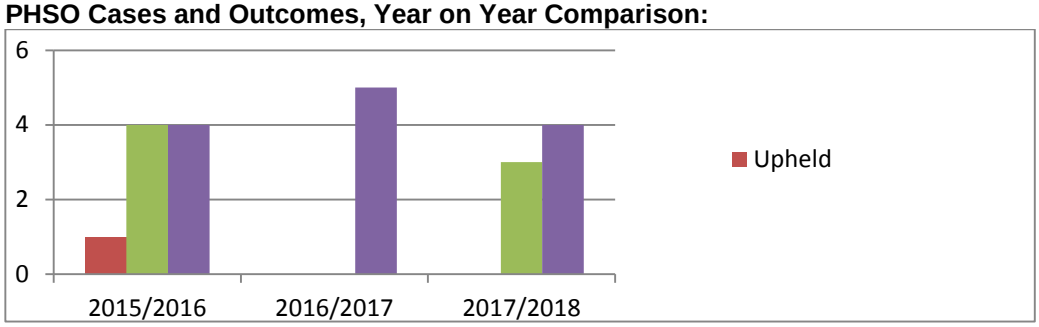
The work with divisions and 'profile raising' of the need to negotiate timeframes with the complainant has resulted in a year end position of 85% of all complaints responded to within timeframe agreed with the complainant. This is a significant improvement from a year end position of 51% in 2016/2017. On 6 occasions during the last 12 months the Trust also achieved 100% completion.

Outcomes of Formal Complaints

In 2017-2018 a total of 258 complaints were resolved, 20 were upheld with 97 not upheld and 141 partially upheld.

In 2017/18, a total of 8 cases were referred to the Parliamentary and Health Service Ombudsman (PHSO). There are no cases open from the previous year 2016/2017. The outcome figures are shown below; in one case the outcome is yet to be determined.

PHSO Cases and Outcomes, Year on Year Comparison:



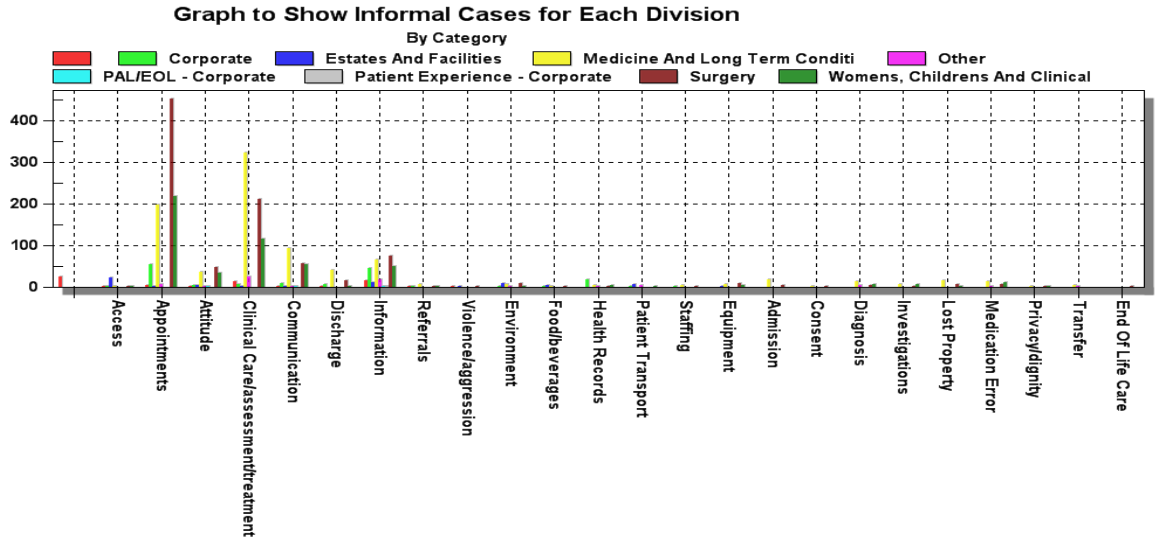
Themes emerging from these complaints to the PHSO included:

- Concerns highlighted with regard to clinical care assessment and treatment
- Poor communication
- Inadequate pain management and poor nursing care

4.2 Informal Concerns

There were a total of 2627 informal concerns received during 2017/2018 (including 8 formal to informal conversions and 455 queries/comments/cases referred on). Surgery equated for 34% (899) of the total activity, with MLTC 32% (859) and WCCSS 19% (505).

Informal Concerns by Division and Category:



Category Type																									
	24	1	3	2	12	2	1	15	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Corporate	0	1	54	3	5	7	5	45	1	0	1	1	16	2	2	0	0	0	0	0	0	0	0	0	0
Estates And Facilities	0	22	1	3	1	1	0	10	0	1	8	4	0	6	0	1	0	0	0	0	0	0	0	0	0
Medicine And Long Term Conditi	0	2	198	36	322	93	41	64	6	0	6	1	3	0	4	5	16	1	12	5	15	12	2	4	0
Other	0	0	5	1	25	1	0	18	0	0	1	0	1	3	0	0	0	0	3	0	0	1	0	2	0
PAL/EOL - Corporate	0	0	0	1	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Experience - Corporate	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	2	452	47	210	57	14	74	2	1	7	1	1	0	1	7	4	1	4	1	5	6	2	0	1
Womens, Childrens And Clinical	0	1	219	32	115	54	2	48	1	0	2	0	3	1	0	3	0	0	6	5	1	11	1	0	0

The main themes identified from the concerns raised include: appointments (927) an increase of 21 on the previous year, clinical care, assessment and treatment 690 (an increase of 85), communication (222), information (277) and staff attitude (125).

5.0 Lessons Learned from Complaints and Concerns

Some of the lessons learned arising from complaints and concerns include:

1. ***A patient felt that her surgical stocking was too tight after her operation and that this caused her wounds which required redressing regularly:***

   One of the Trust's surgical wards composed a checklist for all patients regarding the use and monitoring of ted stockings, this checklist ensures a patients stockings are checked regularly. The checklist documents what action has been taken by staff, any change and the current condition of the patient's legs and feet. This check list was taken to quality board and has since been rolled out across other wards. If this checklist had been in place during the patients stay on the ward it may have encouraged a conversation and would have allowed closer monitoring. The stocking checklist is now in every patient folder who is wearing TEDS for VTE prevention.

2. **Patient raised concerns in relation to answering the telephones in the Outpatient (OPD) Therapies Department**

   Following this concern being raised changes were made to the OPD therapies department and a receptionist allocated to oversee this.

3. **Concerns were raised over confusing signage regarding the escalators in the main atrium of the hospital**

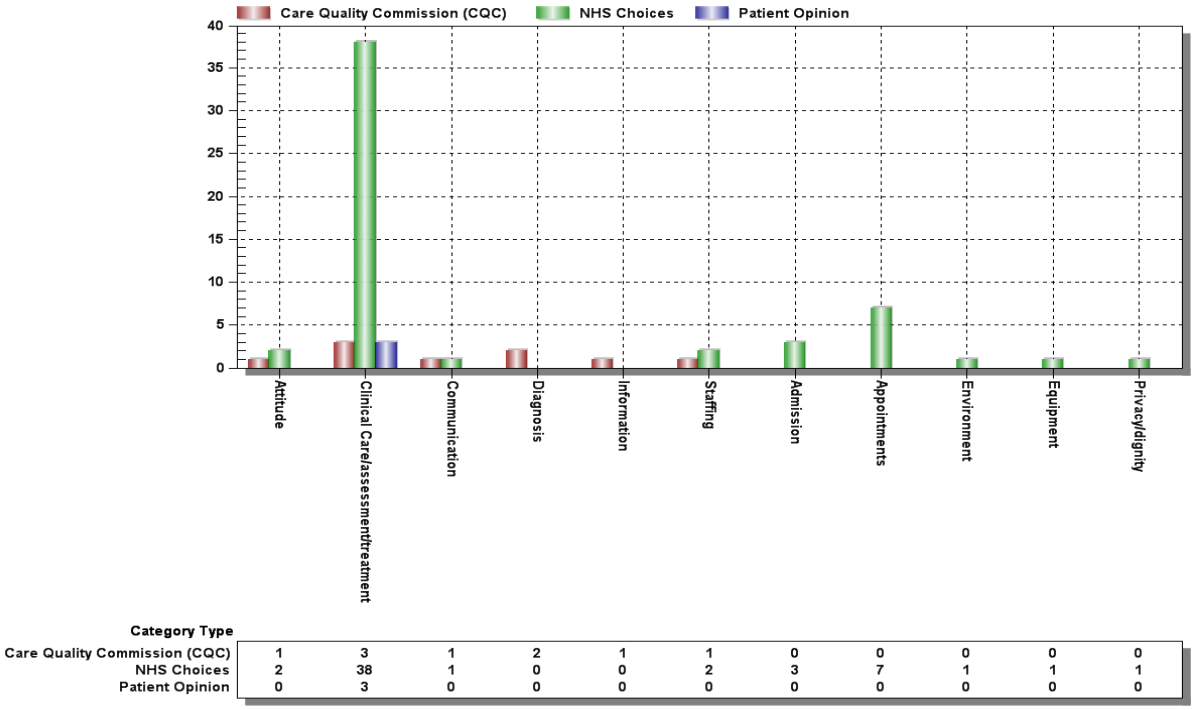
   This signage was changed to make users aware of direction of travel

6.0 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 type is 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 have also come in as Formal complaints and were investigated accordingly.

Where no contact is made with the Trust directly, feedback is provided directly to the CQC following investigation for contact to be made with the person raising the complaint.

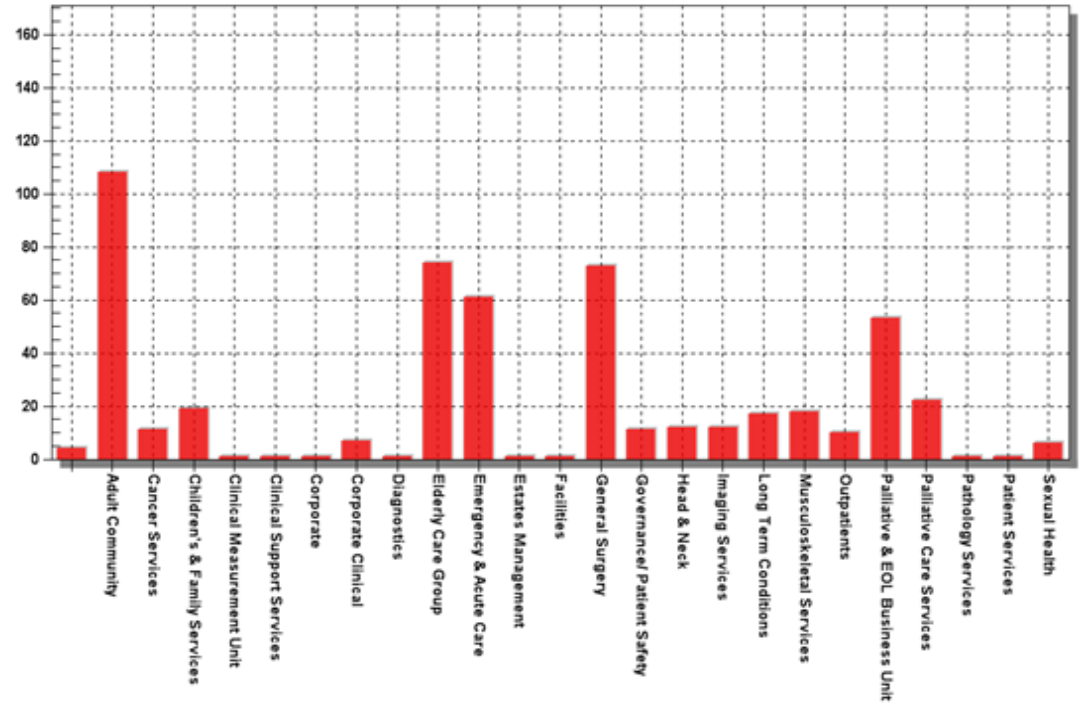
Category Type NHS Choices/Care Opinion/CQC



Category Type											
Care Quality Commission (CQC)	1	3	1	2	1	1	0	0	0	0	0
NHS Choices	2	38	1	0	0	2	3	7	1	1	1
Patient Opinion	0	3	0	0	0	0	0	0	0	0	0

7.0 Compliments

In 2017-2018 there were 734 compliments received by the Trust (the figure is 756 when including the compliments made via the Patient Care/NHS Opinion website). Adult Community Care accounted for the majority of compliments recorded. Areas involved are informed of the types of comments of appreacition received and where appropriate they are refererd for a recogition award via the Trust recognition scheme.



Category Type																							
	4	108	11	19	1	1	1	7	1	74	61	1	1	73	11	12	12	17	18	10	53	22	1	1	6

8.0 Complaints Monitoring and Reviews

8.1 Complaints Monitoring Review Panels

The Complaints Monitoring Panel was 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. The panel is led by lay members with professional advice provided as and when required. Since its inception the panel has grown in confidence and as a result set up two sub-groups to focus its attention. One sub-group looks at the complaints process, and issues relating to quality. The other sub-group carries out reviews of cases which are proving difficult to resolve where an independent review is offered.

The panel has continued to meet throughout the year and has undertaken the following:

- 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

8.2 Complaint Satisfaction Questionnaire

The Trust feedback survey is based on the 'I' statements outlined in the user-led vision (PHSO). Answers are requested using a scale of 0-5 with 0 as completely disagree and 5 completely agree. 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 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%

8.3 Equality Monitoring

An equality monitoring form is issued at the point of acknowledgement with 14% (44) returned in 2017/2018.

- 95% of service users who responded to our survey where white British, the remaining 5% where Black Caribbean and Asian.
- 82% of service user who responded to our survey where age 51 plus (36% being 51-60), only 4% where under 30. We are hoping to see an increase in range by using a survey monkey which will allow service users the opportunity to complete a form online
- 71% of service users stated their religion was Christianity, 4% Hindi, 4% spiritual and 21% did not wish to say, or had no belief.
- 70% of responses were received back from females, 26% men and 4% did not wish to state.
- 77% of patients were heterosexual, 8% bisexual, 4% Gay, 4% Lesbian, 7% did not wish to state.
- Relationship status was varied, with the highest response being married (56%)
- 30% of service users would consider themselves to have a disability.

9.0 Conclusion

Activity levels throughout 2017/2018 has increased however it is important to note that local resolution handling has improved, the Trust is getting consistently better at responding in a timely

way and improving processes. In 2018-2019 the team will focus on actions to address some of the consistent themes associated with complaints including communication, attitude and information/discharge issue and a detailed action plan is currently being developed.

MEETING OF THE PUBLIC TRUST BOARD – 5th July 2018					
Quality and Safety Highlight Report					**AGENDA ITEM: 11**
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 and discuss the information contained in this report.				
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 items discussed at the most recent Quality & Safety Committee meeting held on the 29th June 2018 together with the confirmed minutes of the meeting held on 31st May 2018 (appendix 1).

Key items discussed at the meeting were:

- The 5 CDiff cases YTD and the concerns in relation to the target of 17 cases for the year
- The Winter Plan overview and the positive impact that this plan will have with the planning taking place earlier in the year
- The approval of the Quality Account by the Committee
- The learning from Health and Safety incidents including the RIDDOR reported staff incidents, and whether all incidents where staff have been assaulted resulting in injury are reported as serious incidents
- The Safer Nursing Care Tool Audit (SNCT) was currently being undertaken using the nationally recommended tool, and it was acknowledged that there had been some local interpretation of the national tool previously, this had also been identified by the NHSI report who outlined in their review that the SNCT was not being used accurately on a consistent basis across all ward areas

The meeting held on the 29th June 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 items from the meeting held on 29th June 2018

The Committee was quorate and discussed a number of items. Minutes will be provided to the Trust Board in August 2018. The highlights for the Trust Board to be aware of are as follows:

3.0 Performance and Quality Report

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

- CDiff rates with 5 cases reported against a target for the year of 17 cases.
- Performance for the Dementia screening assessments has decreased, this was being addressed with the clinical teams
- FFT in Outpatients and Inpatients was noted to have declined this month. The Matron in Outpatients is now sending the FFT results to speciality teams for actioning as well as the work she is undertaking to improve this. Ensuring patients are offered the opportunity to complete the FFT is included on the Discharge Checklist to prompt the teams, the ward areas are also awaiting delivery of iPads to use for completion of the FFT.
- There was a discussion about pressure ulcers and the difficulties in benchmarking these as they are recorded differently in different organisations, e.g. the recording of a pressure ulcer as hospital acquired range from 6 hours post admission to 72 hours making comparison between organisations more difficult. NHS Improvement released a new definition and measurement framework for implementation in April 2019 which will aid comparison in the future.
- Safeguarding Training compliance had improved, at present the Trust is now compliant with level 1 and 3 Adult and Children Safeguarding training but level 2 training remains below the 85% target
- The committee discussed the drivers of poor performance and the actions required to address this.

4.0 Annual Complaints Report

The Annual Complaints report was presented and the following points were noted:

- The number of complaints remained comparable with the previous year (with only 9 less formal complaints reported)
- The clinical areas reporting the highest number of complaints and the themes of these complaints remained the same
- The Complaints team are currently pulling together a work plan for 2018-2019 which includes the further role out of the customer care approach which will be delivered in the Emergency Department, a medical ward and surgical ward following the launch of the new Trust Values in July 2018.

5.0 The Winter Plan

A presentation of the Winter Plan was presented. The key points highlighted included:

- The current plans for winter 2018/2019 which outline the likely admitted medicine bed demand which can be expected in 2018/2019 and the impact of these and mitigating actions being developed across the health economy to address this
- The plans to maintain 1 ward throughout the year and recruit to this ward to avoid the negative impact of bed occupancy which is consistently 100% and the related impact this has on the quality, safety and patient experience of care
- The engagement of external partners in this process
- The re-launch of Red to Green and Safer on the adults wards
- The ongoing support from ECIP

6.0 Monthly Safe Staffing Report

The following key points were noted and discussed:

- The overall fill rates for May 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 May 2018 but remained below peers in the Black Country and nationally,
- The NHS Improvement report of the nursing workforce was received in the 3rd week of June 2018.
- Roster compliance KPIs improved in May 2018
- The daily acuity tool was implemented on 25th June 2018, further work continues to embed its use into the daily decision making around the deployment of staff
- The Safer Nursing Care Tool Audit (SNCT) was currently being undertaken using the nationally recommended tool, and it was acknowledged that there had been some local interpretation of the national tool previously, this had also been identified by the NHS Improvement report who outlined in their review that the SNCT was not being used accurately on a consistent basis.

7.0 Quality Account

The Quality Account was discussed and the report was agreed by the Committee.

8.0 PCIP Update

It was agreed at the previous meeting that the Quality and Safety Committee would receive a monthly update report for the PCIP. The report was provided to the committee and included:

- The good progress being made in maternity in relation to their PCIP
- An update on the regulatory breaches was provided
- Progress was being made against these breaches however, further work was required particularly in relation to documentation
- Divisional update in relation to the ‘must’ and ‘should’ do actions was outlined

- The development of a system to record and report all actions continues to be pursued

9.0 Risk Management Report

The report was presented and discussed:

- The two surgical serious incidents were discussed
- The reduction in acquired pressure ulcers noted for May 2018
- The learning from Health and Safety incidents including the RIDDOR reported staff incidents, and whether all incidents where staff have been assaulted resulting in injury are reported as serious incidents
- The agreement that RIDDOR incidents, investigations and outcomes/actions should be reported through to the Quality Committee
- The discussion including the development of the Patient Safety Report and the focus on learning from incidents and SIs

10.0 Conclusion/Recommendations

The Committee identified the following items for escalation to the Board:

- The 5 CDiff cases YTD and the concerns in relation to the target of 17 cases for the year
- The Winter Plan overview and the positive impact that this plan will have with the planning taking place earlier in the year
- The approval of the Quality Account
- The learning from Health and Safety incidents including the RIDDOR reported staff incidents, and whether all incidents where staff have been assaulted resulting in injury are reported as serious incidents
- The Safer Nursing Care Tool Audit (SNCT) was currently being undertaken using the nationally recommended tool, and it was acknowledged that there had been some local interpretation of the national tool previously, this had also been identified by the NHSI report who outlined in their review that the SNCT was not being used accurately on a consistent basis across all ward areas.

Walsall Healthcare NHS
NHS Trust

APPENDIX 1

MINUTES OF THE QUALITY & SAFETY COMMITTEE
HELD ON THURSDAY 31ST MAY 2018 AT 9.00 A.M
ROOM 10, MLCC, WALSALL MANOR HOSPITAL

Present:	Professor R Beale	Non-Executive Director (Chair)
	Mrs K Blackwell	Acting Director of Nursing
	Mr R Beeken	Chief Executive
	Mrs V Harris	Non-Executive Director
	Mr N Rashid	Divisional Director, MLTC (On behalf of the Medical Director)
	Mr P Thomas-Hands	Chief Operating Officer
	Mrs J White	Interim Trust Secretary
In Attendance:	Mr A Aldridge	Emergency Care Improvement Programme (ECIP), NHS Improvement (Up to item 28/18 only)
	Miss S Garner	Executive Assistant (minutes)
Apologies:	Mr P Gayle	Non-Executive Director
	Mr R Caldicott	Director of Finance & Performance
	Mr A Khan	Medical Director

23/18 Welcome and Introductions

Professor Beale welcomed everyone to the meeting.

24/18 Quorum

The meeting was quorate in line with Item 6 of the Committee Terms of Reference; The Committee will be deemed quorate to the extent that the following members are present: At least two Non-executive Directors, The Medical Director, The Director of Nursing and the Chief Executive or the Chief Operating Officer

25/18 Declarations of Interest

There were no declarations of interest.

26/18 Minutes of the Meeting Held on Thursday 26th April 2018

Resolution
The minutes of the meeting held on 26th April 2018 were agreed as a true and accurate record.

27/18 Action Sheet and Matters Arising

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

- 155/17 Work was underway by the A&E Delivery Board to review the Winter Plan 2017-18 which was being overseen by Mr Thomas-Hands and a report would be provided in June. The Winter Plan for 2018-19 was also being developed and would be finalised by the end of June. Winter 2018-19 was expected to begin at the end of October therefore the Trust were being proactive in the approach to developing the plan.
- 197/17 The report on the equipment replacement programme had been deferred to June due to inaccuracies identified between the Trust's asset register and wedical devices database. Work was on-going to ensure that an accurate baseline was available to finalise the equipment replacement programme. Mr Beeken confirmed that urgent equipment was being replaced whilst this work was on-going.

Resolution

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

28/18 Emergency Care Improvement Programme

Mr Aldridge introduced himself to the committee and confirmed that he had now been identified as the Improvement Manager for the ECIP work being undertaken with the Trust. He had recently taken over from his colleague, Lucy Roberts, who was now on sick leave. Mr Aldridge was working on setting up meetings with key leads for the programme to ensure he was up to date with the work his colleague had started.

Committee members were advised that a gap analysis had been undertaken by the ECIP team in January and a concordat agreement had been developed and signed off by the Trust. The agreement outlined 5 key workstreams in relation to patient flow, and ward processes including embedding the Safer bundle and the principles of Red to Green. The team had also recommended that the Trust undertake a review of its site management processes. Mr Thomas-Hands highlighted that the Trust had acted on the initial recommendations and key leads had been identified for each workstream. An additional pathway had also been agreed in relation to operational processes. The Urgent and Emergency Care Operations Group would receive updates on progress with each pathway on a monthly basis which would be reported into the A&E Delivery Board.

Professor Beale queried whether timescales had been agreed for

delivery of each part of the plan. Mr Thomas-Hands confirmed that each pathway would be reviewed at the first meeting of the operational group next week and project plans would be received with an update on metrics and timescales for completion.

Mr Rashid confirmed that he also chaired a weekly meeting to receive updates on the pathways to ensure that progress was being made. He explained the importance of embedding processes prior to the next winter period and ensuring the pace remained throughout the summer months. The bed management process had also been streamlined to improve efficiency. Mr Beeken raised concerns in relation to the current approach for bed management planning throughout the night and identified that patient information provided through the PAS system would need to be accurate to improve this. He also queried the timeframe for progress with the ward processes pathway including standardising of ward rounds and ensuring medically fit patients were discharged. Mr Rashid confirmed that good progress was being made with this; further work was required in some areas.

Mr Aldridge confirmed that he had reviewed processes in acute medicine during the previous year and identified that the implementation of the Red 2 Green approach had been seen to be overly dependent on clinical time and had not been particularly well received. Mr Thomas-Hands confirmed that this was the case and the Red 2 Green approach would be built into the ward processes pathway to avoid resistance from clinicians.

Professor Beale thanked Mr Aldridge for the update on the ECIP work and requested that Mr Thomas-Hands provide a brief update on progress being made to the committee for the next few months. Mr Aldridge was also invited to attend. **PTH**

Resolution

The Committee received and noted the update on the Emergency Care Improvement Programme and it was agreed that a brief update on progress being made would be provided to the committee for the next few months.

29/18 Performance & Quality Report

Mr Rashid presented the Performance & Quality report and highlighted that there had been 5 cases of C. Diff year to date. In April, Two cases were reported on Ward 15 and one case on ward 17, following an RCA cases were deemed unavoidable. A further 2 cases had been reported in May on ASU, representing a period of increased incidence, an RCA would be completed for both cases, and the ward was being relocated to enable a deep clean of the area to take place. One MRSA bacteraemia was

reported in Critical Care in April, the RCA deemed this to be unavoidable. Members raised concerns that the C. diff target for 2018-2019 would be exceeded if the number of cases continued. Ms Blackwell highlighted that the number of cases was being monitored through the Infection Control Committee on a monthly basis and was also being picked up at the weekly serious incident meetings. The Committee agreed to monitor the number of C. diff cases reported at the next meeting to identify whether the period of increased incidence had continued. **ALL**

Concerns were also raised regarding the deterioration in completion of the Electronic Discharge Summaries (EDS). A multidisciplinary audit on documentation was planned to be undertaken across the Trust with specific actions to address improvement following this. There were 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. Mr Beeken confirmed that feedback on the audit and actions taken would be provided to the committee to provide assurance that individuals were being held to account. Ms Blackwell agreed to confirm the timeframe for the audit. **KB**

Professor Beale recognised that compliance with safeguarding training was currently below the Trust target. Ms Blackwell confirmed that this was now being managed on a weekly basis and a revised target had been agreed with the CCG. The committee also noted the capacity issues within the children's child safeguarding team and a business case had been developed and was awaiting a decision from the CCG.

Resolution

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

30/18 Trust Quality Executive Report

Ms Blackwell presented the report from the Trust Quality Executive held on 25th May and highlighted issues in relation to current ESR and training data being up to date. A discussion had taken place regarding the option of having a Manager Self Service element on ESR so that data could be updated by individuals and signed off by their line manager. It was agreed that an amnesty of local records would be required to enable ESR to be up to date. It was also recognised that there were other systems available to the Trust to record training data. The committee recommended that the People & Organisational Development Committee oversee a programme of work to ensure that data available in ESR was accurate and up to date and also consider other options for recording data. **POD**

Discussions had also taken place at the Trust Quality Executive regarding infection control and cleanliness concerns and the divisional teams were working with the infection control team to improve compliance with environmental audits and a trajectory for improvement would need to be agreed. Further work was also required in relation to prioritisation of areas for cleaning and additional recruitment of domestic staff was expected to support with this.

The Preventing Future Deaths report and the risks associated with this were also escalated to the committee. Ms Blackwell explained that the report had been received in relation to a gynaecology patient with a retained pessary who had been lost to follow up. The main concerns were in relation to patient safety risks associated with the follow up back log and work continued to reduce the back log.

Mr Beeken highlighted that the PCIP was currently being used to measure progress against the key issues and would remain in place until the integrated improvement programme had been developed and implemented. He raised concerns that the committee had not been sighted on progress with the PCIP to date. Ms Blackwell confirmed that this had been discussed at the TQE meeting and the divisions were currently updating progress against the 'must' and 'should' do actions; the corporate actions against the regulatory breaches were also being updated. It was agreed that the PCIP would need to receive increased scrutiny monthly via the newly formed Trust Management Board and an update on progress would be included in the highlight report to the Quality and Safety Committee. **KB**

<u>Resolution</u>
The Committee received and noted the report from the Trust Quality Executive and recommended that the People & Organisational Development Committee oversee a programme of work to ensure that data available in ESR was accurate and up to date and also consider other options for recording data.

31/18 Maternity Oversight Committee Update

The committee received the Maternity Oversight Committee update which highlighted progress on elements of the section 29A warning notice, details of the maternity PCIP and the maternity dashboard. The Oversight Committee had requested that some of the measures in the section 29A warning notice be included on the dashboard in future.

There was a further debate at the oversight committee about whether an incident should be reported when a HDU competent

midwife was not available on shift. It was agreed that an incident would be reported if a patient required HDU input and a trained midwife was not available.

The committee also received an update on the CNST Incentive scheme which would need to be signed off by the Trust Board prior to submission to NHS England.

Mr Beeken raised concerns in relation to the level of detail discussed at the Oversight Committee due to the high level of assurance being provided by the team on a monthly basis. He suggested that the service were potentially ready for a re-inspection.

Committee members recognised that there had been a cultural improvement within the department following the changes to the senior nursing and clinical leadership. Mr Beeken advised that he had met with the consultant, midwifery and management teams to inform them of next steps being taken by Edgcumbe. A programme of work had also been agreed with the Royal College of Midwives and a plan was in place to bring both workstreams together facilitated by Edgcumbe.

Resolution
The Committee received and noted the Maternity Oversight Committee Update.

32/18 Trust Quality Account 2018-19

The draft Quality Account was shared with members and it was noted that due to the tight timeframe for approval, the Trust Board would be delegating responsibility to the Quality & Safety Committee to approve the final version in June. The document had been shared with key stakeholders for comments and the committee were advised that comments received from Health Watch and CCG colleagues had been supportive and objective.

Professor Beale requested that the final version be circulated to members as soon as possible to enable members to consider the document in detail prior to sign off at the next meeting. **KB/ ALL**

Resolution
The Trust Quality Account 2018-19 was received and noted by the Committee.

33/18 Risk Management Committee Information & Escalation Report

Mrs Blackwell presented the Risk Management Committee Information and Escalation report and the following points were

highlighted:

- There were 2 serious incidents in relation to patients who had fallen and sustained serious harm. An RCA had been undertaken for both and themes had been identified in relation to completion of falls assessments.
- There had been an increase in the number of pressure ulcers reported, there were 17 incidents reported in April, however it was noted that there was a delay with the RCA and validation process. Further work was being done to improve this and reduce the delay.
- Compliance with Duty of Candour had improved and a new leaflet had been rolled out to support with informing patient relatives quickly.

Professor Beale raised concerns regarding the current process for duty of candour and queried whether a rapid investigation should be undertaken prior to enacting duty of candour to avoid confusion with patients and their families. Ms Blackwell confirmed that national guidance suggested that patient's families were informed that there was a potential issue as quickly as possible before an investigation was undertaken. She agreed to look into this further and consider whether practice could be changed and Mr Beeken recommended that a discussion take place with the Trust's Quality lead at NHS Improvement. Feedback would be provided at the next meeting. **KB**

Resolution

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

34/18 Monthly Nursing & Midwifery Quality & Staffing Report

Ms Blackwell presented the monthly report and the following points were highlighted:

- 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 had not reported any incidents /omissions in care linked to staffing.
- The agency and bank hours used reduced in April due to bed closures. There was an on-going focus on roster compliance, particularly, in the Emergency Department and AMU.
- Overall Thornbury usage reduced significantly in April and shifts that were covered with Thornbury staff were in relation to 1-1 care being provided for CAMHS patients.
- The report was being developed further in line with NQB guidance.

Mr Beeken highlighted that the Board had been focusing on

temporary workforce usage recently and the executive team had agreed to provide clarity on this in line with the NHS Improvement review undertaken. It was recognised that the financial views were being overseen at the Performance, Finance & Investment Committee, and the committee agreed to oversee the quality perspective of this work. The report would be shared with both committees at the end of June prior to submission to the Trust Board in July.

Concerns were raised in relation to the reduction in care hours provided to patients which did not correlate with the 90% compliance with fill rates. Ms Blackwell confirmed that further work was being done with NHS Improvement to ensure data was being submitted correctly.

Ms Blackwell identified that she planned to provide a brief report on staffing every month to the committee with a more detailed report being provided on a quarterly basis which would include an update on recruitment and retention and analysis of the Model Hospital data. A daily acuity tool was now being utilised and would identify any issues in relation to care being provided. Professor Beale suggested that it would be useful to include the quality impacts of this in the report. **KB**

Resolution

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

35/18 Tissue Viability Overview Report

Mrs Blackwell presented the Tissue Viability Overview report and the following points were noted:

- There was some uncertainty in relation to the requirements from the Tissue viability service across community services, specifically in relation to nursing homes and practice nurse bases.
- The wound care group had been working to review and monitor formulary which had generated some savings for the Trust and ensured that patients were getting the equipment required.
- Some issues had been identified in relation to training being provided in the hospital. Discussions were on-going with the divisional nurses to deliver the training more effectively on the wards.
- There had been an increase in stage 2 pressure ulcers reported compared to the previous year. An increase had also been seen throughout the year in relation to unstageable ulcers. Reporting of unstageable ulcers had commenced in April, therefore, a benchmark was not yet available.

Members raised concerns in relation to lost TNP pumps across the Trust which was causing financial impacts. Ms Blackwell confirmed that the equipment was booked out by the surgery team, however, was often not returned. It was suggested that the implementation of an equipment coordinator role would support with this. Mr Thomas-Hands suggested that this be looked at more widely to monitor equipment across the whole Trust.

Professor Beale queried whether there was a process in place to monitor the PFI building to enable re-claims for any issues not resolved by the provider. Mr Beeken confirmed that there was not currently a process in place for this, however, external advice was being sought in relation to the PFI contract and the team in estates were being restructured to enable the contract to be performance managed.

Resolution

The Committee received and noted the Tissue Viability Overview Report.

36/18 Mortality Report

Mr Rashid presented the Mortality report and the following key points were noted:

- HSMR data was reported at 102.5 and SHMI at 127.25.
- There were no specific themes around mortality against diagnosis.
- Advice notification received from Imperial College London 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 required further analysis. The business case for this was being developed. It was suggested that the management of the duty of candour process be included in the medical examiner role.
- Feedback on learning from mortality reviews was discussed at the mortality surveillance group to consider wider trends. The key themes around deaths in the 0-1 day length of stay group had been reviewed and the majority of patients should not have been brought into hospital in the first place. Actions were being addressed with community colleagues and the wider health economy to identify these patients and ensure advanced care planning was in place.

Professor Beale identified that the report provided good assurance that learning was being embedded from the mortality review process. Mr Beeken raised concerns that the mortality indicators were monitored against a moving average which reflected the national acuity changes in winter and therefore the increase in deaths reported during December 2017 – February 2018 was concerning. Mr Thomas-Hands highlighted that concerns had also been raised at the A&E Delivery Board and were being picked up as part of the hospital avoidance pathway. Mr Beeken agreed to have a discussion with Mr Khan about triangulating the data to get a better understanding of the Trust's position and request an update in the next report. **RB/AK**

Resolution

The Mortality Report was received and noted by the Committee.

37/18 Patient Experience Quarterly Report

Ms Blackwell presented the report which outlined patient experience and complaints data for quarter 4. The following points were noted:

- The Friends and Family Test (FFT) response rates improved for quarter 4 for Outpatients and ED
- ED 'would recommend' scores trailed behind the national results and an action plan overseen by the ED matron was in place
- Response rates in maternity remained low but the 'would recommend scores increased in quarter 4 and the 'would not recommend' reduced significantly
- There was an overall increase in the number of complaints and concerns received in quarter 4, the themes around complaints had not changed and included clinical care/assessment, attitude, waiting times and communications.
- 97% of complaints were responded to within the agreed timeframe.

There was a further discussion about the persistent themes of complaints, particularly in relation to communication and attitude and it was recognised that there needed to be an increased emphasis on the lessons learnt from complaints and actions to address these. Professor Beale highlighted that there was a need for the Trust to outline the expectations of staff in relation to how they communicate information and manage their behaviour. There was a further suggestion of including charger lockers for mobile phones in the Emergency Department which would potentially improve patient's experience.

Mr Thomas-Hands highlighted that with the implementation of the

Red 2 Green initiative, there was an expectation that patients were informed of where they were in their journey through the hospital. It was hoped that this would also improve communication with patients. Concerns were also raised in relation to the increase in the number of formal complaints per 10,000 spells in March for elective activity. Mr Thomas-Hands confirmed that there had not been a large amount of elective surgeries cancelled during this point and agreed to look into the reasons for this spike. **PTH**

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

38/18 Items for Referral to the Trust Board

Resolution
The Committee resolved that the following items would be referred to the Trust Board at its meeting on the 7th June 2018:

- 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

39/18 Any Other Business

There was no other business.

40/18 Reflections on Meeting: Post Meeting Questions from Trust Meeting Etiquette and Proposals for Trust Board Walks

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

41/18 Date & Time of Next Meeting

Thursday 28th June 2018, 9:00am
Seminar room, route 126

<table>
<tr><td colspan="6">MEETING OF TRUST BOARD, 05 July 2018</td></tr>
<tr><td colspan="5">Update on outcomes of developmental reviews for Divisional Directors July 2018</td><td>AGENDA ITEM: 12</td></tr>
<tr><td>Report Author and Job Title:</td><td colspan="2">Louise Ludgrove, Interim Director of OD and HR</td><td>Responsible Director:</td><td colspan="2">Louise Ludgrove, Interim Director of OD and HR</td></tr>
<tr><td rowspan="2">Action Required</td><td rowspan="2">Approval</td><td rowspan="2">Decision</td><td colspan="3">Assurance and Information</td></tr>
<tr><td>To receive and discuss</td><td colspan="2">To receive</td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is recommended to note the content of the Report for information.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="5">BAF, No 8; That we are not successful in our work to establish a clinically-led, engaged & empowered culture.</td></tr>
<tr><td>Resource implications</td><td colspan="5">There are no resource implications.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="5">There are no legal or equlity and diversity implications.</td></tr>
<tr><td rowspan="4">Operational Objectives 2018/19</td><td colspan="4">Continue our journey on patient safety and clinical quality through a comprehensive improvement programme</td><td>X</td></tr>
<tr><td colspan="4">Develop the culture of the organisation to ensure mature decision making and clinical leadership</td><td>X</td></tr>
<tr><td colspan="4">Improve our financial health through our robust improvement programme</td><td>X</td></tr>
<tr><td colspan="4">Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts</td><td>X</td></tr>
</table>

Update on outcomes of developmental reviews for Divisional Directors July 2018

1. PURPOSE OF REPORT

To provide the Board with an update on outcomes from developmental reviews for Divisional Directors.

2. BACKGROUND

The Trust introduced a clinically led model in September 2016 with the appointment of three clinical Divisional Directors, each of whom was allocated 4 programmed activities per week to deliver their duties as a Divisional Director. This was alongside their clinical commitments.

Initial development was put in place through a development programme delivered by Academyst which covered broad topics including understanding of the wider NHS systems, service improvement approaches and use of resources. This was followed up in 2017 by a Kings Fund programme for the Teams of Three, including Divisional Directors.

The Board agreed in August 2017 that following completion of the programmes, a review would be conducted with each Divisional Director to establish their learning against five key objectives, through the development outlined above and based on their experience of having worked in the roles for a period of time.

3. DETAILS

Process

The first phase of this review process was to run a 360 degree feedback exercise for each Divisional Director from prescribed individuals within their structures (both senior and junior to them) based on establishing their learning against five key objectives: Strategic leadership, financial management, best practice standards in provision of safe care, cohesive team working and implementation of governance processes across Divisions.

The output from this feedback was fed back to each Divisional Director by the Interim Director of OD & HR through a discursive, coaching approach.

The next phase required the Divisional Directors to deliver a presentation to a Panel of Executive and Non-Executive Directors, outlining their learning against the five key objectives. This phase combined the presentation of their self-assessment against these objectives with a viva conducted by a group of Executive and Non-Executive Directors, intended to explore areas of achievement and further support going forward.

Output

The output from the above review stages revealed a largely consistent picture of significant development over a period of 18 months since individuals were appointed into these leadership roles. Each Division had its own particular aspects of challenge relating to those services within it but the broader experience of all three Directors

identified rapid exposure and commensurate development of skills across consistent areas of focus. Examples of these include:

Participants collectively reflected significant benefits from the Kings Fund Development programme; all had engaged with and accepted responsibility for the rapid development of cultural change within their Divisions; recognition of the role of the Divisional Director in modelling behaviour and challenging inappropriate behaviour from colleagues; significant emphasis on close and effective team working amongst the three Divisional Directors, within Teams of Three and across Divisions; recognition of the need to empower their Care Group leaders and teams and provide support to them; a need to rely on clinical colleagues to support provision of services; a focus on continuous improvement and aspirational service developments; accepting responsibility for care of team members and themselves; responsibility for all staff within their Divisions and not just medics; leading a multi professional approach to care and new roles; responsibility for financial management, delivery of CIPs and productivity; exposure to ownership of organisational pressures; responsibility for governance across their Divisions; understanding of the need to develop accountability across teams and to develop a Quality Improvement approach to service delivery; ongoing individual reflection on progress in delivering all of the imperatives described above.

Next steps

The development of a clinically led model within any organisation is an ongoing process and takes considerable time to learn and mature to achieve maximum benefit. Ongoing development and reflection on the changing needs for these roles in a time of rapid change within the external environment is essential.

It has become clear through this process that each of the three Divisional Directors has made significant individual progress in their development within their roles and consideration is currently being given to appropriate further targeted development on an individual basis.

The recent introduction of a Trust Management Board is a significant step towards recognising the partnership between the Executive and the clinical leadership and enabling discussions to take place and decisions to be made on a shared basis.

It is intended to reflect on the findings demonstrated in this report to review the role of senior clinical leaders going forward, in order to ensure that the Trust supports them effectively and enables individuals to make their most effective contribution to our journey going forward.

4. RECOMMENDATIONS

The Board is recommended to note the content of the Report for information.

Report Author: Louise Ludgrove, Interim Director of OD and HR
Date of report: 27/06/2018

<table>
<tr><td colspan="6">MEETING OF TRUST BOARD, 05 July 2018</td></tr>
<tr><td colspan="5">People and Organisational Development Committee highlight report</td><td>AGENDA ITEM: 13</td></tr>
<tr><td>Report Author and Job Title:</td><td colspan="2">Louise Ludgrove, Interim Director of OD and HR</td><td>Responsible Director:</td><td colspan="2">Philip Gayle, Non-Executive Director</td></tr>
<tr><td rowspan="2">Action Required</td><td rowspan="2">Approval</td><td rowspan="2">Decision</td><td colspan="3">Assurance and Information</td></tr>
<tr><td>To receive and discuss</td><td colspan="2">To receive</td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is recommended to note the content of the Report for information.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="5">BAF Risks:
No 7. That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff
No 8. That we are not successful in our work to establish a clinically led, engaged and empowered culture.
No. 11. That our governance remains “inadequate” as assessed under the CQC Well Led standard.</td></tr>
<tr><td>Resource implications</td><td colspan="5">There are no resource implications raised within the Report.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="5">Compliance with Trust Standing Orders.</td></tr>
<tr><td rowspan="4">Operational Objectives 2018/19</td><td colspan="4">Continue our journey on patient safety and clinical quality through a comprehensive improvement programme</td><td>X</td></tr>
<tr><td colspan="4">Develop the culture of the organisation to ensure mature decision making and clinical leadership</td><td>X</td></tr>
<tr><td colspan="4">Improve our financial health through our robust improvement programme</td><td>X</td></tr>
<tr><td colspan="4">Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts</td><td>X</td></tr>
</table>

EXECUTIVE SUMMARY

1. PURPOSE OF REPORT

To inform the Board of key issues discussed at People and Organisational Development Committee.

2. BACKGROUND

The report highlights the key issues discussed at the People and Organisational Development Committee meeting held on 18 June 2018.

3. DETAILS

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

Key issues discussed were:

1. The Committee discussed content within the Trust Annual Plan relating to Equality, Diversity & Inclusion. It was agreed that this should include our commitment as a Trust. It was noted that this narrative had been supplied for the Plan.

2. It was noted that applications had been received for the E, D& I secondment post currently being advertised on a six month basis. Louise Ludgrove also advised that it was intended to create a permanent position for this role within the restructure of the OD & HR Directorate. Louise reported that agreement had been reached at Director level to bring together the two arms within the Trust relating to E, D & I for patients/public and for staff. This would enable a more robustly resourced position and ensure consistency across the approach for all.

3. Marsha Belle reported that she was currently drafting a strategy document for the next EDIC meeting, which has now been moved to monthly frequency in order to better enable progress.

4. Philip Gayle reported that he had sourced attendance at EDIC from Walsall Council and that this had contributed a valuable perspective to discussions which would enable closer working and beneficial contacts going forward.

5. Sebastian Smith-Cox delivered a presentation covering the impact of a recent Learning into Action event around E, D & I, which had also been supported by staff side. The event had sold out within days of being advertised and it was intended to run a further event later this year.

6. Sebastian also provided a powerful account of the experience of participants in the Leadership Academy's Stepping Up programme and detailed the benefits that his participation in the programme had delivered for him as an employee of the Trust.

7. Sandra McShane presented a report to the Committee on the Workforce Key Performance Indicators. She updated on the outcome of a deep dive into fluctuating performance on sickness absence during the last quarter and identification of the key drivers of this change, linking to outbreaks of Norovirus, flu etc. Sukhbinder Heer suggested the introduction of a score card, identifying the impact of winter

effect, ward closures, vacancy levels and ward closures as a monitoring tool towards delivering improvements.

8. Daren Fradgley noted the importance of ensuring that mandatory training is relevant to individual roles. He reported that the Quality Academy had run a session within mandatory training in line with Sukhbinder's suggestion at Trust Board, acknowledging the relevance of mandatory training to individual roles and considering how to make subject matters relatable and interesting for attendees.

9. Karen Bendall updated the Committee on the current and developing position around delivery of Mandatory Training targets and reported on the various initiatives relating to the rapid improvement of performance in this area.

10. Amir Khan presented an update report on Consultant vacancies and noted that the implementation of new roles was being explored to provide some longer term solutions in covering vacancies where we were unlikely to recruit. It was noted that the present work around sustainability reviews was actively considering these issues and Daren Fradgley reported that it was anticipated that the outcome of this work would be presented to Executives in July and to Board Committees in August.

11. Kara Blackwell updated the Committee on the latest position relating to agency usage in nursing. Sukhbinder Heer expressed his concerns around the level of assurance relating to controls for agency spend and Louise Ludgrove reminded the Committee that a formal report from the external NHSI review was awaited. It was anticipated that this would bring clarity to the discussions moving forward.

12. Marsha Belle provided an update on the introductory work around new roles. She noted the support being provided by the Transformation team working with Divisions in taking forward this work and the group discussed the importance of cultural development in enabling services to consider effective deployment of alternative roles as a means of addressing long term workforce shortages.

4. RECOMMENDATIONS

The Board is recommended to note the content of the Report for information.

Report Author: Louise Ludgrove, Interim Director of OD and HR
Date of report: 26/06/2018

TRUST BOARD					
FINANCE REPORT MONTH 2					**AGENDA ITEM: 14**
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**		
			To receive and discuss X	**To receive**	
Recommendation	To inform members of the Performance Finance & Investment Committee of the financial performance of the Trust for the year to date May 2018 (M02). Noting and endorsing the recommedations within the report for recovery of the financial performance to plan.				
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Delivery of the 2018/19 financial plan and 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. Impact on the Trust ability to secure additional capital resources from central funds to support significant capital investment.				
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				
	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 inform members of the Trust Board of the financial performance of the Trust for the year to date May 2018 (M02)

2. Background

The Trust has adopted a financial plan for the 2018/19 financial year that delivers an £18.6m deficit. The key component for achievement being 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).

The Trust has subsequently accepted an improved offer of control total at £10.6m deficit (£15.6m excluding Provider Sustainability Funding - PSF)

3. Details

The Trust has attained the following financial performance as at May 2018:

- Deficit of £4.5m in YTD (£0.2m adverse variance to plan)
- CIP delivered £1.1m YTD behind plan by £0.3m (£0.6m non-recurrent)
- Temporary workforce costs for May totalled £1.8m (£0.4m higher than May 2017)

The Trust is required to reduce this run rate in order to deliver the planned outturn for the financial year, key risks being:

- CIP delivery of £13m for the year (noting the phasing into the later part of the year)
- Overspends continue, driven by temporary workforce
- Disputed 2017/18 balances by the commissioner

Actions being taken:

Financial Recovery Plan (owned throughout the Trust) presented to an Extra-ordinary Performance, Finance & Investment Committee, components being:

- Monthly income and expenditure trajectories (by Division and expense category)
- Temporary workforce annual expenditure profile (Medical and Nursing focus)
- Mitigations discussed within PFIC (to include sale of assets modelled)
- Cost Improvement Programme delivery (ahead of profile to remove risk to delivery at close of the financial year)
- Communication strategy

Focus placed upon delivery of Improvement Work-streams (productivity & efficiencies) with weekly meetings with the Chair for Performance, Finance and Investment Committee

4. Capital

Capital schemes are progressing (ICCU complete November 18 / Maternity commenced May 2018 and ED prioritised by STP (local providers and commissioners of healthcare)

5. Recommendations

Members are asked to note the reported performance to month 2 and the action being progressed to ensure robust enhanced monitoring and delivery of the 2018/19 financial plan.

6. Appendices

Please see attached finance report

Walsall Healthcare NHS
NHS Trust

2018/19 Finance Report
May 2018 (Month 2)

Becoming your partners for first class integrated care

2018/19 Finance Report: (Month 2)	Page
• Key Messages	3
• Overall Summary and RAG Assessment	4-5
• Temporary Staffing Analysis	6-7
• Cost Improvement Target Achievement	8
• Capital Programme	9
• Statement of Financial Position	10
• Statement of Cash Flows	11

Key Messages

Financial Month 2 plan.	• Trust has set a plan to deliver an £18.6m deficit for the financial year • At month 2 the Trust has a deficit of £4.5m (£0.2m off plan) • Trust is required to reduce this run rate significantly to attain plan
CIP	• The Trust's Cost Improvement Target for the year £13m • YTD Month 2 total savings of £1.1m delivered (£1.4m plan) of which £0.6m non-recurrent • Increasing births delivered at the Trust will off-set £0.25m of the non-recurrent delivery
Bank, Agency & Locum	• Spending on temporary workforce is £1.8m for the month (£0.4m higher than May 2017) • Nursing £0.1m and Medical £0.3m higher than prior year
Capital Developments	• Maternity works commenced in May (£5.6m) and the ICCU development is set to open in November 18 • The Emergency Department development was ranked as a priority for investment by the STP in month
Financial Risks	• CIP Delivery for the year (£13.0m target) requires traction on the 'Improvement Work-streams' • Overspends in month 2 continue (largely temporary workforce) giving a run rate risk
Management of the financial risks	Financial Recovery Plan (owned throughout the Trust) presented to an Extra-ordinary Performance, Finance & Investment Committee, components being: • Monthly income and expenditure trajectories (by Division and expense category) • Temporary workforce annual expenditure profile (Medical and Nursing focus) • Mitigations discussed within PFIC (to include sale of assets modelled) • Cost Improvement Programme delivery (ahead of profile to remove risk to delivery at close of the financial year) • Communication strategy • Focus upon delivery of Improvement Work-streams (productivity & efficiencies) with weekly meetings with the Chair for Performance, Finance and Investment Committee • Enhanced scrutiny in meetings with the Divisions to assure plans are robust and Quality Impact assessed

Summary Financial Performance to May 2018 (Month 2)

Financial Performance - Period ended 31st May 2018					
Description	**Annual Budget**	**Budget to Date**	**Actual to Date**		**Variance**
	£'000	£'000	£'000		£'000
Income					
NHS Activity Revenue	227,981	37,340	37,240		(100)
Non NHS Clinical Revenue (RTA Etc)	1,025	186	132		(54)
Education and Training Income	6,856	1,166	1,258		92
Other Operating Income (Incl Non Rec)	7,419	1,349	1,518		168
Total Income	**243,281**	**40,042**	**40,148**		**106**
Expenditure					
Employee Benefits Expense	(175,420)	(28,869)	(29,066)		(197)
Drug Expense	(7,398)	(3,074)	(3,045)		29
Clinical Supplies	(17,475)	(2,929)	(2,984)		(54)
Non Clinical Supplies	(15,544)	(2,661)	(2,720)		(59)
PFI Operating Expenses	(5,081)	(881)	(856)		25
Other Operating Expense	(26,441)	(3,279)	(3,353)		(74)
Sub - Total Operating Expenses	**(247,360)**	**(41,693)**	**(42,024)**		**(331)**
Earnings before Interest & Depreciation	**(4,079)**	**(1,652)**	**(1,876)**		**(224)**
Interest expense on Working Capital	51	9	7		(2)
Interest Expense on Loans and leases	(8,012)	(1,586)	(1,612)		(25)
Depreciation and Amortisation	(6,560)	(1,093)	(1,007)		86
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(14,521)**	**(2,671)**	**(2,612)**		**59**
Total Expenses	**(261,881)**	**(44,365)**	**(44,636)**		**(271)**
RETAINED SURPLUS/(DEFICIT)	**(18,600)**	**(4,323)**	**(4,488)**		**(165)**
Adjustment for Gains on Donated Assets			(21)		(21)
Adjusted Financial Performance (Control Total)	**(18,600)**	**(4,323)**	**(4,509)**		**(186)**

Division	YTD Budget £000's	YTD Actual £000's	Variance £000's	*Narrative*
MLTC	10,146	10,814	(668)	*MLTC overspent as a result of nursing wards and specialist areas (£0.6m) and Medical agency cover for Elderly/Respiratory Care.(£0.15m).*
SURGERY	8,701	8,940	(239)	*Surgery overspends are within Nursing £0.1m and medics £0.1m (Anaesthetics)*
WC & CSS	11,396	11,224	172	*WCCSS is underspent by £0.2m driven by vacancies within Therapies, off-setting medical overspends (£0.1m) within Paediatrics and income underperformance.*
ESTATES AND FACILITIES	2,550	2,518	32	*Division has delivered ahead of plan*

Financial Performance

- The Trust attained a deficit of £4.5m at month 2 against a plan of £4.3m, which results in an unfavourable YTD variance of £0.2m.
- The contracted income shows an unfavourable variance to plan of £0.1m, the under-performance occurring in clinical support . However, this is net of the over-performance on elective that has generated CIP recurrently in month 2 in excess of £0.1m.
- 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 £331k YTD. The main area of overspending is pay owing to the continued use of high cost temporary staffing in Medical (£358k) and Nursing (£782k).
- The Trust Board has adopted a revised deficit plan of £10.6m for the financial year (after receipt of £5m Provider Sustainability Funds - PSF)

CIP 2017/18 Delivery

- The Trust's Annual Cost Improvement Programme requirement is £13m.
- The Trust has delivered £1.1m CIP to month 2 (plan £1.4m) £0.6m non-recurrently.
- An element of the non-recurrent delivery reflects the delays in the Trust increasing Obstetric activity to cap (so will be off-set by recurrent income delivery).
- Non-recurrent delivery places 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 £1.28m.
- The interest payable on the increased borrowing adds to future savings requirement.
- The level of interest currently payable on borrowing to date and to service the current financial plan is circa £2.3m for the year.

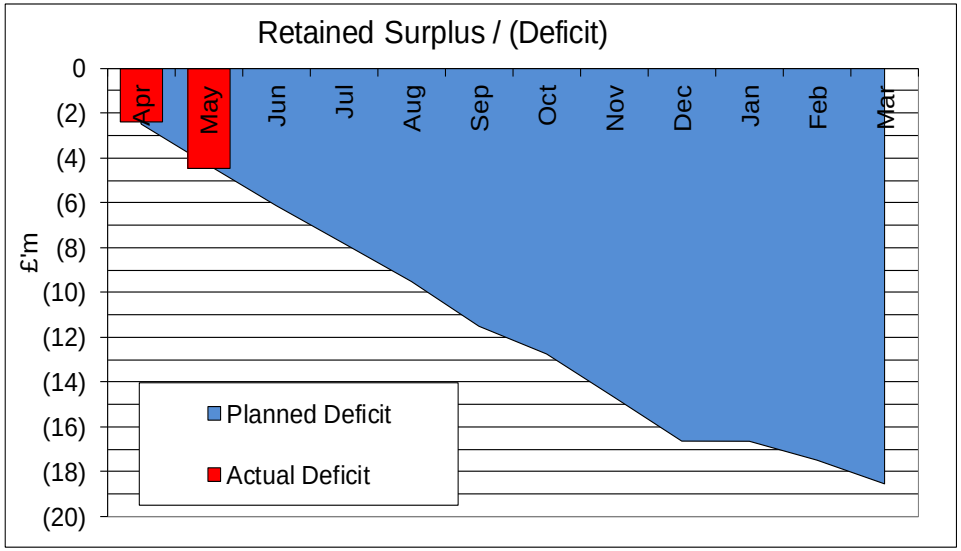
Capital

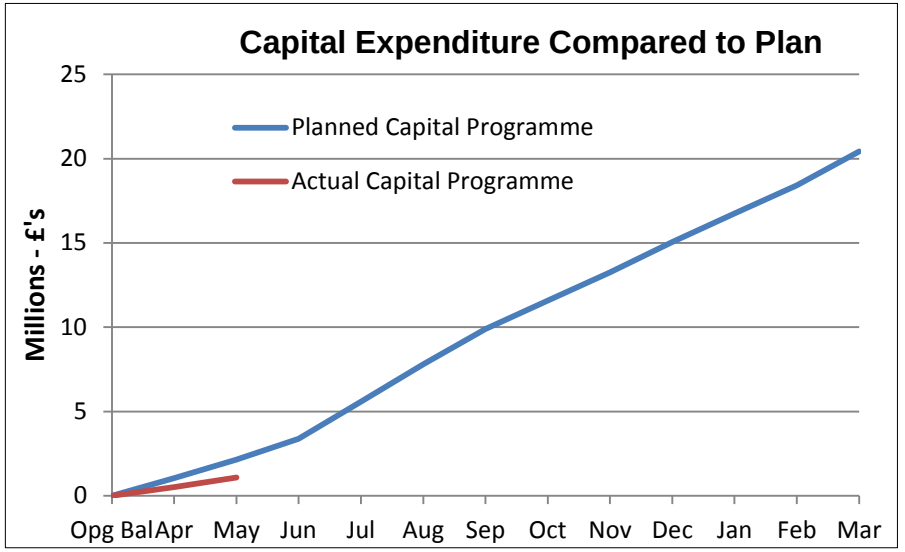
- The year to date capital expenditure is £1.1m, with ICCU set to complete in November 2018, Maternity works commenced in May 2018 and the Trust Emergency Department development prioritised in month by the STP (local commissioners and providers of healthcare).

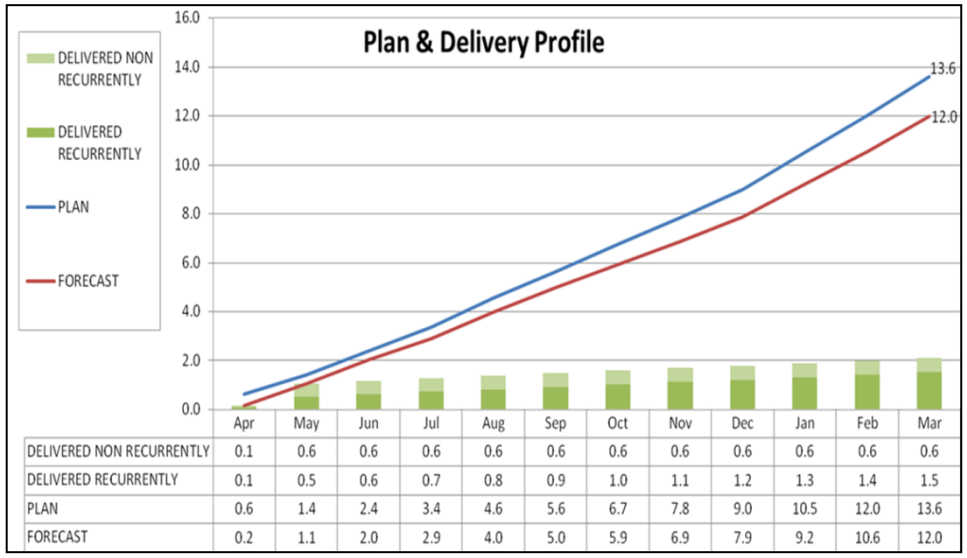
Temporary Workforce

- Total expenditure on temporary workforce is £1.828m (May 2018) which represents a £86k reduction on the April total following the reduction in capacity
- The Trust continues to spend resource in excess of historic performance (£1.42m May 2017) and this is driving levels of overspend within the Divisions.

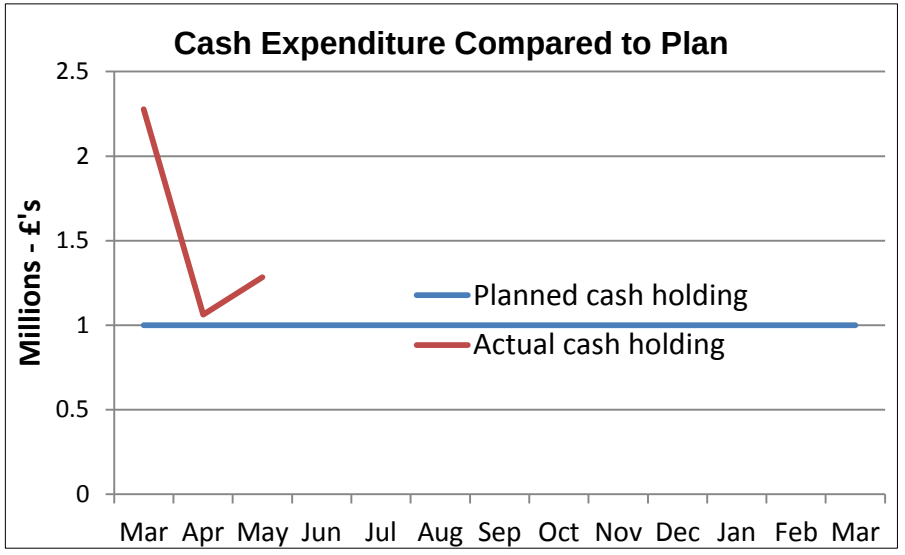
Overall Summary and RAG Assessment continued



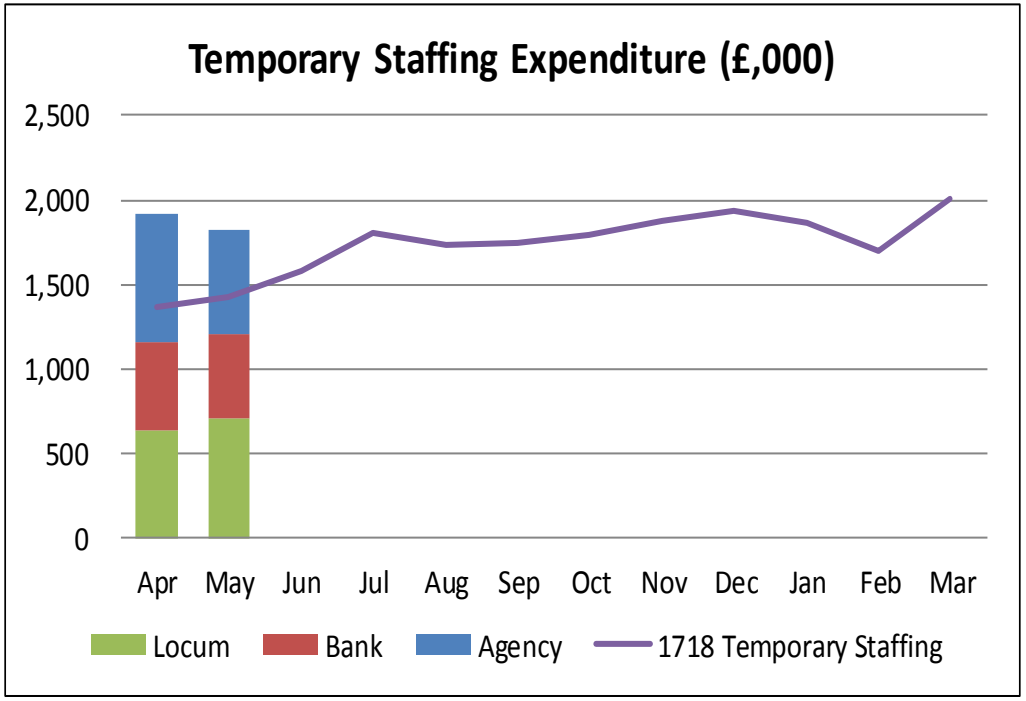




	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.1	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6
DELIVERED RECURRENTLY	0.1	0.5	0.6	0.7	0.8	0.9	1.0	1.1	1.2	1.3	1.4	1.5
PLAN	0.6	1.4	2.4	3.4	4.6	5.6	6.7	7.8	9.0	10.5	12.0	13.6
FORECAST	0.2	1.1	2.0	2.9	4.0	5.0	5.9	6.9	7.9	9.2	10.6	12.0



TEMPORARY EXPENDITURE 2018/19

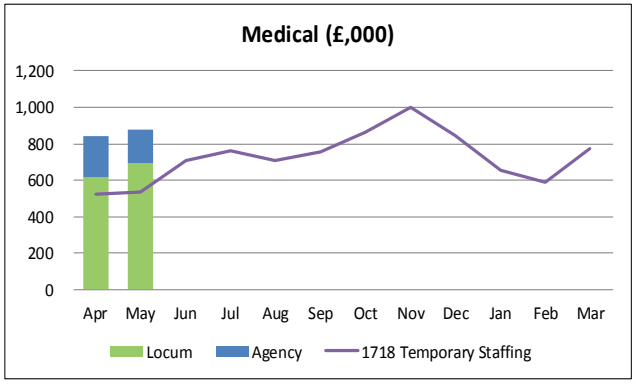


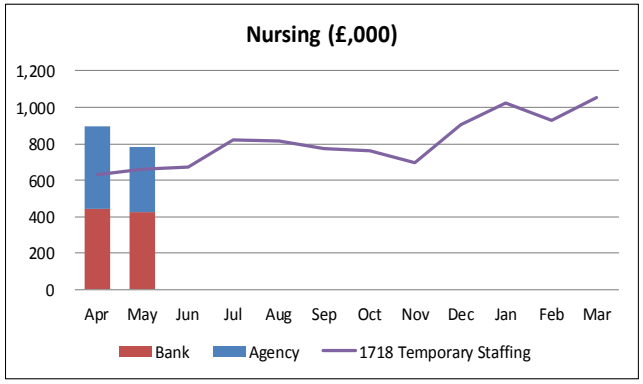
Commentary

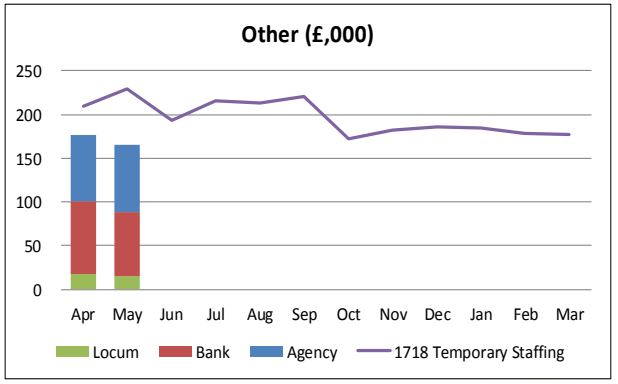
- Temporary staff costs totalled £1.8m in May 2018 (£1.9m April 2018), of which agency is £0.623m.
- The NHS Improvement target for the Trust is to spend no more than £6.5m on agency in 2018/19. This is a £0.5m reduction on the 2017/18 target and £1m reduction on 17/18's outturn.
- The Table below shows an annual forecast for temporary workforce spending:-

Description	2018/19		*2017/18*
	YTD May £000's	Annual £000's	*Annual £000's*
Temporary worker	1,828	22,867	*20,830*
Agency	1,377	8,670	*7,503*

- Total spend in May 18 (£1.8m) is significantly higher than the same period last year (£1.4m May 2017).







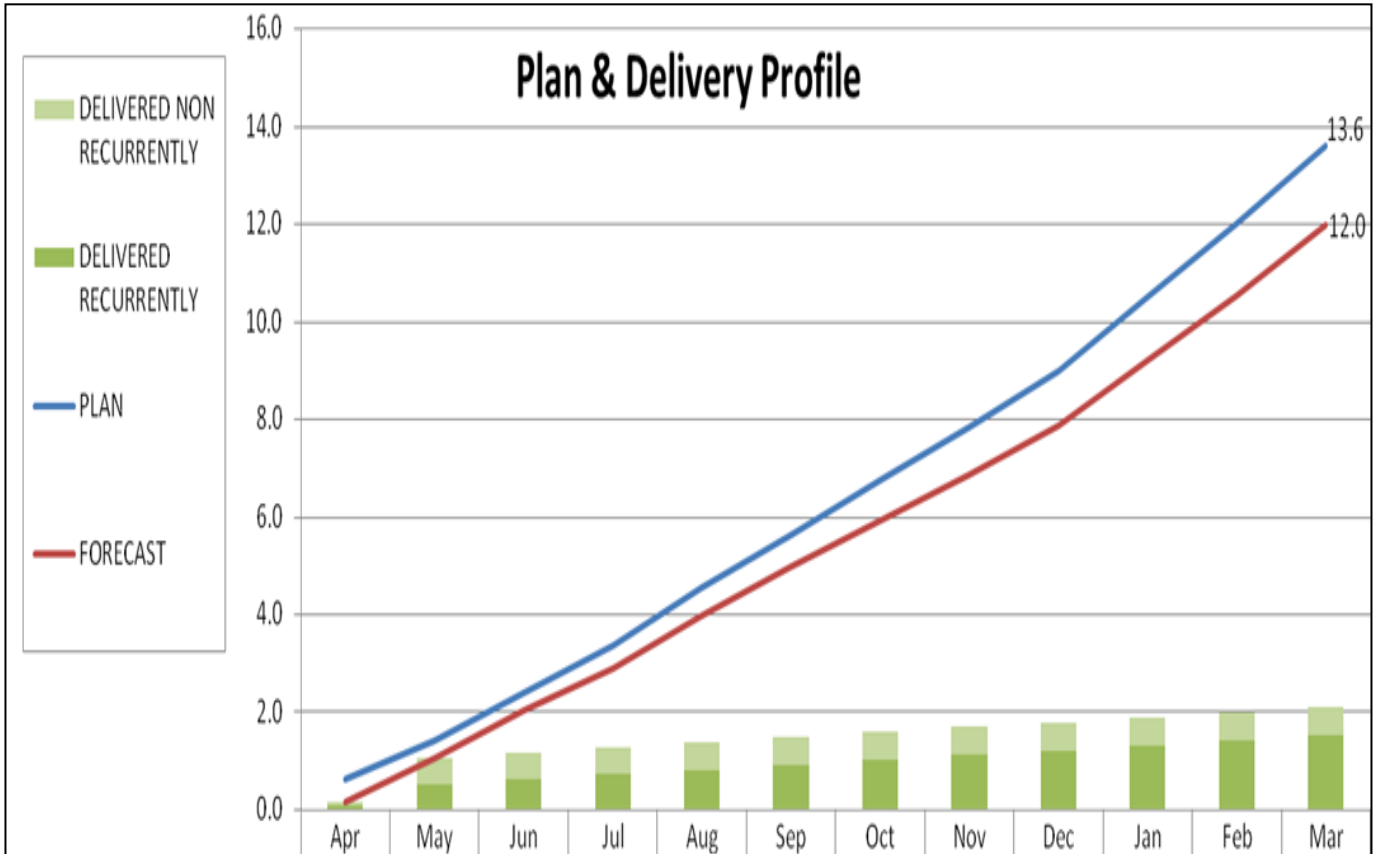
TEMPORARY WORKFORCE EXPENDITURE 2018/19

Agency	17/18												18/19		
	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total	Apr	May	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	189	280	213	153	194	174	317	215	169	163	126	2,306	223	187	410
PTB	18	21	19	23	11	15	-6	1	14	14	14	150	12	9	21
Nursing & Midwifery	330	301	332	432	264	367	244	392	555	404	352	4,221	455	359	814
Other Staff Groups	87	59	77	84	83	62	89	78	53	60	36	827	63	68	131
Agency Total This Year	**625**	**660**	**641**	**692**	**553**	**618**	**644**	**686**	**791**	**641**	**527**	**7,504**	**754**	**623**	**1,377**
Monthly Movement	199	35	(19)	51	(139)	65	26	42	105	(149)	(114)		226	(131)	

Bank	17/18												18/19		
	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total	Apr	May	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	330	370	489	382	511	393	454	512	467	526	705	5,525	442	425	867
Other Staff Groups	72	79	91	85	104	79	83	93	105	84	107	1,083	84	74	158
Bank Total This Year	**402**	**449**	**580**	**466**	**616**	**473**	**537**	**605**	**571**	**610**	**811**	**6,608**	**526**	**499**	**1,025**
Monthly Movement	(85)	46	131	(114)	149	(143)	64	68	(34)	39	201		(285)	(27)	

Locum	17/18												18/19		
	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total	Apr	May	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	348	430	551	553	561	691	683	630	486	425	645	6,414	617	691	1,308
PTB	51	35	30	22	21	16	17	14	13	20	18	299	15	13	28
Nursing & Midwifery	0	0	0	0	0	0		0				0	0	0	0
Other Staff Groups	0	0	0	0	0	0		0			3	4	2	1	3
Locum Total This Year	**399**	**465**	**581**	**575**	**582**	**707**	**700**	**644**	**499**	**446**	**667**	**6,718**	**635**	**705**	**1,340**
Monthly Movement	(55)	66	116	(6)	7	125	(7)	(56)	(145)	(53)	221		(32)	70	
Grand Total	**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**	**1,827**	**3,741**
Total Monthly Movement	60	147	228	(69)	17	47	83	54	(74)	(163)	308		(109)	(87)	

Cost Improvement Target Achievement: May 2018 (Month 2)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.1	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6
DELIVERED RECURRENTLY	0.1	0.5	0.6	0.7	0.8	0.9	1.0	1.1	1.2	1.3	1.4	1.5
PLAN	0.6	1.4	2.4	3.4	4.6	5.6	6.7	7.8	9.0	10.5	12.0	13.6
FORECAST	0.2	1.1	2.0	2.9	4.0	5.0	5.9	6.9	7.9	9.2	10.6	12.0

Headlines & Commentary

Cost Improvement Programme Target for 2018/19 is £13m.

YTD Delivery

- Delivered £1.1m at month 2 (May)
- Plan to deliver £1.4m, giving an under-delivery of £0.3m
- Of the total savings £0.6m is delivered non-recurrently
- Non-recurrent delivery will be off-set by £0.25m for increased Obstetric activity (births).

Full Year Plan

- The full year delivery forecast totals £12m (current shortfall against plan £1m) 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 2 schemes is £2.1m, of which £1.5m is delivered recurrently.

Capital Programme

Capital Schemes 2018/19	2018/19 Plan £'000	Actual Expenditure 2018/19 £'000	Remaining Balance £'000
Estate			
Life cycle – estate maintenance	1,101	112	989
Integrated Critical Care Unit	2,907	738	2,169
Maternity	5,600	74	5,526
Emergency Department	10,000	8	9,992
Medical Equipment Replacement	516	0	516
Information Management & Technology			
Hardware & Software	100	41	59
Total Mobile	100	104	(4)
Contribution to SLR	0	0	0
Total Cost of Capital Schemes	**20,324**	**1,077**	**19,247**

Commentary

- Total planned capital expenditure is £20.3m
- Major schemes are the Integrated Critical Care Unit (ICCU) £3m & Maternity and Neo-Natal Unit £5.6m
- The ICCU scheme is set to complete November 2018, Maternity building work commenced 21st May
- The Emergency Department (ED) was planned to incur £10m of costs. However, revised estimates place this value at £2m for the year
- The ED scheme has been provisionally ranked as a priority for investment by the STP (council, providers and commissioners of healthcare)
- The Outline Business Case (OBC) for the ED development is with NHS Improvement for review.
- The Trust is seeking additional capital resource to support further medical equipment replacement in year.

Statement of Financial Position

Statement of Financial Position			
	as at 31/03/18	as at 31/05/18	Movement
	£000	£000	£000
Non-Current Assets			
Property, plant & Equipment	138,291	138,360	69
Intangible Fixed Assets	1,311	1,369	58
Total Non-Current Assets	**139,602**	**139,729**	**127**
Current Assets			
Receivables & pre-payments less than one Year	17,214	18,698	1,484
Cash (Citi and Other)	2,277	1,283	(994)
Inventories	2,277	2,361	84
Total Current Assets	**21,768**	**22,342**	**574**
Current Liabilities			
NHS Payables less than one year	(7,817)	(2,291)	5,526
Payables less than one year	(22,885)	(29,743)	(6,858)
Borrowings less than one year	(60,740)	(66,031)	(5,291)
Provisions less than one year	(432)	(432)	-
Total Current Liabilities	**(91,874)**	**(98,497)**	**(6,623)**
Net Current Assets less Liabilities	**(70,106)**	**(76,155)**	**(6,049)**
Non-current Assets			
Receivables greater than one year	1,054	1,872	818
Non-current liabilities			
Borrowings greater than one year	(127,859)	(127,243)	616
Total Assets less Total Liabilities	**(57,309)**	**(61,797)**	**(4,488)**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	58,318	58,318	-
Revaluation	16,023	16,023	-
Income and Expenditure	(131,650)	(131,650)	-
In Year Income & Expenditure	-	(4,488)	(4,488)
Total TAXPAYERS' EQUITY	**(57,309)**	**(61,797)**	**(4,488)**

Commentary

Non Current Assets

- There is little movement year to date with depreciation and amortisation being almost equal to capital expenditure incurred.

Current Assets

- Receivables & pre-payments have increased by £1.48m since 31st March 2018, the adjustment reflecting movements in pre-paid contracts at the start.
- Cash is £1.0m lower than the balance at 31st March 2018. The high balance held at year end being specifically to assist delivery of the Capital Resource Limit (CRL) target.

Current Liabilities

- Liabilities have increased since March and primarily reflecting additional borrowing to support the revenue deficit position.

Provisions

- The balance of provisions remains unchanged

Tax Payers' Equity

- Income & Expenditure reflects the current deficit of £4.4m and shows the brought forward balances on the revaluation reserve and Income & Expenditure Reserve.

Cash Flow Statement

	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	(2,886)
Depreciation and Amortisation	1,007
Donated Assets Received credited to revenue but non-cash	(58)
Fixed Asset Impairments	0
(Increase)/Decrease in Trade and Other Receivables	(2,304)
Increase/(Decrease) in Trade and Other Payables	1,786
Increase/(Decrease) in Stock	(84)
Increase/(Decrease) in Provisions	0
Interest Paid	(1,608)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	(4,147)
Cash Flows from Investing Activities	
Interest received	7
(Payments) for Property, Plant and Equipment	(1,428)
Receipt from sale of Property	0
Net Cash Inflow/(Outflow)from Investing Activities	(1,421)
Net Cash Inflow/(Outflow) before Financing	(5,568)
Cash Flows from Financing Activities	4,574
Net Increase/(Decrease) in Cash	(994)
Cash at the Beginning of the Year 2017/18	2,277
Cash at the End of the Month	1,283

Commentary

Cash Flow

- The Trust made an adjusted operating deficit of £2,886k at the end of May and received cash of £1,007k in respect of depreciation and amortisation.
- Trade and Other Receivables increased over the period (a negative impact on cash).
- Trade and Other Payables increased over the period (a positive impact on cash).
- The Trust spent a total of £1,428k in relation to payments for outstanding capital projects from 2017/18 and current 2018/19 projects.
- The Trust has received a total of £5.2m against the temporary borrowing loan facility by the end of May to support working capital payments.

MEETING OF TRUST BOARD – 05.07.18					
Performance and Quality Report					**AGENDA ITEM: 15**
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			✓	
	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			✓	

Walsall Healthcare NHS
NHS Trust

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 89.7% compared to 87.22% in April. May's performance exceeded the trajectory of 85%.
- **Ambulance Handover:** The number of delayed ambulance handovers totalled 42 compared to 43 in April. Within this the number delayed by more than 1 hour increased to 5 from 1.
- **Cancer** – All cancer metrics achieved in April with the exception of 62 day referral to treatment (83.33% against an 85% target). Unvalidated results for May show achievement against all cancer measures.
- **18 Weeks Referral to Treatment Incomplete: Target 92%:** May's performance further improved to 88.33%.
- **Diagnostic waits:** 99% target continued to achieve (99.57%).
- **HSMR (HED) & SHMI -** February HSMR rate was 102.55. December SHMI changed to 127.25 from 103.66 in November. 78 deaths were recorded in May
- **Infection Control** – There were two reported cases of C Difficile and no cases of MRSA
- **Pressure Ulcers – (category 2, 3 & 4's) – Avoidable per 1000 beddays (Acute) / CCG per 10,000 population (Community)** – These two new metrics have been included and were reported as 0.84 and 0.03 respectively for April (unvalidated)
- **Falls** - The rate of falls per 1000 bed days declined to 5.62 from 5.32 in April and was within the target of 6.63. There were no falls resulting in serious injury.
- **Safeguarding and Prevent Training** – Compliance rates were not achieved with the exception of Prevent Level 1 and 2 and Children's Safeguarding Level 3. Trajectories have been established to achieve by end of Q1.
- **Open Contract Performance Notices** – Seven contract performance notices remain open.
- **DNA rates**: Slightly declined in May to 11.03% from 10.47% in April and failed to achieve the trajectory of 9.00%.
- **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: 29th June 2018

APPENDICES
Performance & Quality Report

Walsall Healthcare NHS
NHS Trust

Performance & Quality Report

Trust Board

June 2018
(May 2018 Results)

Author: Alison Phipps – Head of Performance and Strategic Intelligence
Lead Director: Russell Caldicott – Director of Finance and Performance

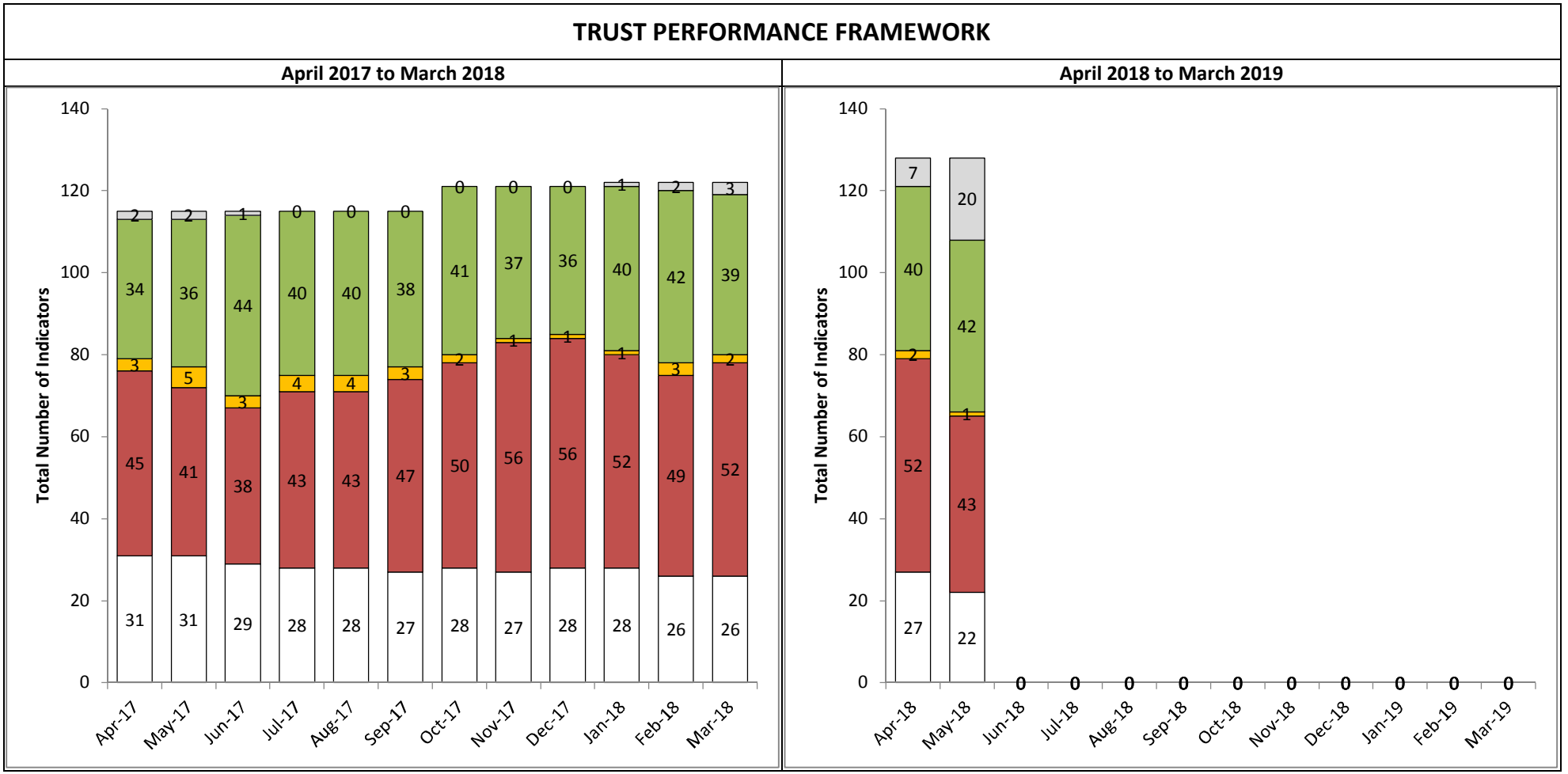
Becoming your partners for first class integrated care

Contents

Indicator	Page
Trust Performance Framework Chart	3
Trust Strategic Values Framework Chart	4
Quality & Safety Committee	
Key Messages	6
Dashboard	7-9
Performance, Finance & Investment Committee	
Key Messages	11
Dashboard	12-14
People & Organisational Development Committee	
Key Messages	16
Dashboard	17
Exception Pages	
Emergency Department	19
Cancer 62 Day Referral To Treatment (Apr 18)	20
18 Weeks Referral to Treatment – Incomplete Pathways (Apr 2018)	21
Open Contract Performance Notices	22
Outpatients	23
Length of Stay	24
Delayed Transfers of Care (Apr 2018)	25
Mortality (Feb 2018)	26
Infection Control	27

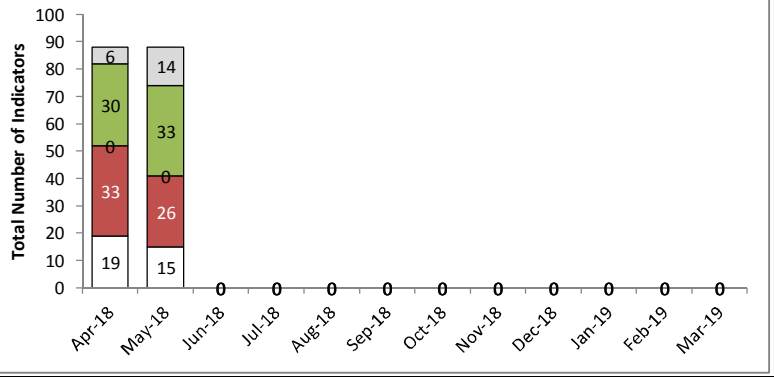
Indicator	Page
Pressure Ulcers (Mar 2018)	28
Falls	29
Medication Errors	30
Emergency Readmissions (Apr 2018)	31
Electronic Discharge Summaries	32
Dementia (Apr 2018)	33
Friends & Family Test	34
Mandatory Training Compliance	35
Safeguarding Compliance	36
Sickness Absence	37
PDR Compliance	38
CQUINs	
CQUIN Summary	40-44
Glossary	
Glossary of Acronyms	46-47

TRUST PERFORMANCE FRAMEWORK

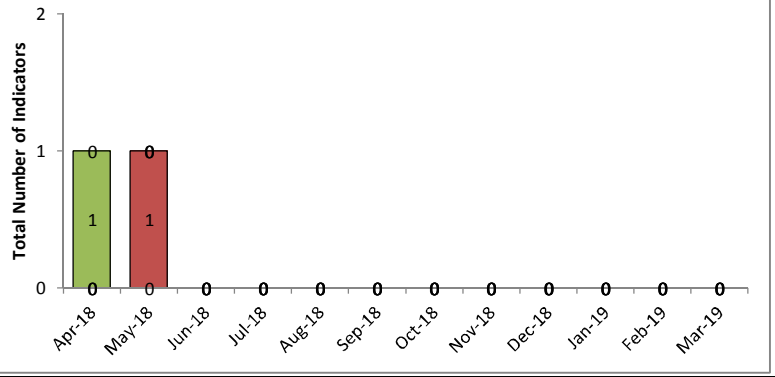


TRUST STRATEGIC VALUES FRAMEWORK

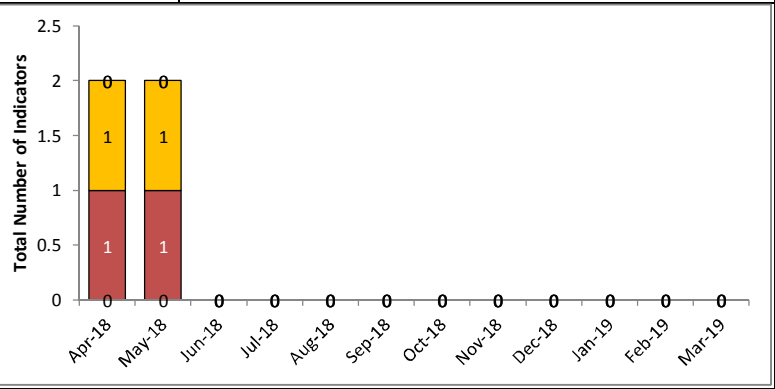
Provide Safe, High Quality Care Across All Our Services



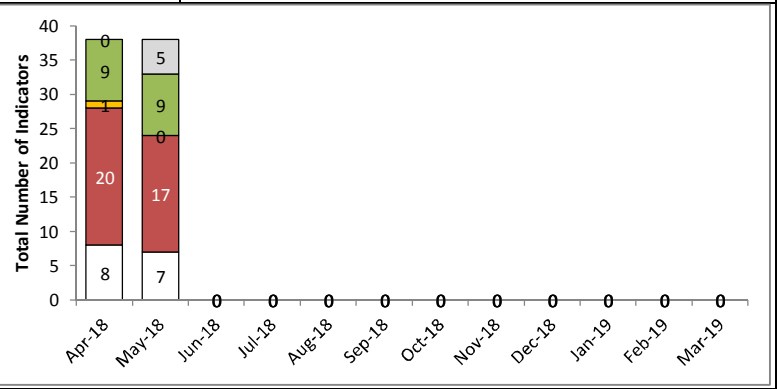
Care For Patients At Home Whenever We Can



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



Use Resources Well To Ensure We Are Sustainable



Indicators with No Targets

Failing to meet Target or Major Variance from Plan

Minor Variance from Plan

Achieving Target or On Plan

Indicators reported in Arrears or not yet available in Month

Walsall Healthcare NHS
NHS Trust

Quality and Safety Committee

Becoming your partners for first class integrated care

Quality & Safety Committee – Key Messages

Please refer to dashboard and exception pages for further detail

Quality & Safety Committee

PERFORMANCE ACHIEVED – OF NOTE:. There were no sleeping accommodation breaches during May. There were 2 cases of C Difficile within the month which is within the monthly trajectory and no cases of MRSA. One to One care in established labour achieved the 100% target. Children's safeguarding training level 3 compliance exceeded the 85% target.

PERFORMANCE NOT ACHIEVED: HSMR improved to 102.55 in February from 113.00 in January. There were 8 avoidable pressure ulcers reported for March. April and May figures are provisional. Midwife to Birth Ratio did not achieve at 1:29.2. Emergency Readmissions within 30 days did not achieve in April with performance of 11.27%. EDS compliance significantly improved to 92.29% in May. Dementia deteriorated to 66.62% in April, against a target of 90%, however methodology to determine performance of this metric is still under review. Seven FFT areas failed to achieve in May. Six of the Safeguarding metrics failed to achieve in May.

TO NOTE:
The number of deaths reduced in May to 78. There were 11 Hospital & 5 Community serious incidents in April. Pressure Ulcers will be reported as Acute per 1000 bed days and Community per 10,000 CCG population and included in the next version for Trust Board.

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: There were 309 births n May.

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE 2018-2019

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no	Sleeping Accommodation Breaches	9	3	2	8	3	0	3	0	66	N
no..	HSMR (HED)	131.87	115.45	102.55					100.00		N
no..	SHMI (HED)	127.25							100.00		BP
no	Number of Deaths in Hospital	137	139	112	113	90	78	168		1166	BP
%..	% of patients who achieve their chosen place of death	46.30%	63.04%	57.78%	57.69%	54.05%	58.93%	56.99%			
no	MRSA - No. of Cases	0	0	0	0	1	0	1	0	0	N
no	Clostridium Difficile - No. of cases	4	0	0	0	3	2	5	17	11	N
%..	% of patients screened for Sepsis (IP & ED) (CQUIN quarterly audit)	95.00%	92.00%	95.16%	95.74%				90.00%	93.82%	
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired Avoidable per 1,000 beddays					0.84					
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired Avoidable per 10,000 CCG Population					0.03					
no	Pressure Ulcers - (category 2, 3 & 4's) - Hospital	11	15	17	20	27	20	47			
no	Pressure Ulcers - (category 2, 3 & 4's) - Community	9	17	14	14	14	14	28			
no	Falls - Total reported	95	88	83	95	89	85	174		1026	BP
no..	Falls - Rate per 1000 Beddays	5.79	5.11	5.10	5.64	5.32	5.62		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	1	1	0	0	4	0	4	0	8	BP
no	Falls - Avoidable Falls resulting in severe harm or injury	1	1	0	0						BP
no	Falls - Unavoidable Falls resulting in severe harm or injury	0	0	0	0						BP
%..	VTE Risk Assessment	93.45%	91.30%	93.18%	95.49%	96.34%	96.28%	96.31%	95.00%	88.49%	N
no	National Never Events	0	0	0	1	0	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	9	9	13	12	14	11	25		123	L
no	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	4	8	4	5	8	5	13		77	L
no	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	28	22	24	18	28	27	55		262	L
no	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	2	16	4	8	6	6	12		89	L
%..	% of incidents resulting in moderate, severe harm or death as a % of total incidents	3.09%	3.31%	2.89%	2.33%	3.17%	3.07%	3.12%		2.78%	L

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE 2018-2019

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
%..	Deteriorating patients: Percentage of observations rechecked within time	88.19%	88.72%	90.27%	90.52%	91.20%	93.46%	92.30%	85.00%		
%..	Medication Storage Compliance (one month in arrears)	93.00%	89.00%	89.00%	91.00%						
%..	Controlled Drug Compliance (quarterly audit)	78.00%			71.00%						
%..	% of Pharmacy Interventions made based on charts reviewed	26.56%	22.62%	22.49%	13.00%	14.00%	12.00%				
%..	Trust-wide Safety Index - % of medication incidents resulting in harm (one month in arrears)	34.48%	30.59%	20.00%	17.54%	20.75%		20.75%	12.00%		BP
no	No. of reported medication incidents level 3, 4 or 5 (reported one month in arrears)	5	1	1	3	1		1	0		
no..	Midwife to Birth Ratio	1:25.4	1:24.8	1:22.4	1:26.3	1:29.8	1:29.2		1:28	1:26.3	N
%..	One to One Care in Established Labour	98.91%	98.98%	99.43%	99.48%	99.06%	100.00%	99.54%	100.00%		N
%..	C-Section Rates	33.09%	27.34%	26.61%	31.80%	27.06%	27.12%	27.09%	30.00%		
%..	Instrumental Delivery	8.93%	14.36%	9.09%	10.03%	9.48%	8.09%	8.78%	10.00%		
%..	Induction of Labour	33.45%	32.01%	31.85%	30.39%	32.01%	32.68%	32.35%			
%..	NHS Safety Thermometer - Maternity - Women's Perception of Safety	91.30%	82.60%	100.00%	94.30%	100.00%	100.00%		92.00%		
%..	NHS Safety Thermometer - % Harm Free	97.12%	95.29%	95.70%	94.75%	95.93%	94.21%		94.00%		BP
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	11.44%	10.44%	10.18%	10.26%	11.27%		11.27%	10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	89.73%	91.63%	91.84%	89.51%	83.45%	92.29%	87.81%	100.00%	89.33%	N/L
%..	Dementia Screening 75+ (Hospital) (Internal audit Dec17 onwards)	80.79%	79.55%	72.12%	78.26%	66.22%		66.22%	90.00%		N
%..	Compliance with MCA 2 Stage Tracking		71.00%	77.00%	77.00%	55.00%	81.00%		100.00%		
no	Complaints - Total Received	13	24	23	33	26	32	58		291	BP
%..	Complaints - Percentage responded to within the agreed timescales	100.00%	100.00%	100.00%	90.32%	87.50%	93.55%	91.49%	70.00%		BP
no	Clinical Claims (New claims received by Organisation)	10	10	14	8	9	19	28		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	9.78%	9.96%	9.20%	9.13%	9.79%					
%..	Friends and Family Test - Inpatient (% Recommended)	91.00%	93.00%	97.00%	94.00%	96.00%	95.00%		96.00%		N
%..	Friends and Family Test - Outpatient (% Recommended)	91.00%	91.00%	91.00%	92.00%	92.00%	92.00%		96.00%		N
%..	Friends and Family Test - ED (% Recommended)	77.00%	75.00%	79.00%	76.00%	79.00%	76.00%		85.00%		N
%..	Friends and Family Test - Community (% Recommended)	99.00%	97.00%	99.00%	97.00%	97.00%	98.00%		97.00%		N

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE 2018-2019

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
%..	Friends and Family Test - Maternity - Antenatal (% Recommended)	80.00%	97.00%	0.00%	81.00%	90.00%	91.00%		95.00%		N
%..	Friends and Family Test - Maternity - Birth (% Recommended)	83.00%	100.00%	100.00%	100.00%	100.00%	90.00%		96.00%		N
%..	Friends and Family Test - Maternity - Postnatal (% Recommended)	85.00%	97.00%	100.00%	96.00%	97.00%	91.00%		92.00%		N
%..	Friends and Family Test - Maternity - Postnatal Community (% Recommended)	100.00%	99.00%	100.00%	98.00%	100.00%	94.00%		97.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	99.61%	98.84%	98.80%	96.56%	98.59%	98.29%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	63.93%	69.07%	70.90%	75.97%	76.07%	77.51%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	96.73%	95.51%	93.10%	93.86%	94.14%	93.35%		95.00%		
%..	Adult Safeguarding Training - Level 2 Compliance	59.50%	63.80%	66.37%	70.09%	74.57%	79.13%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	62.05%	71.85%	74.09%	77.64%	78.06%	80.55%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	98.85%	96.28%	94.06%	92.12%	91.61%	92.00%		95.00%		
%..	Children's Safeguarding Training - Level 2 Compliance	73.16%	74.03%	73.84%	73.25%	75.49%	76.74%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	66.32%	68.87%	67.48%	71.07%	73.72%	87.10%		85.00%		L
	RESOURCES										
no	Total Births	280	280	253	289	306	309	615		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: Six of the seven national cancer measures continued to achieve in April and provisional figures for May show achievement of all seven.

PERFORMANCE NOT ACHIEVED: The ED 4 hour performance continued to improve to 89.7%. ED median waiting time also improved in May. The number of delayed ambulance handovers totalled 42 compared to 43 in April. Within this the number delayed by more than 1 hour increased to 5 from 1. Incomplete 18 weeks RTT for April improved further to 88.33%. The number of open contract notices remains at 7.

TO NOTE: For April's validated 62 day cancer target results, we have been unable to calculate the impact of applying the national cancer breach allocation guidance for tertiary referrals as the new national system has not been sufficiently developed to capture the Inter Provider Transfer data. The National Service Desk have estimated this issue may be fixed by 5th July. 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.

PERFORMANCE NOT ACHIEVED : ED reattenders within 7 days failed to achieve the internal target of no more that 7% recording a result of 7.68%.

NONE APPLICABLE.
There are no specific Value Colleagues metrics identified for inclusion within the dashboard for this committee.

PERFORMANCE ACHIEVED – OF NOTE:

PERFORMANCE NOT ACHIEVED: DNA Rates for Acute and Community increased to 11.03% from 10.47% in April. Average length of stay improved however failed to achieve the 7.01 target reporting 7.22 days. DTOC did not achieve but has shown an improvement compared to the previous month. The average number of medically fit patients throughout the month; based on a weekly snapshot average, was 87 which exceeds the target of 80.

FINANCE: Please refer to Finance report. Month one results have been refreshed.

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-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)	83.38%	82.68%	82.81%	81.23%	87.22%	89.70%	88.51%	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)	179	181	178	187	167	152		120		
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	58.42%	59.73%	71.31%	70.36%	80.95%	80.65%	80.80%	85.00%	65.80%	BP
no	Ambulance Handover - No. of Handovers completed between 30-60mins	246	259	108	144	42	37	79	0	1836	N
no	Ambulance Handover - No. of Handovers completed over 60mins	35	37	21	9	1	5	6	0	236	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	97.42%	95.16%	96.61%	97.90%	93.45%	93.55%	93.51%	93.00%	95.45%	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	100.00%	94.12%	96.55%	100.00%	94.00%	94.03%	94.02%	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%	98.82%	100.00%	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%	90.91%	95.00%	90.00%	98.03%	N
%..	Cancer - 62 day referral to treatment of all cancers	90.12%	87.36%	85.71%	87.69%	83.33%	85.39%	84.24%	85.00%	88.05%	N
%..	Cancer - 62 day referral to treatment from consultant upgrade	85.71%	90.91%	79.52%	86.89%	92.54%	85.48%	89.15%	85.00%	86.20%	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	80.99%	82.48%	83.69%	84.74%	85.89%	88.33%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	1	1	0	0	0	0	0	0		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Admitted	0	1	0	1	1	0	1	0		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Not Admitted	0	0	1	0	0	1	1	0		N
%..	Diagnostic Waits - % waiting under 6 weeks	99.15%	99.54%	99.66%	98.06%	99.05%	99.57%	99.30%	99.00%	99.06%	N
%..	Elective Cancellations - No. of last minute cancellations on day of operation or after patient admission	0.51%	0.19%	0.35%	0.39%	0.09%	0.35%	0.23%	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)	248	326	225	258	212					

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
%..	% of RN staffing Vacancies	9.78%	9.96%	9.20%	9.13%	9.79%					
no	No. of Open Contract Performance Notices	6	6	6	7	7	7		0	7	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	7.00%	6.71%	6.18%	6.87%	6.80%	7.68%	7.26%	7.00%	6.76%	BP
	RESOURCES										
%..	Booking Utilisation (booked as a percentage of capacity)	91.14%	90.13%	90.41%	92.87%	93.17%	94.97%	94.12%	90.00%	89.90%	L
%..	Outpatient DNA Rate (Hospital and Community)	14.36%	12.11%	11.27%	10.73%	10.47%	11.03%	10.47%	8.00%	12.16%	
no..	New to follow up ratio - WHT	2.03	2.04	2.01	2.04	2.09	1.88		2.14	1.99	BP
%..	Theatre Utilisation - Touch Time Utilisation (%)	66.31%	58.16%	63.60%	70.73%	80.91%	83.76%		75.00%		
no..	Length of Stay	7.51	7.50	7.59	7.59	8.24	7.22	7.72	7.01	7.22	BP
%..	Delayed transfers of care (one month in arrears)	2.16%	3.11%	3.44%	3.63%	2.97%		2.97%	2.50%	2.56%	L
no	Average Number of Medically Fit Patients					98	87		80		0
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only					21	26				0
no	Average Number of Medically Fit Patients - Trust					49	42				0
no..	Average LoS for Medically Fit Patients (from point they become Medically Fit)					8.61	10.57		5		0
no	Hospital beds open at month end	483	532	514	519	488	470				L
%..	Day case rates	88.82%	90.32%	88.44%	86.78%	88.31%	90.25%	89.36%		88.14%	BP
%..	Bank & Locum expenditure as % of Paybill	8.53%	7.29%	7.42%	10.31%	7.93%		7.93%	6.30%	7.67%	L
%..	Agency expenditure as % of Paybill	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)	-£20,342	-£20,395	-£23,257	-£23,267	-£2,386	-£4,509	-£4,509		-£23,267	L
£	Variance from plan (year to date) (000's)	-£3,991	-£3,622	-£4,238	-£2,511	-£2,483	-£186	-£186		-£2,511	L
£	CIP (£) (000's)	£6,620	£7,213	£7,826	£10,900	£168	£1,080	£1,080		£10,900	L
%..	CIP % delivered (year to date)	71.00%	72.30%	74.80%	99.10%	6.90%	11.00%	11.00%	100.00%	99.10%	L
£	Income variance from plan (year to date) (000's)	£464	£640	-£927	-£2,306	£236	£106	£106	£0	-£2,306	L
£	Expenditure - Variance from Plan (year to date) (000's)	£4,271	£3,991	-£3,389	-£222	-£154	-£331	-£331	£0	-£222	L
£	Cash Against Plan (variance) (000's)	£526	£73	£121	£128	£1,004	£1,280	£1,280		£128	L
£	Capital spend YTD (000's)	£5,663	£6,674	£7,438	£9,662	£506	£1,100	£1,100		£9,662	L

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-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)	6419	8730	8712	9073	8750		8750			BP
no	Total Elective Activity (Contracted)	218	250	250	322	284	277	561		3725	L
no	Total Non Elective Activity (Contracted)	138	61	62	39	31	80	111		578	L
no	Total Outpatient attendances (Contracted)	15371	15932	18388	20094	19133	21485	40618		230583	L
no	Total Day Case Activity (Contracted)	1500	2089	1812	1847	1776	2124	3900		22253	L
no	Total Emergencies Activity (Contracted)	2689	2815	2551	2682	2462	2554	5016		31847	L
no	Total ED Attendances Type 1 Pbr (Excl Badger) (Contracted)	6577	6551	5984	6606	6193	6611	12804		74003	L
no	Total AHP Activity (Contracted)	1337	1811	1866	1799	1665	1799	3464		21600	L
no	Total Critical Care Days (Contracted)	1232	990	895	829	1008	918	1926		11242	L
no	Total Unbundled Chemo Delivery Activity (Contracted)	241	323	318	353	341	361	702		3975	L
no	Total Maternity Pathway	720	881	766	801	1041	789	1830		11712	L
no	Total Community Contacts (Contracted)	13823	23589	27787	27787	29198	29926	59345		361113	L
no	Total Births	280	280	253	289	306	309	615		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

PERFORMANCE ACHIEVED – OF NOTE: Children's safeguarding training level 3 compliance exceeded the 85% target.
PERFORMANCE NOT ACHIEVED Mandatory training reported 78.76% compliance against a target of 90%. Six of the Safeguarding metrics failed to achieve in May. Trajectories to achieve by the end of Quarter One have been established.

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 further from 5.06% in April to 4.71% in May. PDR's compliance improved in May to 82.42% .

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

Walsall Healthcare NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 2018-2019

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	% of RN staffing Vacancies	9.78%	9.96%	9.20%	9.13%	9.79%					
%..	Mandatory Training Compliance	79.65%	78.14%	77.61%	76.61%	76.99%	78.76%	78.76%	90.00%	76.61%	L
%..	PREVENT Training - Level 1 & 2 Compliance	99.61%	98.84%	98.80%	96.56%	98.59%	98.29%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	63.93%	69.07%	70.90%	75.97%	76.07%	77.51%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	96.73%	95.51%	93.10%	93.86%	94.14%	93.35%		95.00%		
%..	Adult Safeguarding Training - Level 2 Compliance	59.50%	63.80%	66.37%	70.09%	74.57%	79.13%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	62.05%	71.85%	74.09%	77.64%	78.06%	80.55%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	98.85%	96.28%	94.06%	92.12%	91.61%	92.00%		95.00%		
%..	Children's Safeguarding Training - Level 2 Compliance	73.16%	74.03%	73.84%	73.25%	75.49%	76.74%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	66.32%	68.87%	67.48%	71.07%	73.72%	87.10%		85.00%		L
	VALUE COLLEAGUES										
%..	Sickness Absence	5.81%	6.23%	5.00%	5.65%	5.06%	4.71%	4.86%	3.39%	5.30%	L
%..	PDRs	75.90%	78.24%	79.47%	78.17%	80.55%	82.42%	82.42%	90.00%	78.17%	L
	RESOURCES										
%..	Bank & Locum expenditure as % of Paybill	8.53%	7.29%	7.42%	10.31%	7.93%		7.93%	6.30%	7.67%	L
%..	Agency expenditure as % of Paybill	4.69%	5.39%	4.51%	3.68%	5.15%		5.15%	2.75%	4.32%	L
no	Staff in post (Budgeted Establishment FTE)	4100	4100	4116	4095	4125		4125			L
%..	Turnover	8.93%	8.77%	8.89%	9.13%	9.83%	9.92%	9.92%	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	May-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%	85.00%	89.70%	88.51%	▲	
Ambulance Handover - Percentage of handovers completed within 15mins of arrival	85.00%		80.65%	80.80%	▼	

What is driving the reported underperformance?

ED Overall		Mar-18	Apr-18	May-18
Type 1 Attenders		6607	6193	6688
Type 3 Attenders		3271	3323	3671
WiC Attenders		3358	3329	3545
Breaches (Type 1)		2471	1640	1423
Trolley Waits >12Hours		0	0	0
Median Wait		187	167	152
Ambulance Handover (WMAS)	<15mins	1956	2090	2176
	15-30	671	449	480
	30-60	144	42	37
	>60	9	1	5
	No Time	68	31	61
	Total	2848	2613	2759
ED Reattenders		6.87%	6.80%	7.68%

- Average attendances per day were 216 compared to 206 (Apr)
- Average breaches per day were 46 compared to 55 (Apr)
- Average number of ambulances to ED per day was 89, compared to 87 (Apr).
- There were over 90 ambulance arrivals to ED on 17 days during the month, an increase compared to April (14) and 6 days where the Trust saw over a 100 ambulances to ED which is an increase compared to April (1).

Benchmarking

ED 4 Hour - (May 2018) - National position = 80/133 Trusts & Regional position = 7/14 Trusts.

Ambulance - (May 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 May 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 May a fine of £12,400 will be incurred.

What actions have we taken to improve performance?

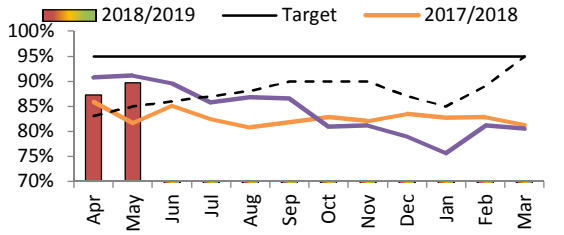
New Actions:

- Improvement Groups are now established and have been meeting as a minimum bi-weekly over the last 2 months. The 5 workstreams place are: ED & Acute, Frailty, Escalation Process, Ward Processes and Stranded Patients. The clinical leads for each of these streams are meeting weekly with the Divisional Team of Three to measure and monitor success.
- The Frailty Group have implemented a new Frailty Tool to increase the number of patients that are same day discharge from ED. Metrics to measure success have been put in place.
- The Lead for developing ward processes has carried out an audit across all MLTC wards to monitor standards for SAFER board and ward rounds. Communication for standards have been developed and are in place on all wards and KPIs set. Ongoing checks and audits are in place to monitor.
- The Emergency & Acute Group have implemented a new handover process within the Care Group. AMU huddles occur twice daily and aim to reduce the delays with patient handovers and encourage real time patient transfers being planned.
- ED have commenced trialling a new area for rapid assessment and treatment. A rota is in place for MDT early assessment and metrics are being monitored.
- Standards for escalation for services has been agreed and are in place on wards. The standards list local agreements from services and process for escalate when they are not met.
- A new process for stranded patients is in place for all specialities. Expectations for LoS reviews are in place.

Continuing Actions:

- Ward Managers continue to attend Capacity Meetings throughout the day with the newly established Discharge Plans that are produced.
- 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 th Medically Fit lists and continue to remove and reduce delays to discharge and Multi Disciplinary Meetings continue to manage Frequent Attenders coming to ED.

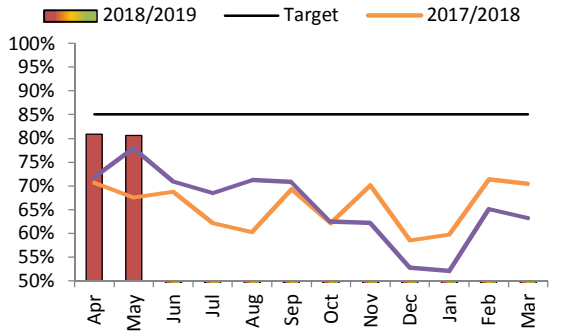
Contractual Financial Penalties (LCA)	YTD £	
	ED	£0
	Amb	£12,400



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 ED Reattenders - June 2018
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Cancer 62 Day Referral to Treatment of all Cancers	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
	85.00%		83.47%	83.47%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £	£0

Performance results (Validated April 2018):

Performance of 83.47% in April is a decline compared to 87.69% in March and does not achieve the target of 85%. This is the first month where we did not achieve the target since May 2016.

- Haematology 1 patient - 1.0 breach (multiple MDT meetings).
- Head & Neck: 2 patients - 1.0 breach. Shared breach with University Hospitals Birmingham NHS Foundation Trust (complex pathway) and The Royal Wolverhampton NHS Trust (delay in investigations).
- Lower GI: 3 patients - 2.5 breaches. Shared breach The Royal Wolverhampton NHS Trust (multiple MDTs, multiple investigations & complex pathway).
- Upper GI: 2 patients - 1.5 breaches. Shared breach The Royal Wolverhampton NHS Trust (delay in treatment & multiple MDTs).
- Urology: 4 patients - 3.5 breaches. Shared breach The Royal Wolverhampton NHS Trust (multiple MDTs, multiple investigations & delay in investigations).

The Trust failed to achieve the 85% target by one breach. Summary breakdown of breaches is:
Complex cases = 3.5
Tertiary centres = 3.5
Histology = 1.5
Capacity at Walsall = 1

This was forecast at the last EAPG and members were informed.

Benchmarking:

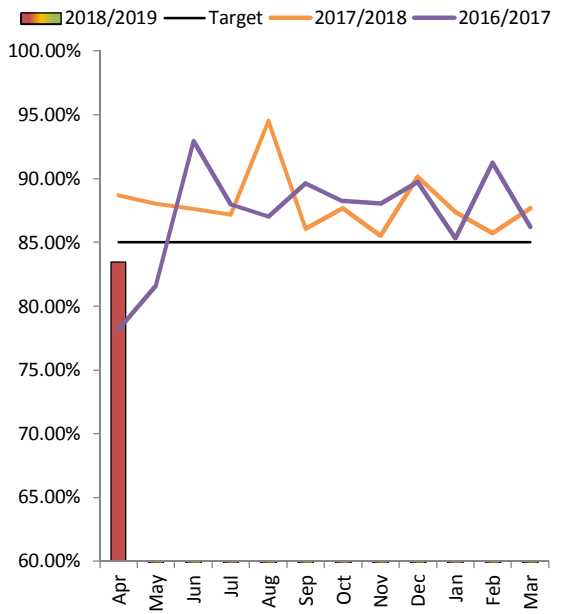
For Quarter Four 17/18, the Trust ranked 38th nationally out of 133 and 2nd out of 14 regionally.

New Actions:

.As the Trust narrowly missed achieving the target by one breach this was not considered a significant issue, the unvalidated results for May show achievement of the target.

Continuing Actions:

- Cancer trackers continue to review and escalate issues for patients daily across all sites.
- Weekly Urology Access Meeting continues. This is chaired by Cancer Services Manager and is well attended by Clinical Teams
- NHS I report produced weekly & reviewed against cancer PTL.
- Delays of 104 days or more, patients are being tracked on a daily basis, with an escalation process throughout the week; trackers are checking, chasing letters and discharge summaries. - All 62 cancer breaches are escalated to the Clinical Harm Group.



Trajectory 2017/18					
Apr	May	Jun	Jul	Aug	Sept
Oct	Nov	Dec	Jan	Feb	Mar

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

National Contract	X	Local Contract		Best Practice		CQUIN	

Walsall Healthcare NHS Trust

18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
	92.00%	84.20%	85.89%		▲	

What is driving the reported underperformance?

Performance results (Validated April 2018)

The Trust achieved 85.89%, which is a further improvement compared to 84.74% in March, and is also ahead of the recovery trajectory of 84.20%. The number of patients waiting over 18 weeks has reduced again by 168 compared to March.

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

		Feb-18	Mar-18	Apr-18
PTL Size		14755	14693	14695
No. over 18 Weeks		2407	2242	2074
No. over 52 Weeks		0	0	0
Clock Stops	Total	5749	5977	5730
	Admitted	906	893	868
	Not Admitted	4843	5084	4862
Specialties achieving 92%		7	8	9

Performance of Divisions (target 92%):
- MLTC achieved 87.51% compared to 86.80% in March.
- Surgery achieved 82.94% compared to 81.24% in March.
- WCCSS achieved 95.73% compared to 96.09% in March.

Benchmarking:

For April, the Trust ranked 85th out of 128 Acute Trusts nationally who submitted information and 9th out of 14 Trusts regionally. 78 Acute Trusts reported breaches of over 52 week waits in April.

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 lettering process completed. This has shown a variable contact rate by patients across specialities, with up to 19%. The remaining pre 2017 access plans are being managed by a combination of manual validation and development of automatic re-outcoming of clinic appointments to enable closure of the access plan. Scoping is underway to look at 2017 access plans and create an on going data quality function that can be automated using robotics.
- Validators continue to work on duplicate and 'attended' status access plans. Work is underway to develop a single point of access and processing for appointments. This would have a significant impact on data quality.
- ERS rollout for new appointment bookings has made good progress over the last 6 months. Electronic bookings will reduce duplicate referrals and support improved data quality.

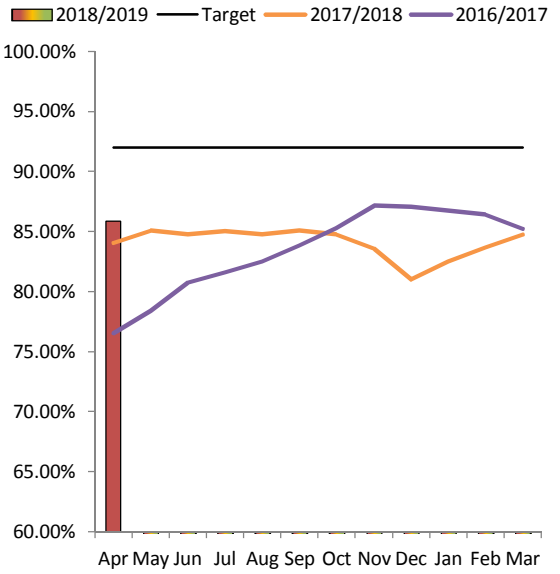
Capacity Improvements:

- WLI clinics in place to support cancer delivery and long waiters in RTT.
- Partial booking for follow up patients continues to be rolled out. It is anticipated this will reduce cancellation and DNA numbers. Focus continues on reducing DNA and cancellations rates. Booking utilisation has shown improvement, but DNA rates and cancellations pull down the attendance utilisation across all divisions.

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 £** £312,600



Proposed Trajectory

Apr	May	Jun	Jul	Aug	Sept
84.20%	84.80%	85.50%	86.30%	85.50%	85.90%
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
86.20%	86.20%	86.20%	87.00%	88.20%	89.10%

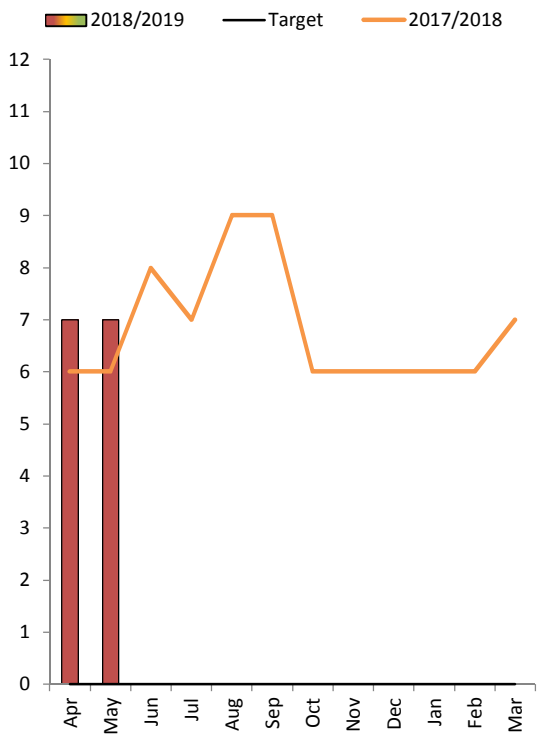
Expected date to meet standard	Achieve trajectory 84.2% for April.
Lead Director	Chief Operating Officer

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

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties for numbers open - applied to individual performance areas.	YTD £
As at 31st May 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	May-18	YTD	Change on last month	Year End Forecast
Outpatient DNA Rates	8.00%	9.00%	11.03%	10.77%	▼	
Booking Utilisation (booked as a percentage of capacity)	90.00%		94.97%	94.12%	▲	

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 11.03%.
Divisional performance is as below:-
MLTC - 11.74% (May) (compared to 10.51% in Apr)
SURG - 9.92% (May) (compared to 8.87% in Apr)
WCCSS - 11.70% (May) (compared to 12.10% in Apr)

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 - 97.46% (May) (compared to 96.61% in Apr)
SURG - 93.43% (May) (compared to 93.16% in Apr)
WCCSS - 95.96% (May) (compared to 90.54% in Apr)

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:-

- Text/voice reminder systems in place. Divisional and Central teams validating long waiters and acting as reminder calling in addition to text reminder service.

- Partial booking roll out continues, with two more services coming on board In May.

- Call Centre software has go live date in June. This will enable tracking of call abandonment rate vs DNA levels.

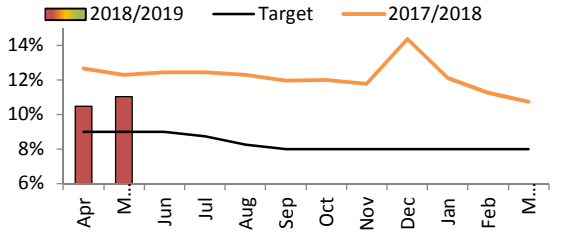
- A standard report is in place to enable Care Groups to interrogate DNA rates, drilling down to booking methods and previous cancellations.

- 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. This will be complete in July 2018.

- Trust has started to receive electronic referrals for dental services, this went live in April.

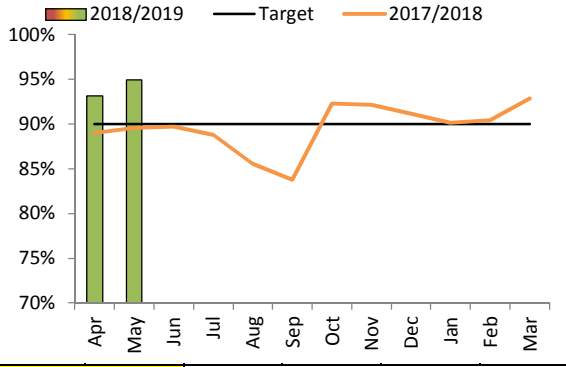
- This metric is covered within the Outpatients Improvement Programme, the Executive Lead is the Chief Operating Officer and the Operational Lead is the Corporate Director.



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	May-18	YTD	Change on last month	Year End Forecast
	7.01		7.22	7.72	▲	

What is driving the reported underperformance?

Performance results:

Overall performance for LoS in May was 7.22 days. This is a signficant improvement compared to 8.24 days reported in April. 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 Apr	Ave LoS May	% LoS <72hr	% LoS of "0"
MLTC	9.99	8.32	55.09%	26.55%
SURG	6.16	6.14	67.03%	27.16%
WCCSS	3.21	3.71	92.42%	65.66%

The average LoS for Medicine and Long Term Conditions and Division of Surgery improved during May compared to April. Women's, Children's and Clinical Support Services LoS slightly declined in May however their length of stay remains relatively low overall.

Benchmarking:

No formal national reports.

Contractual status:

No contractual requirements apply.

What actions have we taken to improve performance?

New Actions:-

• The Emergency Care Improvement Team is working with the Trust on a range of areas; focusing on LOS reduction.

• The Patient Flow group continues to meet and develop new actions as outlined above.

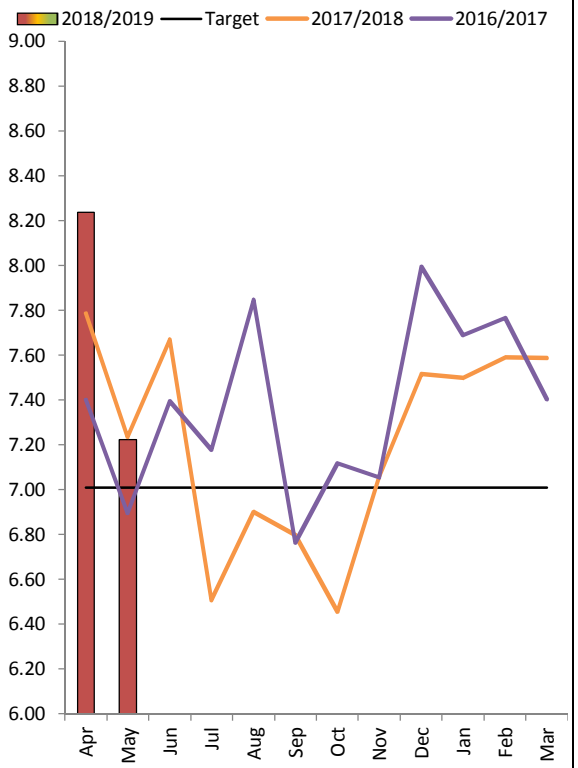
• One works stream is focused on ward processes, namely: twice daily multidisciplinary board rounds, review of the 'sick & quick' patients; discharge planned for next day; use of discharge lounge in the morning.

• There is a weekly review on the acute medical wards of the strande patients (any patient over 7 days LOS).

• Involvement of discharge teams in the board rounds. 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	

	Year Standard	Monthly Trajectory	Apr-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%		2.97%	2.97%	▲	

What is driving the reported underperformance?

DTOC Performance results: Reported one month in arrears

The national definition for DTOC is when a patient is ready to depart from care but is still occupying a bed. To be considered ready to depart the patient must have; a clinical decision that they are ready f transfer, a MDT decision has been made that the patient is ready for transfer and it is safe.

The national 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. DTOC is therefore more accurately reported.

The target of 2.50% or below attributable to delays as a total of available bed days was not achieved in April with performance of 2.97%. This is an improvement in performance compared to 3.63% reported in March.

MFFD Performance results:

Internal metric: Medically Fit For Discharge are patients who have ha a clinical decision made that they are ready to be transferred. These patients have not had the MDT decison and therefore are not counted as DTOC.

Four new metrics have been introduced within this report; all are taken from weekly snapshots each Thursday:

- The average number of medically fit patients; includes out of area
- The average number of medically fit patients awaiting social care only
- The average number of medically fit patients awaiting social care and health.
- Average LoS for medically fit patients; including out of area

DTOC Benchmarking:

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

Latest benchmarking shows, 390 bed days were impacted in April 2018 from delayed transfers taken at the snapshot position. This ranks the Trust 41st out of 133 Trusts nationally and 4th out of 14 Trusts regionally.

What actions have we taken to improve performance?

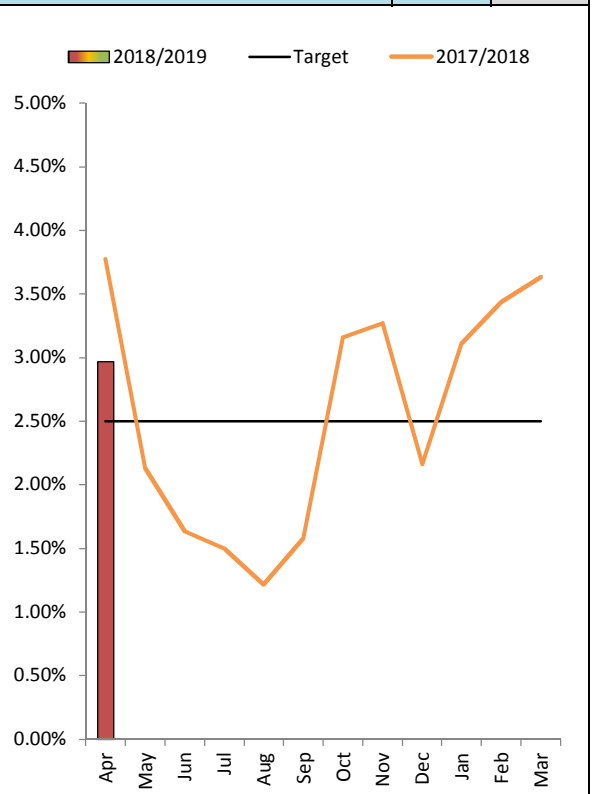
Continuing actions:

- 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.

No Contractual Financial Penalties | **YTD £**



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

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.

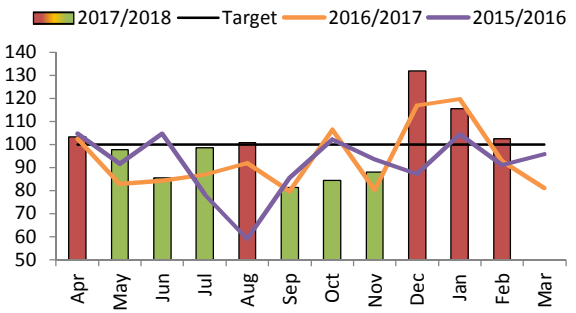
SHMI Benchmarking Based on NHS Digital Data:
SHMI published by the NHS Digital has been released for the period from April 2016 to March 2017 which shows a SHMI rate of 1.06. This ranks the Trust 92nd nationally and 8th regionally.

Contractual status:
No contractual requirements apply.

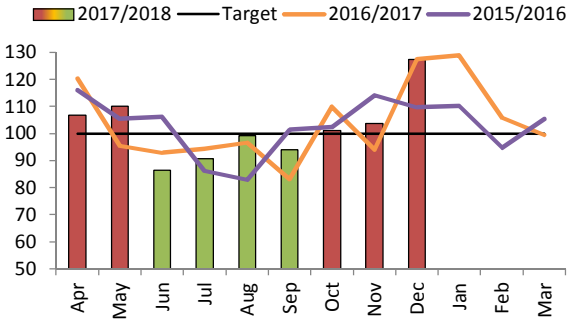
New actions:
- A review of deaths recorded in Feb/March is to be undertaken with the results to be shared in June.
- Align the actions to address poor documentation to the CQC PCIP work relating to documentation.
- Ensure mortality reviews are a standing agenda item at care group quality meetings and 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	May-18	YTD	Change on last month	Year End Forecast
CDiff - Total number of cases of Clostridium Difficile recorded in the Trust	17	2	2	5	▲	
MRSA - total number of cases of MRSA recorded in the Trust	0		0	1	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £	CDiff	
				MRSA	£10,000

Performance results:

CDiff:

There were 2 reported cases of C.Difficile attributed to Walsall Healthcare NHS Trust during May 2018 against a trajectory of 2. The cases were reported on Acute Surgical Unit (ASU).

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

Benchmarking:

CDiff:

Data published one month in arrears by Health Protection England confirms that for April 2018, there were 3 cases of hospital attributable C.Difficile toxin at Walsall Healthcare. This compares to 4 cases at Dudley and 3 cases at Wolverhampton.

MRSA:

Data published one month in arrears shows there were no cases of MRSA recorded regionally for 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.

New actions:

CDiff - There were 2 C.Difficile cases reported in May 2018.
A serious incident for investigation of period of increased incidence of C.Diff toxin on ASU is in progress.
RCA's on both cases have been completed and were considered avoidable due to evidence of poor infection control practices.
Additional infection control support has been given on ASU
Results of Typing is awaited.
The Trust is currently above C.diff target trajectory financial year to date.

MRSA - There were no MRSA cases reported in May 2018.

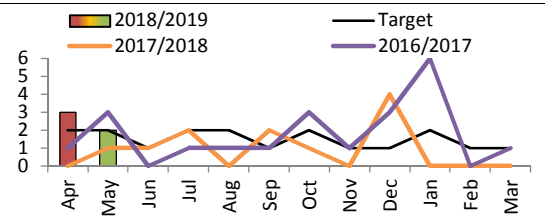
Deep cleans have been completed on ASU, and ward 9.
deep cleans on AMU and ward 2 planneed for June 2018

Continuing actions:

CDiff Joint monthly IPC audits continue
Weekly C.diff ward rounds continue
- 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.
All acute C.diff cases have a case review.

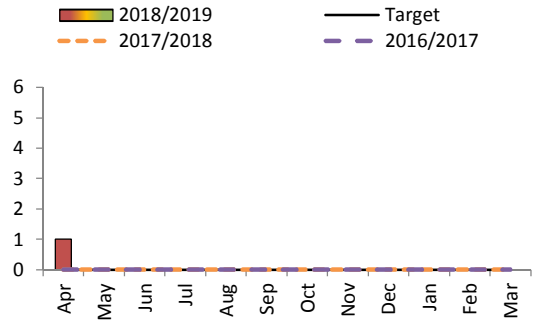
MRSA - improvement work for care of peripheral vascular devices continues throughout the Trust.
- Work continues with the Continence and Urology services to improve the care of urinary catheters. This will be monitored via the NHS Safety Thermometer.
- The Infection Control nurses continue to follow up all positive MRSA results and re-screen at 28 days post admission.
IPCT continue to provide ward education and support where audits have shown deficits in practice.

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	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Pressure Ulcers - (category 2, 3 & 4's) - Avoidable per 1000 beddays	Year Standard	Monthly Trajectory	Mar-18	YTD	Change on last month	Year End Forecast
Figures based on all avoidable pressure ulcers acquired within the Trust			0.48		▲	

What is driving the reported underperformance?

Performance results:

Figures have been updated to reflect the outcomes of RCAs, it is usually expected that these are completed within 60 days of reporting and therefore greater reliance can be placed upon the earlier months results

		Hospital		Community	
		Total	*Avoid*	Total	*Avoid*
Mar-18	Cat 2	16	*4*	8	*0*
	Cat 3	0	*0*	0	*0*
	Cat 4	0	*0*	0	*0*
	Unstage	4	*0*	6	*4*
*Apr-18	Cat 2	19	*7*	6	*0*
	Cat 3	2	*1*	1	*0*
	Cat 4	0	*0*	0	*0*
	Unstage	6	*3*	7	*1*
*May-18	Cat 2	16	*2*	9	*1*
	Cat 3	1	*0*	1	*0*
	Cat 4	0	*0*	0	*0*
	Unstage	3	*0*	4	*0*

Rate per 1000 Beddays					
Mar-18	0.48	*Apr-18	0.72	*May-18	0.20

*Figures for these months are still being validated - please note there are X PU's for March still awaiting final validation but initial discussions have already taken place with the wards involved.
There were 34 PU related incidents reported in March.
The highest reported area of prevalence continues to be on patients heels. There have been 8 incidents confirmed as avoidable in March.

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 avoidable 3/4 & unstageable:

All community incidents related to upgrade of equipment it seems du to increasing demand of high specification air mattresses. This has been communicated to equipment provider and records will be kept to monitor the situation.

Education

Short education sessions are being provided to ward staff in response to action plans following investigations. Short sessions are planned for ward 15 and AMU. 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, draft version has been developed for non registered nurses.

Equipment

The use of air mattresses across the hospital site has reduced but still higher use than necessary has been witnesses. It appears staff are still unclear of the correct process to condemn foam mattresses with new mattresses left on corridors to be condemned and when checked they require cleaning only (at least 8 in past month). The company continue to provide support to embed process and provide education. A business case has been resubmitted for an equipment coordinator to support the processes

Policy

Wound care and Leg ulcer management policies have been revised and sent for comment.

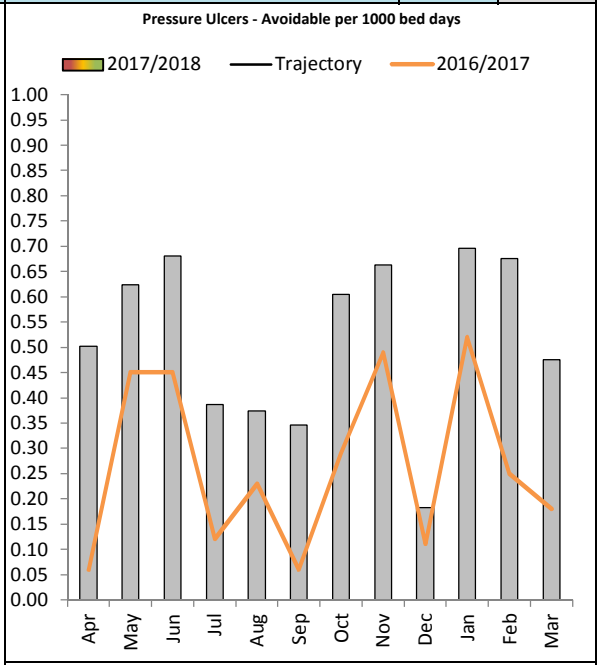
Patient information

Information leaflets have been ratified for wound care pressure ulcer prevention and leg ulcers. These leaflets, together with translated versions in top 3 languages are now available on the Tissue viability intranet page to print.

Wound Care Formulary Group

The wound care formulary group continue to meet monthly with good represention from both hospital and community staff to look at dressing products that will offer savings to the Trust without compromising the patient needs. The group is working with Black Country Alliance and making effort to improve the timeliness of

Contractual Financial Penalties | **YTD £**



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	May-18	YTD	Change on last month	Year End Forecast
Falls - Number of Falls reported			85	174	▲	
Falls - Rate per 1000 Bed Days	6.63		5.62		▼	

What is driving the reported underperformance?

Performance results:

There were 85 falls reported during May 2018, equating to a rate of 5.62 falls per 1000 beddays for the month which is a decline compared to 5.32 in April but still achieves the Trust target of 6.63.

Based on Calendar Month		Mar-18	Apr-18	May-18
Count of Falls	Total	95	89	85
	MLTC	80	72	72
	Surgery	14	15	11
	WCCSS	1	0	2
	Comm / Corporate	0	2	0
	Other	0	0	0
Rate per 1000 beddays - All Falls		5.64	5.32	5.62
Rate per 1000 beddays - Moderate & Severe Falls		0.00	0.24	0.07

There were 13 reported incidents of patients falling more than once in May which is less than in April (17). In total these patients had 25 falls. The highest no.of falls were reported on Ward 04 (16 falls), Ward 17 (7 falls), Ward 01 (7 falls), Ward 03 (6 falls) & Ward 07 (6 falls).

There was 1 fall resulting in moderate or severe harm (on Ward 20b - patient suffered injuries to head and arm).

NHS Safety Thermometer results for May show performance of 0.71% 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:

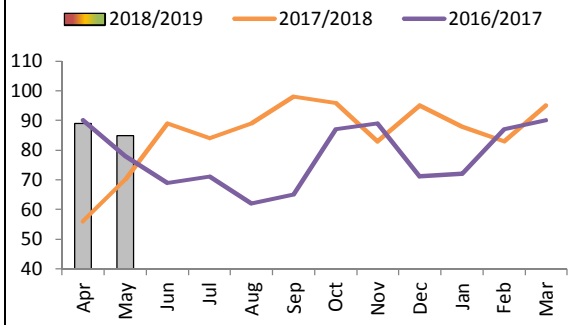
- Training programme continues with face to face training at ward level, this includes the use of bedrails. This training is evaluating well.

Continuing actions:

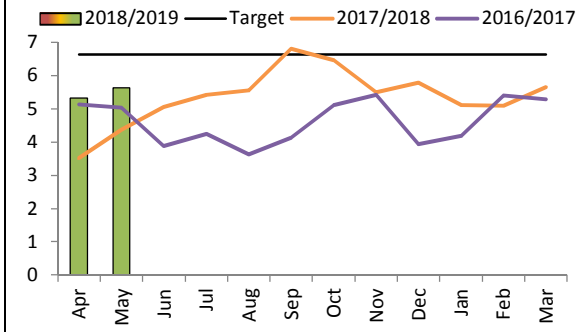
- Monthly falls audits continue.
- Falls dashboard is shared with all wards and is monitored via the ward review process.
- All incidents relating to falls are recorded within the Safeguard system.
– Moving and handling training includes Falls scenarios and includes completion of the falls and bedrail 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.
- Falls steering group continues with good representation across both community and acute trust. Terms of reference agreed.

No Contractual Financial Penalties | **YTD £**

Number of Falls reported



Rate per 1000 Bed Days



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

National Contract		Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Trust-wide Safety Index - % of Medication Incidents resulting in harm / potential harm	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
This measure relates to the number of medication errors reported each month and of those, how many resulted in harm / potential harm	12.00%		20.75%	20.75%	▼	

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

Performance results:

There were 53 validated medication error incidents reported in April 2018. The Trust's overall profile remains red as we currently exceed the regional and national averages. An internal target of 12% has been agreed to bring the Trust in line with the regional position.

Of the 53 incidents reported in April, 1 incident resulted in harm.

- 10 x low level 2
- 1 x moderate level 3
- 0 x severe level 4

The level 3 incident related to a patient requiring surgical interventon and admission to ITU. This incident did not arise in the Trust but in primary care and has been referred to Quality Concerns.

Benchmarking:

The most recent data published on NHS England website for percentage of harmful events is for April 2017 to September 2017. Walsall Healthcare NHS Trust performance for this period is 20.44% which is higher than the national figure of 11.21% and higher than the regional figure of 9.18%.

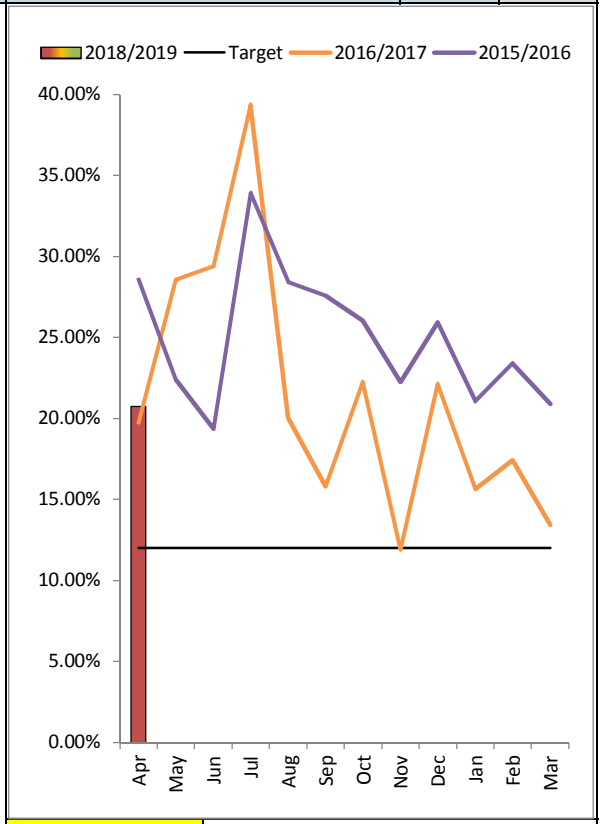
Contractual status:

No contractual requirements apply.

New actions:

- Medicines Safety Report has now been ratified at both MSG and MMC.

- Medicines Safety LiA action plan progressing satisfactorily; for example, pre-printed drug charts for Maternity and self-administration policy approved at MMC and DQT.



Expected date to meet standard	To be confirmed
Lead Director	Medical Director

National Contract		Local Contract		Best Practice	X	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	Apr-18	YTD	Change on last month	Year End Forecast
	10.00%		11.27%		▼	

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.
The performance for April was 11.27% which is a decline compared to 10.26% in March 2018 and doesn't achieve the internal target of 10%.

There were 564 emergency readmissions in April, of which, 44 were related to GAU cohort.

Of the patients who were re-admitted in April:-
- Approximately 25% of the readmissions were aged under 30 (an increase compared to 24% in March).
- Approximately 35% of the readmissions were aged over 70 (an increase compared to 33% in March).

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

For those patients discharged in the month who were an emergency readmission within 30 days, the average length of stay of the readmission was 4.3 which is a decrease compared to 4.8 in March.

Benchmarking:

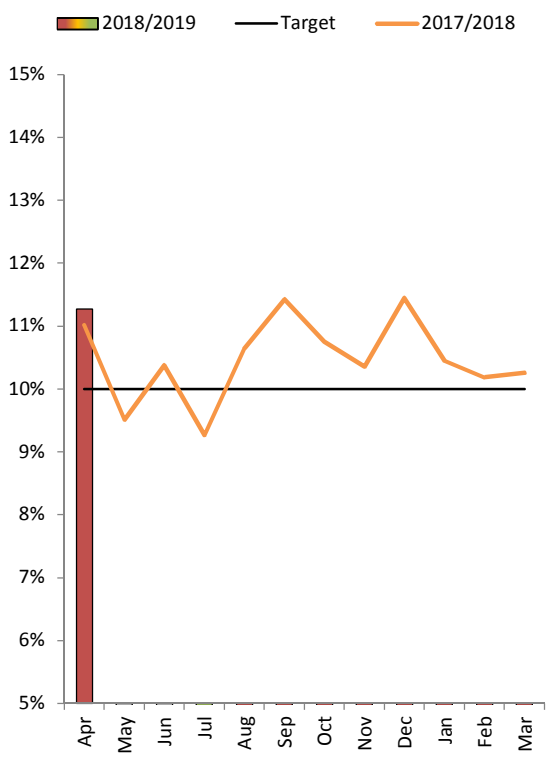
There are no formal national reports published for this metric.

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	May-18	YTD	Change on last month	Year End Forecast
Number of EDS completed within 48 hrs of the point of patient discharge	100.00%		92.29%	87.81%	▲	

What is driving the reported underperformance?	No Contractual Financial Penalties	YTD £

Performance results:

This indicator measures the percentage of EDS completed within 48 hours of the point of patient discharge. Performance has improved significantly in May to 92.29% compared to 83.45% in April but is below the locally agreed target of 95%.

Divisional performance for May 2018 was as follows:-
- Surgery: 89.61% (84.68% in April)
- MLTC: 94.17% (74.81% in April)
- WCCSS: 92.73% (92.80% in April)

Continuous education and training of staff has contributed to the improved performance.

Benchmarking:

No national or regional benchmarking available for this measure.

Contractual status:

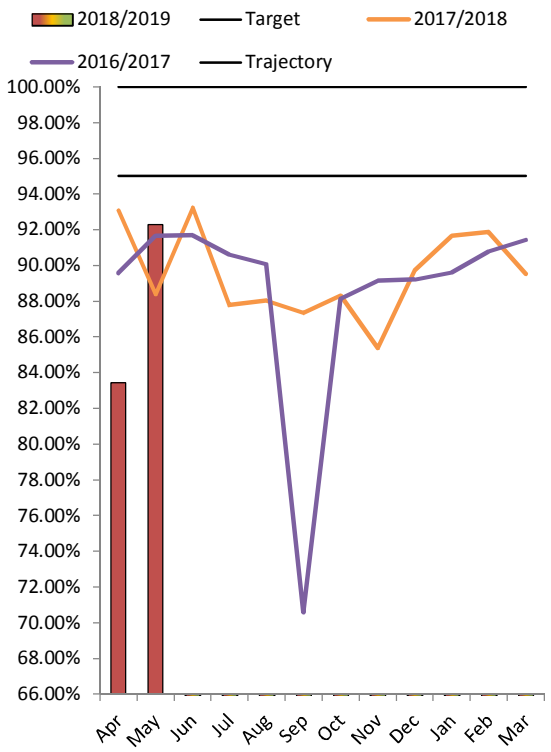
The NHS contract states when transferring or discharging a Service User from an inpatient or daycase or accident and emergency service, the Provider must within 24 hours following that transfer or discharge issue a Discharge Summary to the Service User's GP and/or Referrer and to any third party provider,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

Walsall Healthcare NHS Trust

Dementia Screening 75+ (Hospital)	Year Standard	Monthly Trajectory	Apr-18	YTD	Change on last month	Year End Forecast
	90.00%		66.22%	66.22%	▼	

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 2018/19 as a requirement of the standard contract for all acute Trusts. This data collection reports on the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours in England who have been identified as potentially having dementia, who are appropriately assessed and who are referred on to specialist service The target for all 3 requirements (screen, assess and refer) remains at 90%.

During April 2018 the Trust failed to achieve the 90% screening target for patients aged 75 years and over with performance of 66.22%. This is a decline compared to the reported result in March 2018 (78.26%).

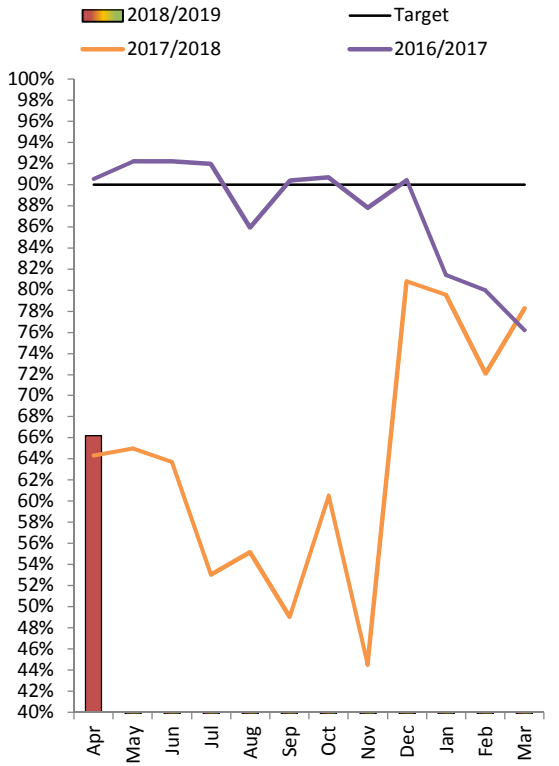
In agreement with WCCG and the Trusts executive lead, the reporting methodology has changed to utlising an audit approach rather than against the full cohort as it was not possible to capture the assessments for all applicable patients due to electronic system limitations.

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 December 2017 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 - ED (% Recommended) Friends & Family Test - Inpatient (% Recommended)	Year Standard	Monthly Trajectory	May-18	YTD	Change on last month	Year End Forecast
	85.00%		76.00%		▼	
	96.00%		95.00%		▼	

What is driving the reported underperformance?

Performance results:

This page relates to all of the areas covered by the Friends & Family measure.

Measure	Target	Apr	May
Inpatient	96%	96%	95%
Outpatient	96%	92%	92%
ED	85%	79%	76%
Community	97%	97%	98%
Maternity-Antenatal	95%	90%	91%
Maternity-Birth	96%	100%	90%
Maternity-Postnatal Ward	92%	97%	91%
Maternity-Postnatal Community	97%	100%	94%

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 (April) ranks the Trust 122nd out of 128.

For Inpatients, the latest benchmarking (April) ranks the Trust 77th out of 130.

Contractual status:

NHS standard contract applies but no contractual financial penalties.

What actions have we taken to improve performance?

Inpatients:

- Always Event® programme progressing well on AMU, after the intial feedback exercise with patients and carers to identify improvement opportunties, a similar approach has been used to gather feedback from different groups of staff members. Next stage will see the Point of Care team co-developing with patients/carer the vision statement and main aims for the AMU project.
- 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.

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. Regular FFT data trends will now been included the new OP key performance indicators dashboard.

Maternity:

- Local ward teams are being encouraged to increase use of ipads for improving quality of feedback and promoting accessiblity. A maternity service app, similar to the paediatric app, is also being explored.

Community:

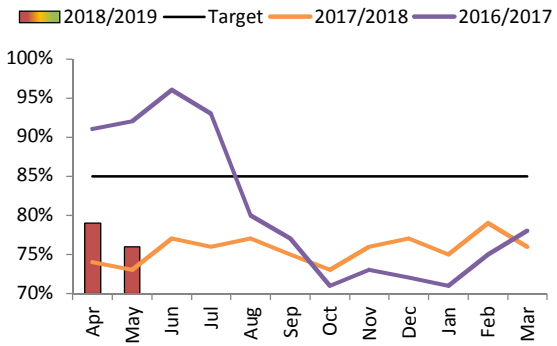
- Maintaining current level of support with Community Teams.

Continuing actions:

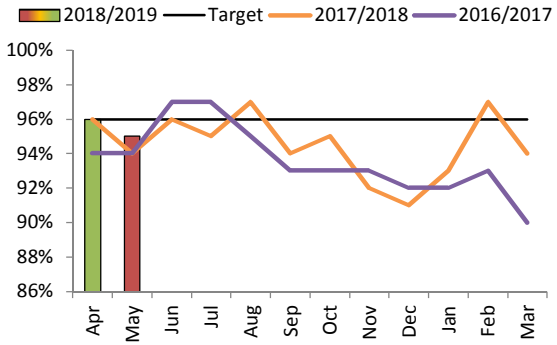
- FFT results reports regularly presented at the PEG, TQE, TSC & Trust Board.
- Increase use of 'Sound Bites' (audios of patient feedback)
- FFT results available to key staff online and via printed weekly reports.

No Contractual Financial Penalties | **YTD £**

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

PDR Compliance	Year Standard	Monthly Trajectory	May-18	YTD	Change on last month	Year End Forecast
	90.00%		82.42%	82.42%	▲	

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 May 2018 was 82.42%, an increase on April's 80.55%. This represents a rise of 1.87% month on month.

127 Band 7 & above colleagues required an annual appraisal at the end of May 2018, resulting in a 78% compliance rate for this group.

The majority of divisions experienced a rise in compliance levels over the past month, of between 1% and 10%.

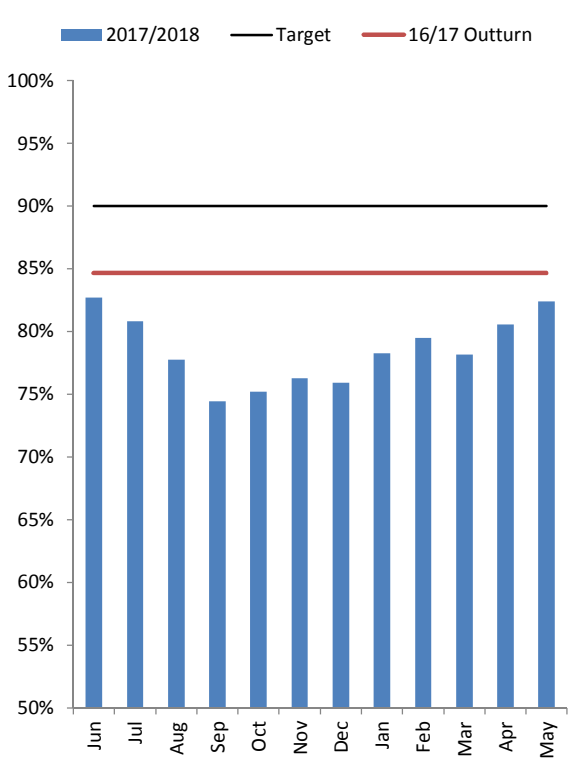
The Women's, Children's & Clinical Support Services division has th highest level of compliance at 89.98%.

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

Contractual status:
No contractual requirements apply.

New Actions:
- Team Appraisals are being undertaken in certain areas to support the appraisal process.
- The appraisal paperwork that is being redesigned will be linked to the new Trust Values & Behavioural Framework and will be launched in July 2018.

Continuing Actions:
- Training sessions for Appraisers are on-going.
- The publication of HR KPI league tables, with the performance of services ranked in a meaningful and engaging way, is being tabled f 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

	Year Standard	Monthly Trajectory	May-18	YTD	Change on last month	Year End Forecast
Adult Safeguarding Training - Level 3 Compliance	85%		80.55%		▲	
Children Safeguarding Training - Level 3 Compliance	85%		87.10%		▲	

What is driving the reported underperformance?

Performance results:

There is a mandatory requirement for 85% of staff employed by the Trust to routinely undertake Safeguarding Training Levels 2 and 3 (Adults and Children). Safeguarding Level 3 has achieved for May.

Based on Calendar Month	Target	Apr-18	May-18
PREVENT Level 1 & 2	85%	98.59%	98.29%
PREVENT Level 3	85%	76.07%	77.51%
Adult Safeguarding Level 2	85%	74.57%	79.13%
Adult Safeguarding Level 3	85%	78.06%	80.55%
Children Safeguarding Level 2	85%	75.49%	76.74%
Children Safeguarding Level 3	85%	73.72%	87.10%

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.

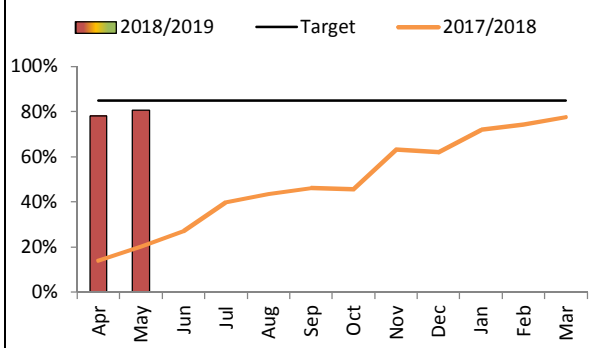
What actions have we taken to improve performance?

New actions:- Screensaver reminding staff of the importance of safeguarding training.
- Divisions to take accountability for staff training compliance and to receive reports naming staff who are non-compliant.
- To promote access to training and continue to advertise the differing methods of training e.g. via workbook, face to face or e-learning.
- Statistics included within the Board Performance Report.

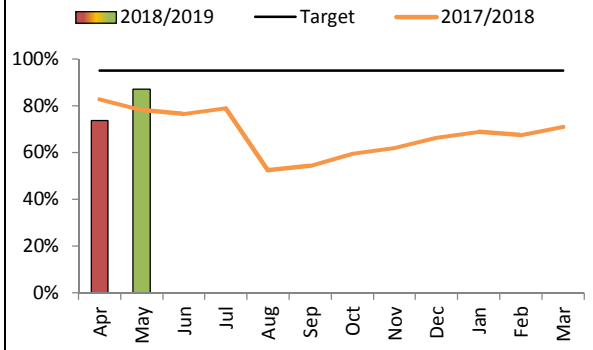
Continuing actions:
- Face to face sessions arranged for Level 2 so that staff have a choice of training methodology.
- Staff requiring Level 3 training (face to face) automatically booked onto a training session and notified by MLCC.
- Continual monitoring of training spaces to ensure adequate number 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	Adult Safeguarding Level 3 - June 2018 Children Safeguarding Level 3 - achieved in May 2018
Lead Director	Director of Nursing

National Contract	X		X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Sickness Absence	Year Standard	Monthly Trajectory	May-18	YTD	Change on last month	Year End Forecast
	3.39%		4.71%	4.86%	▲	

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

Performance status:
Sickness levels improved in May with performance of 4.71% compared to 5.06% in April 2018 but did not achieve the target of 3.39%. This represents a fall of 0.17% compared to same period 2017/18.

Monthly short-term sickness during May 2018 totalled an estimated cost of £122k and long-term sickness totalled an estimated cost of £274k.

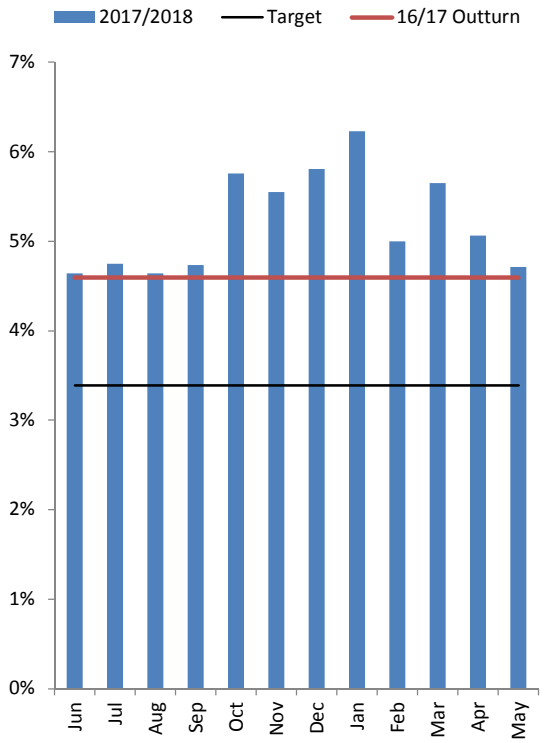
There were 163 long-term episodes of sickness during May 2018. 15 LTS cases extend to 6 months or more.
The largest cause of absence during May 2018 was Anxiety/stress/depression/other psychiatric illnesses - 1640 FTE Days across 92 episode(s) including 54 long-term.
The second largest cause of short-term absence was Other musculoskeletal problems - 589 FTE Days across 45 episode(s) including 17 long-term.
The sickness absence during the past 12 months stands at 5.30%, 1.91% above the Trust target.

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

Contractual status:
No contractual requirements apply.

New Actions
- HR carried out root cause analysis, with regards to fluctuates in absence levels between Jan & Apr 18. This review identified that flu and norovirus related illnesses had a major impact upon sickness rates.

Continuing Actions:
- Work continues in respect to Mental Health, with the OH department offering weekly Stress Management groups for staff, including access to a psychologist.
- Walsall & Dudley Mental Health Trust provide 1-1 training sessions; offering managers training around Resilience and Stress Management.
- Mindfulness training is also available to all staff; something which was 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	May-18	YTD	Change on last month	Year End Forecast
	90.00%		82.42%	82.42%	▲	

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 May 2018 was 82.42%, an increase on April's 80.55%. This represents a rise of 1.87% month on month.

127 Band 7 & above colleagues required an annual appraisal at the end of May 2018, resulting in a 78% compliance rate for this group.

The majority of divisions experienced a rise in compliance levels over the past month, of between 1% and 10%.

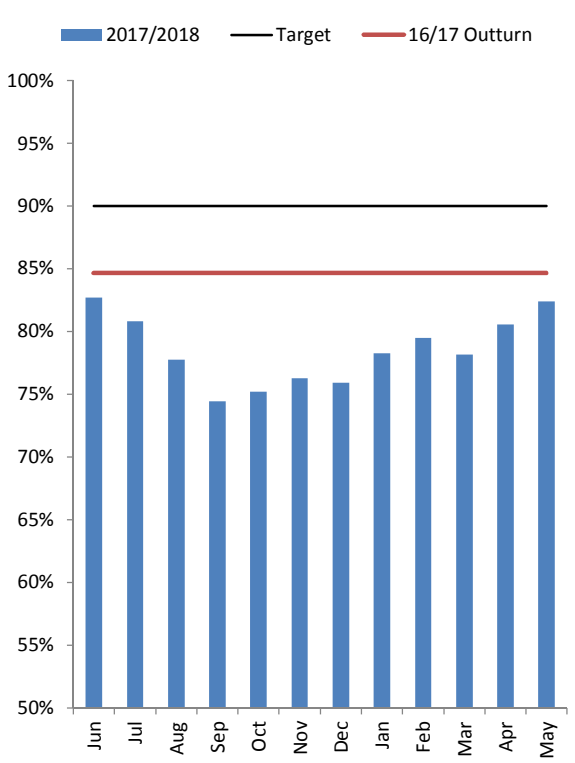
The Women's, Children's & Clinical Support Services division has th highest level of compliance at 89.98%.

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

Contractual status:
No contractual requirements apply.

New Actions:
- Team Appraisals are being undertaken in certain areas to support the appraisal process.
- The appraisal paperwork that is being redesigned will be linked to the new Trust Values & Behavioural Framework and will be launched in July 2018.

Continuing Actions:
- Training sessions for Appraisers are on-going.
- The publication of HR KPI league tables, with the performance of services ranked in a meaningful and engaging way, is being tabled f 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
NHS Trust

CQUINs

Becoming your partners for first class integrated care

	Total year 1	Q1 - Confirmed	Q2 - Confirmed	Q3 - Confirmed	Q4 - Confirmed / TBC in amber	ELEMENTS / Progress
Walsall CCG		**Risk Rating**				
NHS Staff Health & Wellbeing Director of OD	£460,151				£73,624	**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% although this fails to achieve the national target, WCCG have agreed a partial payment of 48% to reflect the progress made on promoting health & well being. Local proposal agreed for year 2 33% or national average. (national average 2017 = 34%)
					£39,880	**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). Local proposal agreed for year 2 79% or national average. (national average 2017 = 74%)
					£39,880	**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 agreed for year 2 63% or national average. (national average 2017 = 64%)
					£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. Achieved
					£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		£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 0.83. Project team established, fortnightly meetings scheduled. ASI rate target of 4% or less challenged with WCCG & NHS Digital. **Risk: Confirmed by WCCG Achieved**
	£257,685		£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**
				£32,211		**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 acknowledge the significant progress and have agreed a partial payment for Q3. (50% of available monies)
				£32,211		
					£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 or the 0.2 requested local target.
Sub totals	£257,685	£64,421	£64,421	£64,421	£64,421	
Offering advice and guidance D of S&T		£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.**
	£257,685		£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. Q3 Achieved
					£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.
Sub totals	£257,685	£64,421	£64,421	£64,421	£64,421	
Personalised care and support planning DoN			£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.**
	£257,685			£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		£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%.**
	£276,091		£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 **Risk:** Achieved
			£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 **Risk**: Achieved
	£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

<table>
<tr><td colspan="6">MEETING OF THE TRUST BOARD</td></tr>
<tr><td colspan="5">General Ultrasound (Non obstetrics)</td><td>AGENDA ITEM: 16</td></tr>
<tr><td>Report Author and Job Title:</td><td colspan="2">Demetri Wade, Professional Lead for Imaging Services</td><td>Responsible Director:</td><td colspan="2">Philip Thomas-Hands, Chief Operating Officer</td></tr>
<tr><td rowspan="2">Action Required</td><td>Approval
X</td><td>Decision</td><td colspan="3">Assurance and Information</td></tr>
<tr><td></td><td>To receive and discuss</td><td colspan="2">To receive</td></tr>
<tr><td>Recommendation</td><td colspan="5">Peformance and Finance Investment Committee recommend members of the Trust Board to:

Approve option 6a - Install additional ultrasound scanner in OPDCC, with associated workforce. Equipment acquired on a 5 year lease programme.

Reasons for recommendation:

• Reduction in clinical risk as detailed below
• Enables appropriate prioritisation of inpatients due to dedicated capacity increase to see this patient group alongside outpatients and GPs.
• Achieve inpatient KPI of 24 hour turnaround. Current average wait is 38 hours, 23% patients are waiting more than 24 hours.
• Better management and increased prevention of acute kidney injury through early diagnosis and appropriate triage.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="5">Yes.

Risk 690 - Phillips IU22, Phillips HD15, GE E9 and Sonosite Micromax Ultrasound Machine in Imaging dept and additional USS in NNU of poor resolution quality, which compromises diagnosis for fine detail examinations. All equipment is coming to or past end of life and identified by Medical Physics QA as unsuitable for use, not meeting current IPCC rules and requires immediate action to replace.

This risk will be mitigated through the additional install of new equipment.

Risk 176 - There are significant issues surrounding establishment and retention of Sonographers which will impact on the ability to provide both a general and obstetric ultrasound service.

This risk will be mitigated by increasing staff establishment and bringing the workforce requirements in line with local standards, which will directly result in improved staff retention.</td></tr>
</table>

<table>
<tr><td>Resource implications</td><td colspan="2">Costs:

• Additional staffing costs - £293k
• Non-pay costs - £63k including 5 year lease, equipment maintenance and consumables.
• Capital costs - £33k refurbishment required to bring additional room in to use.
• Additional replacement equipment following failed quality assurance testing and end of life cycle.

Benefit:

• 2567 bed day reduction (£612k). 1367 due to increased capacity reducing length of stay, 1200 due to preventable Acute Kidney Injury.
• Income based on additional activity with an assumed operating level of 105% (£100k). This will be delivered as greater sonographer capacity will increase productivity of scanning lists.

Cost Avoidance:

• WLI spend reduction (£16k)
• Agency spend reduction (£50k)</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="2">Implementation of the business case will provide better access to ultrasound for all patient groups and ensure equality across the service.</td></tr>
<tr><td rowspan="4">Operational Objectives 2018/19</td><td>Continue our journey on patient safety and clinical quality through a comprehensive improvement programme</td><td>X</td></tr>
<tr><td>Develop the culture of the organisation to ensure mature decision making and clinical leadership</td><td>X</td></tr>
<tr><td>Improve our financial health through our robust improvement programme</td><td>X</td></tr>
<tr><td>Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts</td><td>X</td></tr>
</table>

REF: W014

Business Case for:

General Ultrasound (Non obstetrics)

Version: 15

Prepared by:

Peter Cogings – Consultant Sonographer

Jo Lydon – Divisional Director of Clinical Support Services

Demetri Wade – Professional Lead for Imaging Services and Clinical Measurement Unit

Authorisation	Date	Next Step/Action
Business Development	22 May 2017	
Divisional Committee	22 May 2017	Amendments to be made – then forward to Executive Committee for approval
Divisional Amendments	1 December 2017	Supported for progression
Exec Committee	30 January 2018	High level agreement with amendments to benefit realisation in financial modelling
Exec Committee		
PFIC	27 June 2018	Supported by the Committee to be taken forward to Trust Board on Thursday 05 July 2018.
Board		
Other		

1: Describe the problem/opportunity (not the solution).

Overview

The non-obstetric ultrasound service provides support to outpatient, A&E and Inpatient care pathways, and is an integral diagnostic procedure for a large number of clinical specialities. GP direct access is also supported.

There are four issues that this business case aims to address:

1. Insufficient ultrasound capacity to meet the needs of service users, compromising quality of care provided and ability to achieve National targets.

2. Increased risk of repetitive strain injury placed on Sonographers and Radiologists who are undertaking excessive numbers of scans in order to attempt to mitigate the risk of insufficient capacity

3. Failure to perform ultrasound scans in accordance with NICE recommended times scales e.g. Acute Kidney Injury

4. Clinical quality and fitness for purpose of one of the ultrasound machines.

The core service is delivered in two separate locations;-

1. West Wing - there are two scan rooms, one which accommodates outpatients and the other which should be for inpatients only.

2. Outpatient and Diagnostic Treatment Centre (OPDCC) there is one room which only accommodates outpatients.

Due to the increased demand and pressures on physical capacity there is a need for urgent and specialist outpatient ultrasound scans to be accommodated in the inpatient scan room, in order to avoid 18week and cancer breeches. In turn this reduces the availability of ultrasound for inpatients leading to excessive waiting times. In addition GP direct access referral to scan performance is poor. Additional capacity is also provided by the breast imaging machine which is not ideal with regard to its location.

It is well recognised that the risk of repetitive strain injury in Sonographers is great. The numbers of patients scanned in the three rooms, particularly the inpatient room, exceeds recommended numbers, compromising staff health and wellbeing as a result.

The mitigation is further compromised by the fact that one of the ultrasound scanners in West Wing is no longer suitable for fine detail examinations. The image quality is poor and there is a significant risk of misdiagnosis as a result. Therefore, such examinations have to be accommodated on the remaining scanners.

The modification detailed above has been in place for a long period of time in order to accommodate demand on the service without the need for investment. Work has taken place to review booking templates, appropriateness of scan requests and also to develop a Sonographer lead 7 day service in order to maximise the use of resources available. However, despite this over the last 12 months capacity issues have become more of an issue which has been exacerbated by concerns relating to clinical quality which have been identified via audit.

There is therefore a need to increase capacity for inpatient, outpatient, A&E and GP referrals for non-obstetric ultrasound so that performance can be improved and also protect the health and wellbeing of staff.

National/local drivers:

The challenges faced are:-

1. The need to reduce length of stay and increase flow throughout the hospital.
   - Examinations are not always performed in a timely manner with only 75% of inpatient scans performed within 24hours (average April – August 17) extending length of stay

2. National waiting times
   - 18 Week Referral to Treatment – on average (April – August 17) 71% of outpatients have their ultrasound

scan performed within 4 weeks. 6 week breaches are only narrowly avoided.

3. National guidelines
   For assessment of some acute conditions a maximum access time for non-obstetric ultrasound is stipulated. The service is failing to meet the target timelines on various pathways particularly Acute Kidney Injury (AKI) – failing 60% of patients with reference to the 24 hour target. This is reflected in risk 1117 on the Imaging Risk Register.

4. Increasing demand
   - Demand has increased resulting in reduced timeliness of scans being undertaken with compromised performance across all pathways, this is from the Trust and GPs
   - Demand is predicted to be 44,000 examinations in 17/18 compared to 41,398 in 16/17 and 39,655 in 14/15
   - The split in demand is approximately 19% in-patients, 42% outpatient, 1% AE and 38% GP referrals.
   - It is assumed that 85% of demand converts to activity based on review of referrals (average over last 9 years)
   - The shortfall in capacity is therefore 18,400 examinations per annum.
   - This equates to 118 scanning hours per week or 3.6 WTE (including 18% relief for annual leave and sickness)

5. Risk of Occupational repetitive strain injury
   - In an effort to accommodate all of the above points, the health and safety of Sonographers / Radiologists is being compromised increasing the risk of occupational repetitive strain injury.

6. Image quality – resolution of one existing machine
   - The quality of the inpatient scanner is poor and although within its accepted lifespan, the resolution and fine detail is below requirements resulting in some images produced being undiagnostic leading to compromised diagnosis.

As a result the non-obstetric ultrasound service provided is not meeting the needs of its patients or staff in terms of safety, quality and timeliness

Current status:
Current state in relation to the four issues that this business case aims to address is detailed below:-

Insufficient ultrasound capacity to meet the needs of service users, compromising quality of care provided and ability to achieve National targets.

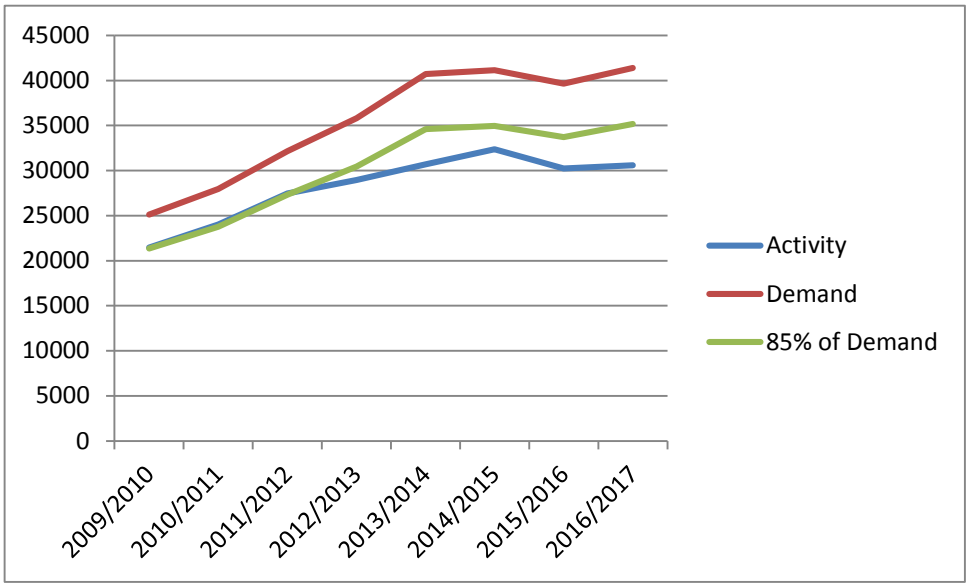
Imaging has three Ultrasound machines used for non-obstetric ultrasound scanning.

Room 1 – Imaging A (main room)
Room 2 – Imaging A (Annexe)
Room 3– OPDCC

Only one of these examination rooms can accommodate inpatients in beds due to structural limitations. This reduces flexibility in relation to these patients. Some additional capacity is provided in the breast imaging unit.

In total the scanners give a capacity of 19,000 examinations per annum. The three main rooms routinely see activity over and above this level because the 20 minute examination time proposed by the Society of Radiographers is not met. The

actual activity in 2016/17 was 30,233 patients. This 60% over the acceptable capacity. This compares to demand of 41,000 examinations, which is estimated to be 44,000 in 2017/18. This gap between activity and demand is increasing resulting in a backlog and increasing patient waiting times which are currently 6 weeks. The graph below visually details this trend.



The table below details current performance for access to ultrasound from inpatient, outpatient and GP pathways.

LOCAL PERFORMANCE TARGET	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
In patient - 90% US performed within 24 hours of referral	373 80%	415 75%	373 69%	383 73%	378 76%	342 78%	357 75%
Out patient - 90% US performed within 4 weeks of referral	701 72%	804 72%	816 69%	777 72%	822 71%	701 71%	851 72%
GP - 90% US performed within 4 weeks of referral	203 23%	223 20%	284 27%	250 26%	237 22%	189 21%	213 22%

This performance is despite regular WLIs. There has been a minimum of 1 WLI per week since 2010. This has increased periodically. This equates to a minimum spend of £22,000 per annum. Option 6 would reduce the reliance on WLI as the additional consultant sonographer would reduce the need for radiologist support.

Risk 1117 on the imaging risk register relates to this capacity shortfall.

<u>Increased risk of repetitive strain injury placed on Sonographers and Radiologists who are undertaking excessive numbers of scans in order to attempt to mitigate the risk of insufficient capacity</u>

The duty of care that the Trust has towards its staff is being compromised by the volumes of work being undertaken by the team. The excessive numbers of scans the Sonographers / Radiologist perform puts them under an unreasonable and unsustainable pressure. This is not safe or acceptable nor is it sustainable, presenting a real and on-going risk to staff and patients. On a daily basis ultrasound scans are being performed well in excess of capacity placing patients and staff at risk.

It is well documented that scanning carries a risk of repetitive strain injury (RSI) involving neck/shoulder/wrist.

The Society of Radiographers and the British Society of Medical Ultrasound 2015 state in their Guidelines for Professional Ultrasound Practice that:

"A sonographer has a professional responsibility to ensure that the time allocated for an examination is sufficient for it to be carried out and reported on competently and for critical and urgent findings to be dealt with appropriately. This is vital for safe patient management."

The Society and College of Radiographers advise that a minimum of 20 minutes per examination is allocated. The capacity assumptions for this case are based on 20 minute appointments. As stated above the ultrasound team are regularly underperforming against this guideline. This is reflected on the imaging risk register – risk 197.

The risk of injury to staff may lead to limitations of what the present service can provide and significant risk of compensation claims. To date no reports of musculo-skeletal injury are reported by members of the imaging team, but this is increasingly likely if the current pattern of working continues.

Brown and Baker (2004) found that 20% of Sonographers reportedly left the profession due to persistent discomfort.

The Society of Radiographers recently published a civil case where an ex-sonographer was awarded almost £230K for her career ending with repetitive strain injury.

A review of literature has revealed the following pertinent points:-

- Of the total population surveyed, an average of 84% experienced pain or discomfort since starting work as a sonographer
- The average length of time a sonographer is in the profession before experiencing pain is 5 years
- The current career ending injury rate in the profession is 20% and more than 73% of workers compensation claims for sonographers are accepted

In order to mitigate these risks as far as reasonably practicable sonographers are referred to occupational health for assessment on an annual basis. Varied booking of scans and rotation of staff is carried out to avoid repetition of the same type of scans. By varying work undertaken within a session, the risk of RSI injury is minimised.

Benchmarking

Imaging took part in National benchmarking in relation to 2016/2017 out turn position, allowing comparison with peers. Unfortunately this report does not allow for comparison of ultrasound.

Local comparison with the peer group would indicate that Walsall Healthcare is an outlier in terms of activity performed relative to capacity. New Cross, Stoke, Cannock and Burton all state that appointment times of 20-40minutes are rigidly adhered to and that no over booking of lists is permitted.

Failure to perform ultrasound scans in accordance with NICE recommended times scales e.g. Acute Kidney Injury

NICE guidelines stipulate an ultrasound scan for Acute Kidney Injury should be performed within 24hrs from admission.

NICE state that AKI is common, causes considerable harm, is financially costly but its course and development is modifiable. It is associated with many conditions and has proven statistical significance in increased mortality, length of stay and re-admission rates. It is therefore considered that improved management of these cases with earlier scanning (within 24 hours of hospital admission).

An audit was performed in September 2017 to assess performance against this standard. The performance below references the period time of request to time of scan. The limitation of the audit was that time of admission was not known. However it can be seen that although numbers are small access to ultrasound is inadequate and NICE guidelines are not being met.

April August 2017	April	May	June	July	August	Ave
Average wait for USS in hrs	26hrs	30hrs	28hrs	23hrs	22hrs	25.8
Patients with AKI	48	30	56	57	23	42.8
Patients scanned <24hrs	31	12	22	33	13	22.2
Patients scanned >24hrs	17	18	34	24	10	20.6

This will be leading to delayed diagnosis of renal tract obstruction and in identifying patients with AKI, leading to increased length of stay. Nationally patients with AKI stay in hospital for 5 days longer, on average than those without. Indications are that 20% of all admissions go on to have AKI and of these one third are preventable if diagnosed early. This can only be carried out with additional capacity.

Clinical quality and fitness for purpose of one of the ultrasound machines.

The equipment in room 1 (inpatient ultrasound room) has poor resolution quality, which compromises diagnosis for fine detail examinations. This is reflected in risk 690 on the Imaging risk register. As of May 2017 it is not being used for fine detail imaging. These patients are being accommodated in other rooms, creating backlog and extended waiting times.

2: Proposed Solution and Strategic Link

Tick as appropriate:
Safe/Quality Care? ☒ Care at Home? ☐ Partners? ☐ Value Colleagues? ☒ Resources? ☒

Option 6 is the preferred option - Install a further 2 new scanners with associated workforce and refurbishment of clinical area.

A sonographer training programme has successfully developed new staff over the past two years and recruitment of qualified staff has proved positive with vacancies being filled. Therefore recruitment of the additional workforce identified is considered to be achievable. If posts were not filled substantively, limited agency staff would be utilised in order to maintain services, however this would be operated within budget.

Option 6a in the detailed costing provides optimal service continuity and removes the requirement of up front capital costs for equipment.

3: Options Considered (preferably a minimum of three including “do nothing” and “do the minimum”).

It is considered that the issues outlined above could be addressed by either capping activity or increasing capacity. Each option considers each risk with partial and full mitigation options.

Option 1- Do nothing

Option 2 – Maintain capacity and cap outpatient and GP activity with no replacement of equipment

Option 3 – Replace existing ultrasound scanner, maintain current capacity with no cap on activity

Option 4 - Replace existing equipment and cap outpatient and GP activity

Option 5 – Install additional ultrasound scanner in OPDCC, with associated workforce and partial cap on outpatient and GP activity.

Option 6 - Install a further 2 new scanners with associated workforce and refurbishment of clinical area.

Option 7 - Install additional ultrasound scanner in OPDCC with associated workforce with no cap on activity.

Option 6 is the preferred option.

Option 1- Do nothing

Benefit:- None

Risk:- The outlined risks remain- this option does not address any of the risks or issues identified.

Financial impact:- Potential risk of personal injury claim from staff in the event of injury. Risk of diagnostic breaches and negative impact on length of stay.

This is not a viable option and is not supported.

Option 2 - Maintain capacity and cap outpatient and GP activity with no replacement of equipment

Benefit:-This option would see no change to capacity but a capping of outpatient and GP activity to ensure that scans were being performed appropriately for both patients and staff. Both outpatient and GP activity would be reduced to bring total activity to 19,000 examinations, a level which could be accommodated safely within the capacity available. This would be maintained whilst capacity remained constant.

No investment in equipment or workforce would be required.

Risk:-This option addresses the risk associated with insufficient capacity for demand and the risk of injury placed on staff. It ensures a better service to those that fall within the cap. It does not address the quality concerns relating to the existing ultrasound machine. Furthermore it creates a financial risk for the Trust due to the loss of income. It places a risk on outpatient and direct access pathways and an alternative ultrasound service would need to be sourced, meaning that patients outside of the cap receive a different service.

Financial Impact:- There would be an associated reduction in outpatient unbundled tariff and GP direct access income relating to 11,000 examinations per annum, equivalent to £535m

Option 3 – Replace existing ultrasound scanner, maintain current capacity with no cap on activity

Benefit- This option would see a replacement of the ultrasound scanner which is of poor quality in room 1, Imaging A. This would address the quality issue of poor resolution referenced in risk 690. It would not address the issues

associates with capacity.

Risk;- With no cap on activity the risks to patients and staff would still remain and current poor performance would remain.

Financial Impact- Cost of replacement ultrasound scanner (Lease or capital purchase). Potential risk of personal injury claim from staff in the event of injury. Risk of diagnostic breeches and negative impact on length of stay.

This is not a viable option and is not supported.

Option 4 - Replace existing equipment and cap outpatient and GP activity

Benefit:- This option would see the delivery of a safe service. The equipment in room 1 would be replaced but no additional capacity would be provided. In order to ensure the safety of patients and staff was promoted, outpatient and GP activity would be capped and reduced by 19,00 examinations per annum.

Risk:- This option addresses the risk associated with insufficient capacity for demand and the risk of injury placed on staff. It ensures a better service to those that fall within the cap. It also addresses the quality concerns relating to the existing ultrasound machine. Furthermore it creates a financial risk for the Trust due to the loss of income. It places a risk on outpatient and direct access pathways and an alternative ultrasound service would need to be sourced, meaning that patients outside of the cap receive a different service.

Financial Impact:- Cost of replacement ultrasound scanner (Lease or capital purchase) plus there would be an associated reduction in outpatient unbundled tariff and GP direct access income relating to 11,000 examinations per annum.

Option 5 – Install additional ultrasound scanner in OPDCC, with associated workforce and partial cap on outpatient and GP activity.

Option 6 - Install a further 2 new scanners with associated workforce and refurbishment of clinical area.

Benefit:- 2 new ultrasound scanners would be purchased (Lease or capital purchase). A scanner would be purchased and placed in an empty room in OPDCC. A second scanner would be placed in a refurbished room in Imaging A. This would have the benefit of creating 2 new rooms of capacity.

The refurbished room would become a large inpatient examination room, close by the inpatient waiting area. Whilst the existing inpatient room would become an outpatient facility, running back to back with the existing imaging A outpatient room. Another room would offer outpatient and GP capacity in OPDCC. Separation of inpatient and outpatient capacity will improve productivity by allowing greater activity throughput for direct access and outpatients.

Capacity would increase by a further 6000 examinations taking capacity to 31,000 examinations.

The increased capacity would allow all in patient ultrasound examinations to be performed within 24hours. In regard to inpatient demand, 72% converts to activity of which 23% is currently not performed within 24 hours. It is assumed that if this 23% had a length of stay reduction of 1 day it would release capacity of 1,367 bed days.

Furthermore, the additional capacity would allow an improved service for those patients with or with suspected AKI. Of the 600 AKI referrals currently received per annum, only 50% are seen within 24 hours. This could be increased to 100% meaning that a further 300 patients could be seen sooner, and 100 of these could have their AKI avoided.

The Consultant Sonographers will work in conjunction with colleagues across other specialities to ensure a robust pathway is in place to identify and scan patients presenting with indicative symptoms. This will form the basis of scanning straight from ED to avoid admission.

For the purpose of this case it is assumed that a further 600 per annum will be identified (this is conservative), and therefore a further 200 of these cases will be preventable and will have their length of stay reduced by 4 days.

The total length of stay reduction therefore would be 2,567, a financial saving of £612k.
Risk – All risks mitigated. No loss of income and quality / safety would immediately improve.

Financial Implications:- 2 x Ultrasound scanners, room refurbishment costs, 1 x Band 8a, 2.6 x Band 7 Sonographers, 3.6 x Band 2 Clinical Support Workers. The 8a Sonographer will be a Consultant Practitioner, instead of a Consultant Radiologist, undertaking more complex examinations and future proofing the service.

Option 7 - Install additional ultrasound scanner in OPDCC, with associated workforce and no cap on outpatient and GP activity.

Benefit:- This option sees an additional new ultrasound scanner installed to accommodate outpatient and GP patients. This increases capacity and addresses the quality issues with the imaging A scanner. Capacity would increase by 6000 appointments making capacity 25,000. This is still insufficient for current levels of demand. This represents a capacity increase of 24%. Assuming the same percentage reduction in inpatient waiting times and that this would reduce length of stay of those inpatients by up to 50%, approximately 1100 bed days would be released – a financial saving of £262k.

Risk:-There would be a no cap on activity meaning that there would be an expectation that over 30,000 examinations would be performed, nearly 30% above capacity. This would result in appointment times of approximately 16minutes. This would increase the risk to staff of repetitive strain injury and also provide a reduced quality service to patients, potentially leading to mis-diagnosis. However, it is noted that the quality of service for patients and staff would be improved from the current position. This option does not address the issue of demand exceeding capacity and further future investment would be required as a second phase to address risk.

Financial Impact- Cost of additional ultrasound scanner (Lease or capital purchase). 1.8 x Band 7 Sonographer and 1.8 x Band 2 Clinical Support Worker to staff the additional room. This would provide an additional 54.5 hours of capacity per week. Current income levels would be maintained.

5: Finances.

Detailed financial modelling of each option can be found in the appendices of this paper. The below table shows a summary of the financial comparison of the options.

This is recurrent yearly spend and non-recurrent in year 1.

Financial Impact £000	1	2	Option 3			Option 4			Option 5			Option 6			Option 7		
	Status Quo	Cap Activity to 19,000	Replace Equipment but no cap on activity			Replace equipment and cap at 19,000			Increase capacity with additional machine cap at capacity			Increase capacity with two additional machines			As per option 5 but no cap imposed on activity		
			5 yr lease	7 yr lease	Cap Purch	5 yr lease	7 yr lease	Cap Purch	5 yr lease	7 yr lease	Cap Purch	5 yr lease	7 yr lease	Capital Purch	5 yr lease	7 yr lease	Capital Purch
Staffing Costs	0	0	0	0	0	0	0	0	142	142	142	293	293	293	142	142	142
Non Pay Costs	0	0	14	11	11	14	11	11	32	29	29	63	58	58	32	29	29
Income	0	535	0	0	0	535	535	535	255	255	255	-612	-612	-612	-262	-262	-262
Total Recurrent Impact	**0**	**535**	**14**	**11**	**11**	**549**	**547**	**547**	**429**	**426**	**426**	**-256**	**-261**	**-261**	**-89**	**-92**	**-92**
Non Recurrent (Inc Capital)	0	0	0	0	47	0	0	0	3	3	83	33	33	194	3	3	83
Replacement Equipment - see appendix 4 based on 5 year lease inc. maintenance	191	191	191	191	191	191	191	191	191	191	191	191	191	191	191	191	191

Staffing costs take into account the additional sonography and clinical support staff to operate additional ultrasound machine(s) as well as estates support for bringing additional rooms into use.

Non pay costs include equipment lease/depreciation and maintenance costs as well as an assumption of a small increase in consumable usage.

The income impact varies between options. Options 2, 4 and 5 assume activity is capped at capacity (either 19,000 or 25,000 scans). Options 1, 3 and 7 assume that current levels of activity remain constant regardless of capacity; however these options do not meet the Society and College of Radiographer guidance on examination times.

Option 6 shows an income benefit due to the additional capacity being sufficient to meet demand which would allow all inpatient scans to be completed within the target 24hours. As previously mentioned 23% scans do not currently meet this target – if these patients' length of stay were to reduce by 1 day this would release 1,367 bed days.

As mentioned earlier there is a further length of stay benefit for patients with Acute Kidney Injury. There are currently approx. 600 referrals per year for AKI of which only half are scanned with 24 hours. If the remaining half could be scanned within 24 hours roughly one third of cases would be preventable. In addition to this the increased ultrasound capacity would allow a more proactive approach to managing AKI as twice as many patients could be scanned leading to a further 200 preventable cases of AKI. Based on length of stay reduction of 4 days this would release a further 1,200 bed days.

The total length of stay reduction would therefore be 2,567, a financial saving of £612k.

Option 7 increases capacity by 24%, assuming the same percentage reduction in inpatient waiting times and that this would reduce length of stay of those inpatients by up to 50%, approximately 1100 bed days would be released – a financial saving of £262k.

Following a recent QA assessment all of the existing ultrasound equipment has been deemed not fit-for-purpose and will

need to be replaced, see Appendix 4 for details. The cost of replacing this equipment under a 5 year lease has been included in the table above, this is inclusive of maintenance costs. If these were to be replaced on capital purchase the cost would be approx. £558k with annual maintenance of approx. £79k.

Income based on additional activity with an assumed operating level of 105% (£100k). This will be delivered as greater sonographer capacity will increase productivity of scanning lists.

6: Implementation Plan.

Action	Responsibility	Anticipated Completion Date
Set up working group for implementation	Peter Cogings/Julie Hannon	November 2017
Refurbish Room Imaging A	Jane Longden	Q3 - 4
Recruitment of Portering and cleaning Services	Jane Longden	Q3 - 4
Procurement/leasing : Equipment	David Smith	Q3 - 4
Staffing : Recruitment	Julie Hannon Peter Cogings	Q3 - 4
Review of benefits realisation - annually	Peter Cogings/Julie Hannon	September 2019

7: Risks and Mitigations.

Unable to recruit to posts	Students in training are due to qualify imminently. It the service is operating to appropriate standards and reasonable capacity, it is quite likely that staff who have recently left the service may be willing to return.
Risks to staff/patient wellbeing during replacement programme	The activity will be reduced to match capacity; where necessary activity will be outsourced to partner organisations. Risks will be monitored at DQC.
Inability to meet RTT targets	The staffing and equipment resource will provide safe capacity to meet the required levels of activity, with little or no need for WLIs and the use of agency/bank staff.

8: Benefits Realisation

Benefit	Measurement and Controls
Improved patient experience	Patient surveys, complaints and comments as reported through Divisional Quality Committee. Downgrade or closure of risk on Risk Register
Improved staff morale	Staff survey (national, Trust and service surveys). Absence reports, IPDRs. Complaints and compliments received.
Waiting lists will be reduced	CRIS will be used to match activity and capacity. Patient feedback will be reported at DQC Achievement against RTT targets Reduction costs of WLIs as reported by divisional finance team.
Improvement in patient flow	Improvement in request to exam times. Reduction in length of stay as monitored by Performance Team/divisional dashboard.
Better use of resources	Refurbishing the empty room will provide a better patient experience (no mix of inpatient and outpatients), evidenced through comments/complaints, surveys. In addition we will be able to make limited use of existing equipment for specific and agreed inpatient activity in support of urgent diagnosis – the impact will be measured through divisional dashboard – request to exam time, RTT and patient outcomes.
Financial Impact	Reduction in Agency Staffing. (2015-16 £300k) – as reported via HR and divisional dashboard. Reduction in Consultant WLIs due to diagnostic backlogs – reported by Trust Performance Team and reviewed at Quality Committee Reduction in Sonographer Bank costs : as reported by HR and divisional dashboard. Reduction in the cost of repeat examinations having to be made due to poor quality of diagnostics – evidenced via consultant and staff feedback/surveys, patient comments and complaints and reviewed at Divisional Quality Committee.

9: Impact on other services

Refer to Section 2.9 of the Guidance: Indicate which of the support services you have spoken to. .**Briefly describe the impact of this option on support services, confirm who you have spoken to and that they agree with your assessment of the impact on their services.**

Estates:☒ Clinical support services: ☒ IM&T: ☐ Procurement: ☒ Corporate services (e.g. HR please specify) ☐_____

We have worked closely with our colleagues in Estates and procurement and linked to IM&T to ensure we have taken into account all of their considerations.

Estates have previously looked at making unused room in imaging A fit for use as an ultrasound room. IT and PACs already installed though we need to check if live. Need PC and 'phone.
Procurement support the leasing option of equipment.

10: Recommendations:

Refer to section 2.10 of the Guidance: Clarify what are you asking the approving committee to do ?

The Committee is asked to **CONSIDER & APPROVE** Option 6

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Service Overview & Improvement Action Plan: Equality Analysis Form

Title: Business Case for: General Ultrasound equipment and staffing.	What are the intended outcomes of this work? To meet the safety and quality standards advocated by national bodies, and in Trust strategic objectives
Who will be affected? Service Users	Evidence: Patient Feedback

ANALYSIS SUMMARY: considering the above evidence, please summarise the impact of the work based on the Public Sector equality duty outcomes against the 9 Protected characteristics			
Public Sector Duty Protected Characteristics (highlight as appropriate			
AGE / DISABILITY/ RACE	*Patients with mobility issues or in wheelchairs, will be able to access the appropriate diagnostic room*		
SEX (Gender)/ GENDER REASSIGNMENT			
RELIGION or BELIEF/ SEXUAL ORIENTATION			
PREGNANCY & MATERNITY			
MARRIAGE & CIVIL PARTNERSHIP			
What is the overall impact?			

Name of person completing analysis	*Peter Cogings*	Date Completed	1 June 2016
Name of responsible Director	**Russell Caldicott**		
Signature			

Appendix 1 – Financial analysis

Financial Metrics Summary - Evaluated over 7 year period

	Option 1 - Status Quo	**Option 2** - Cap activity at current capacity	**Option 3** - Replace 1 US Machine			**Option 4** - Replace 1 US Machine and Cap to capacity			**Option 5** - Replace 1 US Machine and Reutilise in OP to increase capacity (Inc Additional staffing) Partial Cap on Activity			**Option 6** - Replace 1 US Machine and Reutilise, Purchase additional US Machine to further increase capacity (Inc Additional Staffing)			**Option 7** - Replace 1 US Machine and Reutilise, Purchase additional US Machine to further increase capacity (Inc Additional Staffing) No Cap		
	Does not address staffing or equipment safety issues	Addresses capacity issue but not equipment safety	Addresses Equipment safety issue but does not address capacity issue														
			7yr Lease	**5yr Lease**	**Cap Purch**	**7yr Lease**	**5yr Lease**	**Cap Purch**	**7yr Lease**	**5yr Lease**	**Cap Purch**	**7yr Lease**	**5yr Lease**	**Cap Purch**	**7yr Lease**	**5yr Lease**	**Cap Purch**
Net Cash Flow	£00	(£3,748)	(£43)	(£54)	(£89)	(£3,790)	(£3,802)	(£3,837)	(£2,972)	(£2,990)	(£2,972)	(£2,475)	(£2,497)	(£2,475)	(£1,189)	(£1,207)	(£1,188)
NPV at 3.5%	£00	(£3,274)	(£37)	(£48)	(£84)	(£3,310)	(£3,321)	(£3,357)	(£2,595)	(£2,612)	(£2,605)	(£2,165)	(£2,185)	(£2,185)	(£1,038)	(£1,054)	(£1,048)
Total Recurrent Benefits	£00	£00	£00	£00	£00	£00	£00	£00	£00	£00	£00	£4,286	£4,286	£4,286	£1,836	£1,836	£1,836
Total Recurrent Costs	£00	(£3,748)	(£47)	(£59)	(£47)	(£3,795)	(£3,807)	(£3,795)	(£2,982)	(£3,000)	(£2,981)	(£2,457)	(£2,479)	(£2,457)	(£1,195)	(£1,214)	(£1,195)
Net Recurrent Costs/benefits	£00	(£3,748)	(£47)	(£59)	(£47)	(£3,795)	(£3,807)	(£3,795)	(£2,982)	(£3,000)	(£2,981)	£1,829	£1,807	£1,829	£641	£623	£641
Total Non-Recurrent Benefit	£00	£00	£05	£05	£05	£05	£05	£05	£10	£10	£10	£15	£15	£15	£10	£10	£10
Total Non-Recurrent Costs	£00	£00	£00	£00	£00	£00	£00	£00	(£1)	(£1)	(£1)	(£3)	(£3)	(£3)	(£3)	(£3)	(£3)
Net Non-Recurrent Costs/benefits	£00	£00	£05	£05	£05	£05	£05	£05	£09	£09	£09	£12	£12	£12	£07	£07	£07
Capital Costs	£00	£00	£00	(£12)	(£47)	£00	(£12)	(£47)	£00	(£20)	(£80)	(£30)	(£70)	(£191)	£00	(£20)	(£80)

£ in £1,000s

Numbers in parenthesis are negative numbers

Appendix 2 – Detailed Costings

Option 2 – Status Quo

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction									0.0
Non Pay cost reduction									0.0
									0.0
									0.0
Total Recurrent Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff									0.0
Maintenance									0.0
									0.0
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff									0.0
Depreciation (lease)									0.0
Interest (lease)									0.0
Income Loss		(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(3747.8)
Total Recurrent Costs	0.0	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(3747.8)
Net Recurrent Costs/benefits	0.0	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(3747.8)
Non-Recurrent Income (+ve)									
Warranty									0.0
Total Non-Recurrent Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Non-Recurrent costs (-ve)									
Ultrasound Couch									0.0
									0.0
									0.0
Total Non-Recurrent Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Non-Recurrent Costs/benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment									0.0
									0.0
									0.0
Total Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Costs	0.0	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(3747.8)
CASH IMPACT (to exclude depreciation)									
Benefits and Gains	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Costs	0.0	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(3747.8)
NET	**0.0**	**(535.4)**	**(535.4)**	**(535.4)**	**(535.4)**	**(535.4)**	**(535.4)**	**(535.4)**	**(3747.8)**
Cumulative Net	0.0	(535.4)	(1070.8)	(1606.2)	(2141.6)	(2677.0)	(3212.4)	(3747.8)	(3747.8)
NPV									
At 3.5%	0.0	(517.3)	(499.8)	(482.9)	(466.6)	(450.8)	(435.6)	(420.8)	**(3273.7)**

Option 3a – Replace Equipment, no cap on activity – 5 year lease

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction									0.0
Non Pay cost reduction									0.0
									0.0
									0.0
Total Recurrent Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff									0.0
Maintenance		(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(32.4)
									0.0
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff									0.0
Depreciation (lease)		(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(5.9)	(5.9)	(45.3)
Interest (lease)		(2.7)	(2.7)	(2.7)	(2.7)	(2.7)			(13.6)
Income Loss									0.0
Total Recurrent Costs	0.0	(14.1)	(14.1)	(14.1)	(14.1)	(14.1)	(10.5)	(10.5)	(91.3)
Net Recurrent Costs/benefits	0.0	(14.1)	(14.1)	(14.1)	(14.1)	(14.1)	(10.5)	(10.5)	(91.3)
Non-Recurrent Income (+ve)									
Warranty		4.6							4.6
Total Non-Recurrent Income	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Non-Recurrent costs (-ve)									
Ultrasound Couch									0.0
									0.0
									0.0
Total Non-Recurrent Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Non-Recurrent Costs/benefits	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment							(11.8)		(11.8)
									0.0
									0.0
Total Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	(11.8)	0.0	(11.8)
Total Costs	0.0	(14.1)	(14.1)	(14.1)	(14.1)	(14.1)	(22.3)	(10.5)	(103.0)
CASH IMPACT									
Benefits and Gains (excl LOS)	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Costs (Inc Depn - lease)	0.0	(14.1)	(14.1)	(14.1)	(14.1)	(14.1)	(16.4)	(4.6)	(91.3)
NET	**0.0**	**(9.4)**	**(14.1)**	**(14.1)**	**(14.1)**	**(14.1)**	**(16.4)**	**(4.6)**	**(86.6)**
Cumulative Net	0.0	(9.4)	(23.5)	(37.5)	(51.6)	(65.6)	(82.0)	(86.6)	(86.6)
NPV									
At 3.5%	0.0	(9.1)	(13.1)	(12.7)	(12.2)	(11.8)	(13.3)	(3.6)	**(75.9)**

Option 3b - Replace Equipment, no cap on activity – 7 year lease

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction									0.0
Non Pay cost reduction									0.0
									0.0
									0.0
Total Recurrent Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff									0.0
Maintenance		(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(32.4)
									0.0
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff									0.0
Depreciation (lease)		(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(47.0)
Interest (lease)		(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)
Income Loss									0.0
Total Recurrent Costs	0.0	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(79.5)
Net Recurrent Costs/benefits	0.0	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(79.5)
Non-Recurrent Income (+ve)									
Warranty		4.6							4.6
Total Non-Recurrent Income	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Non-Recurrent costs (-ve)									
Ultrasound Couch									0.0
									0.0
									0.0
Total Non-Recurrent Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Non-Recurrent Costs/benefits	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment									0.0
									0.0
									0.0
Total Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Costs	0.0	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(79.5)
CASH IMPACT									
Benefits and Gains	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Costs (Inc Depn - lease)	0.0	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(11.4)	(79.5)
NET	**0.0**	**(6.7)**	**(11.4)**	**(11.4)**	**(11.4)**	**(11.4)**	**(11.4)**	**(11.4)**	**(74.9)**
Cumulative Net	0.0	(6.7)	(18.1)	(29.5)	(40.8)	(52.2)	(63.5)	(74.9)	(74.9)
NPV									
At 3.5%	0.0	(6.5)	(10.6)	(10.2)	(9.9)	(9.6)	(9.2)	(8.9)	**(65.0)**

Option 3c - Replace Equipment, no cap on activity – Capital Purchase

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction									0.0
Non Pay cost reduction									0.0
									0.0
									0.0
Total Recurrent Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff									0.0
Maintenance		(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(32.4)
									0.0
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff									0.0
Depreciation		(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(47.0)
Interest									0.0
Income Loss									0.0
Total Recurrent Costs	0.0	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(79.4)
Net Recurrent Costs/benefits	0.0	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(79.4)
Non-Recurrent Income (+ve)									
Warranty		4.6							4.6
Total Non-Recurrent Income	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Non-Recurrent costs (-ve)									
Ultrasound Couch									0.0
									0.0
									0.0
Total Non-Recurrent Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Non-Recurrent Costs/benefits	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment	(47.0)								(47.0)
									0.0
									0.0
Total Capital Costs	(47.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(47.0)
Total Costs	(47.0)	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(126.4)
CASH IMPACT (to exclude depreciation)									
Benefits and Gains	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Costs (Excl Depreciation)	(47.0)	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(11.3)	(126.4)
NET	**(47.0)**	**(6.7)**	**(11.3)**	**(11.3)**	**(11.3)**	**(11.3)**	**(11.3)**	**(11.3)**	**(121.8)**
Cumulative Net	(47.0)	(53.7)	(65.1)	(76.4)	(87.7)	(99.1)	(110.4)	(121.8)	(121.8)
NPV									
At 3.5%	(47.0)	(6.5)	(10.6)	(10.2)	(9.9)	(9.5)	(9.2)	(8.9)	**(111.9)**

Option 4a – Replace equipment and cap activity – 5 year lease

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction									0.0
Non Pay cost reduction									0.0
									0.0
									0.0
Total Recurrent Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff									0.0
Maintenance		(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(32.4)
									0.0
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff									0.0
Depreciation (lease)		(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(5.9)	(5.9)	(45.3)
Interest (lease)		(2.7)	(2.7)	(2.7)	(2.7)	(2.7)			(13.6)
Income Loss		(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(3747.8)
Total Recurrent Costs	0.0	(549.5)	(549.5)	(549.5)	(549.5)	(549.5)	(545.9)	(545.9)	(3839.1)
Net Recurrent Costs/benefits	0.0	(549.5)	(549.5)	(549.5)	(549.5)	(549.5)	(545.9)	(545.9)	(3839.1)
Non-Recurrent Income (+ve)									
Warranty		4.6							4.6
Total Non-Recurrent Income	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Non-Recurrent costs (-ve)									
Ultrasound Couch									0.0
									0.0
									0.0
Total Non-Recurrent Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Non-Recurrent Costs/benefits	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment							(11.8)		(11.8)
									0.0
									0.0
Total Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	(11.8)	0.0	(11.8)
Total Costs	0.0	(549.5)	(549.5)	(549.5)	(549.5)	(549.5)	(557.7)	(545.9)	(3850.8)
CASH IMPACT									
Benefits and Gains (excl LOS)	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Costs (Inc Depn - lease)	0.0	(549.5)	(549.5)	(549.5)	(549.5)	(549.5)	(551.8)	(540.0)	(3839.1)
NET	**0.0**	**(544.8)**	**(549.5)**	**(549.5)**	**(549.5)**	**(549.5)**	**(551.8)**	**(540.0)**	**(3834.5)**
Cumulative Net	0.0	(544.8)	(1094.3)	(1643.7)	(2193.2)	(2742.7)	(3294.4)	(3834.5)	(3834.5)
NPV									
At 3.5%	0.0	(526.4)	(512.9)	(495.6)	(478.8)	(462.6)	(448.9)	(424.5)	**(3349.7)**

Option 4b – Replace equipment and cap activity – 7 year lease

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction									0.0
Non Pay cost reduction									0.0
									0.0
									0.0
Total Recurrent Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff									0.0
Maintenance		(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(32.4)
									0.0
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff									0.0
Depreciation (lease)		(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(47.0)
Interest (lease)		(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)
Income Loss		(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(3747.8)
Total Recurrent Costs	0.0	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(3827.3)
Net Recurrent Costs/benefits	0.0	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(3827.3)
Non-Recurrent Income (+ve)									
Warranty		4.6							4.6
Total Non-Recurrent Income	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Non-Recurrent costs (-ve)									
Ultrasound Couch									0.0
									0.0
									0.0
Total Non-Recurrent Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Non-Recurrent Costs/benefits	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment									0.0
									0.0
									0.0
Total Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Costs	0.0	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(3827.3)
CASH IMPACT									
Benefits and Gains	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Costs (Inc Depn - lease)	0.0	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(546.8)	(3827.3)
NET	**0.0**	**(542.1)**	**(546.8)**	**(546.8)**	**(546.8)**	**(546.8)**	**(546.8)**	**(546.8)**	**(3822.7)**
Cumulative Net	0.0	(542.1)	(1088.9)	(1635.7)	(2182.4)	(2729.2)	(3276.0)	(3822.7)	(3822.7)
NPV									
At 3.5%	0.0	(523.8)	(510.4)	(493.1)	(476.5)	(460.4)	(444.8)	(429.8)	**(3338.7)**

Option 4c – Replace equipment and cap activity – Capital Purchase

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction									0.0
Non Pay cost reduction									0.0
									0.0
									0.0
Total Recurrent Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff									0.0
Maintenance		(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(32.4)
									0.0
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff									0.0
Depreciation		(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(47.0)
Interest									0.0
Income Loss		(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(535.4)	(3747.8)
Total Recurrent Costs	0.0	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(3827.2)
Net Recurrent Costs/benefits	0.0	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(3827.2)
Non-Recurrent Income (+ve)									
Warranty		4.6							4.6
Total Non-Recurrent Income	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Non-Recurrent costs (-ve)									
Ultrasound Couch									0.0
									0.0
									0.0
Total Non-Recurrent Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Non-Recurrent Costs/benefits	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment	(47.0)								(47.0)
									0.0
									0.0
Total Capital Costs	(47.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(47.0)
Total Costs	(47.0)	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(3874.2)
CASH IMPACT (to exclude depreciation)									
Benefits and Gains	0.0	4.6	0.0	0.0	0.0	0.0	0.0	0.0	4.6
Costs (Excl Depreciation)	(47.0)	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(546.7)	(3874.2)
NET	**(47.0)**	**(542.1)**	**(546.7)**	**(546.7)**	**(546.7)**	**(546.7)**	**(546.7)**	**(546.7)**	**(3869.6)**
Cumulative Net	(47.0)	(589.1)	(1135.9)	(1682.6)	(2229.4)	(2776.1)	(3322.8)	(3869.6)	(3869.6)
NPV									
At 3.5%	(47.0)	(523.8)	(510.4)	(493.1)	(476.5)	(460.3)	(444.8)	(429.7)	**(3385.6)**

Option 5a – Increase capacity with 1 additional machine – 5 year lease

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction									0.0
Non Pay cost reduction									0.0
Income Loss									0.0
									0.0
Total Recurrent Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff		(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(908.9)
Maintenance		(14.2)	(14.2)	(14.2)	(14.2)	(14.2)	(14.2)	(14.2)	(99.7)
Consumables		(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(29.8)
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff		(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(83.9)
Depreciation (lease)		(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(10.0)	(10.0)	(77.4)
Interest (lease)		(2.8)	(2.8)	(2.8)	(2.8)	(2.8)			(13.9)
Income Loss		(255.2)	(255.2)	(255.2)	(255.2)	(255.2)	(255.2)	(255.2)	(1786.3)
Total Recurrent Costs	0.0	(429.8)	(429.8)	(429.8)	(429.8)	(429.8)	(425.5)	(425.5)	(2999.8)
Net Recurrent Costs/benefits	0.0	(429.8)	(429.8)	(429.8)	(429.8)	(429.8)	(425.5)	(425.5)	(2999.8)
Non-Recurrent Benefit (+ve)									
Warranty		9.9							9.9
Total Non-Recurrent Income	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Non-Recurrent costs (-ve)									
Ultrasound Couch									0.0
Computer Hardware	(0.5)								(0.5)
									0.0
Total Non-Recurrent Costs	(0.5)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.5)
Net Non-Recurrent Costs/benefits	(0.5)	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.4
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment							(20.1)		(20.1)
									0.0
									0.0
Total Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	(20.1)	0.0	(20.1)
Total Costs	(0.5)	(429.8)	(429.8)	(429.8)	(429.8)	(429.8)	(445.6)	(425.5)	(3020.4)
CASH IMPACT									
Benefits and Gains (excl LOS)	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Costs (Inc Depn - lease)	(0.5)	(429.8)	(429.8)	(429.8)	(429.8)	(429.8)	(435.6)	(415.5)	(3000.3)
NET	**(0.5)**	**(419.9)**	**(429.8)**	**(429.8)**	**(429.8)**	**(429.8)**	**(435.6)**	**(415.5)**	**(2990.4)**
Cumulative Net	(0.5)	(420.4)	(850.1)	(1279.9)	(1709.6)	(2139.4)	(2574.9)	(2990.4)	(2990.4)
NPV									
At 3.5%	(0.5)	(405.7)	(401.2)	(387.6)	(374.5)	(361.8)	(354.3)	(326.6)	**(2612.2)**

Option 5b – Increase capacity with 1 additional machine – 7 year lease

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction									0.0
Non Pay cost reduction									0.0
Income Loss									0.0
									0.0
Total Recurrent Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff		(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(908.9)
Maintenance		(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(92.4)
Consumables		(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(29.8)
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff		(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(83.9)
Depreciation (lease)		(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(80.3)
Interest (lease)		(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)
Income Loss		(255.2)	(255.2)	(255.2)	(255.2)	(255.2)	(255.2)	(255.2)	(1786.3)
Total Recurrent Costs	0.0	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(2981.7)
Net Recurrent Costs/benefits	0.0	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(2981.7)
Non-Recurrent Benefit (+ve)									
Warranty		9.9							9.9
Total Non-Recurrent Income	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Non-Recurrent costs (-ve)									
Ultrasound Couch									0.0
Computer Hardware	(0.5)								(0.5)
									0.0
Total Non-Recurrent Costs	(0.5)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.5)
Net Non-Recurrent Costs/benefits	(0.5)	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.4
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment									0.0
									0.0
									0.0
Total Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Costs	(0.5)	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(2982.2)
CASH IMPACT									
Benefits and Gains (excl LOS)	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Costs (Inc Depn - lease)	(0.5)	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(426.0)	(2982.2)
NET	**(0.5)**	**(416.1)**	**(426.0)**	**(426.0)**	**(426.0)**	**(426.0)**	**(426.0)**	**(426.0)**	**(2972.3)**
Cumulative Net	(0.5)	(416.6)	(842.5)	(1268.5)	(1694.4)	(2120.4)	(2546.4)	(2972.3)	(2972.3)
NPV									
At 3.5%	(0.5)	(402.0)	(397.6)	(384.2)	(371.2)	(358.6)	(346.5)	(334.8)	**(2595.5)**

Option 5c - – Increase capacity with 1 additional machine – Capital Purchase

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction									0.0
Non Pay cost reduction									0.0
Income Loss									0.0
									0.0
Total Recurrent Benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff		(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(908.9)
Maintenance		(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(92.4)
Consumables		(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(29.8)
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff		(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(83.9)
Depreciation		(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(80.3)
Interest									0.0
Income Loss		(255.2)	(255.2)	(255.2)	(255.2)	(255.2)	(255.2)	(255.2)	(1786.3)
Total Recurrent Costs	0.0	(425.9)	(425.9)	(425.9)	(425.9)	(425.9)	(425.9)	(425.9)	(2981.4)
Net Recurrent Costs/benefits	0.0	(425.9)	(425.9)	(425.9)	(425.9)	(425.9)	(425.9)	(425.9)	(2981.4)
Non-Recurrent Benefit (+ve)									
Warranty		9.9							9.9
Total Non-Recurrent Income	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Non-Recurrent costs (-ve)									
Ultrasound Couch									0.0
Computer Hardware	(0.5)								(0.5)
									0.0
Total Non-Recurrent Costs	(0.5)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.5)
Net Non-Recurrent Costs/benefits	(0.5)	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.4
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment	(80.3)								(80.3)
									0.0
									0.0
Total Capital Costs	(80.3)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(80.3)
Total Costs	(80.8)	(425.9)	(425.9)	(425.9)	(425.9)	(425.9)	(425.9)	(425.9)	(3062.2)
CASH IMPACT (to exclude depreciation)									
Benefits and Gains (Excl LOS)	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Costs (Excl Depreciation)	(80.8)	(414.5)	(414.5)	(414.5)	(414.5)	(414.5)	(414.5)	(414.5)	(2981.9)
NET	**(80.8)**	**(404.6)**	**(414.5)**	**(414.5)**	**(414.5)**	**(414.5)**	**(414.5)**	**(414.5)**	**(2972.1)**
Cumulative Net	(80.8)	(485.3)	(899.8)	(1314.2)	(1728.7)	(2143.2)	(2557.6)	(2972.1)	(2972.1)
NPV									
At 3.5%	(80.8)	(390.9)	(386.9)	(373.8)	(361.2)	(349.0)	(337.2)	(325.8)	**(2605.4)**

Option 6a – Increase capacity with 2 additional machines – 5 year lease

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction		612.3	612.3	612.3	612.3	612.3	612.3	612.3	4285.8
Non Pay cost reduction									0.0
Income Loss									0.0
									0.0
Total Recurrent Benefits	0.0	612.3	612.3	612.3	612.3	612.3	612.3	612.3	4285.8
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff		(269.2)	(269.2)	(269.2)	(269.2)	(269.2)	(269.2)	(269.2)	(1884.2)
Maintenance		(26.4)	(26.4)	(26.4)	(26.4)	(26.4)	(26.4)	(26.4)	(184.8)
Consumables		(8.5)	(8.5)	(8.5)	(8.5)	(8.5)	(8.5)	(8.5)	(59.5)
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff		(24.0)	(24.0)	(24.0)	(24.0)	(24.0)	(24.0)	(24.0)	(167.7)
Depreciation (lease)		(22.9)	(22.9)	(22.9)	(22.9)	(22.9)	(20.1)	(20.1)	(154.8)
Interest (lease)		(5.6)	(5.6)	(5.6)	(5.6)	(5.6)			(27.8)
									0.0
Total Recurrent Costs	0.0	(356.5)	(356.5)	(356.5)	(356.5)	(356.5)	(348.1)	(348.1)	(2478.8)
Net Recurrent Costs/benefits	0.0	255.7	255.7	255.7	255.7	255.7	264.2	264.2	1807.0
Non-Recurrent Benefit (+ve)									
Warranty		15.1							15.1
Total Non-Recurrent Income	0.0	15.1	0.0	0.0	0.0	0.0	0.0	0.0	15.1
Non-Recurrent costs (-ve)									
Ultrasound Couch	(2.0)								(2.0)
Computer Hardware	(1.0)								(1.0)
									0.0
Total Non-Recurrent Costs	(3.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(3.0)
Net Non-Recurrent Costs/benefits	(3.0)	15.1	0.0	0.0	0.0	0.0	0.0	0.0	12.1
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment	(30.0)								(30.0)
Equipment							(40.1)		(40.1)
									0.0
									0.0
Total Capital Costs	(30.0)	0.0	0.0	0.0	0.0	0.0	(40.1)	0.0	(70.1)
Total Costs	(33.0)	(356.5)	(356.5)	(356.5)	(356.5)	(356.5)	(388.2)	(348.1)	(2552.0)
CASH IMPACT									
Benefits and Gains (excl LOS)	0.0	15.1	0.0	0.0	0.0	0.0	0.0	0.0	15.1
Costs (Inc Depn - lease)	(33.0)	(356.5)	(356.5)	(356.5)	(356.5)	(356.5)	(368.2)	(328.0)	(2511.8)
NET	**(33.0)**	**(341.4)**	**(356.5)**	**(356.5)**	**(356.5)**	**(356.5)**	**(368.2)**	**(328.0)**	**(2496.7)**
Cumulative Net	(33.0)	(374.4)	(730.9)	(1087.5)	(1444.0)	(1800.5)	(2168.7)	(2496.7)	(2496.7)
NPV									
At 3.5%	(33.0)	(329.9)	(332.8)	(321.6)	(310.7)	(300.2)	(299.5)	(257.8)	**(2185.5)**

Option 6b – Increase capacity with 2 additional machines – 7 year lease

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction		612.3	612.3	612.3	612.3	612.3	612.3	612.3	4285.8
Non Pay cost reduction									0.0
Income Loss									0.0
									0.0
Total Recurrent Benefits	0.0	612.3	612.3	612.3	612.3	612.3	612.3	612.3	4285.8
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff		(269.2)	(269.2)	(269.2)	(269.2)	(269.2)	(269.2)	(269.2)	(1884.2)
Maintenance		(26.4)	(26.4)	(26.4)	(26.4)	(26.4)	(26.4)	(26.4)	(184.8)
Consumables		(8.5)	(8.5)	(8.5)	(8.5)	(8.5)	(8.5)	(8.5)	(59.5)
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff		(24.0)	(24.0)	(24.0)	(24.0)	(24.0)	(24.0)	(24.0)	(167.7)
Depreciation (lease)		(22.9)	(22.9)	(22.9)	(22.9)	(22.9)	(22.9)	(22.9)	(160.5)
Interest (lease)		(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.5)
									0.0
Total Recurrent Costs	0.0	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(2457.2)
Net Recurrent Costs/benefits	0.0	261.2	261.2	261.2	261.2	261.2	261.2	261.2	1828.6
Non-Recurrent Benefit (+ve)									
Warranty		15.1							15.1
Total Non-Recurrent Income	0.0	15.1	0.0	0.0	0.0	0.0	0.0	0.0	15.1
Non-Recurrent costs (-ve)									
Ultrasound Couch	(2.0)								(2.0)
Computer Hardware	(1.0)								(1.0)
									0.0
Total Non-Recurrent Costs	(3.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(3.0)
Net Non-Recurrent Costs/benefits	(3.0)	15.1	0.0	0.0	0.0	0.0	0.0	0.0	12.1
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment	(30.0)								(30.0)
Equipment									0.0
									0.0
									0.0
Total Capital Costs	(30.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(30.0)
Total Costs	(33.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(2490.2)
CASH IMPACT									
Benefits and Gains (excl LOS)	0.0	15.1	0.0	0.0	0.0	0.0	0.0	0.0	15.1
Costs (Inc Depn - lease)	(33.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(2490.2)
NET	**(33.0)**	**(335.9)**	**(351.0)**	**(351.0)**	**(351.0)**	**(351.0)**	**(351.0)**	**(351.0)**	**(2475.1)**
Cumulative Net	(33.0)	(368.9)	(719.9)	(1071.0)	(1422.0)	(1773.0)	(2124.1)	(2475.1)	(2475.1)
NPV									
At 3.5%	(33.0)	(324.5)	(327.7)	(316.6)	(305.9)	(295.6)	(285.6)	(275.9)	**(2164.8)**

Option 6c – Increase capacity with 2 additional machines – Capital Purchase

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction		612.3	612.3	612.3	612.3	612.3	612.3	612.3	4285.8
Non Pay cost reduction									0.0
Income Loss									0.0
									0.0
Total Recurrent Benefits	0.0	612.3	612.3	612.3	612.3	612.3	612.3	612.3	4285.8
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff		(269.2)	(269.2)	(269.2)	(269.2)	(269.2)	(269.2)	(269.2)	(1884.2)
Maintenance		(26.4)	(26.4)	(26.4)	(26.4)	(26.4)	(26.4)	(26.4)	(184.8)
Consumables		(8.5)	(8.5)	(8.5)	(8.5)	(8.5)	(8.5)	(8.5)	(59.5)
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff		(24.0)	(24.0)	(24.0)	(24.0)	(24.0)	(24.0)	(24.0)	(167.7)
Depreciation		(22.9)	(22.9)	(22.9)	(22.9)	(22.9)	(22.9)	(22.9)	(160.5)
Interest									0.0
									0.0
Total Recurrent Costs	0.0	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(2456.7)
Net Recurrent Costs/benefits	0.0	261.3	261.3	261.3	261.3	261.3	261.3	261.3	1829.1
Non-Recurrent Benefit (+ve)									
Warranty		15.1							15.1
Total Non-Recurrent Income	0.0	15.1	0.0	0.0	0.0	0.0	0.0	0.0	15.1
Non-Recurrent costs (-ve)									
Ultrasound Couch	(2.0)								(2.0)
Computer Hardware	(1.0)								(1.0)
									0.0
Total Non-Recurrent Costs	(3.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(3.0)
Net Non-Recurrent Costs/benefits	(3.0)	15.1	0.0	0.0	0.0	0.0	0.0	0.0	12.1
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment	(30.0)								(30.0)
Equipment	(160.5)								(160.5)
									0.0
									0.0
Total Capital Costs	(190.5)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(190.5)
Total Costs	(193.5)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(351.0)	(2650.3)
CASH IMPACT (to exclude depreciation)									
Benefits and Gains (Excl LOS)	0.0	15.1	0.0	0.0	0.0	0.0	0.0	0.0	15.1
Costs (Excl Depreciation)	(193.5)	(328.0)	(328.0)	(328.0)	(328.0)	(328.0)	(328.0)	(328.0)	(2489.7)
NET	**(193.5)**	**(312.9)**	**(328.0)**	**(328.0)**	**(328.0)**	**(328.0)**	**(328.0)**	**(328.0)**	**(2474.6)**
Cumulative Net	(193.5)	(506.4)	(834.4)	(1162.5)	(1490.5)	(1818.6)	(2146.6)	(2474.6)	(2474.6)
NPV									
At 3.5%	(193.5)	(302.3)	(306.2)	(295.9)	(285.9)	(276.2)	(266.9)	(257.8)	**(2184.7)**

Option 7a - Increase capacity with 1 additional machine – 5 year lease (No cap on activity)

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction		262.4	262.4	262.4	262.4	262.4	262.4	262.4	1836.5
Non Pay cost reduction									0.0
Income Loss									0.0
									0.0
Total Recurrent Benefits	0.0	262.4	262.4	262.4	262.4	262.4	262.4	262.4	1836.5
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff		(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(908.9)
Maintenance		(14.2)	(14.2)	(14.2)	(14.2)	(14.2)	(14.2)	(14.2)	(99.7)
Consumables		(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(29.8)
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff		(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(83.9)
Depreciation (lease)		(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(10.0)	(10.0)	(77.4)
Interest (lease)		(2.8)	(2.8)	(2.8)	(2.8)	(2.8)			(13.9)
Income Loss									0.0
Total Recurrent Costs	0.0	(174.6)	(174.6)	(174.6)	(174.6)	(174.6)	(170.4)	(170.4)	(1213.5)
Net Recurrent Costs/benefits	0.0	87.8	87.8	87.8	87.8	87.8	92.0	92.0	622.9
Non-Recurrent Benefit (+ve)									
Warranty		9.9							9.9
Total Non-Recurrent Income	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Non-Recurrent costs (-ve)									
Ultrasound Couch	(2.0)								(2.0)
Computer Hardware	(1.0)								(1.0)
									0.0
Total Non-Recurrent Costs	(3.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(3.0)
Net Non-Recurrent Costs/benefits	(3.0)	9.9	0.0	0.0	0.0	0.0	0.0	0.0	6.9
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment							(20.1)		(20.1)
									0.0
									0.0
Total Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	(20.1)	0.0	(20.1)
Total Costs	(3.0)	(174.6)	(174.6)	(174.6)	(174.6)	(174.6)	(190.4)	(170.4)	(1236.6)
CASH IMPACT									
Benefits and Gains (excl LOS)	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Costs (Inc Depn - lease)	(3.0)	(174.6)	(174.6)	(174.6)	(174.6)	(174.6)	(180.4)	(160.3)	(1216.5)
NET	**(3.0)**	**(164.7)**	**(174.6)**	**(174.6)**	**(174.6)**	**(174.6)**	**(180.4)**	**(160.3)**	**(1206.7)**
Cumulative Net	(3.0)	(167.7)	(342.3)	(516.8)	(691.4)	(866.0)	(1046.3)	(1206.7)	(1206.7)
NPV									
At 3.5%	(3.0)	(159.1)	(163.0)	(157.4)	(152.1)	(147.0)	(146.7)	(126.0)	**(1054.4)**

Option 7b - Increase capacity with 1 additional machine– 7 year lease (No cap on activity)

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction		262.4	262.4	262.4	262.4	262.4	262.4	262.4	1836.5
Non Pay cost reduction									0.0
Income Loss									0.0
									0.0
Total Recurrent Benefits	0.0	262.4	262.4	262.4	262.4	262.4	262.4	262.4	1836.5
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff		(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(908.9)
Maintenance		(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(92.4)
Consumables		(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(29.8)
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff		(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(83.9)
Depreciation (lease)		(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(80.3)
Interest (lease)		(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)
Income Loss									0.0
Total Recurrent Costs	0.0	(170.8)	(170.8)	(170.8)	(170.8)	(170.8)	(170.8)	(170.8)	(1195.4)
Net Recurrent Costs/benefits	0.0	91.6	91.6	91.6	91.6	91.6	91.6	91.6	641.1
Non-Recurrent Benefit (+ve)									
Warranty		9.9							9.9
Total Non-Recurrent Income	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Non-Recurrent costs (-ve)									
Ultrasound Couch	(2.0)								(2.0)
Computer Hardware	(1.0)								(1.0)
									0.0
Total Non-Recurrent Costs	(3.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(3.0)
Net Non-Recurrent Costs/benefits	(3.0)	9.9	0.0	0.0	0.0	0.0	0.0	0.0	6.9
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment									0.0
									0.0
									0.0
Total Capital Costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Costs	(3.0)	(170.8)	(170.8)	(170.8)	(170.8)	(170.8)	(170.8)	(170.8)	(1198.4)
CASH IMPACT									
Benefits and Gains (excl LOS)	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Costs (Inc Depn - lease)	(3.0)	(170.8)	(170.8)	(170.8)	(170.8)	(170.8)	(170.8)	(170.8)	(1198.4)
NET	**(3.0)**	**(160.9)**	**(170.8)**	**(170.8)**	**(170.8)**	**(170.8)**	**(170.8)**	**(170.8)**	**(1188.5)**
Cumulative Net	(3.0)	(163.9)	(334.7)	(505.4)	(676.2)	(847.0)	(1017.7)	(1188.5)	(1188.5)
NPV									
At 3.5%	(3.0)	(155.5)	(159.4)	(154.0)	(148.8)	(143.8)	(138.9)	(134.2)	**(1037.6)**

Option 7c - Increase capacity with 1 additional machine – Capital Purchase (No cap on activity)

£ in 1000s	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
FINANCIAL BENEFITS / GAINS									
Recurrent Benefits (+ve)									
Length of Stay reduction		262.4	262.4	262.4	262.4	262.4	262.4	262.4	1836.5
Non Pay cost reduction									0.0
Income Loss									0.0
									0.0
Total Recurrent Benefits	0.0	262.4	262.4	262.4	262.4	262.4	262.4	262.4	1836.5
COST ITEMS inflows / (outflows)									
Recurrent Costs (-ve)									
Directorate Costs									
Imaging Staff		(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(129.8)	(908.9)
Maintenance		(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(13.2)	(92.4)
Consumables		(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(4.3)	(29.8)
									0.0
Other Recurrent Costs (-ve)									
Support directorates									
Estates Staff		(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(83.9)
Depreciation		(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(80.3)
Interest									0.0
Income Loss									0.0
Total Recurrent Costs	0.0	(170.7)	(170.7)	(170.7)	(170.7)	(170.7)	(170.7)	(170.7)	(1195.2)
Net Recurrent Costs/benefits	0.0	91.6	91.6	91.6	91.6	91.6	91.6	91.6	641.3
Non-Recurrent Benefit (+ve)									
Warranty		9.9							9.9
Total Non-Recurrent Income	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Non-Recurrent costs (-ve)									
Ultrasound Couch	(2.0)								(2.0)
Computer Hardware	(1.0)								(1.0)
									0.0
Total Non-Recurrent Costs	(3.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(3.0)
Net Non-Recurrent Costs/benefits	(3.0)	9.9	0.0	0.0	0.0	0.0	0.0	0.0	6.9
Capital Costs (include non-recoverable VAT) (-ve)									
Refurbishment									0.0
Equipment	(80.3)								(80.3)
									0.0
									0.0
Total Capital Costs	(80.3)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(80.3)
Total Costs	(83.3)	(170.7)	(170.7)	(170.7)	(170.7)	(170.7)	(170.7)	(170.7)	(1278.4)
CASH IMPACT (to exclude depreciation)									
Benefits and Gains (Excl LOS)	0.0	9.9	0.0	0.0	0.0	0.0	0.0	0.0	9.9
Costs (Excl Depreciation)	(83.3)	(159.3)	(159.3)	(159.3)	(159.3)	(159.3)	(159.3)	(159.3)	(1198.2)
NET	**(83.3)**	**(149.4)**	**(159.3)**	**(159.3)**	**(159.3)**	**(159.3)**	**(159.3)**	**(159.3)**	**(1188.3)**
Cumulative Net	(83.3)	(232.7)	(391.9)	(551.2)	(710.5)	(869.7)	(1029.0)	(1188.3)	(1188.3)
NPV									
At 3.5%	(83.3)	(144.3)	(148.7)	(143.7)	(138.8)	(134.1)	(129.6)	(125.2)	**(1047.6)**

Appendix 3 – Further Options Evaluation

ULTRASOUND BUSINESS CASE - further financial evaluation Options 6 & 7				
	No of Scans			
Existing Ultrasound Capacity	19,000	based on current staffing at 20mins per scan		
Current Ultrasound Activity	30,580	existing machines/staffing are opertating 11000 scans above recommended level		
Current Inpatient Activity	5,944			
Operating Level	161%	based on recommended patient safe level		
Average wait for inpatient scan	38	hours		

		Option 6	**Option 7**	**Notes**
No of Machines	Additional machines	2	1	
		No of Scans	**No of Scans**	
Capacity and Demand	Additional Capacity	12,000	6,000	
	Capacity Increase	63%	32%	
	New Operating Level	99%	122%	Assumes no acitivity growth therefore, Option 6 is opertaing at safe level
	Improvement	62%	39%	
		£'000	**£'000**	
Financial Analysis (£000)	Total Cost	390	176	Based on 5 Year Lease Option
	Total Benefit - LOS Reduction	-612	-262	Based on bed day cost of £238.50 at 2567 beddays saved (see below)
	Net Benefit	**-223**	**-86**	
		Beddays	**Beddays**	
Bed Day Reduction	Due to increased capacity	1,367	1,100	Assumes reduced waiting time for inpatient scan will reduced overall LOS
	Preventable AKI	1,200		300 preventable cases per year - LOS reduction of 4 days per case
	Total	**2,567**	**1,100**	
Breakeven position	Income required to offset recurrent investment	-390	-176	
	Required bedday reduction	1,633	738	Number of inpatients required to reduce LOS by 1 day in order to cover cost of investment
		27%	12%	% of inpatients required to reduce LOS by 1 day in order to cover cost of investment

NOTES;

1. Existing machines are operating above safe capacity ie recommended appointment of 20mins per patient has reduced to 14mins
2. Average wait for an inpatient scan is 38 hours, with 9% of patients waiting 3days or more, therefore increasing LOS
3. Option 6 delivers sufficient capacity to meet demand in addition to the provision of dedicated inpatient capacity. Option 7 increases current capacity but does not meet demand at a safe operating level

4. Reduction in Length of stay dependant upon;

- Assumes patients are discharged earlier with no other factors impacting on discharge
- Assumes current discharge performance remains static
- Assumes external interventions impacting on discharge remain constant
- Realisation of financial benefit due to reduction in LOS is dependant on increased throughput of Elective activity or reduction in bed capacity
- The Trust is required to discharge 1,613 or 755 patients 1 day earlier in order for the options to break even

Appendix 4

April 2018: All the ultrasound equipment in the Imaging Department failed its NHS QA assessment (See below).

QA Results

	Ultrasound WMH			
Machine	Imaging Department	Older than 5yrs	Pass/Fail QA	Comment
1	Logic E9 : DTC Room 1	YES	FAIL	Required ASAP
2	HD15 : Annex	YES	FAIL	Scrapped May 2018 : Short Rental replacement in place Aug 2018
3	Sonosite : Main Dept	YES	FAIL	Scrapped May 2018 : Rented replacement to be sourced ASAP
4	IU22 : Main Dept	YES	FAIL	Scrapped June 2018 : Rented replacement to be sourced ASAP
5	Logic E9 : Breast Imaging	YES	FAIL	Required ASAP
6	Siemens Antares : Main Dept	YES	FAIL	Scrapped May 2018 : Rented replacement to be sourced ASAP

All machines are over 5 years old and have failed their QA and now require immediate replacement.

There is additional ultrasound equipment that requires replacing outside of the scope of this business case that will need to be addressed separately.

MEETING OF THE PUBLIC TRUST BOARD – 5th July 2018					
Performance Finance and Investment Committee Highlight Report				**AGENDA ITEM: 17**	
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 27 June 2018 together with the approved minutes of the meeting held on 30 May 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:

Presentation - The Model Hospital (Benchmark Review) - James Cook NHSI
A comprehensive presentation positioning Walsall against best in class Trust performance for all front line and back office functions. The presentation highlighted areas for improvement and consolidation. The presentation would be shared with Care Groups and NHSI offered support in how to use the data in way to enhance patient services.

May 2018 Financial performance
Performance was slightly adverse to plan mainly due to temporary staffing spend and CIP delivery. 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 and to focus on the profile of CIP delivery in Q2 and Q3. The full year plan currently has a unacceptable level of risk and it was agreed to produce a recovery plan that fully mitigates this. Details of the financial recovery plan will be available within the next two weeks and will be the subject of review at an extraordinary PFIC meeting.

Cost Improvement Programme
The current status of the plan was discussed in detail, whilst in month performance had substantially improved and was slightly adverse, considerable work was still underway to underpin full delivery. Currently the level of risk for delivery of the £13 m requirement was £5m. Work was continuing to convert the list of initiatives into firm plans.

CIP - Outpatient Initiative Review
Current progress was reviewed and the level of improvement achieved over the last 2years. 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 expected to improve over the next few weeks.

Temporary Staffing
Nursing agency and bank usage was adverse to plan for month 2 whilst May position has improved, and it was agreed to update the committee on further actions to address the position as part of the financial recovery plan.

Constitutional standards operational report
A strong performance for the month, highlights:
Cancer standards
A&E performance in advance of plan
RTT performance on plan

Investment Appraisal
The committee made recommendations on the following items:
Ultrasound Business Case - recommendation to proceed for board approval
Gastroenterology Business Case - approval given
Walsall Together Consultancy Commission - recommendation to proceed for board approval
Estates Strategy - recommendation to proceed for board approval
Estates Refurbishment costs - approval given

Post Implementation Review
Change to Nurse Bank Pay Rate - project implementation met project timelines, benefits partially met, further action under consideration.

Committee Terms of Reference
The revised TOR were agreed

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: 29 June 2018

APPENDICES
Minutes

Walsall Healthcare NHS
NHS Trust

MINUTES OF THE PERFORMANCE FINANCE AND INVESTMENT COMMITTEE HELD ON WEDNESDAY 30th MAY 2018 AT 2.00 P.M. IN MEETING SUITE A, MLCC

Present:	Mr J Dunn	Non-executive Director (Chair of Committee)
	Mr S Heer	Non-executive Director
	Mr R Beeken	Chief Executive
	Mr R Caldicott	Director of Finance and Performance
	Mr A Khan	Medical Director
	Mrs K Blackwell	Acting Nurse Director
	Mrs J White	Interim Trust Secretary
In Attendance:	Mr M Dodd	Divisional Operations Director - MLTC
	Mr N Turner	Divisional Director – Surgery (up to Item 005/18)
	Mrs A Winyard	Divisional Operations Director – Surgery (Item 005/18 only)
	Mr Q Zada	PMO Director
	Mrs C Dawes	Executive Assistant (Minutes)
Apologies:	Mr D Fradgley	Director of Strategy & Improvement
	Mrs L Ludgrove	Interim Director of Human Resources and Organisational Development
	Mr P Thomas-Hands	Chief Operating Officer

The Chair welcomed everyone and opened the meeting. Apologies were noted and the meeting was declared quorate. Mr Dodd was in attendance on behalf of Mr Thomas-Hands.

ACTION

001/18 **Quorum**

The meeting was declared quorate in line with Item 5 of the Committee Terms of Reference; The Committee will be deemed quorate for the transaction of business when the two non-executive directors, the Director of Finance and Performance, the Chief Operating Officer and one other Executive Director are in attendance

002/18 **Declarations of Interest**

There were no declarations of interest.

003/18 **Minutes of the Meetings held on 21st February 2018 and Extraordinary meeting held on 8th March 2018**

Resolution:
The minutes of the meetings held on 21st February 2018 and Extraordinary meeting held on 8th March 2018 were approved as an accurate record.

004/18 **Matters Arising and Action Sheet**

The Committee received the status of the following actions:
095/17 Intermediate Care Business Case: report to June meeting.
24/1/18 KPMG Close Out report to be presented at a separate meeting in

September.
28/3/18 People Profile: Agreed not a report for this committee.
28/3/18 CIP Programme: Provide schedule of programme owners attendance at meetings
28/3/18 Change to Bank rates: Report to be presented at June meeting.

Resolution:
The Committee received and noted the status on the actions.

Mrs Winyard joined the meeting at this point.

005/18 Divisional Presentation – Division of Surgery

The Chair welcomed Mr Turner and Mrs Winyard who gave a presentation on the key performance and financial position for the Division of Surgery during Quarter 1.

It was highlighted overspends on nurse and medial staffing, together with CIP under delivery were they key drivers of the overspend position.

The chair acknowledged the improvement in the key performance indicators and highlighted there was a degree of variability in the control of processes and asked what the issues were. Mrs Winyard responded advising there had been a significant culture change and some processes were new and as these become embedded the process would become smoother and performance would improve. The key would be to have a daily co-ordinator overseeing the theatre processes and dealing with any issues and there was a plan to address this.

There was a discussion about the theatre utilisation, in particular when theatres were not being used and it was explained that some cases where more complex than others and it was about getting the best model to give improvement. Mr Khan suggested trialling having a second anaesthetist available to increase the number of cases.

There was a discussion about the centralisation of medical staffing resource in connection with rotas and work was being undertaken to improve the weekly analysis; however it was acknowledged trends were going in the right direction.

The Chair thanked Mr Turner and Mrs Winyard and summarised by noting there had been a big improvement which would give assurance to the Trust Board and focus was on delivery in quarter two.

Mr Turner and Mrs Winyard left the meeting at this point.

006/18 Financial Performance - 2018/2019 Month 1 Report

The Director of Finance and Performance outlined the 2018/2019 Financial position for Month 1 and highlighted the following:

- The Trust was reporting a deficit of £2,386k against a deficit plan of £2,483k, resulting in a favourable YTD deficit of £97k.

- The contracted income showed a favourable variance to plan of £86k. The Trust had agreed a contract with Walsall CCG commissioner

which provided for financial certainty on Emergency Inpatients, Rehabilitation and contract fines & penalties. The remainder of contracts with commissioners were on a cost & volume basis providing opportunity to deliver efficiencies through increased income.

- Expenditure was overspent by £154k YTD. The main area of overspending was non-pay relating to non-delivery of CIP in month. Pay was breakeven, despite overspending within Medical (£115k overspend) and Nursing (£440k overspend) to support the additional capacity open in April. These overspends were offset by underspends in other pay groups and phasing of pay reserves for developments

- The Trust's Annual Cost Improvement Programme requirement was £13m.

- The CIP plan for M1 was £763k (5.9% of the target) and actual delivery wass £168k (1.3% of target), resulting in an under achievement of £595k YTD. In addition, of this total £91k was delivered non-recurrently, placing increased pressure on future financial sustainability.

- The Trust's planned cash holding in accordance with borrowing requirements was £1m. The actual cash holding was £1.004m.

- The Trust's agreed borrowing for 2018/19 was £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 was circa £2.3m payable in 2018/19.

- The year to date capital expenditure was £0.5m, with the main spends relating to ICCU (£0.3m), Estates Lifecycle (£0.07m), Medical Equipment (£0.03m) and Community Mobile technology (£0.05m).

- Total expenditure on temporary workforce was £1.914m (April 2018) representing a £91k reduction on the March total. Agency increased by £227k to £754k, Bank reduced by £285k to £526k and Locum reduced by £32k to £635k.

The Director of Finance and Performance commented the key risks were CIP delivery and temporary workforce expenditure, both of which would show improvement in May.

Questions and Comments

The Chair commented about the finance performance Amber rating at month 1 as he felt this was a generous assumption of the position.

The Chief Executive explained the escalation on bed numbers had not started to run down until late April and annual leave had impacted on efficiencies and was expecting an improvement in May.

There was a discussion on the ED capital scheme which had been included in a list of capital schemes being assessed by the local STP. It was requested this was further discussed at the Private Board in June. **RC**

The Medical Director questioned the under-performance within the divisions noting the elective and outpatient activity was down and WCCSS division were under performing and asked how this would be improved. The Director of Finance & Performance agreed to look into this with the divisions. **RC**

Mr Heer questioned the varying CIP targets within the report and asked for consistency in reporting. It was agreed a CIP delivery total of £13m would be used in future reports. **RC**

Resolution:
The Committee:

- **Received and noted the content of the Month 1 Finance Report.**

007/18 Improvement Programme Update

Mr Zada presented the Cost Improvement Programme update for month 1 and the following key messages were noted:

- The Cost Improvement Programme for 2018/19 was £13m. The month 1 delivery was low due to income data awaiting validation
- Divisions were working to close the gap and complete PIDs for each scheme. Significant risk was highlighted in Medicine Division based on plans to date.
- Meetings arranged with the Chief Executive, Executive Leads, Director of Finance and PMO for all schemes. Mid-point reviews were being initiated.
- Activity in Outpatients and Theatres to be accelerated; however recent performance had demonstrated momentum.
- Work was underway with the divisions to bring forward delivery to reduce the risk of falling within Quarter 4.

There was discussion about the wording used to report progress as it was felt that until an idea had been processed and ratified through the various stages it was not considered a "plan" and should be reported as such. Mr Zada agreed to amend future reports to reflect the comments of the committee. **QZ**

There was discussion about the establishment of the PMO as it was felt that more pace and robust processes were necessary to ensure adequate resource capacity and capability was available for delivery of the target. Mr Zada explained that current members of the PMO were currently going through a Management of Change process. The committee offered any assistance necessary to support the process.

The Chair summarised by noting programmes were being underpinned but there was a degree of risk. Work was underway to re-profile the delivery to in Q2/Q3 to reduce the risk of back loading at the end of the year.

Resolution:
The Committee:

- **Received and noted the content of the Cost Improvement Programme Update**
- **Noted the report would be amended to reflect discussions on terminology**

008/18 NHSI Control Total

The Director of Finance & Performance advised the Trust had received a revised offer of a control total for the 2018/19 financial year and explained the purpose of the report was to confirm the components of the revised offer, assess the benefits and pitfalls from accepting such an offer and seek confirmation of members views in reaching a consensus view that can form a recommendation to Trust Board.

It was acknowledged the paper was easy to understand to enable the committee to discuss and give their views. Members debated the information presented and all agreed with the decision to recommend acceptance of the control total to the Trust Board and to seek to mitigate the financial risk.

Resolution:
The Committee:

- **Received and noted the content of the report**
- **Agreed to recommend acceptance of the Control Total to the Trust Board**
- **Noted the agreement to seek to mitigate the financial risk**

009/18 Temporary Staffing

The Director of Finance and Performance presented an overview of the temporary staffing report and the following highlights were noted:

- The Trust had been set a ceiling for agency expenditure by NHSI of £6.5m, representing a 1% reduction on the 2017/18 actual expenditure.
- The month 1 expenditure was £754k, against a plan of £422k. Both Medical and Nursing expenditure exceeded the phase plan.
- Nursing temporary workforce reduced against March total, however expenditure remained high due to capacity pressures in April. (Highest since January 2018).
- Temporary staffing reduced to £1.9m for April (March £2m) Total expenditure on nurse temporary staffing reduced to £898k for April
- Work was underway to mitigate the £2.5m run rate risk for June report

The committee questioned the effectiveness of grip and control processes as they did not appear to be working at present and what assurance would

be given that the June performance would improve. It was noted the agreed actions had not been captured within the report and these would be included for clarity in the next report.

The chair summarised discussion by noting the disappointing start to the year and there were actions agreed to mitigate the run rate risk for the June report.

Resolution:
The Committee:

- **Received and noted the content of the report**
- **Noted actions had been agreed to mitigate the run rate risk**

010/18 Constitutional Standards Operational Update

Mr Dodd gave an overview of the Constitutional Standards relating to Emergency Department, Elective Access and Cancer. The key messages were highlighted as:

Emergency/Urgent Care:

- April performance had increased to 87.22% against a target of 83%.
- Medically Fit for Discharge (MFFD) list is reducing.
- April saw continued high levels of ambulances to ED (90+ ambulance arrivals on 14 days in month).
- Admissions per day had decreased from 89 in March to 86 in April.
- There were no 12 hour breaches.

Elective Access:

- Performance in April was 85.89% against a trajectory of 84.2%, which was a continued improvement against the March performance of 84.74%.
- The outpatient workstream continues to embed improvements on booking utilisation, reduction in DNA rates and using core capacity to see cancer referrals, whilst keeping WLI clinics to a minimum.
- The trajectory assumed delivery without WLI activity.
- The clinic booking utilisation target of 90% was achieved by all divisions in April
- There were 4 breaches in March.

Cancer:

- All national cancer measures achieved in March. Initial un-validated performance for April shows achievement of all cancer measures.

Diagnostics:
April performance was 99.05% thus achieving the 99% target.

Questions and comments:

The Chair summarised by noting the improved performance and commitment within A & E given the challenges and to concentrate now on improving performance produce a sustainable trend.

Resolution:
The Committee:

- **Received and noted the content of the Constitutional Standards Operational Update.**

011/18 Performance and Quality Report by Exception

The Performance and Quality Report was taken as read.

The Director of Finance asked the committee to note the penalties on performance and highlighted that key metrics were discussed at the Quality & Safety Committee.

Resolution:
The Committee:

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

012/18 NHSI Resource Review

The Director of Finance gave a verbal update reporting that weekly CQC preparation meetings were taking place and a self-assessment run by regional teams would be undertaken with key indicators for CQC Reviews. Self-assessments would be based on Model Hospital.

It was noted Mr James Cook, Regional Productivity Director for East & West Midlands NHSI would be attending to present at the next meeting.

Resolution:
The Committee:

- **Received and noted the content of the report.**
- **Noted the Regional Productivity Director for East & West Midlands NHSI would be attending the next meeting**

013/18 Gastroenterology Business Case

Mr Dodd gave an overview of Phase 2 of the Gastroenterology Business Case for the recruitment of specialist nurses and a pharmacist advising (Phase1 was previously approved) and explained there was a demand for the service as historically there had been underinvestment in specialist Gastroenterology nurse support and consultants resulting in below national performance standards and provision of care for patients, however it required prior agreement with the CCG.

The business case proposed a new workforce model requiring the recruitment of 3.3 wte specialist nurses and a 0.5 wte pharmacist.

The committee were in support from a clinical and patient perspective but agreed not to approve the business case until CCG agreement had been received.

Resolution:

The Committee:

- **Received and noted the content of the Gastroenterology Business Case**
- **Rejected the business case on the basis that CCG agreement had not been received**

014/18 Pharmacy Subco Business Case

The Director of Finance and Performance gave an overview of the Business Case for the establishment of a subsidiary pharmacy to deliver outpatient dispensing services, thus addressing the current delays in the prescription and fulfilment of inpatient discharge medication and improving the customer experience and performance on patient discharges.

The committee raised concern on the ethics and ability to have a subsidiary pharmacy within the organisation if not a Foundation Trust and agreed to have an offline discussion to understand the structure. A meeting to be arranged to explore how to form a legal entity and the Director of Finance agreed to carry out the preparatory work for executive approval.

Resolution:
The Committee:

- **Received and noted the content of the business case**
- **Agreed to have offline discussion on the legality**
- **Noted the Director of Finance would prepare details for executive approval**

015/18 ANY OTHER BUSINESS

There was no other business discussed.

016/18 Date of Next Meeting

The next meeting of the Committee would be held on of **Wednesday, 27th June 2018 at 2p.m.** in Room 10, Manor Learning and Conference Centre, Walsall Manor Hospital.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD – 5th July 2018				
Partnership Update – Public Trust Board				**AGENDA ITEM: 16**
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
July 2018

1. Introduction

In this month's report I will refer to numerous items of work that have been undertaken over the last month with partners. You will see from the information within the report that progress in collaboration with our partners is being made in multiple areas.

2. Visit to Rotherham

During the work undertaken on the Walsall Together Case for Change, several reference sites were used and recommended by KPMG. One of these sites was the borough of Rotherham which shares an almost identical demographic and provider and commissioner landscape. It is worth noting that Rotherham NHS Foundation Trust as an integrated provider of an almost identical size to the Trust is one of our peer sites in the model hospital and NHSi reference groupings.

Members from Walsall Council and the Trust were hosted by partners in Rotherham earlier this month and openly shared their progress and lessons learnt on the integration journey. The similarities between the challenges we face and the solutions we are proposing are so similar that you could read across some of our documents and mistake once for the other. In fact, Rotherham has 7 locality teams – identical to ourselves and their approach to place based care through a Together Programme is identical to the Walsall's.

Rotherham have made more progress in areas such as care coordination (single point of access) and communication than Walsall currently have and lessons can be learnt here. More impressively however, is the IT integration they have achieved internally where capacity and patient flow can be seen moving across acute beds all the way through nursing homes and back into their own home under the care of their locality teams.

In contrast Rotherham haven't made the progress we have with the future provider models and intermediate care. To this end we have a mutual interest to openly share progress and to some extent look at planning as a peer group to test out our future models of care. The team has also expressed their interest in coming to see what we have achieved in Walsall. A real opportunity exists to explore how we can replicate the IT approach within our system with their support and guidance. I have agreed to coordinate regular communication and sharing sessions for our mutual interest which is mirrored across providers and the CCG's.

3. Walsall Together - Planning

Following the commitment of all partners last month to jointly fund the next steps of the Walsall Together Partnership, coordination has commenced to build a programme plan and consider which of the current meetings can be converted into a programme board. Further to this piece of work and ultimately preparation of a full business case, scoping is underway to establish

robust governance process for each organisation to consider and establish appropriate decision making that this complimentary to current Trust governance arrangements. This will be essential for the next stage of the programme and to assure that appropriate steps are taken to consult and approve in the correct order. Board members will be kept fully advised and briefed as this work progresses.

4. Walsall Together – Clinical / Practitioner Leadership Forum

Part of the programme planning mentioned above is a firm commitment from all partners that the next stage of clinical pathways and operational models are shaped by our front-line teams in the order in which the current challenges are face. To this end, a leadership forum has been established that met for the first time two weeks ago.

There was broad agreement in the room that our operational leaders have a willingness to shape the next part of our integration work, aligning the current pathways and removing the barriers that exist between organisations. It was expressed that pathways are often appropriate, but referral times and methods of communication are the issues that needed to be tackled together. It is anticipated with a concerted effort to remove unnecessary duplication of effort we can achieve a better outcome for our population in a shorter timeframe than currently.

There was a strong and universal view shared that a single record view of the patient / care record should be as much a priority as the pathway work itself and whilst it was accepted that different systems would remain in place across the borough, this should not prevent the integration of this information into a single view. The request to share information across systems and data to inform of patient flows and capacity is now being considered a material part of the next steps.

5. Single Care Record – End of life pathway

Towards the end of last year, the CCG with the support of the Walsall Together Partnership Board managed to secure some digital funding to commence a view of a shared record approach. This approach is in line with the request outlined in the previous section of this report.

Scoping work has been undertaken and all partners have agreed that this should be piloted against the national requirement for a single end of life register and patient record. In relation to Walsall Together, this is one of the patient groups that will be within the scope of phase one of the programme and most beneficial of integrated care for patients at the end of their lives.

The first project board met last week to scope out a deployment programme that will ultimately see this record delivered in Q4 of this year. As you can appreciate, this is a hugely complex piece of work, but has been achieved in other areas of the country and therefore those models are being used as templates for the Walsall deployment. This work will also provide the foundation for a wide whole system shared care record shortly afterwards which will need scoping and funding appropriately.

6. Integrated Care System development (formally STP)

A significant amount of work is going on in this area with numerous members of the Executive, Clinical and Technical leadership teams meeting weekly across the Black Country to work

through development plans with the support of NHSe. This is covered in the CEO report this month and therefore not duplicated here.

7. Primary Care Tender outcome for APMS practices

Board members will be aware that the Trust had submitted a joint bid with partners from Walsall Council, Mental Health and led by Modality for the APMS practices within Walsall. The tender relates to the practices noted below and is for a period of 5 years extendable to 10 years.

Lot	Practices	Actual List Size at 1/10/2017
1	Wharf Family Practice	3,542
	Sai Practice	3,750
	Manor Medical	2,913
2	Harden Family Practice	2,738
	Coalpool Family Practice	4,123
	Blakenhall Family Practice	5,844
3	Keys Family Practice	4,833
4	Collingwood Family Practice	5,105

I am pleased to announce that the Partnership was success in winning the Tender across all four lots. This is an amazing achievement for the all lead by Modality and signals a new phase in the Trusts operations across the borough. The successful nature of the bid was around the strength of the integrated working and our collective approach to putting the patient at the core of our place-based thinking. The Trust will be able to support the operation of these practices by linking primary and secondary care clinicians together with community colleagues so that they are able to wrap around the communities that they serve.

As planning for deployment progresses board members will be kept current through board committees.

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8. RECOMMENDATIONS

The Board is asked to **NOTE** the information within this report.

Report Author: Daren Fradgley – Director of Strategy & Improvement
Date of report: 27th June 2018

<table>
<tr><td colspan="6">MEETING OF THE TRUST BOARD</td></tr>
<tr><td colspan="5">Change of Vision Statement</td><td>AGENDA ITEM: 19</td></tr>
<tr><td>Report Author and Job Title:</td><td colspan="2">Roseanne Crossey, Head of Business Development and Planning</td><td>Responsible Director:</td><td colspan="2">Daren Fradgley, Director of Strategy and Improvement</td></tr>
<tr><td rowspan="2">Action Required</td><td>Approval
X</td><td>Decision</td><td colspan="3">Assurance and Information</td></tr>
<tr><td></td><td colspan="2">To receive and discuss</td><td>To receive</td></tr>
<tr><td>Recommendation</td><td colspan="5">Members of the Trust Board are asked to approve the change of the Trust’s Vision statement from: Becoming your Partners for First-Class Integrated Care to: Caring for Walsall Together.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="5">N/A</td></tr>
<tr><td>Resource implications</td><td colspan="5">Communications plan and engagement of stakeholders. Rebranding of Trust literature and signage.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="5">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="4">Continue our journey on patient safety and clinical quality through a comprehensive improvement programme</td><td></td></tr>
<tr><td colspan="4">Develop the culture of the organisation to ensure mature decision making and clinical leadership</td><td></td></tr>
<tr><td colspan="4">Improve our financial health through our robust improvement programme</td><td></td></tr>
<tr><td colspan="4">Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts</td><td>√</td></tr>
</table>

EXECUTIVE SUMMARY

In 2016/17 the Trust adopted the vision statement of ***Becoming Your Partners for First-Class Integrated Care***. It is underpinned by five strategic objectives as depicted below:

Figure 1: Trust's Current Vision Statement and Strategic Objectives.

More recently the Trust has undertaken an engagement exercise to reset its values, which will be released in July. During this refresh we took the opportunity to revisit the existing vision statement, which has had mixed reviews and has been described as too complex and not memorable.

Developments in our partnering relationships confirm that our existing strategic objectives remain relevant to the Trust, and whilst the strategy requires additional work most notably by a supporting delivery plan, it remains fit for purpose.

The current vision statement draws together the ambition for high quality care delivered in partnership. It is felt that these components should not be lost in the refresh of the statement, but merely simplified.

Following a variety of views and discussions with, staff and other internal and external stakeholders, the Executive team feel that this is the right time to refresh our vision statement only.

The proposed new vision statement is:

Caring for Walsall Together.

It is the general consensus that the revised statement addresses the issues of memorability, and strategic intent, and importantly aligns with our determined ambition to be the host organisation of the Walsall Together Partnership.

The proposed change of vision statement has been discussed and endorsed by the Executive Committee and, subject to Board approval, will be implemented with immediate effect.

RECOMMENDATION

The Board is asked to **approve** the new vision statement.

Daren Fradgley
27th June 2018

Walsall Healthcare NHS Trust

MEETING OF THE PUBLIC TRUST BOARD – Thursday 5th July 2018				
Charitable Funds Committee – Highlight Report				**AGENDA ITEM: 21**
Report Author and Job Title:	Jackie White Trust Secretary		**Responsible Director:**	Vicky Harris Non-Executive Director
Action Required	**Approval**	**Decision**	**Assurance and Information X**	
			To receive and discuss	**To receive X**
Recommendation	Members of the Trust Board are asked to: Discuss the content of the report and raise any questions in relation to the assurance provided			
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			
	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			

Charitable Funds Committee Highlight Report

1. Introduction

The Committee reports to the Corporate Trustee meeting following its meeting. The Trustees receive the approved minutes from the previous Committee meeting and a highlight report on the key issues raised at the most recent meeting. The report covers the key issues from the meeting held on 21st June 2018 together with the approved minutes of the meeting held on the 19th April 2018.

2. Key Issues from Meeting Held on 21st June 2018

2.1 The meeting was quorate and Chaired by Mrs Vicky Harris, Non-Executive Director and Committee Chair

2.2 The Committee noted a number of substantial donations (£20,000 and £5,000) and wished to record its thanks. These donations provided sufficient funding for a Unique & CFM Starter Kit and a Sertain Chair.

2.3 The Committee discussed the fundraising events which were due including the A & E Fundraiser – the coming weekend, NHS 70th Birthday – June and July, and 'It's a Knockout' – 14th July. Members are recommending attendance at the 70th Birthday and 'It's a Knockout'.

3. Recommendations

The Trustees are recommended to discuss the content of the report and raise any questions in relation to the assurance provided.

Report Author: Jackie White – Trust Secretary
Date of report: 29th June 2018

APPENDICES

Approved minutes of the Charitable Funds Committee held on 19th April 2018

MINUTES OF CHARITABLE FUNDS COMMITTEE HELD ON THURSDAY 19TH APRIL 2018 SEMINAR ROOM ROUTE 126

Present:

Mrs V Harris	Non-Executive Director

In Attendance:

Mr R Caldicott	Director of Finance
Mrs S Jones	Charitable Funds Accountant
Mr T Kettle	Deputy Director of Finance
Mrs G Westley	Fundraising Manager
Mrs J White	Trust Secretary

Apologies for Absence:

Mr T Baker	Chief Financial Accountant
Mrs B Beal	Director of Nursing
Mr R Beale	Non-Executive Director

Action

Mrs Harris welcomed everyone to the meeting.

01/18 **Declarations of Interest**

There were no declarations of interest raised in relation to the agenda items.

02/18 **Minutes of Meeting Held on 17th January 2018**

The minutes of the meeting held on 17th January 2018 were agreed as a true record.

Resolution:
The Committee received and approved the minutes of the meeting held on 17th January 2018.

03/18 **Action Tracker**

The items on the action tracker were discussed and updated.

62/17 Retirement Lunches: Mrs Harris confirmed that a debate had previously been held regarding the funding of lunches, however, the committee were not aware that any communication had been circulated to the wider organisation. Mr Caldicott confirmed that in accordance with the amended Charitable Funds Policy the Committee would not agree any further funds for retirement lunches. Mrs Ilic to take forward.

Resolution:
The Committee received and noted the progress and update on the action tracker.
A communication to be made to the wider organisation regarding funding of retirement lunches **JI**

04/18 **Matters Arising**

a) **Pooling of Funds:** Mr Caldicott advised that the committee should agree the priorities for investment from the General Fund and if the resource was exhausted then a priority list would be in place until the resource was available. Mr Caldicott expressed the view that the paper presented was radically different. Mr Kettle advised that the shortfall in funding was due to the £200,000 for the support of the Gamma Camera. Mr Caldicott confirmed that the support of the Gamma Camera was a separate conversation and a paper would be provided for the Corporate Trustees Meeting to agree a method of funding.

Mrs Jones queried the Robotic Software and ED post, a commitment of £298,000 with £24,000 remaining in the General Fund. Mr Caldicott expressed the view that the committee needed to be clear about the commitments made from the General Fund which could not be afforded. Mrs Jones confirmed that some of the items had already been purchased and Mr Kettle reminded the committee that the items were agreed by a Chair's action from several months ago. Mrs Harris requested that the governance around charitable requests be tightened with a move back to a committee decision. Mrs White advised that the committee needed to agree how the process would be managed with the resources in the funds matched to the requests and the paperwork policed. It was agreed that Mrs Jones and Mrs Ward would liaise to clarify the process. Following discussion around taking Chair's action it was agreed that all decisions would be made within the committee process. The following requests were identified as agreed without the availability of funds:

- Enhanced therapy
- Robotic software
- ED post

b) IPADS for Surgery and MLTC: Mr Kettle confirmed that no further information had been received regarding the request to purchase. It was agreed that the item would be removed from the agenda.

c) Lifestyle Services: Mrs Westley advised that this was a pilot project to enable some members of staff within the organisation following the loss of the Lifestyle Services contract, Mrs Westley further confirmed that the members of staff had now left the Trust. Following discussion, it was agreed that feedback on the project should be provided and Mrs Davis, Head of Learning and Development would be invited to the next meeting to provide an appropriate report.

Resolution:

The Committee received and noted the progress with matters outstanding	
Mr Caldicott to update the Corporate Trustees in relation to funding of the Gamma Camera	**RC**
Funding requests for the Committee to be clarified	
IPADS to be removed from the agenda	**SJ/AW**
Report to be received on the Lifestyle Services Project	**AW**
	AW

05/18 **Quarterly Review of Expenditure Below £5k**

The content of the report was noted by the Committee.

Resolution:
The Committee received and noted the contents of the report

06/18 **Review of Expenditure Requests £5k to £99,999 for Authorisation**

IPADS for Friends & Family Test – Mrs Harris advised that clarity would be needed around the request and the committee could not agree until the paperwork was presented.

Long Service Awards – Mrs Jones advised that the paperwork had been received today. Mr Caldicott expressed the view that there needed to be a discussion with the Corporate Trustees about the funding of Long Service Awards and the Trust Ball. Mr Caldicott agreed to present a paper to Corporate Trustees Meeting regarding the over commitment of the General Fund for a decision on whether to top slice or not from other funds, together with a resolution regarding the funding of staff events.

Birthing Pool Hire – Mrs Jones advised that the birthing pool hire request was for a decision in principle. A discussion took place regarding the offering of a birthing pool facility at home and Mr Caldicott suggested that the pools should be trialled through the Divisional budget. A further discussion took place regarding any liability insurance that would need to be in place prior to offering the facility in patients own homes in relation to damage or failure, Mrs Ilic confirmed that other hospitals offered the service and felt that a disclaimer would be in place. Mr Caldicott advised that he felt the request had come to the wrong committee as the request was a clinical change of practice and should be discussed at Trust Quality Executive. The Committee agreed that feedback should be provided to the Division and Mr Caldicott agreed to provide the detail to confirm that the committee did not endorse the request as it was felt it was a service change for enhancement.

Digitrapper – Mr Caldicott queried whether the VAT was recoverable and advised that if the VAT was recoverable then the requester had sufficient funds in their own Trust Fund. It was agreed that should the VAT not be recoverable then the committee could not approve.

HDU Monitors – Mrs Harris confirmed that she had approved from the maternity fund prior to the meeting. Mrs Harris signed the paperwork as agreed.

Mrs Jones queried the process for requests that were £4900 and whether there was any particular action the committee wished her to take, Mrs White suggested that a review could be taken afterwards, if the cost was not noted at the time.

Resolution:
The Committee agreed that approval would not be granted until appropriate paperwork received for requests
Mr Caldicott to discuss funding for Long Service Awards and the

position of the General Fund at Corporate Trustees Meeting **RC**
Birthing Pool Hire – rejected
Mrs Jones to advise regarding the VAT on Digitrapper
The Committee approved the purchase of HDU Monitors **SJ**

07/18 **Review of Expenditure Requests £100+ for Recommendation to Trustees**

There were no requests for consideration.

08/18 **Quarterly Review of Charitable Income & Expenditure**

Mr Kettle summarised the income and expenditure and advised that expenditure was higher than income. The review also contained the list of individual funds. The balance of funds was noted at £1.2m with a commitment of £181,000 of which £200,000 was restricted funds. Mrs White queried whether the committee could do anything to encourage fund raising, Mrs White agreed to discuss further with Mr Caldicott outside the meeting.

Mrs White queried how people would feel if the committee decided to pool the funds, Mrs Westley responded that she felt staff would be unhappy. Mr Kettle confirmed that pooling had occurred previously but by specialty, Mrs White suggested a short-term movement of funds, Mr Caldicott responded that a proposal would be needed and the committee could agree to top slice, however, that could have a departmental effect on other funds and queried whether the Trustees would be happy for that to occur at the discretion of the Charitable Funds Committee. The comments were noted for information.

Resolution:
The Committee received and noted the contents of the Income & Expenditure report.

09/18 **Estimate of Income & Expenditure for Year/Budget Planning**

Mr Caldicott advised that the paper was a Trust summary highlighting the issue of going below the agreed level of available cash, Mrs White confirmed that a report would be needed to the Corporate Trustees if the fund decreased to below the threshold.

Resolution:
The Committee received and noted the contents of the Budget Planning report.

10/18 **Report on Investment Portfolio Year to Date**

Mr Kettle provided an overview of the Investment portfolio and advised that the fund had decreased between September 2017 – December 2017 from £1.5m - £1.3m due to selling of some investments to fund expenditure previously approved. Mr Kettle further confirmed that the transfer of the investment funds to the new fund manager had not yet occurred. Mr Caldicott requested a confirmed date when the transfer would be made and also requested that W H Ireland be asked why they had put all the funds into UK equities. Mr Caldicott requested that the committee be

made aware of the transfer date to the new provide.

Resolution:
The Committee received and noted the content of the investment report
Mr Kettle to query the funds all being in UK equities **TK**
Mr Kettle to advise the transfer date to the new investment provider **TK**

11/18 **Fundraising Update**

Mrs Westley provided an update on fundraising activities planned.

- Boxing evening including an auction
- Yam Yam Elvis – date to be confirmed
- Make A Will Fortnight

Mrs Westley advised that work would be undertaken on legacy funding, a marketing package would also be put together for use on televisions that would help to fund the Trust Ball and Long Service Awards. Mrs Harris expressed the thanks of the committee to Mrs Westley.

Mrs Westley further advised that the organisation had been approached by Aston Villa Academy regarding fund raising, this would be in relation to Ward 21. Mrs Harris suggested that Skanska could be approached to undertake some refurbishment under their corporate charitable fund, Mrs Westley described a scheme that Skanska had previously discussed whereby they would pay in the Charitable Fund if they found items that needed attention in the retained estate, Mr Caldicott urged caution with the scheme, Mrs Westley agreed to obtain further detail.

Mrs Westly queried whether charitable money was being spent, Mrs White confirmed that fund managers could approve up to £5k and the trigger would be the list of requests which could be followed up with a communication.

Mrs Westley advised that the staff located in the Purple Hub would be relocated and fund raising would have a shop in the present ambulance bay. Mr Caldicott confirmed the plans. A discussion took place with regard to raising the profile of the organisation in relation to fund raising Mrs Westley confirmed that she had discussed with Enoch Evans and they had confirmed that legacy income had reduced in general terms, however, Mrs Westley would continue to work with people who wished to leave a sum of money to the organisation.

Resolution:
The Committee received and noted the Fundraising update
Mrs Westley to obtain further details of the Skanska Charitable Scheme **GW**

12/18 **Receipt of Fundraising Committee Highlight Report/Minutes**

Mrs Westley confirmed that the last meeting was an update discussion

between three people. Mr Caldicott advised that going forward he would be part of the Fundraising Committee. Mrs Westley advised that a workshop would be held in conjunction with the Finance Department and Communications during May to which fund managers would be invited.

Resolution:
The Committee received and noted the verbal report.

13/18 **Fundraising Strategy**

Mrs Harris confirmed that the Fundraising Strategy was to be presented at the Corporate Trustee meeting for ratification, following discussion it was agreed that the strategy should be updated prior to the meeting on 3rd May, Mrs Ilic to re-circulate to members once refreshed.

Resolution:
The Committee agreed to receive an updated Fundraising Strategy for presentation to Corporate Trustees Meeting. **JI**

14/18 **Any Other Business**

There were no further items for discussion

15/18 **Date & Time of Next Meeting**

Thursday 21st June 2018 at 10.00 a.m., Seminar Room 5