Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 2 AUGUST 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 Director of Governance via 01922 721172 or jenna.davies@walsallhealthcare.nhs.uk

A G E N D A

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
1.	Staff Story	Learning		Verbal	**10.00**
CHAIR'S BUSINESS					
2.	Apologies for Absence	Information	Chair	Verbal	**10.30**
3.	Declarations of Interest	Information	Chair	ENC 1	**10.35**
4.	Minutes of the Board Meeting Held on 5 July 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**
SAFE HIGH QUALITY CARE					
8.	Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Acting Director of Nursing	ENC 6	**11.05**
9.	CQC Preparedness Update	Information	Chief Executive	ENC 7	**11.15**
10.	Responsible Officer Revalidation and Appraisal Report	Approval	Medical Director	ENC 8	**11.20**
11.	Learning from deaths report	Discussion	Medical Director	ENC 9	**11.35**
VALUE COLLEAGUES					
12.	Freedom to Speak Up Guardians Report	Discussion	Director of OD & HR	ENC 10	**11.45**
BREAK – TEA/COFFEE PROVIDED					**11.55**
RESOURCES					
13.	Financial Performance Month 3	Discussion	Director of Finance & Performance	ENC 11	**12.10**

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
14.	Performance and Quality Report Month 3	Discussion	Chief Operating Officer	ENC 12	**12.20**
15.	IT update	Information	Director of Strategy & Improvement	ENC 13	**12.30**
PARTNERS					
16.	Partnership update	Information	Director of Strategy & Improvement	ENC 14	**12.35**
GOVERNANCE AND COMPLIANCE					
17.	Quality and Safety Committee Highlight Report and Minutes	Information	Committee Chair	ENC 15	**12.40**
18.	Performance, Finance & Investment Committee Highlight Report & Minutes	Information	Committee Chair	ENC 16	**12.45**
19.	**QUESTIONS FROM THE PUBLIC**				**12.50**

20. **DATE OF NEXT MEETING**
Public meeting on **Thursday 6 September 2018** at 10.00 a.m. at the Manor Learning and Conference Centre, Manor Hospital

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

MEETING OF THE PUBLIC TRUST BOARD – 2 August 2018			
Declarations of Interest			**AGENDA ITEM: 3**
Report Author and Job Title:	Jackie White Interim Trust Secretary	**Responsible Director:**	Danielle Oum
Action Required	Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
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.		
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.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

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).
Mrs Anne Baines	Associate Non-executive Director	Director at Middlefield Two Ltd Associate at Provex Solutions Ltd
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: 23 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 5TH JULY 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 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
Ms K Blackwell	Acting Director of Nursing
Mr P Thomas-Hands	Chief Operating Officer
Mr R Caldicott	Director of Finance

In Attendance:

Mrs P Furnival	Associate Non-Executive Director
Ms A Baines	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
Miss J Wells	Senior Executive PA (Minutes)

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

068/18 Staff Story

Unfortunately, the patient who was attending the meeting to share their positive experience was unwell and unable to attend. The patient has been invited to attend on a later date to share their story.

069/18 Apologies for Absence

Apologies were noted from Mr J Dunn, Non-Executive Director

070/18 Declarations of Interest

There were no declarations made.

071/18 Minutes of the Board Meeting Held in Public 7th June 2018

Mr Beeken clarified that Suzie Loader had joined the Trust as an Improvement Consultant.

The minutes of the meeting held on 7th June 2018 were approved as a correct record.

Resolution
The Board approved the minutes of the meeting held on the 7th June 2018 as an accurate record.

072/18 Matters Arising and Action Sheet
The Board received the action sheet and the following updates were provided;

044/18 Staff Story – Mr Fradgley advised that the meeting took place on 27th June not 2nd June as detailed on the action sheet. A further meeting had been planned.

059/18 Financial Performance Month 1 – Mr Caldicott advised that a conversation had taken place with the Non-Executive Directors and NHS Improvement regarding the quarterly review and a presentation was being drafted.

Ms Oum clarified that the action was in relation to the discipline required in the narrative and elements of the quarterly review that would be useful to utilise with financial recovery. Mr Caldicott would review with Ms Davies.

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

073/18 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.

074/18 Chief Executive's Report
Mr Beeken presented the report and highlighted the following key points;

- The Financial Control Total offer had been accepted. The Trust would work to a deficit plan of £15.6 million for 2018/19 and a deficit of £10.6 million at year end.
- Confirmed offers had been made to candidates following the Medical Director and Director of Nursing interview process. Both had accepted but confirmation letters had not yet been issued nor references obtained. Communication to the Trust would be issued within the coming days.
- Joint working with local authorities continued and work was progressing on bringing the services together under the appointment of a Director of Community Services.
- The LiA Pulse Check had been pushed hard with a view to obtain above a 50% response. A briefing unveiling the results would take place the following week.

- National guidance emphasised reducing length of hospital stays, particularly in cases of stranded patients (inpatients of more than 7 days without an estimated date of discharge). Such cases within the Trust were being performance managed and the Trust needed to form action plans for a 25% reduction.

Mr Gayle advised that the national guidance report was a useful appendix to the CEO report. Mr Gayle asked Mr Thomas-Hands whether the Trust had the right trajectory to reduce patients by 25% by December. Mr Thomas-Hands advised that work had been ongoing and the numbers were reducing. The plan was currently being built and would form part of the winter plan.

Mr Gayle queried why a Director of Community Services was required, particularly when the CQC had rated the service as outstanding. Mr Beeken replied that there was a large range of community services that needed to be brought together under Walsall Together. More progress would be made at pace with the local authority working together. **RB**
Ms Furnival agreed that it was timely to drive integration.

Mr Beeken stated that there were some bold options for the board in terms of technology. Criticism had been received for not being explicit enough with timelines and resources. An overview would be created and published to the public before the end of Quarter 2. Mr Beeken would confirm timescales at the next meeting.

Mr Fradgley advised that the electronic records management options had been commissioned and was being reviewed by Committees. A survey had also been completed in relation to the wider electronic journey and suitability for the needs of the user. A paper regarding Informatics would be shared at the next meeting.

Mr Khan agreed that integration within the Black Country and close communication links with neighbours and their systems would be beneficial for wider record sharing.

Professor Beale praised the plans underway but was concerned that the Trust did not seem to be moving quick enough to implement new technology.
Mr Fradgley replied that the team were enthusiastic and capable but that there had not been any significant capital investment into IT due to the Trust priorities.

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

075/18 Monthly Nursing and Midwifery Safer Staffing Report
Ms Blackwell presented the Serious Incident report and highlighted the following key points;

- There had been an improvement in care hours of 7.3 against a

national average of 7.6 due to bed occupancy improvements and roster KPI progress.
- The Daily Acuity Tool was implemented the previous week and was being embedded into daily conversations.
- The Bi-annual audit national tool had been utilised.
- Overseas recruitment had been confirmed.

Mrs Furnival queried whether the board members would benefit having sight of the QIAs in relation to risk to ensure the balance of money and quality.

Mr Gayle referenced agency spend and asked whether there was evidence of staff taking up bank shifts following the raise in the hourly rate. Ms Blackwell responded that rostering had helped to reduce agency costs, however the bank rate increase had not made a significant difference. It appeared that staff wanted to work within their own teams on their own wards.

Ms Oum was reassured by the rise in care hours and asked whether it was too early to see the impact of this. Ms Blackwell replied that it was expected that there would be improvements seen within the number of patient falls and pressure ulcers, particularly with heel ulcers.

Mr Heer advised that the model hospital report had been reviewed by members of the Performance, Finance and Investment Committee and asked when work from that would be incorporated. Ms Blackwell advised that the model hospital data was usually a couple of months behind but a paper would be included at an upcoming Trust Board meeting.

Resolution

The Board received and noted the report
Agreed to see QIAs to ensure the balance of money and quality.

CQC Preparedness Update

076/18

Ms Blackwell presented the update paper which outlined the current position of the Patient Care Improvement Plan and highlighted the following key points;

- The Maternity Improvement Plan was reported separately.
- Divisions were active in managing their actions and a revised version of the plan would be reviewed at the next Board meeting.
- Safeguarding and mandatory training were ongoing.
- Key targeted actions in relation to audit were being planned and had been discussed at the Quality and Safety Committee.

Mr Beeken advised that the Patient Care Improvement Plan would remain the vehicle for board members to determine whether progress was being made until the improvement programme had been

developed following the CQC process.

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

077/18 Annual Complaints Report

The annual report was presented by Ms Blackwell and the following key points were highlighted;

- Activity was similar to that of the previous year. Similar concerns were raised relating to appointments, communication and attitude.
- A work plan was being created with divisions and the complaints and experience team.
- Communications within ED were underway which would feed information such as waiting times etc.
- The Customer care programme would be rolled out, targeting ED, medical and surgical wards.

Mrs Furnival referenced the thematic areas on page 5 and asked how assurance was received that the actions were being implemented. Mr Khan replied that there was an audit programme to check progress made.

Mr Gayle made reference to the equality monitoring form, noting a number of 44 returns and only 5% from the BME community. Mr Gayle asked whether those numbers were a true reflection and whether patients knew how to make a complaint. MS Blackwell acknowledged Walsall's demographic and agreed that more work needed to be done. Members noted that the current paperwork was currently only available in English and again this would be reviewed.

Ms Oum reiterated the importance of ensuring that lessons were learnt from compliments and complaints. Ms Oum asked that Mrs Furnival shared templates from the local authority in order to compare and encouraged the promotion of access across communities. **PF**

Resolution
The Board received and noted the content of the report Agreed a more structured approach to capture of lessons learnt and changes to practice is articulated in future reports.

078/18 Quality and Safety Committee Highlight Report and Minutes

Professor Beale presented the highlight report from the most recent meeting held on 29th June 2018, together with the approved minutes of the meeting held on 31st May 2018.

Mr Khan provided an update following the Gosport War Memorial Hospital inquiry:

- Accepted practices and the Trust's own processes and policies had been reviewed.
- Questionnaires had been given to families.

- No links had been established following mortality surveillance.
- The Director of Pharmacy regularly reviewed the use of controlled drugs and there were no misuse of opiates uncovered.
- There were no concerns raised in relation to any individuals working within the trust.
- The Medicine Management Committee reviewed any mismanagement of drugs.

Professor Beale stated that the winter plan had been reviewed and it appeared that the Trust was in a better position currently than the previous year.

Professor Beale advised that the Safer Staffing Nursing Care Tool Audit had been discussed and it was acknowledged that there had been some local interpretation of the national tool across ward areas. Mr Beeken advised that locally, there had been occasions when the tool was modified But that this was not uncommon across the NHS.
Ms Blackwell stated that the daily acuity tool was now being utilised and communication had been issued to managers.

Ms Baines advised that board members needed to have confidence in the numbers and consistency was key.

Discussion took place surrounding a recent RIDDOR reportable incident that was not raised as a serious incident. The incident was reviewed by the serious incident panel though it was deemed to not meet the criteria. Ms Oum expressed that staff's safety was valued and such incidents should be reported as a serious incident irrespective of RIDDOR status.
Mr Beeken would lead further discussions and would report back to the board. **RB**

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

079/18 Update report on the assessment of the Clinical Leaders Development Programme

Mrs Ludgrove provided a summary of the progress made which included a 360 degree feedback exercise, presentation of self-assessment and benefits from the kings fund development programme.

The recent introduction of a Trust Management Board was a significant step towards recognising the partnership between the Executives and clinical leadership.

Mr Thomas-Hands commented that the members should not underestimate the changes made by those individuals who had participated in the programme. Mr Khan agreed and stated that he would discuss Kings Fund programmes for the next generation of **AK/LL**

leaders with Mr Beeken and Ms Ludgrove.

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

080/18 People & OD Committee Highlight Report and Minutes

Mr Gayle presented the report for the meeting held on 18th June 2018 and highlighted the following key points;

- Applications had been received for the ED&I Coordinator position on a six month secondment. There was intention to make the post substantive following a restructure of the OD and HR directorate.
- Though the frequency of the People and OD Committee had changed to bi-monthly, there was still an issue of Executive Director attendance.

Ms Oum sought assurance that the EDIC success criteria that had been agreed for the conditional sign off of the annual plan at the Audit Committee had in fact been included. Mr Fradgley commented that the operational plan could be amended but that the narrative for the annual report was reviewed at Audit Committee and locked down.

Resolution
The Board received and noted the report
Agreed that all board members should receive copies of the Annual report and Operational Plan.

081/18 Financial Performance Month 2

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

- The Trust had adopted a financial plan for 2018/19 that delivered an £18.6m deficit.
- An improved offer of control total at £10.6m deficit had been accepted.
- The Cost Improvement Programme had been loaded into the latter part of the plan.
- There was a deficit of £4.5m year to date.
- CIP delivered £1.1 year to date.
- Temporary workforce costs remained high within nursing and medical which still required mitigation.
- The development of a financial recovery was planned as there were clear risks.
- Capital schemes were progressing – The ICCU was slightly behind plan but due to open in November 2018. Work had started in Maternity and Neonatal. The Trust had received approval of the strategic outline case for the new Emergency Department and had been prioritised by the STP.

Ms Oum welcomed the approval of the outline business case for ED.

Professor Beale asked for further clarification of the figures and Ms Oum suggested utilising a Board Development meeting as a workshop for understanding the detail.

Mr Heer expressed concern of the Trust being off plan and the financial challenges that needed to be met. The recovery plan was required as soon as possible.
Mr Caldicott advised that the Executive Directors were reviewing the recovery plan on Tuesday of the following week.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Agreed a workshop of understanding would be held at a Board Development meeting.**
- **Agreed that an extraordinary PFIC would be convened to consider a financial recovery plan**

082/18 Performance and Quality Report Month 2

Mr Caldicott presented the Performance and Quality Report for month 2 and highlighted the following key points:

- 4 hour A&E performance had improved to 89.7%.
- Referral to Treatment performance had improved to 88.3%
- Unvalidated results showed achievement against all cancer measures.
- Diagnostic waits achieved at 99.5%.

Mr Thomas-Hands advised that during April, the cancer target was missed by one patient who had been sent back by the tertiary centre on day 62.
There was a risk to performance with a financial recovery plan, particularly with Referral to Treatment.
There were a number of medical staffing vacancies which were having an impact upon temporary staffing figures.

Mr Heer observed data gaps on the dashboard, which may be due to timing, however there needed to be discipline when populating.
Mr Beeken agreed with Mr Heer's comment and advised that Suzie Loader, Improvement Consultant, was working with colleagues to populate sufficiently.

Ms Blackwell added that the Trust were compliant with safeguarding.

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

083/18 Ultrasound business case
Mr Thomas-Hands presented the business case, informing that it had been reviewed at the Performance, Finance and Investment

Committee who had recommended approval by board members.

Mr Heer observed that there were good clinical grounds for the approval.

Professor Beale queried why partnerships didn't appear to have been reviewed at all.
Mr Fradgely replied that partnerships with both Sandwell and the Royal Wolverhampton had been considered and explored but were deemed not viable and therefore not included within the report.

The Board members approved the business case.

Resolution
The Board:

- **Approved the Ultrasound Business Case.**

084/18 Performance, Finance & Investment Committee Highlight Report and Minutes

Mr Heer presented the highlight report of the meeting held on 27th June 2018, together with the approved minutes of the meeting held on 30th May 2018. The following key points were highlighted;

- A presentation of the Model Hospital was reviewed and outlined areas for improvement and consolidation which would be shared with care groups.
- The bank pay rate had not delivered the anticipated financial benefit.
- There was concern that the recovery plan had not delivered. An Extraordinary Performance, Finance and Investment Committee would be scheduled shortly.

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

085/18 Partnership Update

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

- Members from the Trust and Walsall Council visited Rotherham NHS FT who shared their experiences of their integration journey.
- Over 50 practitioners attended the Leadership Forum who would assist to design clinical pathways and operational models.
- All partners had agreed the pilot of the Single Care record for end of life patients across all partners and scoping work was underway.
- A bid was submitted for the APMS practices contract, which the partnership was successful in winning the tender process across 8 practices.

Ms Oum congratulated the partnership on their hard work in securing the successful tender.

Mr Heer advised that though the paper was a helpful, strategic oversight, he would like to see future plans, timelines and outcomes.
Mr Fradgley replied that a Programme plan was being created to be included with the Walsall Together work, where it would be reviewed.

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

086/18 Refresh of Trust Vision

Mr Fradgley advised that the 5 Trust strategic objectives discs were largely recognised, though the organisation struggled with the mission statement as it was not memorable.
The proposed new vision statement was 'Caring for Walsall Together'.

Mr Heer queried whether there was a need for a vision statement as the priorities set out were clear and driven by values.
Mr Beeken replied that the Trust should have a vision statement linked to values.

Professor Beale noted that there was a partnership entitled 'Walsall Together', therefore the statement could be taken out of context.

Following discussion, the board members agreed to an amendment of the statement to be 'Caring for Walsall, together'.

Resolution
The Board received approved the new vision statement as 'Caring for Walsall, together'.

087/18 Audit Committee Highlight Report and Minutes

Mr Heer provided a verbal update from the meeting held on 25th June 2018 and highlighted the following key points:

- Ms Davies had been asked to review dates of meetings and the interaction of chairs of sub-committees.
- The Board Assurance Framework process and how it was imbedded drove the agenda.
- The Internal Audit Plan was reviewed and required further work in terms of partnerships, collaboration and workforce.
- The business case process was reviewed with focus on how cases were reviewed, funding, options and timelines.

Resolution
The Board noted Mr Heer's verbal update.

088/18 Charitable Funds Committee Highlight Report

On behalf of Mrs Harris, Mr Caldicott referred members to the key points in the highlight report from the meeting held on 21st June 2018 and the approved minutes of the meeting held on 19th April 2018.

Ms Oum advised that Mrs Harris had expressed concern that the investment portfolio had not been transferred and was insufficiently diverse. Mr Caldicott confirmed that there had been a delay in moving the investment portfolio to a new broker but that The investment portfolio was to be transferred across intact to the new investment broker and that the successful broker has requested the funds arrive as cash, they do not wish to sell the investments to move them in line with current investments they hold on behalf of other clients

Mr Caldicott confirmed that he would contact the broker and discuss this further and arrange for the investment broker to attend a future Trustees meeting to confirm future investment. **RC**

Resolution
The Board received and noted the report.

089/18 Questions from the Public

Mrs Shana Akhtar attended the meeting to share her complaint with board members. In summary Mrs Akhtar's 9 year old daughter had a condition and required psychology support but did not meet the criteria for CAMHS and a Psychology service was not available. Mrs Akhtar advised that her daughter was not getting the support that she needed and queried what steps were being taken in order to resolve the issue.

Ms Oum appreciated Mrs Akhtar attending the meeting to share her experience.
Mr Beeken advised that at the Trust Management Board held earlier in the week, a business case relating to diabetes and Paediatric Psychology was agreed. Though he was not able to provide details on timescales, Mr Beeken provided clarity moving forward and apologised for the distress caused.

Mr Khan informed that there may be a challenge of recruiting the right person to the role, which was a national issue.

Mr Thomas-Hands advised that he had spoken to Ms Akhtar previously on the phone regarding the issue and agreed that there had not been the required level of support available. Though the business case had been approved, the service would not be in place quickly, therefore Mr Thomas-Hands had agreed to commission as Psychologist to assist.

Ms Oum thanked Mrs Akhtar for raising the issue, which was being addressed. A contracted Psychologist would be sought in the short term.

090/18 Date of Next Meeting

The next meeting of the Trust Board held in public would be on

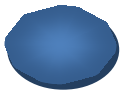
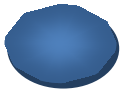
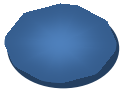
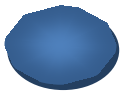
Thursday 2nd August 2018 at 10:00a.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

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

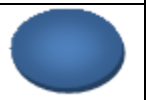
Walsall Healthcare NHS Trust

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.	Acting Director of Nursing	02/08/18	**Complete** CQC Preparedness report on agenda	
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~~ 30/08/18	**Update** Business case being progressed through the Mortality Surveillance Group and will be presented to the Quality	

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
				& Safety Committee in August.	
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 27th 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	**Update** Meeting took place and breifing distributed in advance of the quarterly review	
077/18 Annual Complaints Report	Ms Furnival to share templates from the local authority in order to compare and learn lessons.	Associate Non-Executive Director	02/08/2018		

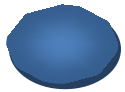
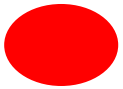
ENC 3

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

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

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.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD – 2nd August 2018			
Chair's Report		**AGENDA ITEM: 6**	
Report Author and Job Title:	Danielle Oum, Chair	**Responsible Director:**	Danielle Oum, Chair
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
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.		
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.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Walsall Healthcare NHS
NHS Trust

Chair's Update

PRIORITY OBJECTIVES FOR 2018/19

1. **Financial improvement**
   I attended the NHSI Quarterly Review where Trust priorities and financial improvement were discussed.

2. **Improving staff engagement and development of a clinically led organisation**
   There was a fantastic turnout and atmosphere at the Annual Leadership Conference held at Bescot Stadium where Sarah-Jane Marsh from Birmingham Women's & Children's Hospital was the key speaker.

   I attended the Trust AGM which showcased the work of the community, partnerships and patient flow.

   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.

   I met with Trust graduates of Stepping Up, an NHS leadership programme designed to support BME colleagues to overcome the organisational barriers that have inhibited diversity in senior leadership across the NHS. I was impressed by the positivity and ambition within the group and will be interested to see the benefits of the programme are maximised fot the participants and the Trust.

3. **Developing our Clinical Services Strategy through organisational collaboration**
   I am pleased to announce that Matthew Lewis has been appointed as Medical Director and will join the trust in October 2018. Karen Dunderdale will be joining the Trust on 6th August 2018 as the Director of Nursing.

Meetings attended / services visited

Paediatrics
Freedom to Speak up Guardians
Therapies

RECOMMENDATIONS
The Board are asked to note the report

Danielle Oum

August 2018

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD – 2nd August 2018			
Chief Executive Report		**AGENDA ITEM: 6**	
Report Author and Job Title:	Richard Beeken, Chief Executive	**Responsible Director:**	Richard Beeken, Chief Executive
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	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 July 2018 and assures the Board through an allocation to the relevant executive director.		
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.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

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 July 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

The Trust held its Annual General Meeting on 11 July 2018. I was very pleased with the turn out and recognised some familiar faces in the audience. The staff stalls were well received.

I was pleased to hear that our Patient Safety teams for Medicine and Surgery have been named winners in the 'Integrated approach of changing cultures in clinical governance/patient safety' category at this year's HSJ Patient Safety Awards.

Staff were recognised for their efforts around embedding the 'Learning from Excellence' approach to working, hosting Risk Roadshows for frontline staff, creating patient liaison roles that enable clear communication between the Trust and the people we care for and for encouraging active conversations around risk reporting – amongst many other things.

Improve our financial health through our robust improvement programme

A number of Board members recently met with NHS Improvement to discuss our latest performance the main topic was our financial delivery being poor. We have agreed a number of actions with NHSI that we will deliver our financial plan by:

- Delivering cost efficiencies on productivity which we have evidence to prove we can achieve - particularly on improving outpatient services; our DNA rate and booking efficiency
- Controlling our expenditure on temporary medical and nursing staff- running far over the levels of this time last year
- Scrutinising discretionary expenditure, particularly on non-pay items
- "Think like a patient and act like a tax payer" - We all need to deliver the financial plan and come up with new ideas to improve our financial position

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

I was pleased to host the 2018 Leadership Conference at the Banks Stadium Walsall on the 6th July. 200 senior clinical and operational leaders from across the organisation gathered to discuss how we can make and lead improvements across all areas of the Trust. We were delighted to welcome the CEO of Birmingham Women's and Children's Hospital Sarah Jane Marsh, who talked about the importance of colleague engagement at all levels of the organisation. Sarah Jane also highlighted the importance of executive visibility as a key factor in their current CQC ratings. This was the perfect segue into the launch of the brand new, staff chosen Trust Values. Following the big reveal of the 4 single word values, Respect, Compassion, Teamwork and Professionalism, Staff Engagement Lead Simon Johnson and Listening into Action Lead Tom Johnson ran a workshop encouraging all colleagues to think about how these values might look, sound and feel when embedded within the organisation. The objective of this session was to begin to create a Values Framework which will underpin the Values and showcase what will and will not be acceptable behaviours. Post lunch, Matt Tite from NHS Elect delivered an eye opening and thought provoking session around measurement for improvement. This interactive session highlighted the importance of understanding why and how we collect data, and also how we present our findings so that it gives us a useable insight into the systems/processes we are reviewing. The final session focused on how we as individuals and teams lead change projects. Dr Hesham Abdalla, Paediatric Consultant and Trust Quality Improvement Clinical Lead, asked tables to firstly think about the worse way to lead change, before focusing on what we need to do better to ensure more improvement projects succeed and are supported.

This year's long service awards were held in the Manor Learning Conference centre. 96 colleagues this year have achieved either 20, 30, 40 or 50 years' service; this equates to 2450 years' NHS service in total. One lady Diane Shaw – Theatre Practitioner achieved an amazing 50 years!. I was very pleased to opened the event and present certificates with an opportunity for photos for those that wanted to capture this memorable occasion. Afternoon tea was served to all those that attend.

This month I have delivered the Chief Executive's Brief in the community and hospital and will do so every month. I understand staff in the community found this very positive.

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

Over the last month work has continued some pace on the Walsall Together Partnership with the development of a Program plan that will be shared with the Board members later. This plan will show a route to the selection of a host provider, design of a governance structure for the future model which takes into consideration the delegated authority of all of the organisations and the future clinical operating model. This business case will be ready for October as scheduled. The Director of Strategy & Improvement will provide a fuller update in his report.

I have also been taking part with other Executive team members in the final part of the development program for the STP. We have been working on how we turn the strategy of working at scale and reducing variation in care into a model that is deliverable and addresses the Triple Aim as outlined in the Five Year Forward View. The final workshop took place last week the will result in a coordinated programme of delivery for the STP across all 18 organisations. More importantly, the STP workshops have recognised that the strength of the partnership lies within the place based models, in our case Walsall Together.

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 July, 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
	Getting It Right First Time (GIRFT): urology report NHSI have produced a report on urology from the GIRFT programme which includes 18 recommendations to help achieve a more productive urology service which is better for patients and could help the NHS deliver £32.5 million in efficiencies and savings each year this — including greater consultant focus on emergency care and a better career structure for urological nurses.	Information	Chief Operating Officer
	Vaginal mesh: high vigilance restriction period A national 'pause' has been announced in the use of surgical mesh/tape to treat stress urinary incontinence (SUI) and for urogynaecological prolapse where the mesh is inserted through the vaginal wall. This pause takes the form of a high vigilance restriction, and all cases should be postponed immediately if it is clinically safe to do so.	Action	Chief Operating Officer / Medical Director
	Measles exposures and infections: recommended actions NHSI have outlined recommended actions to ensure the Trust's occupational health and infection prevention and control teams are prepared.	Action	Director of OD & HR / Director of Nursing
	Manage bed capacity more effectively with the long-stays dashboard NHSI have issued a dashboard and technical guidance which will support the Trust to effectively manage bed capacity, reduce the number of long stay patients and improve flow to enable the Trust to reduce the number of long-stay patients by 25%.	Information	Chief Operating Officer
	Update on the Single Oversight Framework	Information	All

	(SOF) NHSI have made some minor updates to ensure the framework reflects the following: • NHS-controlled providers are now overseen under the SOF • our approach to monitoring progress in eliminating out-of-area placements for adult mental health services • the access standard for people with a first episode of psychosis has been updated from 50% to 53% as set out in the Five Year Forward View for Mental Health • ambulance providers will have until October 2018 to meet the new operational performance standards introduced through the Ambulance Response Programme		
	2016/17 medical workforce data now live on Model Hospital Model hospital data on 2016/17 medical workforce for the three acute specialties: trauma and orthopaedics, accident and emergency, and radiology has been released.	Information	Director of Finance & Performance
	Learning from deaths: new guidance The National Quality Board has issued new guidance for trusts on supporting bereaved families as part of the Learning from Deaths programme, including a written resource for families you can use alongside your local information.	Information	Medical director / Director of nursing
	Reviewing the registration processes for nurses and midwives from outside the EEA The Nursing and Midwifery Council has additional processes in place to check nurses and midwives from outside the EEA meet registration requirements. They are now reviewing their existing registration processes to make sure these are as straightforward as they can be, and the first of these assessment changes will be in place from 16 July.	Information	Director of OD & HR / Director of Nursing
	Deliver same-day care with help from new ambulatory emergency care (AEC) guides NHSI have issued three new AEC resources which focus on how to: identify a large cohort of patients who can be safely treated on the same	Information	Chief Operating Officer

	day; optimise outcomes for frail older people; and avoid unnecessary admissions, reduce length of stay and improve flow during winter.		
	Three new safe staffing improvement resources To help standardise safe, sustainable and productive staffing decisions, NHSI have published safe staffing improvement resources for children and young people's inpatient wards, neonatal care and urgent and emergency care. These resources include recommendations for board accountability and outline expectations for clinical leaders.	Information	Director of Nursing
	We are the NHS' recruitment campaign launched A new campaign has launched this week to help recruit more staff into the NHS, and to retain existing staff. It will initially focus on nursing and then highlight other roles, particularly those with the largest shortages — such as mental health and learning disability, from the autumn.	Information	Director of OD & HR
	National Guardian Office **New report calls for independent and timely investigations** The National Guardian has published her latest case review report about the speaking up culture at Derbyshire Community Health Services NHS Foundation Trust. In the report Dr Henrietta Hughes highlights areas of good practice, but also calls for the government to commission guidance to help support trusts to properly investigate speaking up independently and within reasonable timescales.	Information	Director of OD & HR
	Patient Safety Alert: resources to support safer modification of food and drink NHSI Have issued a patient safety alert to support Trusts transition to the International Dysphagia Diet Standardisation Initiative (IDDSI) framework, which introduces standard terminology to describe texture modification for food and drink.	Action	Director of Strategy & Improvement
	Stop the Pressure: definition and measurement framework and national curriculum for pressure ulcer prevention NHS I have released new recomendations for a	Information	Director of Nursing

	revised definition and measurement framework (for April 2019 implementation) and national educational curriculum are part of the national Stop the Pressure campaign to help reduce the incidence of pressure ulcers.		
	New learning disability improvement standards People with learning disabilities, autism or both can find it difficult to access NHS services and, in turn, receive much poorer experiences as a result. NHSI have developed four standards to address these needs. They are made up of improvement measures and actions to help you to achieve them.	Information	Director of Strategy & Improvement
	Getting It Right First Time (GIRFT): cranial neurosurgery report Patients with some types of brain tumour could avoid long stays in hospital if trusts adopted an urgent care pathway. NHSI Have issued a report which includes 15 recommendations to support a more productive cranial neurosurgery service, helping to treat patients more promptly, free up hospital beds and avoid bottlenecks.	Information	Medical Director
	Doctors and nurses to be taken out of tier 2 visa cap Earlier this month the Home Office announced that doctors and nurses will be excluded from the cap on skilled worker visas. This means there will be no restriction on the numbers of doctors and nurses who can be employed through the tier 2 visa route.	Information	Director of OD & HR / Medical Director / Director of Nursing

MEETING OF THE PUBLIC TRUST BOARD – Thursday 2nd August 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	Approve ☐ Discuss ☒ Inform ☐ Assure ☒		
Executive Summary	This report provides an overview of the Nursing and Midwifery workforce during the month of June 2018. The report outlines performance against key national and local staffing indicators and comparison to previous months. It also outlines the use of temporary registered nursing hours in June 2018 compared to the previous months. The following key highlights are outlined in the report: • Overall fill rates of 96.72% in June 2018 • Care hours per patient day (CHPPD) in June were 7.4, this was a slight improvement from the previous month but the Trust remains below the national median of 7.9 CHPPD and remains in the lowest quartile for CHPPD. • Mandatory roster clinics continue with improved compliance with roster KPIs • Daily acuity now being collected to inform decision making regarding staffing • NICE Red Flags added to risk assessment to enable collection of the impact of staffing deficits on patient care.		
Recommendation	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 facilitating 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		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	

	Partners ☐	Value colleagues ☐
	Resources ☒	

Monthly Nursing and Midwifery Safer Staffing Report

1. PURPOSE OF REPORT

The purpose of this report is to present to the board a review of ward nurse staffing levels 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 June 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. DETAILS

2.0 Right Staff

2.1 Safe Staffing UNIFY Data

The overall fill rate in June 2018 was 96.72%. The overall fill rate for RNs was 97.2% and for CSW staff the overall fill rate was 96.1% meaning that the Trust target of above 90% fill rate was achieved across both registered and unregistered staffing on both days and nights in June 2018. There are times when it is appropriate, following a risk assessment by the senior nurse on duty to utilise unregistered staff to support safe staffing in the absence of a registered nurse; CSWs are also used to provide 1:1 care for patients with mental health needs requiring this level of supervision which explains why fill rates sometimes exceed 100% for CSWs. Divisional Directors of Nursing, matrons, ward leads and site nurse practitioners make these operational patient safety decisions on a shift by shift basis to ensure all clinical areas are safely staffed. From 25th June 2018 these decisions have been informed by the completion of a daily acuity tool undertaken on each adult inpatient ward.

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

Figure 1: Unify Safe Staffing Fill Rate June 2018

Day				Night			
RN/Midwives		Care Staff		RN/Midwives		Care Staff	
Total Planned	Actual	Total Planned	Actual	Total Planned	Actual	Total Planned	Actual
31757.5	30811.55	25350	23284.2	24817	24182	18050.5	18425.5
Average Fill Rate - RN/Midwives (%)		Average Fill Rate - Care Staff (%)		Average Fill Rate - RN/Midwives (%)		Average Fill Rate - Care Staff (%)	
97.0%		91.9%		97.4%		102.1%	

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:

Ward	Fill Rates less than 90% - RN
18	Day 82.2% Night 82.7%
AMU	Day 88.5%
4	Night 79.3%
Ward	**Fill Rates less than 90% - CSW**
PAU	Day 87.8%
4	Day 83.2% Night 84.1%
AMU	Day 80.8%
18	Day 42.1% Night 56.7%
23	Day 82.5%
24/25	Day 83% Night 86.6%
29	Day 89.9%

2.2 Average Care Hours per Patient Day (CHPPD)

Care Hours per Patient Day (CHPPD) continues to be collated locally on a monthly basis and reported as part of the Unify data report. The CHPPD for June 2018 was 7.4; this was a slight increase from last month. The national average, reported via the Model Hospital is 7.9 CHPPD (reported in April 2018) WHCT remains in the lowest quartile for CHPPD.

2.3 Safe Staffing, Quality and Safety KPIs

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

Ward	Hospital Acquired Pressure Ulcer	Falls with Harm	Serious Incidents	Complaints	FFT Score	Number of Staffing Related Incidents	Any correlation between staffing and KPI dates?
18	**0**	**0**	**0**	**0**	**95.24%**	**0**	**no**
AMU	**0**	**4**	**0**	**2**	**96.15**	**9**	**1 / yes**
4	**0**	**3**	**1**	**0**	**95.12%**	**3**	**1 / yes**
PAU	**0**	**0**	**0**	**0**	**100%**	**0**	**no**
23	**0**	**0**	**0**	**0**	**97.18%**	**0**	**no**
24/25	**0**	**0**	**0**	**0**	**100%**	**0**	**no**
29	**0**	**0**	**0**	**2**	**95.21%**	**0**	**no**

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 June are currently going through the RCA investigation process.

In relation to the Ward 4 staffing incident, this date correlates with a fall which was rated as low harm for the patient. A Root Cause Analysis has been conducted at local level and staffing levels is not cited as contributory on the incident report.

In relation to the AMU staffing incident, this correlates with a fall that caused low harm. On reviewing the staffing incident, it references that at the time of the fall, there was no nurse in the bay. However, the patient was moved to an area of higher visibility following this fall.

As part of the implementation of the safe staffing risk assessment the NICE (2015) Safe Staffing Red Flags have been incorporated into the risk assessment to enable the identification and collection of these staffing red flags to demonstrate the impact of shortages in staffing on patient quality indicators (see Appendix 1)

Staffing Related Incidents

There was a total of 40 staffing related incidents which related to low staffing due to gaps in temporary staffing cover. None of the incidents had a high level of impact but there were some departments who had more than one incident throughout the month. There were no serious incidents related to staffing.

Ward	Number of incidents	Level of Impact
7	1	Low
ASU	4	Low/No harm
Ward 16	4	None
AMU	8	Low/no harm
Ward 14	2	No harm
ED	2	Low/no harm
Ward 4	3	No harm/low
Theatres	6	No harm
Ward 15	2	No harm
PAU	1	Low
Delivery	3	No harm/low
Ward 2	3	No harm/low
ITU	1	No harm
20a	1	No harm

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 for 4 weeks from 25th June - 22nd July 2018. The data is currently being reviewed as part of an establishment review for the adult inpatient areas using a triangulated approach. A full report will be produced for early August.

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. Surgery is running a specific recruitment day for the surgical wards in September 2018.
- The Professional Development Unit are also hosting a regional RN recruitment event in September 18.
- 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.
- Student RNs are offered a conditional job offer upon commencement of placement with the Trust and for September 18 we have 37 RNs who could commence, depending upon if they obtain a role elsewhere. Normal retention is above 90%.
- We have 2 cohorts of Trainee Nurse Associates in place currently at the Trust and a 3rd is planned for September 18. The first cohort qualify in Jan 2019 with allocated jobs across the Divisions. The 2nd cohort commenced training in March 2018 and will qualify in March 2020.

The current vacancies in June 2018 for RNs (excluding Theatres) are:

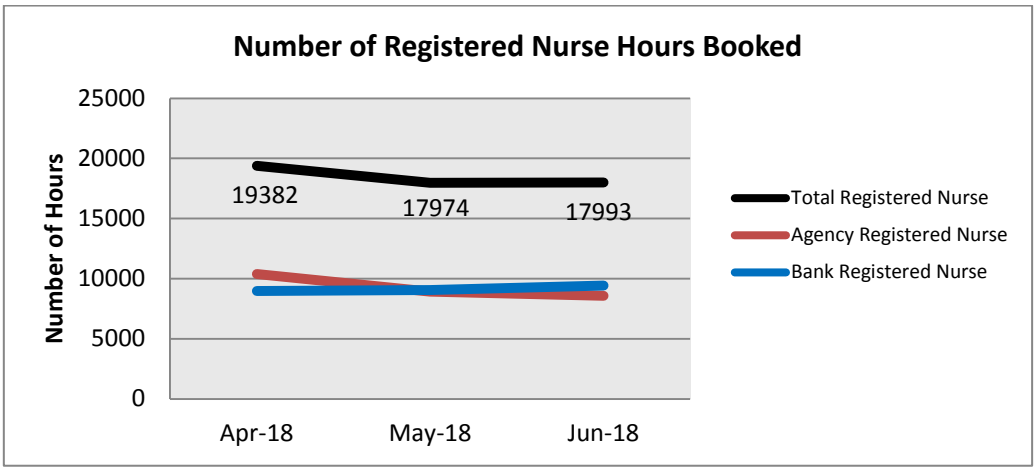
DIVISION	WTE VACANCIES- Registered Nurse
MLTC	50.19 (increase due to opening ward 14)
SURGERY	18.91
COMMUNITY	4.0

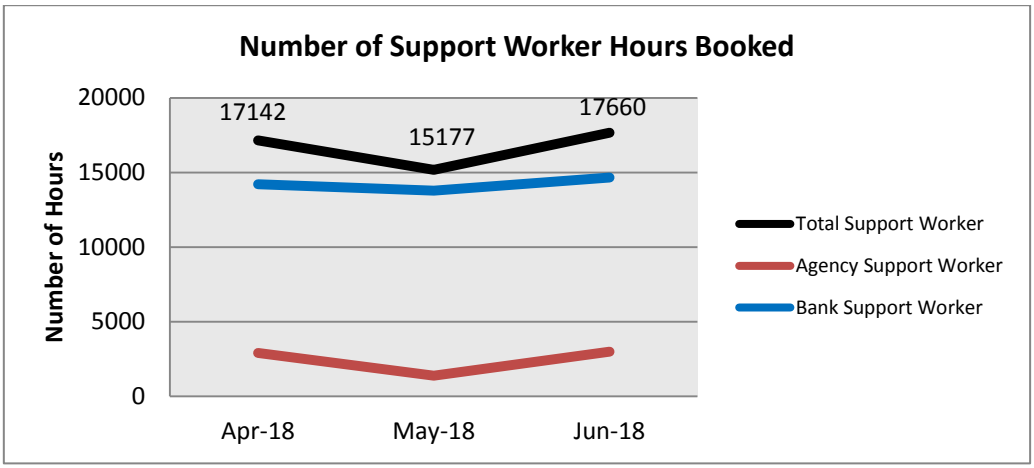
4.0 Right Place and Time

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

4.1 Efficient Deployment and minimising agency

There is a continued focus on reduction of agency staff across the Trust. There was a slight reduction in the use of agency registered nursing hours in June 2018 compared to the previous month. Bank RN use was higher than Agency RN use and the overall number of Temporary RN hours used overall was 19 hrs more than last month despite there being an additional 28 unfunded beds open. Overall there are now approx. 55WTE less RNs being used in June than in March 2018.





- There were 2483 hours more of CSW temporary staffing hours used in June 2018 compared to May 2018 and there was a rise in CSW Agency use of 1605 hrs. The position has taken a return to the figures seen in April 18. During June, Ward 10 and other ad hoc areas have been opened for extra capacity as well as increased demand for 1:1 for patients assessed by the Older People's Mental Health Team as requiring additional supervision.

The number of NHSi Cap breaches increased during June 2018 to 280 shifts, this is an increase of 22 shifts on last month and Off Framework (Thornbury) use within June 2018 was 3 shifts, a reduction of 2 shifts on last month. Off Framework bookings were for the Emergency Department during June 2018 and were authorised by the Executive On-call.

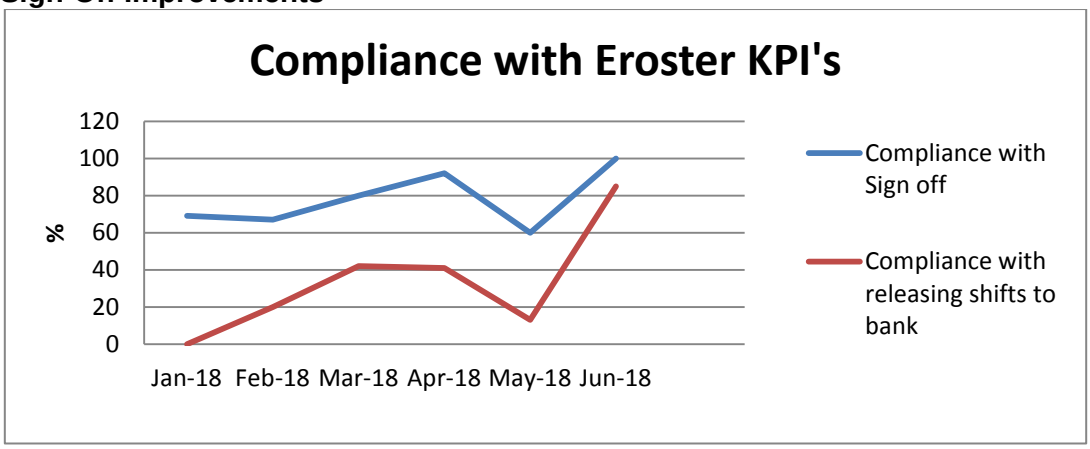
4.2 Additional Capacity

The opening of extra capacity within the trust will impact upon the ability to fill staffing requirements when they are elevated as a result. Ward 10 (28 beds) remains open and the funding of this ward and the recruitment to substantive staff had been agreed and is progressing.

4.3 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. Rosters are expected to be signed off 8 weeks in advance and to request gaps in rosters to go out to bank at the time of sign off to optimise the opportunity to fill with bank. The 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 alternatives 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 poor attendance at the roster clinics that month. This has now improved with additional review clinics and an increased level of scrutiny at Corporate level including attendance by the Director of Nursing at some roster clinics.

4.4 Efficient Deployment and Flexibility

The daily acuity for Adult in patient wards is recorded via the Safe Staffing UNIFY reporting template. From the 25th June 2018 the wards have started to collect daily acuity data.The Senior Nurse for Workforce is liaising with the Performance Team to allow for Trust wide visibility of acuity via a system approach. This will provide real-time visibility across the Trust of appropriate levels of staffing for our patients. 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 facilitating decision making in relation to the deployment of staff via the implementation of a daily acuity tool.

3. RECOMMENDATIONS

Clearly set out the recommendations and proposed actions arising from the conclusions reached by the report.

The recommendation should match the action required on the front sheet of the report.

Walsall Healthcare NHS Trust

MEETING OF THE TRUST BOARD – 2nd August 2018			
CQC Preparedness Update			**AGENDA ITEM: 9**
Report Author and Job Title:	Suzie Loader Improvement Consultant	**Responsible Director:**	Richard Beeken Chief Executive
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	This paper aims to update the Quality & Safety Committee on the actions the trust has been taking over the past 2 months to prepare the organization for the next CQC inspection. The majority of these actions are designed to become embedded in practice in order to facilitate continuous improvement (rather than just be preparation for an exam). The paper outlines: • Compliance against regulatory notices and Must Do's, indicating that there is still work to be undertaken in some areas in order to achieve full compliance • Initial outcomes from the CQC inspection into Maternity services, which were largely positive, although there are some corporate issues which need to be addressed • Preparation for the forth-coming inspection in relation to: Provider information request, self-assessment against the key lines of enquiry (KLOE) • Implementation of peer review audits aimed to assess achievements against the fundamental standards of care • Actions taken in relation to preparing for the CQC well-led and use of resources inspections		

Recommendation	Members of the Trust Board are asked to: o Discuss and challenge the content of this report o Support implementation of the CQC preparation plan (particularly in relation to the well-led section/board visibility & development)	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 11: That our governance remains "inadequate" as assessed under the CQC Well Led standard.	
Resource implications	Undertaking this work will require people's time on a regular basis; particularly participation in peer review audits and board development.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☒	

CQC Preparedness Update

Purpose

1. This report aims to update the Quality & Safety Committee and Trust Board on work being undertaken to prepare the organisation for its next CQC inspection, which is anticipated to be during the autumn of 2018. It should be noted that all actions being taken are aimed at become embedded in everyday practice to facilitate continuous improvement.

2. The report covers; update on the Patient Care Improvement Programme (PCIP) & compliance against regulatory & Must Do actions, verbal feedback following the spot inspection of Maternity Services, Provider Information Request (PIR), Core Service Self-Assessment against the Key Lines of Enquiry (KLOE), implementation of peer review audits to monitor compliance against the fundamental standards of care, Well-Led & Use of Resources self-assessments and preparation of the trust for the next CQC inspection.

Recommendations

3. The trust board are asked to:

   - Discuss and challenge the content of this report
   - Support implementation of the CQC preparation plan (particularly in relation to the well-led section/board visibility & development

The Patient Care Improvement Programme (PCIP)

4. The PCIP was developed following receipt of the Chief Inspector of Hospitals Inspection report (December 2017). The Regulatory & Must Do actions were reviewed by the 'Teams of Three' from the Core Services, following which the first version of the PCIP was established. Since then this document has been developed to include additional improvement actions identified by the Core Services.

5. The PCIP includes a number of actions and previous board reports have summarised how many actions have been achieved, how many have 'slipped' and how many are delayed. However, as the PCIP doesn't identify outcomes, it makes it difficult to know whether the actions taken have delivered the desired outcome.

6. Work has commenced to identify a number of Key Performance Indicators (KPI's) against the Regulatory actions and Must Do's, in order to enhance outcome monitoring. This includes:

   - Mapping the Regulatory & Must Do's against the KPI's contained within the trust Integrated Performance Report and Nursing dashboard to identify what data the trust already collects on a regular basis which would demonstrate compliance against individual Regulatory & Must's.
   - An Outcomes Workshop has been arranged by the Quality Academy for the 04 September 2018. The purpose is to enhance staff's understanding of outcome theory, enabling them to test this out in practice, with the intended outcome of reaching agreement around the outstanding KPI's for the Regulatory breaches and the Must's Do's.

7. Below is a summary of compliance against the regulatory actions. Of 6 regulatory actions (where regular monitoring is appropriate), monitoring is undertaken against 5 of those actions.

Regulatory Issue	Trust Target	Update
Thromboembolism assessments were not carried out for all patients at risk.	95% are assessed on admission by March 2018.	96% (run chart in ap. A)
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	Trust target is aligned to the National vacancy rate of 10.66%	8.73% (run chart in ap. A)
12 (2)(a) Not all staff were compliant or completed timely assessments for patients- in accordance with the **Mental Capacity Act 2005 or Deprivation of Liberty (DOL)**.	90% compliance with MCA training By March 2018 Compliance with MCA when completing DNA CPR decisions by March 2018.	55% (April 2018) 69% (June 2018)
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 undertaken to measure compliance. New build on target for December 2018 opening.
Staff were not up-to-date with **mandatory training**. There were a number of modules that had completion rates significantly lower than the trust's target.	90% compliance by 30th June 2018.	78.76% (trust target is now 85% Run chart ap. A)
Blind cords were not secured in all of the rooms at the child development centre	By March 2018. Risk assessment undertaken Permanent solution to be implemented. Audit of compliance.	All blind cords (including the main hall) have been adjusted to ensure a permanent solution to ensure that children cannot reach them.
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	Achievement of targets for all levels of Children and Adult Safeguarding by end June 2018 Level 1=95%	Training compliance figures in Appendix A

Regulatory Issue	Trust Target	Update
the Intercollegiate document (2014).	Level 2 & 3=85% PREVENT=85%	
Staff were not consistently completing **patient records**. There were trust documentation that was not completed. Staff were not always on 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 for the	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. 'Mobile' notes implemented across community	A new multiprofessional audit is in development (completion 31.07.18) which will be piloted alongside the other fundamental standards peer review audits commencing 15.08.18 Total Mobile note system implemented

Key = Red – not achieved within timescale; Amber – in progress; Green – achieved but on-going monitoring required; Blue – achieved and closed

8. In summary, the trust is now compliant with 4½ of the 8 regulatory actions as summarised above (full details in Appendix A). Of concern, is compliance with MCA & safeguarding training (although there is steady improvement in safeguarding training - Appendix A), and documentation. Plans are underway to audit documentation on a regular basis with results being fed back to individual areas, Care Groups & Divisions so that improvement work can be targeted.

9. The same process has been adopted to demonstrate compliance against the Must Do's where the trust already monitors KPI's (3/14) – more detail in Appendix A.

Issue	Must	Trust Target	Update
Action plans are monitored and managed for serious incidents	Must	Zero outstanding	See appendix A
Lessons are disseminated effectively to enable staff learning from serious incidents, incidents and complaints.	Must	TBA	See appendix A
Patient medical notes are kept secure at all times	Must	TBA	Policy is being developed for implementation & audit
All staff are trained and competent when administering medications via syringe	Must	TBA	80% compliance (Alaris PCAM)

Issue	Must	Trust Target	Update
driver			
Staff follow best practice national guidance (NICE, CAS alerts, Royal College Guidance, local clinical guidelines etc.)	Must	TBA	2 CAS Alerts outstanding: Review of clinical guidelines
The service uses an acuity tool to evidence safe staffing (nursing & midwifery)	Must	100%	SNCT & midwife: birth ratio in place
All staff receive an appraisal in line with local policy	Must	90%	83.41%
COMMUNITY FOR CHILDREN & YOUNG PEOPLE: Continue to follow standard operating procedures with medicines in special schools	Must	TBA	100%
MATERNITY: Risks are explained when consenting women for procedures	Must	TBA	Consent audit undertaken 2017. Re-audit required
ED: completes the action plan completed following the CQC inspection carried out in September 2015	Must	TBA	Currently reviewing compliance
SAFEGUARDING: adults and Safeguarding children policies are up to date and include relevant references to external guidance	Must	100%	Revised Adult policy by 31.07.18 Revised Children's Policy TBC
CRITICAL CARE: All staff working within the outreach team are competent to do so	Must	100% by 01.01.2019	
OUTPATIENTS: All staff have the required competencies to effectively care for patients, and evidence of competence is documented.	Must	90%	90%
OUTPATIENTS: All outpatient clinics are suitable for the purpose for which they are being used	Must	TBA	

10. It is clear there is still quite a bit of work to be undertaken in relation to compliance and the identification of metrics from which improvement can be measured supported by appropriate audits.

11. Currently, the PCIP is generated in Excel and is split between Divisions, making it difficult to gain oversight of the document and therefore compliance as a whole. The trust is looking in the short-term to develop a system on Share Point which will enable the divisions to update and upload evidence directly to the PCIP, whilst providing an overview of the whole plan for the trust. Deadline date emails will also be sent from the system, helping staff to monitor and achieve compliance in a more systematic way. However, once the trust has identified an

integrated reporting system for the trust as a whole, the PCIP will be incorporated into that system.

Maternity Improvement Plan

12. The Maternity Improvement Plan is a much more developed document than the PCIP, which is supported by a comprehensive dashboard. Highlights from the maternity improvement plan (June 2018) include:

13. What is going well:
    - 1:1 care in labour achieved for 2 months
    - Acuity positive 6 months out of last 7
    - Safeguarding training compliance achieved
    - On-going improvements noted on maternity improvement plan
    - CS rate showing normal variation
    - Most guidelines now updated
    - Mandatory training targets being achieved

14. What needs more support / review
    - Induction of labour rates – review to be undertaken (similar to work already completed re: CS rates) see SPC charts in Appendix B
    - SI actions to be closed – overdue
    - CNST incentive scheme – 8 out of 10 actions achieved – 2 remaining will require more work – action plan sent to NHS Resolution with funding request of 49K

CQC spot inspection of Maternity Services

15. On the 05 & 06 June 2018, the CQC undertook an unannounced inspection of Maternity Services and requested a total of 120 pieces of information during June & July 2018. Written feedback following that inspection identified a number of good practices, no concerns around clinical practice, but corporate issues such as fire risk assessments which needed to be improved upon. Full details can be found in Appendix C.

16. In that letter, the CQC also wanted to highlight individuals and services who had been praised by their colleagues during the inspection – there were 6 identified in total.

17. Areas for improvement specifically relating to Maternity have been added to their improvement plan and are in the process of being addressed. Trust wide issues, such as fire assessments and fire doors have been addressed by the Fire Officer, who has re-assessed *all* fire assessments to ensure they are accurate and *all* fire doors within the maternity department.

18. The trust is now waiting for the draft CQC inspection report (anticipated Friday 20 July 2018) to be submitted so that it can be checked for factual accuracy before being returned to the CQC for finalisation and publication.

Provider Information Request

19. Since the CQC inspection in 2017, the CQC have revised their inspection processes, which extends to the Provider Information Request (PIR), which is a request for a number of pieces of data and information about the trust. The new PIR is designed to be less demanding in relation to information requests, but more specific in terms of the information it requires, with a number of requests for narrative rather than documents.

20. As the trust will only have 3 weeks to submit the information when it is formally requested, it has decided to proactively run a 'dummy' PIR using the new PIR templates. The information requested is not yet fully complete, or validated and it is recognised that not all the information collected during this time will be up to date when the PIR is formally requested, however a significant amount will be, thus reducing the demand on staff when the real PIR lands. Further feedback regarding the 'dummy' PIR process will be provided in the next report.

Fundamental Standards of Care

21. The CQC key lines of enquiry (KLOE) offer a suite of fundamental standards, against which it is suggested the trust should be regularly monitoring itself to identify where improvements are required in order to move the trust from Requires Improvement to Good and beyond. Two pieces of work have been commenced to address this:

a) Core Service Self-Assessment against the KLOE

22. One of the errors which can sometimes be made by organisations, is to focus solely on the issues identified within the last CQC inspection report. This often means that if governance systems are weak, other issues are missed which can have a significant impact on quality and safety. In order to prevent this from happening, regular self-assessments should be undertaken against the fundamental standards contained within the KLOE. If done well, it will provide the core services with a full picture of where they are doing well (supported by evidence) and where they need to improve. A self-assessment is also a requirement of the PIR.

23. On the 25 May 2018, the trust undertook a self-assessment with representatives from each of the core services across acute and community. Following those assessments staff were asked to identify a number of actions to be added to their PCIPs:

    - Quick wins
    - Short-term actions
    - Longer-term actions

24. The initial outcome from this self-assessment compared with the outcome from the last CQC inspection is as follows:

	CQC Rating 2017					
	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	Overall
Urgent & Emergency Services	RI	GOOD	GOOD	RI	GOOD	RI
Medical Care	RI	GOOD	GOOD	GOOD	GOOD	GOOD
Surgery	RI	RI	GOOD	GOOD	GOOD	RI
Critical Care	RI	RI	GOOD	RI	RI	RI
Maternity	INADEQUATE	RI	RI	RI	INADEQUATE	INADEQUATE
Gynae	INADEQUATE				INADEQUATE	INADEQUATE
Children & Young People	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
End of Life	GOOD	RI	GOOD		GOOD	GOOD
Outpatients	GOOD	NA	GOOD	RI	GOOD	GOOD
Diagnostics	GOOD	NA	GOOD	RI	GOOD	GOOD
Community (Adults)	GOOD	GOOD	GOOD	GOOD	OUTSTANDING	GOOD
Community (Paeds)	RI	GOOD	GOOD	GOOD	GOOD	GOOD
Community (End of Life)	GOOD	GOOD	OUTSTANDING	OUTSTANDING	OUTSTANDING	OUTSTANDING
OVERALL (Manor Hospital)	RI	RI	GOOD	RI	RI	RI

	Self-Assessment 2018 (May)					
	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	Overall
Urgent & Emergency Services	RI	RI	RI	RI	GOOD	RI
Medical Care	RI	RI	GOOD	GOOD	GOOD	RI
Surgery	RI	RI	RI	RI	GOOD	RI
Critical Care	GOOD	RI	GOOD	RI	RI	RI
Maternity	RI	RI	RI	RI	INADEQUATE	RI
Gynae	GOOD	RI	OUTSTANDING	GOOD	GOOD	GOOD
Children & Young People	GOOD	GOOD	GOOD	OUTSTANDING	GOOD	GOOD
End of Life	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
Outpatients	Good	NA		RI	RI	
Diagnostics	RI	RI	GOOD	RI	RI	RI
Community (Adults)	GOOD	GOOD	GOOD	GOOD	OUTSTANDING	GOOD
Community (Paeds)	GOOD	GOOD	GOOD	GOOD	OUTSTANDING	GOOD
Community (End of Life)	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
OVERALL (Manor Hospital)	RI	RI	RI	RI	RI	RI

25. It is apparent that some core services believe that their services have declined, whilst others have improved since the last CQC inspection. In order to validate this assessment, a 'Confirm and Challenge' meeting has been arranged with each of the core services on the 09 August, whereby the executive team will test out the Core Service's rationale for their assessment, to ensure that the final self-assessment is a robust one, supported by evidence. The rationale is important when submitting the self-assessment as part of the PIR.

26. This self-assessment process will be built into the trust governance systems, being carried out on a quarterly basis; reported to local and trust wide governance meetings and discussed at Divisional Performance Reviews.

b) Monitoring of Fundamental Standards

27. Concerns have been raised, regarding the lack of corporate oversight in relation to delivery of fundamental standards of care. Following a review of audits and audit processes, it is apparent that there is a lack of consistency and standardisation of audits undertaken across the trust and the governance processes associated with them. There appear to be different audit tools used in different divisions monitoring similar issues, which means that the results can't be compared across the organisation, as the questions and tolerances will differ. As regards audit results, some are fed into dashboards and actions monitored via local governance meetings, whilst others don't appear to be reported anywhere; as a result, the organisation is not able to benefit from those results and make improvements. Consequently, it has been agreed that the current audits which relate to aspects of the fundamental standards have been reviewed and are in the process of being streamlined, removing duplication.

28. The new peer review audit document will be divided into 4 key areas:

- ***Environmental Review*** (including: infection control, estates & facilities snagging, equipment, environment, 'how to complaint', chaperoning signs, 15 steps to identify clutter etc., cleaning rotas, COSHH storage etc.)
- ***Patient Feedback Review*** (linking in with the Head of Patient Experience to reduce any duplication)
- ***Staff Feedback Review*** (which includes questions relating to safe, effective, caring, responsive and well-led)
- Multi-professional ***Clinical Records Review***

29. The proposal is that the trust introduces a 'Back to the Floor' clinical half day per week, when there will be no meetings and staff will be discouraged from doing emails; thus enabling as many staff as possible (clinical and non-clinical) to participate in the peer reviews. The peer reviews will be carried out on a 4 weekly cycle. Data will be collected electronically reducing time required to input and analyse data, with results being incorporated into a dashboard in the first instance and then latterly into an integrated performance system on a monthly basis.

30. Results will then be reviewed by wards / departments, Care Groups, Divisions and Corporate areas at their regular governance meetings so that actions can be taken to improve and achievements celebrated. The results will also be incorporated into the monthly performance reviews (divisional & corporate).

Board self-assessment against the CQC Well-Led Framework

31. During June & July 2018, the board carried out a self-assessment against the CQC Well-Led Framework (2017), using the CQC Ratings Characteristics to determine an overall rating of *Requires Improvement*. The outcome from that self-assessment, together with the resulting action plan will be presented to the board in August 2018 for discussion & ratification. Implementation of the actions and outcomes will be monitored via Trust Management Board and the Board.

Board self-assessment against the Use of Resources Framework

32. The executive team are currently conducting a self-assessment against the new Use of Resources Framework (CQC, 2018). Once completed actions will be identified to move the trust forward, which will be incorporated into the well-led action plan outlined above.

CQC Inspection Preparation

33. The trust established a weekly CQC Preparation Steering Group Meeting, chaired by the Chief Executive. The responsibility of the group is to oversee the preparation of the trust for the forth-coming CQC inspection, which includes implementation of the CQC preparation plan (previously discussed at Board) and oversight of key compliance issues.

34. A list of 'hot topics' have been identified and implementation of their solutions, overseen by the group. Examples of issues which have been tackled so far include: the capture of accurate mandatory training figures on ESR, medical device training compliance and prioritisation of the medical device replacement programme.

35. Sharing of best practice has been a feature of the last few meetings: the Emergency Department shared a patient information leaflet, with was strengthened by comments from the group; Maternity Services shared their governance processes which have helped them to monitor steady improvement and finally, the development of an App for Children's services – the App was so

impressive that it has been agreed to develop it to encompass the rest of the hospital.

36. There is a possibility that instead of a full inspection, the CQC will decide to focus on specific clinical areas, as they did with Maternity Services. In order to prepare these areas, 2 weekly Quality assurance meetings are being held with the Care Group triumvirates, to ensure the departments are ready to receive the CQC. However, it is anticipated that there will be a full inspection and plans are in place to prepare the organisation as a whole, which include a Use of Resources and Well-Led inspection.

37. In relation to the Well-led inspection, several actions have been taken, or are planned;

- Visibility Plan is being developed for implementation to enhance the visibility of Divisions & board members across the organisation (July 2018)
- A board briefing pack is being developed, which will be shared with board members in August
- 4 board development sessions have been arranged:
    - Risk Management (July 2018)
    - Well-led Assessment (June & July 2018)
    - Inspection preparation (x 2: August 2018)

Conclusion

38. This report has talked very much about CQC preparation. However, it should be noted that all the actions outlined in this paper are designed to become sustained and embedded in every day practice, as these quality improvements are for life and not just for Christmas.

Appendices:

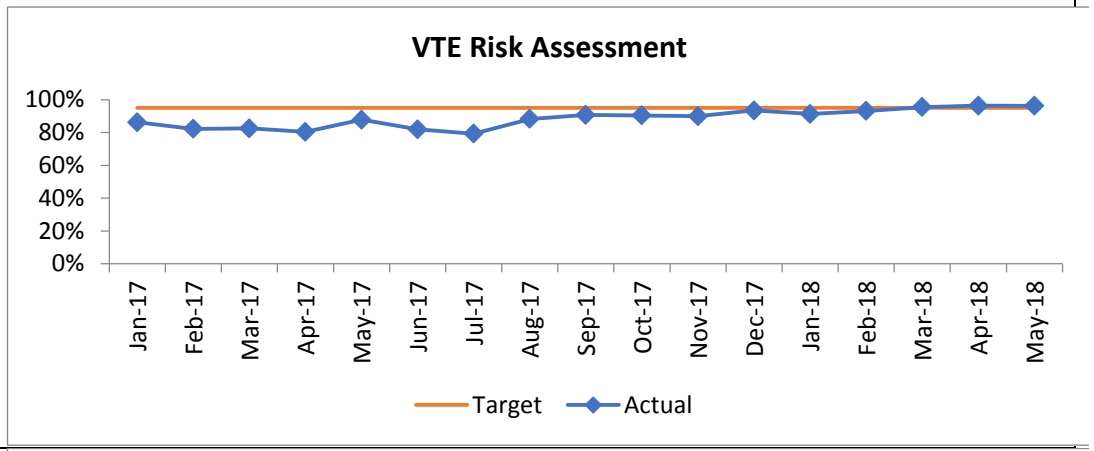
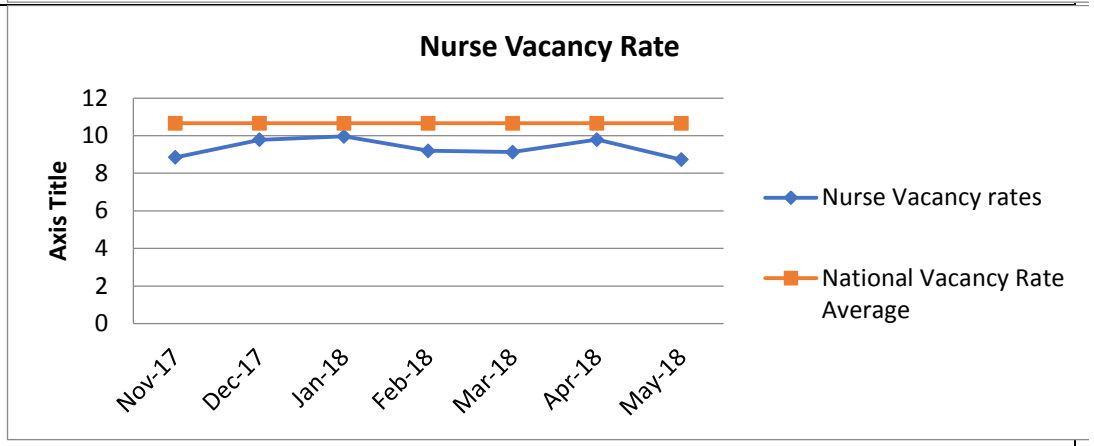
A: Update on Regulatory & Must Do Actions
B: C Section Rates – Maternity Services
C: Written feedback from the CQC following their spot inspection in June 2018

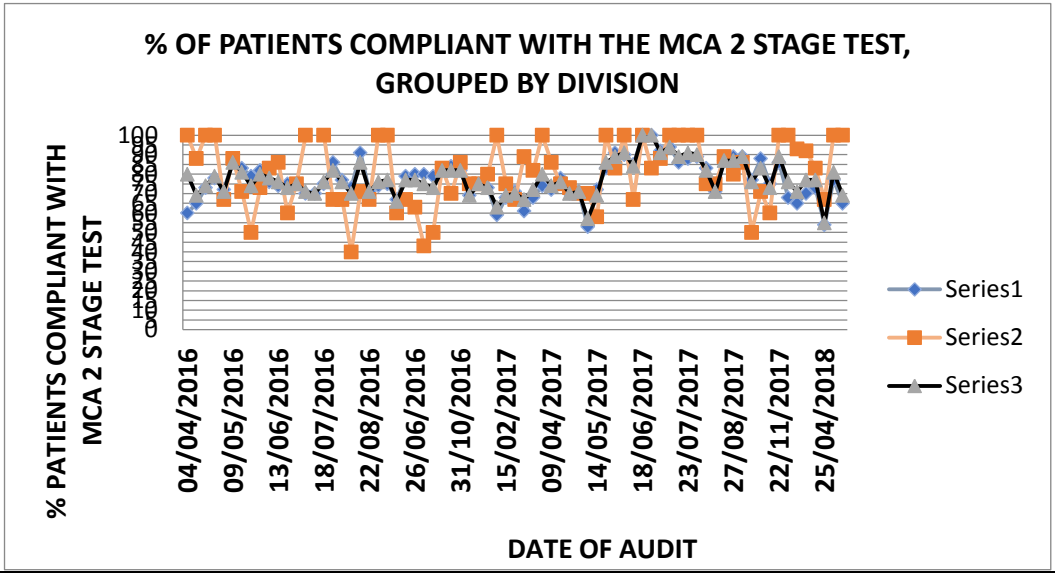
Walsall Healthcare NHS
NHS Trust

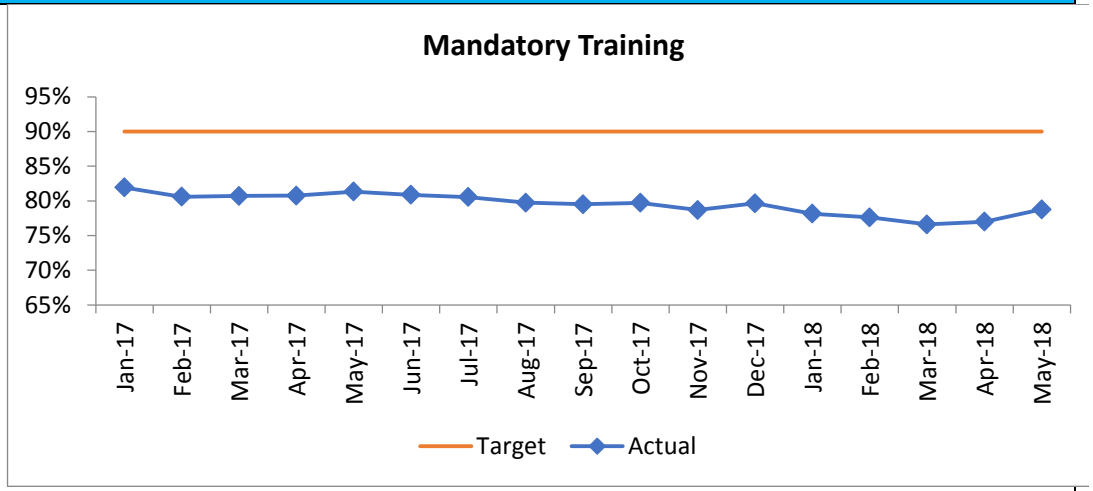
Appendix A

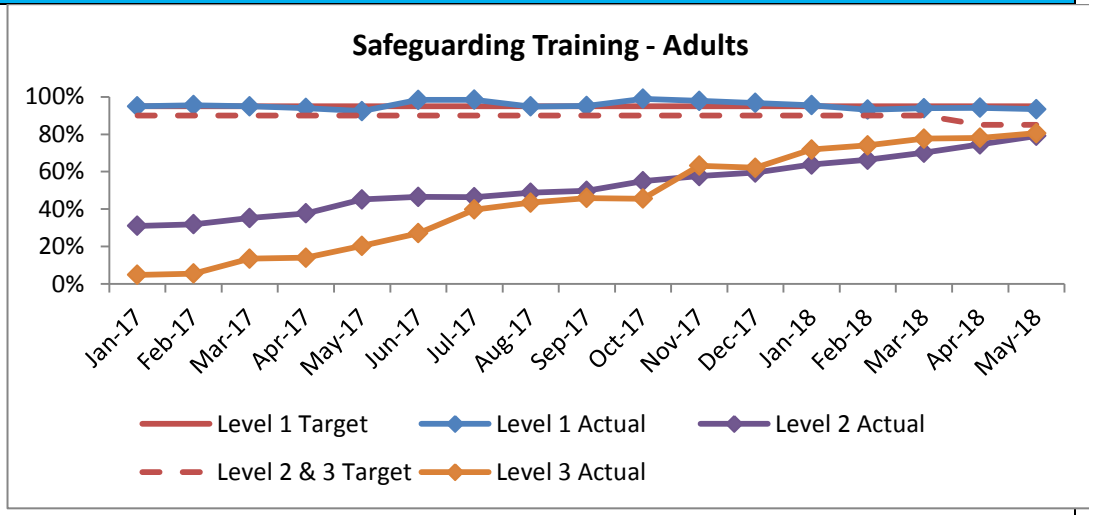
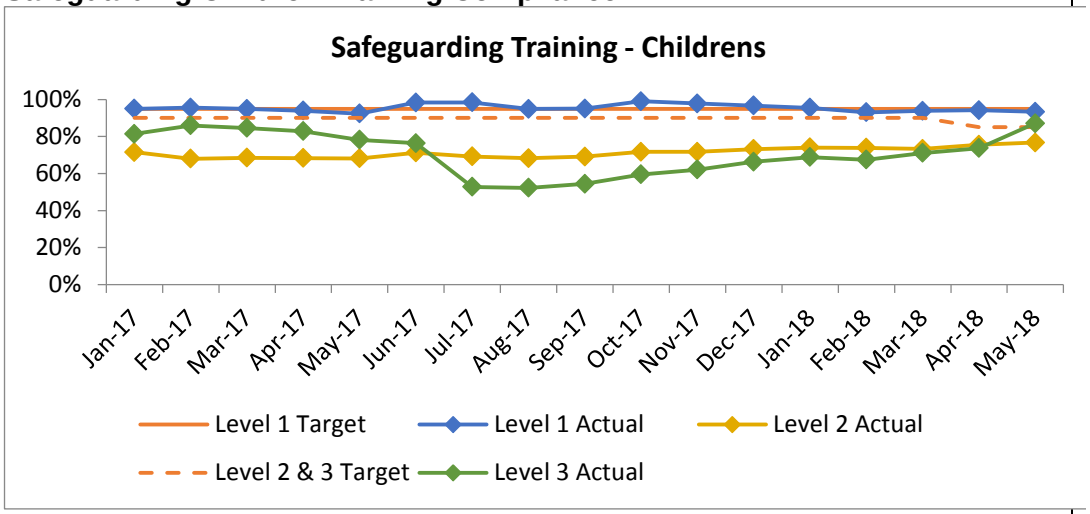
Update on Regulatory & MUST DO Actions (June 2018)

REGULATORY ACTION UPDATE:

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart
Thromboembolism assessments were not carried out for all patients at risk.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	95% are assessed on admission March 2018.	
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	Regulation 18 HSCA (RA) Regulations 2014 Staffing	Trust target is aligned to the National vacancy rate of 10.66%	

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart
12 (2)(a) Not all staff were compliant or completed timely assessments for patients- in accordance with the **Mental Capacity Act 2005 or Deprivation of Liberty (DOL)**.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	90% compliance with MCA training By March 2018 Compliance with MCA when completing DNA CPR decisions by March 2018.	MCA Training compliance = 55% (April 2018) **Compliance with completion of part 2 of the DNACPR form in relation to MCA = 69%** 
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.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	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.

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart
Staff were not up-to-date with **mandatory training**. There were a number of modules that had completion rates significantly lower than the trust's target.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	90% compliance by 30th June 2018.	
Blind cords were not secured in all of the rooms at the child development centre	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	By March 2018. Risk assessment Permanent solution to be implemented. Audit of compliance.	All blind cords (including the main hall) have been adjusted to ensure a permanent solution to ensure that children cannot reach them. Audit of compliance was completed 16th May 2018.
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).	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment	Achievement of targets for all levels of Children and Adult Safeguarding by end June 2018 Level 1=95% Level 2 & 3=85% PREVENT=85%	**Safeguarding Adults training Compliance:**

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart
			 **Safeguarding Children Training Compliance:** 

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart
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.	Regulation 17 HSCA (RA) Regulations 2014 Good governance	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.	A new multi-professional audit is in development (completion 31.07.18) which will be piloted alongside the other fundamental standards peer review audits commencing 15.08.18
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			Total Mobile note system implemented

Walsall Healthcare NHS
NHS Trust

MUST DO ACTION UPDATE:

Issue	Must	Trust Target	Update / SPC Chart
Action plans are monitored and managed for serious incidents	Must	Zero outstanding	The number of outstanding SI actions are reported to the Risk Management Committee and Quality & Safety Committee in the SI report which shows: • the number of SI investigation action plans with open actions in any given month • the number of SI action plans with one or more actions open beyond their target date. This does not show individual overdue actions. A trial to record each SI action in Safeguard to allow tracking and recording is nearing completion. This has enabled the process to be refined and bugs in Safeguard removed. The trust now requires every SI to have an action plan recorded in Safeguard which will enable tracking, monitoring and reporting of every action. Over time, this will inform the trust the number of actions completed (or not) within the agreed timescale with evidence of completion uploaded into Safeguard
Lessons are disseminated effectively to enable staff learning from serious incidents, incidents and complaints.	Must	TBA	Lessons learnt are disseminated via: • Sharing the SI investigation report with the staff involved • Weekly Divisional Safety Huddles • Risk Roadshows • 'Incidents at a glance' one page summaries describing the incident, lessons learned • Lessons learned bulletin • Care Groups quality/audit meeting • Speciality Governance meetings – i.e General surgery, TACC.

Issue	Must	Trust Target	Update / SPC Chart
			Feedback following an incident is also covered in Clinical Update training (but patient safety is potentially being removed from this). There needs to be an increased emphasis and expectation for Line Managers to own and disseminate feedback to their teams/staff and not rely on the Governance teams to do so. Measures: • The number of staff contacted through the Risk Roadshows • Attendance at Care Group governance meetings each month.
Patient medical notes are kept secure at all times	Must	TBA	Policy is being developed for implementation & audit
All staff are trained and competent when administering medications via syringe driver	Must	TBA	80% compliance (Alaris PCAM)
Staff follow best practice national guidance (NICE, CAS alerts, Royal College Guidelines, local clinical guidelines etc. etc.	Must	TBA	2 CAS Alerts outstanding: NATSIPPS Luer lock connectors Clinical Guidelines currently being rationalised and streamlined
The service uses an acuity tool to evidence safe staffing (nursing & midwifery)	Must	100%	SNCT & midwife: birth ratio in place
All staff receive an appraisal in line with local policy	Must	90%	83.41%
COMMUNITY FOR CHILDREN & YOUNG PEOPLE: Continue to follow standard operating procedures with medicines in special schools	Must	TBA	Medication SOPs signed by all the APs in the special schools and a monthly audit of the medication practice is undertaken which is reported on the CCN dashboard. 100% compliance (June 2018)

Issue	Must	Trust Target	Update / SPC Chart
MATERNITY: Risks are explained when consenting women for procedures	Must	TBA	Consent audit undertaken 2017. Re-audit to be undertaken August 2018
ED: completes the action plan completed following the CQC inspection carried out in September 2015	Must	TBA	Currently reviewing compliance
SAFEGUARDING: adults and Safeguarding children policies are up to date and include relevant references to external guidance	Must	100%	Revised Adult Policy to be ratified by 31.07.18 Revised Children's Policy – date to be confirmed
CRITICAL CARE: All staff working within the outreach team are competent to do so	Must	100% by 01.01.2019	
OUTPATIENTS: All staff have the required competencies to effectively care for patients, and evidence of competence is documented.	Must	90%	90% of staff have achieved the required competencies
OUTPATIENTS: All outpatient clinics are suitable for the purpose for which they are being used	Must	TBA	This comment related to the fracture clinic. Actions are being identified to rectify the situation.

Walsall Healthcare NHS
NHS Trust

Appendix B

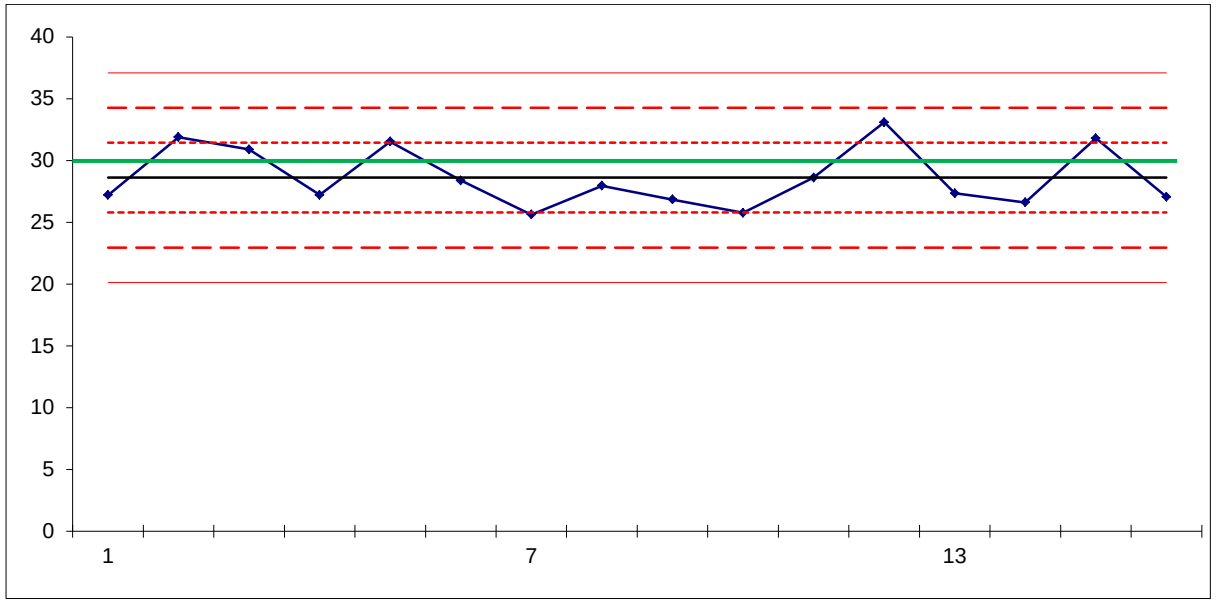
C Section Rates – Maternity Services

Introduction

The maternity unit has introduced the used of statistical process control charts (SPC) to determine whether rates of Caesarean section. 3rd and 4th degree tears and induction of labour are high or low or whether the fluctuations show normal variation.

SPC – Caesarean section – showing normal variation and levels for concern

Green is the target rate set by the Trust and the blue line below is the average rate achieved. Based on the previous charts it is evident that the current rate of CS at WHT is showing normal variation and does not need further review at this time



Rule	Rule Name	Pattern
1	Beyond Limits	One or more points beyond the control limits
2	Zone A	2 out of 3 consecutive points in Zone A or beyond
3	Zone B	4 out of 5 consecutive points in Zone B or beyond
4	Zone C	7 or more consecutive points on one side of the average (in Zone C or beyond)
5	Trend	7 consecutive points trending up or trending down
6	Mixture	8 consecutive points with no points in Zone C
7	Stratification	15 consecutive points in Zone C
8	Over-control	14 consecutive points alternating up and down

Appendix C

Written feedback from the CQC following their spot inspection in June 2018

The excerpt below has been taken directly from the letter received by the CEO from the CQC directly after the inspection in June 2018:

'***Good Practice:***

- Equipment was well maintained, checked and emergency equipment was easily accessible.
- CTG monitoring was well documented and reviewed by 'fresh eyes'.
- The patient and prescription records we reviewed were fully completed.
- The development of the maternity support worker role and PHI training for all midwives was regarded as a positive addition for staff.
- Positive patient experiences were reported which included partner involvement.
- There was a general improvement in staff training compliance rates and competency assessments.
- Appropriate patient pain relief and regular pain relief audits were conducted.
- HDU training completion had improved and two HDU staff covered each shift.
- There was development of the bereavement service.
- The service had a clearer leadership structure.
- There was an improved vision and strategy for the service. We discussed the pace of improvements which needed to be maintained and increased and changes needed to be sustained and nurtured.

Improvements Required:

- On Tuesday 5 June 2018, the fridges to store milk on both Primrose and Foxglove wards were unsecured posing a potential safety risk. However, this had been addressed when we checked on Wednesday 6 June 2018.
- The fire safety risk assessment was not accurate in assessing some of the risks and did not take into account significant changes on Primrose and Foxglove wards.
- We could not find evidence Legionella risk assessments had been conducted and mitigating actions were being completed to address potential risks.
- Some of the environment on the maternity unit was tired with some damage present. For example, we saw some chairs had ripped areas, damaged plaster and wallpaper where effective cleaning to reduce infection risks would not be possible.
- Consultant staffing was dependant on locum consultants particularly at night and to cover the on-call rota.
- There was limited availability of accessible information in different languages, picture formats, and cue cards. The use of the translation phone service was variable and did not always protect patient privacy.
- Overall, we saw improvements in the culture of staff particularly on the delivery suite since our last inspection. However, cultural issues remained an issue with some pockets of staff and reports of staff undermining other staff. '

MEETING OF THE PUBLIC TRUST BOARD – 2nd August 2018			
Revalidation Annual Report & Statement of Compliance 2017/18		**AGENDA ITEM:10**	
Report Author and Job Title:	Mark Read – Medical Revalidation & Job Planning Manager	**Responsible Director:**	Mr Amir Khan – Medical Director
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	Medical revalidation is a legal requirement which applies to all licensed doctors listed on the General Medical Council (GMC) register in both the public and independent sectors. Its purpose is to improve patient care by bringing all licensed doctors into a governed system that prioritised professional development and strengthens personal accountability. There is a need for designated bodies and responsible officers to be able to provide assurance to patients, the public, the service and the profession, that the appropriate systems and processes are in place to ensure that every licensed medical practitioner is safe to practise. This report highlights the framework which pulls together the various governance mechanisms to achieving assurance, to assist the Trust's responsible officer (Mr. Amir Khan - Medical Director) in providing confidence that the doctors working in the Trust are up to date and fit to practise. The General Medical Council (GMC), Care Quality Commission (CQC), Monitor and NHS Trust Development Authority (NHS TDA) expect that boards of designated bodies should monitor their organisation's progress in implementing the Responsible Officer Regulations.		
Recommendation	Members of the Trust Board are asked to: • Note and receive the Annual Report for Revalidation • Approve the 'Statement of Compliance' confirming that the organisation, as a designated body, is compliant with the regulations (Appendix 1) A *Statement of Compliance with the regulations* **(Appendix 1)** should be signed by the Chairman or Chief Executive Officer of the designated body's Board or management team and submitted to Dr David Levy, Regional Medical Director and Higher Level Responsible Officer, NHS England Midlands and East by **30 September 2018**		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.	
Resource implications	There are no resource implications associated with this report.	
Legal and Equality and Diversity implications	The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒

Summary

Medical revalidation is a legal requirement which applies to all licensed doctors listed on the General Medical Council (GMC) register in both the public and independent sectors. Its purpose is to improve patient care by bringing all licensed doctors into a governed system that prioritised professional development and strengthens personal accountability.

There is a need for designated bodies and responsible officers to be able to provide assurance to patients, the public, the service and the profession, that the appropriate systems and processes are in place to ensure that every licensed medical practitioner is safe to practise. This report highlights the framework which pulls together the various governance mechanisms to achieving assurance, to assist the Trust's responsible officer (Mr. Amir Khan - Medical Director) in providing confidence that the doctors working in the Trust are up to date and fit to practise.

The General Medical Council (GMC), Care Quality Commission (CQC), Monitor and NHS Trust Development Authority (NHS TDA) expect that boards of designated bodies should monitor their organisation's progress in implementing the Responsible Officer Regulations.

Performance highlights

- **96%** (236) of doctors had an appraisal between 1 April 2017- 31 March 2018;
- **55%** (11) of doctors due to be revalidated were recommended for revalidation between 1 April 2017- 31 March 2018;
- **45%** (9) of doctors due to be revalidated were deferred owing to insufficient supporting information, or owing to them being subject to an ongoing process;
- 5 of the 15 recommendations made were made late (past the revalidation submission date) (**see Appendix C for Audit**)

Key Actions undertaken between 1 April 2017- 31 March 2018

The Trust invested in Allocate's HealthMedics Optima software in May 2017, which is an integrated workforce management solution that supports the Trust in the tracking and monitoring of key stages of appraisal and revalidation. This includes a live electronic dashboard for the Responsible Officer and reporting functionality. The software was live effective from March 2018 for Appraisal;

Key Actions Planned for 1 April 2018 - 31 March 2019

There will be an increased emphasis in the next 6-12 months on relaunching and key quality elements to embed a culture focused on the quality and calibration of appraisal and the associated outputs, not just compliance rates. This will include a new Policy, monitoring and improving Medical Appraiser performance and revising the Revalidation Steering Group and Appraiser Support Group terms of reference.

Engaging with doctors and Medical Appraisals will be key to creating a culture focused on reflection and application to clinical performance, robust PDP's that are effective and objectives that are aligned to both Trust, service and individual needs.

Building more effective links with the Medical Education department and associated strategies will also be fundamental to improving the experiences of Trust Training grade doctors in terms of annual appraisal and revalidation.

Monthly reporting on compliance data to the Divisional Review with the Executive Team meetings will help build a Clinically Led culture of ownership and accountability within Divisions. Monitoring performance with regards to appraisal and revalidation and identifying actions owned at care group level will help mitigate risks of non-compliance.

Risks and Issues

It has been identified that a key area to improve is the timely identification of appraisal anniversary dates and revalidation submission dates for newly connected doctors to the Trust (recruited to the Trust via Bank or Recruitment processes). This issue has contributed to some of the late revalidation submissions and also, late appraisals. It will be imperative that the Medical Revalidation, Recruitment and Medical Staffing Teams continue to work closely to ensure this risk is mitigated and annual appraisal anniversaries and medical revalidation submission dates are confirmed at appointment stage. An increase in the number of former Locum Agency Doctors joining the Trust Bank and therefore connecting to the Trust for the purposes of revalidation, has also contributed to this matter.

Recommendations

The **Statement of Compliance Regulations (Appendix 1)** should be signed off by the Chairman or Chief Executive Officer of the designated body's Board or management team and submitted to Dr David Levy, Regional Medical Director, NHS England Midlands and East by **30 September, 2018.**

Revalidation Annual Report & Statement of Compliance

August 2018

Department of Health

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annual Board Report

THE NHS CONSTITUTION

the NHS belongs to us all

1. Purpose

For the Board of Walsall Healthcare NHS Trust to review and approve the Medical Revalidation process and the associated annual report of Medical Revalidation and Appraisal activity.

A **Statement of Compliance with the regulations (appendix 1)** should be signed off by the Chairman or Chief Executive Officer of the designated body's Board or management team and submitted to Dr David Levy, Regional Medical Director, NHS England Midlands and East by **30 September, 2018.**

2. Background

A **designated body** is defined as an organisation that a licenced doctor has a professional, educational or employment connection with that provides them with support for revalidation. A **responsible officer** is defined as a senior doctor in a healthcare organisation, who has local responsibility for overseeing the conduct, monitoring the performance, and evaluating the fitness to practise of doctors linked to that organisation.

Licensed Doctors have to revalidate usually every five years, and are required to participate in an annual appraisal based on GMC core guidance for Doctors, *Good Medical Practice.* On the basis of this and other information available to the Trust's Responsible Officer from local clinical governance systems, the responsible officer will make a recommendation to the GMC concerning a Doctor's fitness to practise. The GMC will then consider the recommendation and decide whether to continue the doctor's licence to practise.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards / executive teams will oversee compliance by ensuring that:

- All appraisals undertaken will comply with professional standards. Steps are taken to ensure objectivity of the appraisal, checking there are effective systems in place for monitoring the conduct and performance of doctors.
- As part of the process all appraisees have to complete an evaluation form providing feedback on the organisation, the appraiser and the appraisal discussion. This feedback is forwarded to the appraiser and forms part of their appraisal in order to demonstrate that they are appropriately skilled to undertake this role. Any concerns raised are forwarded to Mr Amir Khan – RO for his action.
- In a revalidation cycle (5 years duration), appraisees must have had an appraisal by at least 2 different appraisers. The Medical Revalidation & Job Planning Manager has an e-Appraisal database in order to monitor this process and all associated processes relevant to the scheduling of

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

appraisal.

- All appraisals must be signed off by the appraisee and the appraiser within 28 days of the appraisal meeting. This is monitored by the Medical Revalidation & Job Planning Manager. Any breach to this standard is recorded on a database and highlighted to Amir Khan – Responsible Officer.
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out by the Medical Staffing Department to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Responsible Officer Regulations

The Responsible Officer Regulations make clear that as part of their respective role as set out in statue, in order to provide assurance, the Responsible Officer will need to be able to demonstrate that: -

- The underpinning systems and processes are in place and functioning effectively, in compliance with nationally agreed standards;
- Their own decision-making, and also that of appraisers and case investigators, is robust and consistent, not only at the individual level and internally within the designated body, but also that they are in alignment with the decision-making of peers in other organisations, from all sectors, across the country.
- The board of the designated body is engaged in the process of revalidation, taking active steps to integrate the systems and processes underpinning medical revalidation into the organisation's broader quality and safety agenda.

It is not anticipated that designated bodies will be routinely requested to submit copies of their annual board reports to their higher-level RO. However, in some instances this may be necessary, should the designated bodies require support from the regional team with implementation.

3. APPRAISAL & REVALIDATION PERFORMANCE 2017/18

3.1 Appraisal Performance Data

Trust Overall Appraisal Performance

1 April 2015 – 31 March 2016	1 April 2016- 31 March 2017	**1 April 2017- 31 March 2018**	1 April 2018 to 18/07/2018
79%	**89%**	**96%**	**88%**

Trust Appraisal Performance by Grade of Doctor

Appraisal compliance between 1 April 2017 - 31 March 2018	
Consultants	97%
SAS (Middle Grades)	97%
Temporary Contract Holders	98%
Other	91%
TOTAL (TRUST)	**96%**

See also **Annual Report Template Appendix A** and the **Annual Organisational Audit (AOA) end of year questionnaire 2017-18.**

Missed Appraisals

During the previous appraisal year 2016/17, the Trust reported 11% of doctors had missed their appraisal, with 10% of these being unapproved missed appraisals and 1% being approved missed appraisal (approved by the Responsible Officer).

In this current reporting period (2017/18) the total number of missed appraisals has reduced to 4%, with 3% of these being approved missed appraisals (due to maternity leave, sickness and ongoing management processes) and 1% were unapproved missed appraisals (owing to the doctor not completing their portfolio in time).

Prior to this, the total number of missed appraisals in 2015/16 was 21%. This demonstrates that in the last 3 appraisal years there has been a significant reduction in the total number of missed appraisals (approved and unapproved) and the Trust's overall Medical Appraisal compliance has risen from 79% to 96% as a consequence.

3.2 Revalidation Performance Data

Revalidation Recommendations

1 April 2017 – 31 March 2018

- **20** doctors were due to revalidate between 1 April 2017- 31 March 2018
- 11 were recommended for revalidation (55%)
- 9 were recommended to be deferred owing to insufficient supporting information/on-going processes concerning the doctor (45%);
- 22 doctors were issued with REV 6 'non-engagement concern letters' by the GMC, for unapproved missed or late appraisal, following referral by the Trust to the GMC.
- 0 doctors were formally determined to be non-engaging doctors by the Trust's Responsible Officer, as the re-engaged in the process.

1 April 2018 to

- **60** revalidation decisions are due between 1 April 2018- 31 March 2019
- 18 have already been recommended for revalidation (figure as at 18/07/2018)
- 5 have already been recommended to be deferred owing to insufficient supporting information/on-going processes concerning the doctor (figure as at 18/07/2018);
- 5 of the doctors due have previously been deferred;

See also **Annual Report Template Appendix C;** Audit of revalidation recommendations

3.3 Managing Prescribed Connections

The Trust currently has 242 Doctors with a prescribed connection. Doctors with a prescribed connection to Walsall Healthcare NHS Trust as their Designated Body are managed through GMC Connect online, by the Medical Revalidation and Job Planning Manager who has delegated access, on behalf of the Trust's Responsible Officer. This is updated as and when doctors join or leave the Trust.

3.4 Appraisers

The Trust currently has **44** appropriately trained appraisers.

Each appraiser should conduct 6 Appraisals per annum to maintain their skill set for which they will receive 0.125 PAs in their Job Plan. The current ratio, based upon 245 prescribed connections is 1: 5.6.

The selection and training of new appraisers is carried out as and when required. National guidelines (e.g. GMC, NHS England etc.) are followed regarding approved training. In June 2017, the Trust trained 16 new Medical Appraisers.

It will be a requirement under the new Policy to undertake top-up/refresher training every **3 years** from the date of completing formal Medical Appraiser Training. In October 2016, the Trust also commissioned an online top up refresher training package for all its existing Medical Appraisers, which will be repeated in October 2019.

3.5 Quality Assurance

- The designated Medical Appraiser will review the doctor's appraisal portfolio to provide assurance that the appraisal inputs, the pre-appraisal declarations and supporting information provided is available and appropriate.

- The quality assurance of appraisal outputs will ensure that they comply with GMC requirements and other national guidance. Currently, the Trust's Appraisal Lead quality assures all appraisal outputs for all Medical Appraisals annually. The Trust's Responsible Officer plans to increase the number of Lead Appraisers to 3 (one per Division).

- The process for reviewing the appraisal portfolio using ASPAT provides assurance that the appraisal outputs, PDP, summary and sign offs are complete and to an appropriate standard.

- The Lead Appraiser will review appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs (if this is applicable).

- During the sign off process, there is an expectation that all reflective elements are clearly evident within the appraisal and supporting documentation. This will include an annual record of continued professional development and the doctor's reflections, a review of lessons learned from any complaints and/or any significant events.

- Trust Policy highlights that the appraisal cannot be signed off without the supporting evidence required.

- Walsall Healthcare undertakes an e360 degree feedback process at year 2 and year 4 of the revalidation cycle, unless any concerns have been raised. In this case, the 360 is repeated the following year. The national requirement for this process is once in a 5 year cycle. The Revalidation Team will collect a minimum of 15 colleague feedback forms and a minimum of 20 patient feedback forms. The patient feedback forms are collated by the Revalidation Team and a summary uploaded onto the Trust electronic appraisal portfolio system. Colleague Feedback is completed electronically via the Trust's e360 system (Allocate).

- As part of the process all appraisees have to complete an electronic evaluation form providing feedback on the organisation, the appraiser and the appraisal discussion. This feedback is monitored by the Trust's Medical Revalidation and Job Planning Manager and a summary is forwarded on an annual basis to the appraiser and forms part of their own annual appraisal in order to demonstrate that they are appropriately skilled to undertake this role. Any concerns raised are forwarded to the Trust's Responsible Officer for action.

- The Medical Revalidation and Job Planning Manager will monitor appraisal activity and escalate any concerns to the Responsible Officer. They will also produce regular performance reports as per **section 3.7**.

- All missed appraisals are tracked with explanations recorded by the Trust's Medical Revalidation and Job Planning Manager. This information is captured and the information held on a database with the reasons why the appraisal was missed and when the next appraisal will be scheduled details the requirements of assurance.

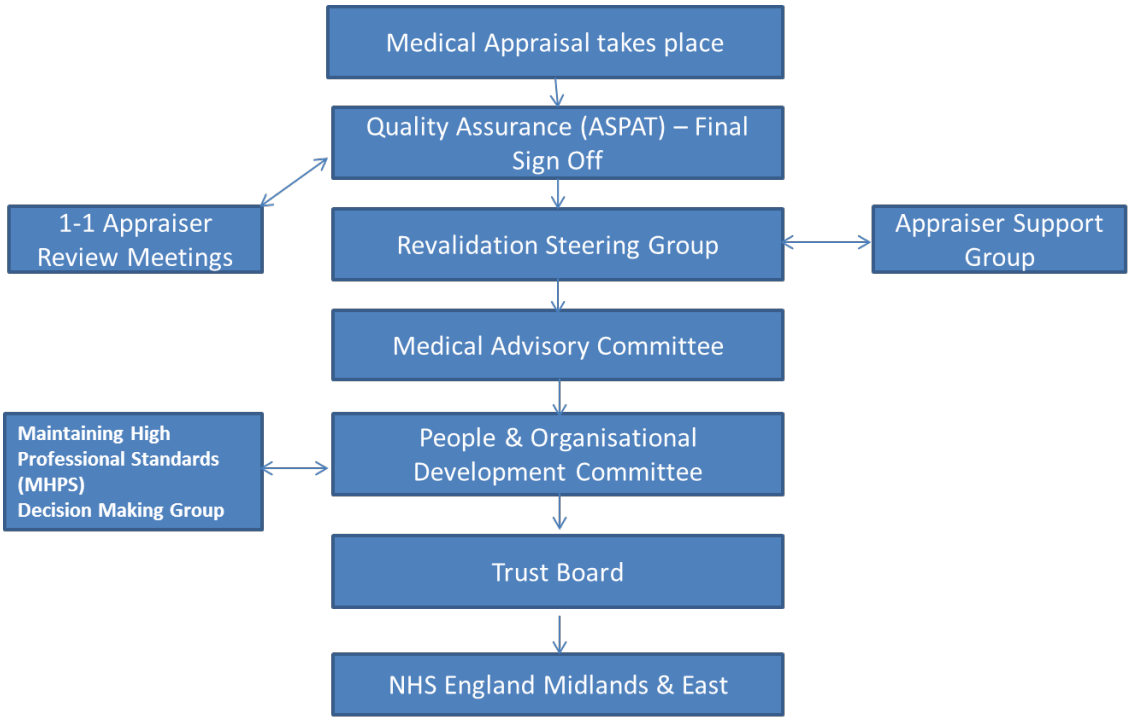
(See **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs)

3.6 Governance

The Policy details the data expectations that the appraisee is expected to provide in support of the process to meet revalidation, e.g. Complaints, clinical incidents, significant events and audit data. In addition, quality outcome data is required.

Trust Governance Structure

The Trust Governance Structure is outlined in Figure 1 Below:



Revalidation Governance Structure - Figure 1

Policy and Guidance

All local policies and procedures have been ratified by the Local Negotiating Committee and the Senior Medical Staff committee. The Trust's existing *Senior Medical Staff Appraisal Policy* will be replaced by a new Medical Appraisal and Revalidation Policy, to be presented at September 2018 Medical Advisory Committee before being cascaded for wider consultation. This Policy has been developed in line with national guidance[2]:

2

Effective Governance to Support Medical Revalidation

Good Medical Practice (GMC, 2006)

Good Medical Practice Framework for Appraisal and Revalidation (GMC, 2011)

Supporting Information for Appraisal and Revalidation (GMC, 2011)

Medical Appraisal Guide (NHS Revalidation Support Team, v4 March 2013)

Quality Assurance of Medical Appraisers (NHS Revalidation Support Team, 2012

Access, security and confidentiality

The new Medical Appraisal and Revalidation Policy details the protocol for the handling of information for appraisals and revalidation which complies with information governance, confidentiality and data protection requirements.

Quality Assurance (ASPAT) - Medical Appraisal

The Appraisal Summary and PDP Audit Tool (ASPAT) is a generic tool that will be used to audit all appraisal summaries and Personal Development Plans (PDP). This will be undertaken by the Medical Appraisal Lead. In the event of any quality issues being identified, these appraisals will be reviewed and discussed at the Revalidation Steering Group and any actions, owners, and associated timelines identified in the associated action plan. Anonymised ASPAT feedback and points of learning will also be raised at the Appraisal Support Group meetings to ensure shared learning is cascaded to all Medical Appraisers.

Revalidation Steering Group (RSG)

The RSG will meet bi-monthly to discuss any revalidation and Medical Appraisal related issues for those Doctors connected to the Trust as a Designated Body. It will discuss forthcoming appraisal allocation, possible deferrals and non-engagement, and any other concerns relating to the administration of the appraisal and revalidation process. The objective of this group is to ensure quality assurance of the appraisal process. A review of appraisal outputs will be undertaken and the Medical Revalidation & Job Planning Manager will present findings relating to quality and risk issues (and focussing on good practice) using the ASPAT reviews undertaken in the last 2 months to ensure the quality of the appraisal outputs meets the GMC Good Medical Practice requirements. The group will report into the People and Organisational Committee, and in turn to Trust Board (**see *figure 1* above**).

Appraiser Support Group (ASG)

All Medical Appraisers are members of the Appraiser Support Group (ASG) which will be chaired by one of the Trust's Lead Appraiser. These meetings will be held quarterly, in line with the commencement of the annual leave year 1 April. The meetings will cover any issues and concerns to be addressed, the appraiser allocations for the forthcoming year and any training and development needs.

It is a requirement that all Medical Appraisers attend a minimum of 2 ASG meetings per appraisal year.

Appraiser Performance Review

The Trust's Lead Appraiser will be required to meet with each Medical Appraiser at least once per Appraisal year, to provide feedback and review development needs. The Lead Appraiser will complete an Appraiser Assurance Review Template following this meeting and a copy of this will be shared and retained by the appraiser and the Revalidation Team. These meetings will be forward planned and diarised over the course of the appraisal year 1 April – 31 March.

3.7 Monitoring Performance

Performance data relating to the quality of appraisals and revalidation is presented through regular reports to NHS England Midlands and East and compliance data concerning appraisals and revalidation will also be assured through regular performance reports to internal stakeholders:

Weekly

Appraisal Performance Dashboard circulated to Divisional Directors for information and action highlighting risks and missed appraisals;

Monthly

Appraisal Performance Dashboard to the Monthly Divisional Review meeting with the Executive Team, for information and action highlighting appraisal compliance rates, risks and missed appraisals;

Bi-monthly

Reports to Medical Advisory Committee regarding appraisal compliance by department and division, missed appraisals, non-engagement and overall appraisal programme performance and action plan

Quarterly

Medical Revalidation Steering Group to report to People and Organisational Development Committee to provide assurance and compliance to national and local indicators;

NHS England - Quarterly appraisal report (Framework of Quality Assurance)

Annually

The Annual Organisation Audit (AOA) report **(appendix 2),** is issued to NHS England each year and details the systems that the Trust has in place for implementing the Responsible Officer Regulations.

Trust Board, confirming the numbers of appraisals completed across the organisation, any key themes that are emerging and recommendations for improving the process and quality (if relevant) for the following year in line with national guidance. A summary of the AOA results is included in the Trust Annual Board Report.

3.8 Recruitment and engagement background checks

See **Annual Report Template Appendix E;** Audit of recruitment and engagement background.

3.9 Responding to Concerns and Remediation

The Trust is currently reviewing the Policy for raising and dealing with concerns. This will follow the 'Maintaining High Professional Standards' framework and NCAS 'Back on Track' framework.

The number of doctors in remediation and disciplinary processes will be reported on monthly at the Trust's Maintaining High Professional Standards (MHPS) Decision Making Group. Terms of Reference **are in place**, and the Group reports directly to the Trust's People and Organisational Committee.

Maintaining High Professional Standards (MHPS) Decision Making Group (DMG)

The DMG will review cases and assist the Responsible Officer (RO) and/or Case Manager with decision making with regards to managing concerns relating to medical practitioners, including determining the need for and outcomes of investigations relating to Medical Practitioner concerns. The remit of the Trust's DMG will include:

- Preliminary decision making in terms of the category and level of concern relating to a medical practitioner;
- Deciding on action that is/is not required and other parties to be involved, for example e.g. commissioning an investigation;
- Consideration of a Medical Practitioner's practice restriction/suspension/exclusion from work;
- Appointing a case manager and case investigator to investigate concerns and providing appropriate timescales for this process;
- Deciding with the RO further action that may be required at conclusion of the investigation process.
- Reporting on the number of doctors in remediation and disciplinary processes

The DMG will meet bi-monthly, but extraordinary meetings will be held at the determination of the RO in the event of significant concern arising.

See **Annual Report Template Appendix D;** Audit of concerns about a doctor's practice.

3.10 Risk and Issues

Identified risks include:

1) Ensuring that all newly connected doctors are identified and their annual appraisal anniversary and medical revalidation submission date confirmed at appointment stage to reduce risk of late submissions and late appraisals;
2) Revised Policy relating to Appraisal and Revalidation yet to be ratified;
3) Improving Overall Trust Appraisal Performance;
4) Clinically led monitoring within Divisions of Appraisal Compliance rates and associated action plans for non-compliance to be timely, effective;
5) Revalidation Team Resources – currently the Medical Revalidation & Job Planning Administrator role is vacant (since May 2018), having not been

appointed to following 2 separate recruitment processes. Temporary Bank support has been secured effective from 23/07/2018;
6) Possible change of Responsible Officer in 2018/19

3.11 Board / Executive Team Reflections

This will form part of the operational requirement for the 2018/19 submission.

3.12 Corrective Actions, Improvement Plan and Next Steps

An action plan for improvement has been developed and this is to be reviewed as part of the Revalidation Steering Group and will be maintained by the Medical Revalidation and Job Planning Manager **(appendix 5);**

In terms of improvements made, the most significant investment was the commissioning of a new Medical Workforce system called Allocate Health MedicsOptima which replaced the previous CRMS system used to manage medics appraisals, Job Plans and leave. eAppraisal went live in March 2018.

The training to all doctors commenced January 2018, and more than 50 sessions were delivered in an IT training facility. Monthly training sessions for new starters will continue.

Actions already taken in 2017/2018

1) Weekly Appraisal Performance Dashboard circulated to Divisional Directors to highlight risks and any missed appraisals;
2) The Trust invested in Allocate's HealthMedics Optima software in May 2017, which is an integrated workforce management solution that supports the Trust in the tracking and monitoring of key stages of appraisal and revalidation. This includes a live electronic dashboard for the Responsible Officer and reporting functionality. eAppraisal was fully implemented effective March 2018;

Actions planned for 2018/19

1) There will be an increased focus in the next 6-12 months on relaunching and embedding the quality elements and strategies, to embed a culture focused on quality and appropriate governance of the appraisal process e.g. Revalidation Steering Group, Appraiser Support Group;
2) Improving focus on quality of appraisal outcomes to include PDP's and objectives that are aligned to both Trust, service and individual needs;
3) Forging more effective links with the Medical Education departments and the Medical Education Strategy and improving links with associated strategies;
4) Continuing to build staff engagement and competency using the new e-Appraisal system;
5) Monthly reporting on compliance to Monthly Divisional Review with the Executive Team to agree individual actions. Data will include any doctor due to be appraised in the next 12 weeks and those doctors within 120 days of their Revalidation Submission Date ("under notice");

6) New Medical Appraisal and Revalidation Policy to be issued for Consultation and to be presented at Medical Advisory Committee in September 2018 **(appendix 3).** This Policy includes a number of key developments, including a proposed 9 month Appraisal Year window: 1 April – 31 December to help improve compliance rates, by reducing the possibility of missed appraisals being reported in the Annual Organisation Audit (AOA) questionnaire **(appendix 2),** which covers the period 1 April – 31 March;
7) Proposed shift to 9 month Appraisal Year window: 1 April – 31 December to improve yearly compliance rates due to winter pressures;
8) All New Starters within 3 months of commencement with the Trust, will develop a Personal Development Plan with their Clinical Manager in line with both Trust objectives and doctor's developmental needs;
9) Live Appraisal & Revalidation Action Plan linked to outcomes of the Medical Revalidation Steering Group **(appendix 5);**

4. Recommendations

The Board is recommended to:-

- Note and receive the Annual Report for Revalidation.
- Approve the 'Statement of Compliance' **(Appendix 1)** confirming that the organisation, as a designated body, is in compliance with the GMC regulations. This should be signed by the Chairman or Chief Executive Officer of the designated body's Board or management team and submitted to Dr David Levy, Regional Medical Director and Higher Level Responsible Officer, NHS England Midlands and East by **30 September 2018**

Report Author: Mark Read, Medical Revalidation & Job Planning Manager

Date of report: 20/07/2018

Appendices	
1	Statement of Compliance (Annex E)
2	Annual Organisational Audit (AOA) Report
3	Medical Appraisal and Revalidation Policy (DRAFT)
4	Revalidation Steering Group Terms of Reference
5	Appraisal & Revalidation Action Plan
6	Medical Appraisers Support Group Terms of Reference

Annual Report Template Appendix A - Audit of all missed or incomplete appraisals

Doctor factors	**Number**
Maternity leave during the majority of the ‘appraisal due window’	1
Sickness absence during the majority of the ‘appraisal due window’	1
Prolonged leave during the majority of the ‘appraisal due window’	0
Suspension during the majority of the ‘appraisal due window’	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	
Appraisal outputs not signed off by doctor within 28 days	
Lack of time of doctor	0
Lack of engagement of doctor	6
Other doctor factors	1
(describe)	Doctor subject to an ongoing process.
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0
TOTAL MISSED APPRAISALS	**9**

Annual Report Template Appendix B - Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed by Trust		236
	All are quality assured to ensure meet revalidation requirements	Yes
Appraisal inputs		
Scope of work: Has a full scope of practice been described?	Yes	
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	Yes	This is checked before final sign off can be made
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	Yes	Dashboards being developed.
Patient feedback exercise: Has a patient feedback exercise been completed?	Yes	
Colleague feedback exercise: Has a colleague feedback exercise been completed?	Yes	All completed before going through revalidation
Review of complaints: Have all complaints been included?	Yes	
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	Yes	
Is there sufficient supporting information from all the doctor's roles and places of work?	Yes	This information is checked before final sign off
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	Yes	Feedback completed at year 2 and year 4 of the 5 year cycle.
Appraisal Outputs		
Appraisal Summary	236	236
Appraiser Statements	236	236
Personal Development Plan (PDP)	236	236

Annual Report Template Appendix C - Audit of revalidation recommendations

Revalidation recommendations between 1 April 2017 to 31 March 2018	
Recommendations completed on time (within the GMC recommendation window)	15
Late recommendations (completed, but after the GMC recommendation window closed)	5
Missed recommendations (not completed)	0
TOTAL	20
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	Doctors had failed to complete their appraisal portfolio and sign off within 28 days.
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	2
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	2
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	5
Describe other	Appraisal sign off incomplete on revalidation date. Recommendation then made as soon as possible.

Annual Report Template Appendix D - Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[3]	Medium level[3]	Low level[3]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	2	5	3	10
Capability concerns (as the primary category) in the last 12 months	2	2	1	5
Conduct concerns (as the primary category) in the last 12 months		3	2	5
Health concerns (as the primary category) in the last 12 months				
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2018 who have undergone formal remediation between 1 April 2017 and 31 March 2018 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				245
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				155
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				34
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, Trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc.) All Designated Bodies				45

[3] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) All Designated Bodies	11
TOTALS	**245**
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April 17 and 31 March 18: Explanatory note: All suspensions which have been commenced or completed between 1 April 17 and 31 March 18 should be included	3
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April 17 and 31 March 18 should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 – 6 months 6 – 12 months	 2 1
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	4
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April 17 and 31 March 18	5
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April 17 and 31 March 18	
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April 17 and 31 March 18	
Had their registration/licence suspended by the GMC between 1 April 17 and 31 March 18	0
Were erased from the GMC register between 1 April 17 and 31 March 18	
National Clinical Assessment Service actions:	5
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April 17 and 31 March 18 for advice or for assessment	3
Number of NCAS assessments performed	

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	9
Temporary employed doctors	169
Locums brought in to the designated body through a locum agency	134
Locums brought in to the designated body through 'Staff Bank' arrangements	357
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc.	0
TOTAL	

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	9	9				9	9	Mr A. Khan	9	9		9	0	0	0	0
Temporary employed doctors	169	169				169	169	Mr A. Khan	0	169		169	0	0	0	0
Locums brought in to the designated body through a locum agency	134	134				134	134		0	134		134	0	0	0	0

Locums brought in to the designated body through 'Staff Bank' arrangements	357	357				357	357	Mr A. Khan	0	357	1	357	0	0	0	0
Doctors on Performers Lists	0	0	0	0	0	0	0	Mr A. Khan	0	0	0	0	0	0	0	
Other (Independent contractors, practising privileges, members, registrants, etc.)	0	0	0	0	0	0	0	Mr A. Khan	0	0	0	0	0	0	0	0
Total	669	669				669	669				1					

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

Explanatory note: Number of locum sessions used (hours) as a proportion of total medical establishment (hours)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE**)**	Consultant: Overall number of locum **hours** used	SAS doctors: Overall number of locum **hours** used	Trainees (all grades): Overall number of locum **hours** used	Total Overall number of locum **hours** used
Surgery	54	233	3,366	1,967	**5,566**
Medicine	117.08	11,504	10,912	11,293	**33,708**
Psychiatry	3	0	0	0	**0**
Obstetrics/Gynaecology	37	1,264	3,137	481	**4,882**
Accident and Emergency	31.6	888	6,514	3,011	**10,413**

Anaesthetics	54	4,585	8,772	127	**13,483**
Radiology	8	16	0	0	**16**
Pathology	15.2	3,095	0	0	**3,095**
Other – Trauma & Orthopaedics	29	248	816	632	**1,696**
Other – Paediatrics/Oncology/GU Medicine/Orthodontics	46.53	0	0	0	**46.53**
Total in designated body (This includes all doctors not just those with a prescribed connection)	**395.41 FTE**	**21,833 hours**	**33,517 hours**	**17,511 hours**	**72,905.53**
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	476	476	476	Not known	
3 days to one week	169	169	169	Not known	
1 week to 1 month	187	187	187	Not known	
1-3 months	120	120	120	Not known	
3-6 months	53	53	53	Not known	
6-12 months	16	16	16	Not known	
More than 12 months	0	0	0	Not known	
Total	1,021	1,021	1,021	Not known	

Appendix 1

DH Department of Health

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Statement of Compliance

THE NHS CONSTITUTION
the NHS belongs to us all

Annex E – Statement of Compliance

Designated Body Statement of Compliance

The board of Walsall Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes, Mr Amir Khan, Medical Director.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Yes, this is maintained by the Medical Revalidation and Job Planning Manager, on behalf of the Responsible Officer who has delegated authority to access GMC Connect.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Yes, 44 trained appraisers and 245 connected doctors providing a ratio of 1:5.6

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Appraisal refresher training was delivered in October 2016 for existing appraisers. Refresher training will be delivered in October 2019 as it is required every 3 years. Training for new appraisers was last delivered in June 2017.

   The Trust's Medical Appraisal Lead will be responsible for quality assuring all appraisals via ASPAT, meeting all appraisers on an annual basis at least once to provide support and feedback on performance.

   The Revalidation Steering Group will review training needs, performance and quality of appraisal and ensure consistency through a review of 5 random appraisal PDP's and summaries bi-monthly. Points of learning and general feedback will be provided to appraisers through quarterly Appraiser Support Group Meetings.

5. All licensed medical practitioners[4] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

A comprehensive dashboard is maintained to ensure annual appraisal takes place, and issues are escalated at appropriate trigger points where concerns arise around an individual practitioner's participation in the annual appraisal process. This dashboard is monitored weekly by Divisional Directors and the RO, and clear actions identified.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Yes, teams and systems provide information data as follows: Clinical Audit attendance (Clinical Audit Team); Mandatory and in-house Training (ESR), complaints and significant events (Safeguard) and 360 feedback (Revalidation Team).

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

The Trust has a Policy in place to manage concerns: Disciplinary and Management of Performance Procedure for Medical Staff.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Yes, as per standard recruitment pre-employment checking process. Also, the MPIT form is requested by the Recruitment Officer for all new starters once a final offer of employment is confirmed. Any handover information received is then forwarded to the RO.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[5] have qualifications and experience appropriate to the work performed; and

Yes, as per standard recruitment process.

[4] Doctors with a prescribed connection to the designated body on the date of reporting.
[5] Doctors with a prescribed connection to the designated body on the date of reporting.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Yes, a local action plan is in place to manage the performance of the appraisal and revalidation programme detailing individual actions and owners. Also, a Dashboard detailing the appraisal schedule for the forthcoming year, which is monitored daily and status reported on weekly to Divisional Directors.

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _

Appendix 2 Annual Organisational Audit (AOA) Comparator Report

(Provided Separately)

Appendix 3 - Medical Appraisal and Revalidation Policy

(Provided Separately)

Walsall Healthcare NHS
NHS Trust

Appendix 4

Revalidation Steering Group (RSG)
Terms of Reference

1.0 Purpose

To discuss any revalidation related issues and issues regarding Medical Appraisal for those Doctors connected to the Trust as a Designated Body. Appropriate actions should be agreed by the Group where necessary; to ensure overall appraisal compliance and quality is maintained, that GMC Revalidation requirements are met and that appropriate arrangements are in place relating to the governance processes concerning the successful deployment of the Trust's Revalidation Programme.

2.0 Remit

1. To provide an update in terms of overall appraisal compliance dashboard (rates by Trust, Division and Department);
2. To highlight any issues which may hinder appraisal compliance, explore the reasons why and agree any action(s) and responsibilities;
3. To highlight any Doctors requiring revalidation in the next 120 days (under notice)
4. To highlight and discuss any issues which may impact on Doctors revalidation
5. To highlight any potential non-engagement issues
6. To highlight any potential deferrals and issues
7. To quality assure Random Sample of 5 anonymised Appraisals and Personal Development Plans using recognised Quality Assurance Tool (ASPAT)
8. To highlight any issues regarding quality assurance around training, education and support for Medical Appraisers
9. To update any changes due to be implemented with regards to the Appraisal and Revalidation programme.

3.0 Membership

Mr Amir Khan - **Chair**
Mr Najam Rashid – **Vice Chair,** Divisional Director, Medicine and Long Term Conditions
Mr N Turner – Divisional Director, Surgery
Dr L Holland– Divisional Director, Women's and Children's & Clinical Support Services
Mr Mark Read– Medical Revalidation and Job Planning manager
Mrs Jo Adams - Business Manager, Medical Directorate

4.0 Frequency

To meet bi-monthly

5.0 Quorate

- Chair **or** Vice Chair (in the Chair's absence)
- 1 Divisional Director

- Medical Revalidation and Job Planning Manager to take notes and actions at the meeting

6.0 Agenda

1.	**Apologies**
2.	**Minutes of previous meeting**
3.	**Action Log**
4.	**Appraisal position statement (dashboard)** • **Overall rate of compliance** • **Departmental compliance** • **Divisional Compliance** • **Appraisal Postponement Applications (if applicable)**
5.	**Revalidations Due in next 120 days** **Deferrals** • **Currently deferred** • **Potential deferrals (issues, concerns)** **Non engagement** • **Current** • **Potential (issues, concerns)**
6.	**Quality Assurance of Appraisals** • **ASPAT Tool review of 5 randomly selected appraisal summaries and PDP's**
7.	**Appraiser Support Group** • **feedback from ASG** • **matters to raise at next ASG**
8.	**Training & Performance** • **new medical appraisers** • **current medical appraisers** • **Appraiser 1-1 review compliance**
9.	**Any Other Business**
10.	**Date and Time of Next Meeting**

6.0 Notes and Live Action Sheet

- To be completed by a member of the Revalidation Team;
- Circulated within **5 working days** of RSG meeting,
- Update of any actions to be circulated **5 working days prior** to the next RSG

RATING	PROGRESS
	YET TO COMMENCE
	BEHIND SCHEDULE
	SOME PROGRESS
	ON SCHEDULE
	COMPLETED

NOTES / ACTION LOG					
[MEETING TITLE]					
Date:					
Attendees:					
Apologies:					
Notes:					
AGENDA ITEM	**ACTION**	**INDIVIDUAL(S) RESPONSIBLE FOR ACTION**	**ACTION(S) PROGRESS**	**ACTION DEADLINE**	**PROGRESS RATING**
1					

8.0 Management and Accountability

The Trust's Medical Director as the Responsible Officer is accountable, as part of the Responsible Officer Regulations [6] as set out in statute, for ensuring that the designated body has all systems and processes in place, including those of clinical governance, underpinning the responsible officer's recommendation to the GMC on a doctor's fitness to practise, and that these are functioning effectively.

9.0 Governance Reporting Arrangements

Bi-monthly

1. Reports to Medical Advisory Committee regarding appraisal compliance by department and division, missed appraisals, non-engagement and overall appraisal programme performance and action plan

2. Report to People and Organisational Development Committee to provide assurance and compliance to national and local indicators

3. Report to MHPS Group

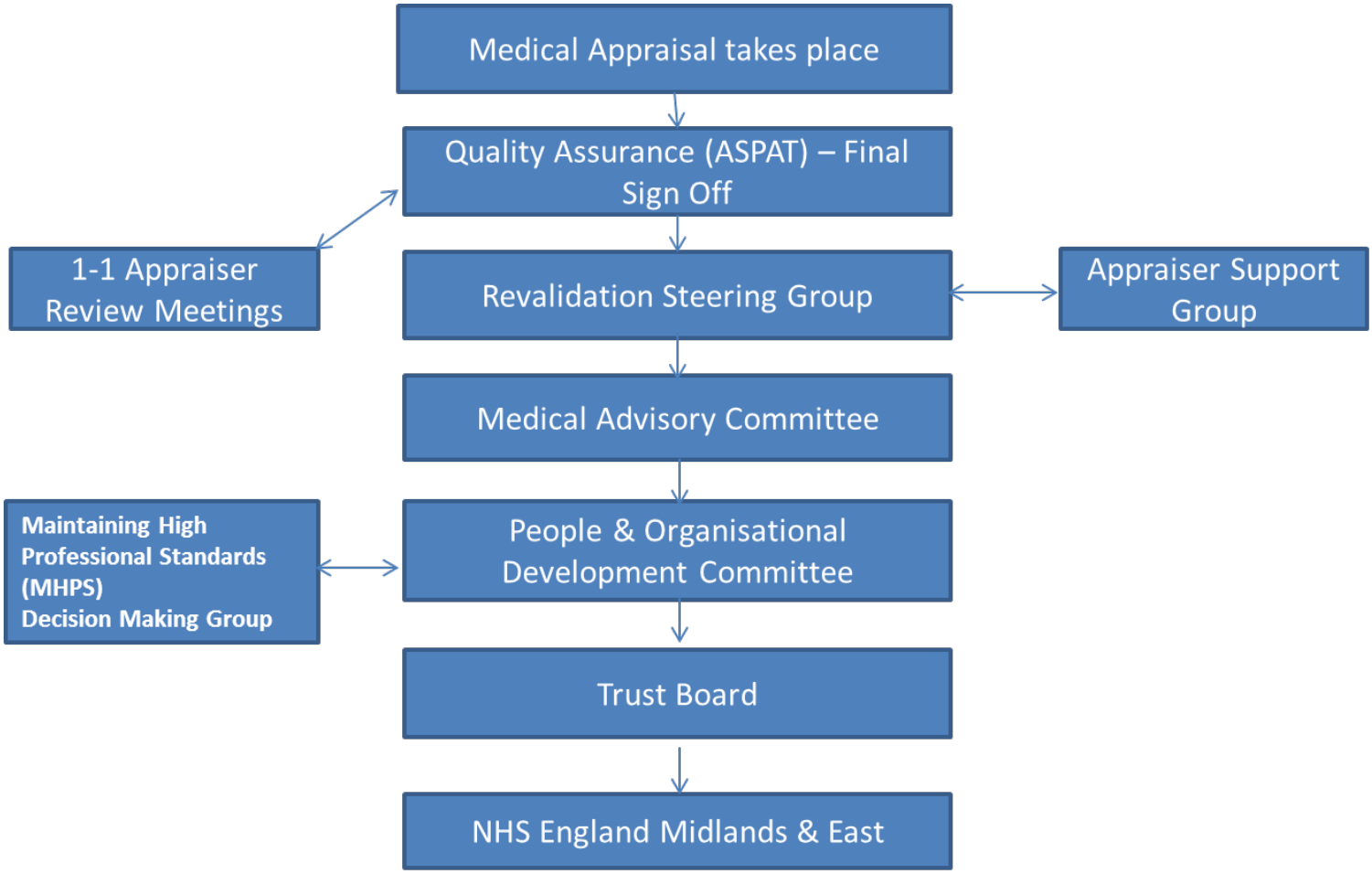
Quarterly

NHS England - Quarterly appraisal report (for Framework of Quality Assurance)

Annually

NHS England Annual Organisation Audit (AOA) (May);
Board Report with regards to Medical Revalidation. (August)

[6] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'



Revalidation Governance Structure - Figure 1

Appendix 5 - Appraisal & Revalidation Action Plan

TRUST REVALIDATION ACTION PLAN UPDATED 18 JULY 2018

RATING	PROGRESS
	YET TO COMMENCE
	BEHIND SCHEDULE
	SOME PROGRESS
	ON SCHEDULE
	COMPLETED

NHS ENGLAND ACTION NUMBER	ACTION REQUIRED	TRUST ACTION(S) NUMBER	INDIVIDUAL(S) RESPONSIBLE FOR ACTION	INDIVIDUAL ACTION(S)	ACTION(S) PROGRESS	ACTION DEADLINE	PROGRESS RATING
1	**Implement an appraisal process that requires doctors to have an appraisal every 12 months**	**1**	**Amir Khan**	RO to e-mail all Trust Doctors to remind them of their Responsibility to undertake an Annual Appraisal within 12 months.	E-mail sent by RO to Trust Doctors.	**COMPLETED**	
		2	**Amir Khan**	RO to disseminate this message at MAC, reminding doctors of their responsibilities To also disseminate message to SAS doctor reminding doctors of their responsibilities	On MAC agenda, to be discussed at April MAC	**COMPLETED**	
		3	**Karen Jenkins**	Ensure that the employment contract specifically states a Doctor is required to comply with Trust Policy and Procedure in this respect.	Standard Paragraphs are yet to be reviewed, Reece Hodgen (Recruitment) and Karen Jenkins to discuss and agree.	**COMPLETED**	

2	**Review Medical Appraisal Policy to ensure it is fit for purpose and supports the process in terms of requirements, expectations and sanctions including non-engagement as reflected**	**4**	**Mark Read**	Draft Policy to include appraisal requirements and process, expectations and sanctions including non-engagement for noncompliance.	In consultation period, circulated to all Doctors via e-mail. To be presented at MAC 5th September 2017.	**31 AUGUST 2018**	
3	**Revise and subsequently review annually all related policies to ensure they are up-to-date, reflect current processes and are cross referenced.**	**5**	**Mark Read**	Job Planning Policy to include Medical Job Planning for Consultants, specialty Doctors and Associate Specialists SOP.	Draft Policy will be presented at LNC	**31 AUGUST 2018**	
		6	**Mark Read**	Trust wide Job Planning Action Plan, identifying schedule of specialities to be addressed over next 24 months.	Schedule/database developed;	**COMPLETED**	

		7	**Amir Khan** **Louise Ludgrove**	Raising and Responding to concerns Policy (Medical Staff) to be reviewed,	Policy not to be reviewed as duplication with Disciplinary Management of Performance (Medical Staff) Policy;	**31 OCTOBER 2018**	
		8	**Louise Ludgrove**	Disciplinary Management of Performance (Medical Staff), LL to assign responsibility	Assign responsibility to review Policy to an appropriate member of the HR/Medical Staffing Team. Policy to be reviewed	**31 AUGUST 2017**	
4	**Implement the use of a recognised quality assurance tool to ensure consistency**	**9**	**Najam Rashid**	The application of a recognised tool Appraisal Summary and PDP Audit Tool (ASPAT) is required when reviewing appraisals undertaken for Final Sign Off. Standing item on Revalidation Steering Group Agenda. Terms of Reference for Steering Group:	Agreed at Revalidation Steering Group 9th March 2017 that Dr Joseph (GU Med) would review Random Sample of 2 Appraisal summaries and PDP's and complete ASPAT's. These ASPAT's would then be reviewed at bi-monthly Revalidation Steering Group.	**COMPLETED**	
		10	**Amir Khan**	Re-establishment of Revalidation Steering Group and random sampling appraisal outputs for quality on a bi-monthly basis required.	Revalidation Steering Group was held 9th March, next date to be held 25th May 2017.	**COMPLETED**	

5	**Implement a Scheme of Delegation to define access to GMC Connect**	**11**	**Amir Khan**	Delegated Access authorisation form to be submitted to the GMC Revalidation Support Team by the Responsible Officer. Also, access for Najam Rashid as Lead Appraiser to be requested.	Delegated access has already been approved by the GMC and the Revalidation and Job Planning Manager has a GMC Connect Account. GMC form is required to add Najam Rashid access also.	**COMPLETED**	
6	**With reference to the negative response in the AOA regarding question 2.2 please implement a system which fully records all explanations for all missed or incomplete appraisals**	**12**	**Mark Read**	The Revalidation Team maintains an Excel spreadsheet database which records all missed appraisals complete with reasons for this, and exceptions are reported to the Revalidation Steering Group where unapproved missed appraisals occur. Trust needs to answer “yes” to the next AOA in 2017 (May) and ensure that all reasons for missed appraisals continue to be recorded, to include ‘non engagement’ when Doctors fail to advise why their appraisal has been missed and communication with the Revalidation Team/Responsible Officer is not made by the Doctor.	Will be completed when next AOA questionnaire received from NHS England Revalidation Team May 2017.	**COMPLETED**	

		13	**Mark Read**	The new Medical Appraisal Policy to make it clear that a Doctor will require authorisation from the Responsible Officer to postpone their appraisal (having provided reasonable grounds for the request) and that failure to notify the Trust as to the reason why an appraisal has not been completed on time will result in 'non-engagement' being recorded as an explanation.	In consultation period, circulated to all Doctors via e-mail. To be presented at MAC 5th September 2017.	**31 AUGUST 2018**	
Recommendation 1	**Consider more frequent opportunities for appraisers to meet, discuss and share experiences through the Appraiser network meetings and consider making at least one of these meetings compulsory.**	**14**	**Najam Rashid**	Appraiser Support Group Meetings to be held quarterly bi-monthly and Appraisers must attend a minimum of one meeting per year. This will be detailed in the new Policy.	Meeting dates are scheduled every 2 months - ongoing	**COMPLETED**	
		15	**Najam Rashid**	1-2-1 feedback meetings with 53 Trust Appraisers to be arranged with the Trust's Lead Appraiser Mr Najam Rashid, in order to feedback on their performance in last 12 months.	Meetings will be scheduled in diaries to be completed by 31/03/18 2 further Lead Appraisers to be trained 7th September.	**31 MARCH 2019**	
Recommendation 2	**Update Scope of Access statement into the Appraisal Policy to reflect access provided to the wider revalidation team**	**16**	**Mark Read**	The Policy will be updated to specifically cover this scope of access, detailing which individuals will have access to appraisal documentation and for what purpose i.e. Quality Assurance, Revalidation etc.	In consultation period, circulated to all Doctors via e-mail. To be presented at MAC September 2018.	**31 AUGUST 2018**	

	to support quality assurance and revalidation recommendations.	**17**	**Mark Read**	CRMS permissions to be reviewed to ensure personnel have appropriate access from and information governance perspective. Revalidation team add users to CRMS and ensure appropriate governance regarding the 'user type' being granted is appropriate.	CRMS access permissions have been reviewed to ensure users have appropriate user type accounts.	**COMPLETED**	
Recommendation 3	**Use the Decision Making Panel to randomly QA appraisals and revalidation recommendations – including those deemed to be fully compliant to ensure consistency.**	**18**	**Najam Rashid**	The Random QA appraisals and revalidation will take place at the Revalidation Steering Group (See Action 9). There is a separate MHPS Decision Making Group which has different terms of reference. See action 19 below. The Lead Appraiser will use ASPAT to QA all appraisals as part of the Final Sign off process for their respective divisions.	This QA of 5 appraisals will be completed at the Revalidation Steering Group, next meeting 15th September 2017.	**31 AUGUST 2018**	
		19	**Amir Khan** **Louise Ludgrove**	The MHPS Decision Making Group will have a specific remit quite separate to the Trust's MHPS Decision Making Group to discuss: 1. Medical practitioners personal conduct, 2. Medical practitioners professional conduct, 3. A medical practitioners health, 4. Capability, 5. Contractual matters, 6. Job planning 7. Safeguarding and dignity at work.		**31 SEPTEMBER 2018**	

Recommendation 4	**It is suggested Responsible Officer training is opened up to appropriate colleagues to provide development opportunities and aid succession planning.**	**20**	**Amir Khan**	3 Divisional Directors to attend NHS England training event https://www.england.nhs.uk/revalidation/about-us/events/	2 Divisional Directors booked on to training 7th September 2017.	**30 SEPTEMBER 2017**	
Recommendation 5	**To ensure timely action consider a generic email address to receive GMC connect updates rather than them going to a named individual.**	**21**	**Mark Read**	Mailbox Access Request Form to be approved and submitted to the IT Helpdesk. Access for: 1. Wendy Fergusson, 2. Mark Read 3. Najam Rashid 4. Ann Ward	Completed.	**COMPLETED**	
Recommendation 6	**It was noted that the Trust has answered "no" in response to question 1.12 of the AOA. Two visits have been carried out by the regional team which enables the Trust to respond positively to this question.**	**22**	**Mark Read**	The NHS England Independent Verification Visit constitutes an independent review of "the governance systems (including clinical governance where appropriate)".	As an independent review has been undertaken, the Trust can now answer "yes" to question 1.12 on next AOA report	**COMPLETED**	

Recommendation 7	**Review whether the revalidation team needs to be enhanced to ensure resilience and the potential for development of systems and processes.**	**23**	**Amir Khan** **Louise Ludgrove**	Review of existing Team Resources, to include a review of IT systems.	LL/AL to present paper to Trust Executive Committee September 2017	**30 SEPTEMBER 2017**	
					Allocate Medical Appraisal and Revalidation modules to be fully implemented	**COMPLETED**	
		23	**Amir Khan** **Mark Read**	Business Case relating to Allocate Health Medics Optima	A Business Case for Allocate Software (eJob Plan, eRota, MedicOnline, MedicOnduty, Activity Manager and MedicAppraisal approved. Allocate Health Medics Optima is being implemented, Project Manager appointed Project Board and Project Team established. Data gathering/preparatory work underway	**COMPLETED**	

Walsall Healthcare NHS
NHS Trust

Appendix 6

Appraiser Support Group (ASG)
Terms of Reference

5.0 Purpose

To discuss any appraisal and revalidation related issues and issues regarding Medical Appraisal for those Doctors connected to the Trust as a Designated Body. The Group will discuss appraisal programme arrangements including forthcoming appraisal allocation for the quarter and any requisite support for Trust Medical Appraisers, including education, training and quality improvement.

Appropriate actions should be agreed by the Group where necessary; to ensure overall appraisal compliance and quality is maintained, that GMC Revalidation requirements are met and that appropriate arrangements are in place relating to the governance processes concerning the successful deployment of the Trust's Revalidation Programme.

6.0 Remit

10. To provide an update in terms of overall appraisal compliance dashboard (rates by Trust, Division and Department);
11. To provide support and guidance to all Trust Medical Appraisers;
12. To highlight any issues regarding quality assurance around training, education and support for Medical Appraisers;
13. To discuss any changes to be implemented with regards to improving the successful deployment of the Appraisal and Revalidation programme, including requisite changes to Policy and/or process.

7.0 Membership

1. Mr N Rashid – **Chair,** Divisional Director, Medicine and Long Term Conditions
2. Dr L Holland– **Vice Chair,** Divisional Director, Women's and Children's & Clinical Support Services
3. Mr N Turner – Divisional Director, Surgery
4. Mr Mark Read– Medical Revalidation and Job Planning manager
5. All Trust Medical Appraisers

8.0 Frequency

To meet quarterly

5.0 Quorate

- Chair **or** Vice Chair (in the Chair's absence)
- Medical Revalidation and Job Planning Manager
- 5 Medical Appraisers

6.0 Agenda

7.	**Apologies**
8.	**Minutes of previous meeting**
9.	**Action Log**
10.	**Appraisal position statement (dashboard)** • **Overall rate of compliance** • **Departmental compliance** • **Divisional Compliance**
11.	**Appraisal Allocation** • **Appraisals allocated to each appraiser for the next quarter**
12.	**Quality Assurance of Appraisals** • **Feedback on quality and learning from randomly selected appraisal summaries and PDP's reviewed at RSGs in last quarter.**
7.	**Appraiser Support** • **feedback matters arising from last RSG** • **discuss organisational support required** • **discuss and review Policy and process** • **discuss matters to raise at next RSG**
8.	**Training & Performance** • **new medical appraisers** • **current medical appraisers** • **Forthcoming Appraiser 1-1 support meeting allocation for the quarter**
9.	**Any Other Business**
10.	**Date and Time of Next ASG Meeting**

Walsall Healthcare NHS
NHS Trust

6.0 Notes and Live Action Sheet

- To be completed by a member of the Revalidation Team;
- Circulated within **5 working days** of ASG meeting,
- Update of any actions to be circulated **5 working days prior** to the next ASG

RATING	PROGRESS
	YET TO COMMENCE
	BEHIND SCHEDULE
	SOME PROGRESS
	ON SCHEDULE
	COMPLETED

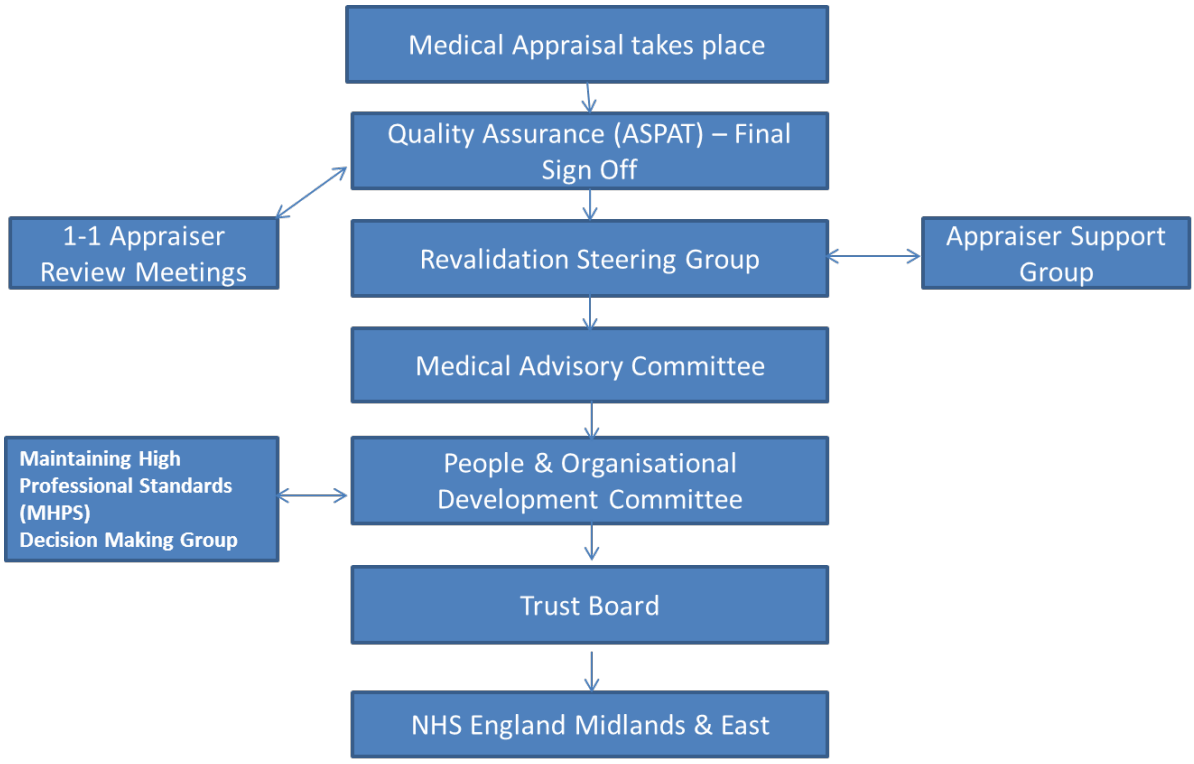
NOTES / ACTION LOG					
Appraiser Support Group Meeting					
Date:					
Attendees:					
Apologies:					
Notes:					
AGENDA ITEM	**ACTION**	**INDIVIDUAL(S) RESPONSIBLE FOR ACTION**	**ACTION(S) PROGRESS**	**ACTION DEADLINE**	**PROGRESS RATING**
1					

8.0 Management and Accountability

The Trust's Medical Director as the Responsible Officer is accountable, as part of the Responsible Officer Regulations [7] as set out in statute, for ensuring that the designated body has all systems and processes in place, including those of clinical governance, underpinning the responsible officer's recommendation to the GMC on a doctor's fitness to practise, and that these are functioning effectively.

9.0 Governance Reporting Arrangements

Reports to the Revalidation Steering Group regarding any organisational or educational factors that may hinder the successful deployment and performance of the appraisal programme.



Revalidation Governance Structure - Figure 1

[7] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

NHS England

Annual Organisational Audit (AOA)
End of year questionnaire 2017-18

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	07760
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	23 March 2018
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2016/17 AOA cleared with Publications Gateway Reference 06491
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Please do not use this version of the form to submit your response.

Annual Organisational Audit (AOA)

End of year questionnaire 2017-18

Version number: 2.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016, 24 March 2017, 23 March 2018

Prepared by: Lynda Norton, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Please do not use this version of the form to submit your response.

Contents

1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play of medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of medical revalidation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2017/18;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2018** for the year ending 31 March 2018. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2018.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 28 September 2018.
- The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 31-32
and www.england.nhs.uk/revalidation

2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Walsall Healthcare NHS Trust	
	Head Office or Registered Office Address if applicable line 1 Manor Hospital	
	Address line 2 Moat Road	
	Address line 3	
	Address line 4	
	City Walsall	
	County West Midlands	Postcode WS2 9PS
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☐
			Acute hospital/secondary care non-foundation trust	☑
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☐
		NHS England Midlands and East	☑
		NHS England London	☐
		NHS England South	☐
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No ☐ N/A

1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☑ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken (requirement being NHS England's face to face responsible officer training & the precursor e-Learning). • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

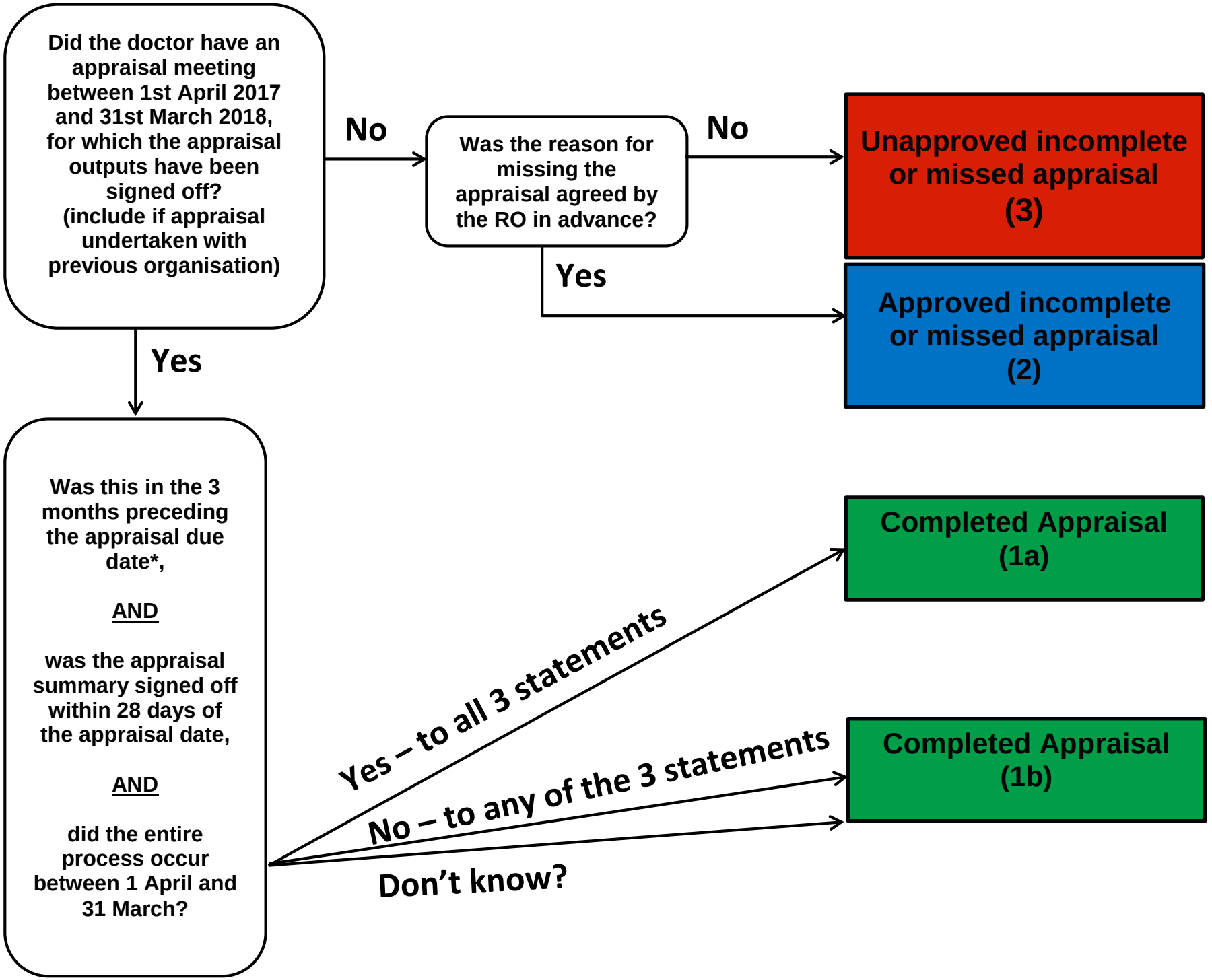
1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2018 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	155	84	67	4	0	155
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	34	18	15	0	1	34
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	45	24	20	1	0	45
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	11	0	10	0	1	11
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	245	126	112	5	2	245

Please do not use this version of the form to submit your response.


Did the doctor have an appraisal meeting between 1st April 2017 and 31st March 2018, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2018** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2018. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).	

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the= responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and= unapproved) for the appraisal year 2017/18 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☑ Yes ☐ No ☐ N/A

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☑ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19 of Good Medical Practice (GMC, 2013) for further details. The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer's statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes: • setting out the common legitimate channels along which information about a doctor's medical practice should flow, describing the information that might apply and arrangements to support its smooth flow • providing useful toolkits and examples of good practice The guidance on information flows to support medical governance and responsible officer statutory functions can be accessed via the link below. https://www.england.nhs.uk/revalidation/ro/info-flows/	

7 Section 5 – Comments

Section 5	Comments	
5.1	Implementation of the new Allocate system, which went live in February 2018 for Medical Appraisal and Revalidation has significantly improved tracking and monitoring processes. Weekly Appraisal Compliance Dashboard issued to RO and 3 Divisional Directors New Appraisal Policy is in the process of being agreed/ratified. Appraiser Support Group Meetings for appraiser support and updates held bi-monthly. Post of Medical Revalidation Administrator currently vacant. Medical Revalidation manager is exploring options in terms of recruitment.	

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Revalidation: A Statement of Intent* (GMC and others, 2010)
8. *Good Medical Practice* (GMC, 2013)
9. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
10. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
11. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
12. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
13. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
14. The GMC protocol for making revalidation recommendations: Guidance for responsible officers and suitable persons (GMC, 2012, updated in 2014)
15. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
16. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
17. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
18. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
19. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
20. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
21. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
22. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
23. *Appraisal in the Independent Health Sector* (British Medical Association and Independent Healthcare Advisory Services, 2012)
24. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002, updated in 2012)
25. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

26. *How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)*
27. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2012)*
28. *Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)*
29. *Medical Appraisal Logistics Handbook (NHS England, 2015)*

Document Title
Medical Appraisal and Revalidation Policy

Document Description	
Document Type	Policy
Service Application	Doctors with a prescribed connection to Walsall Healthcare NHS Trust
Version	5

Lead Author(s)	
Mark Read	Medical Revcalidation & Job Planning Manager
Mr Amir Khan	Medical Director

Change History		
Version	Date	Comments
V5	08.17	Previous Senior Medical Appraisal policy 01/14 replaced

Links with External Standards	
Good Medical Practice Framework	
Responsible Officer Guidance	
Revalidation Support Team Guidance.	
GMC -Medical Appraisal Guide	
2003 Consultant Contract	
2008 Associate Specialist and Specialty Doctor Contract	
Trust's Disciplinary and Management of Performance of Medical Staff Policy	
Trust's Medical Job Planning Policy	
Effective Governance to Support Medical Revalidation	http://www.gmc-uk.org/static/documents/content/Governance_handbook.pdf
Good Medical Practice (GMC, 2006)	
Good Medical Practice Framework for Appraisal and Revalidation (GMC, 2011)	http://www.gmc-uk.org/static/documents/content/RT___Supporting_information_for_appraisal_and_revalidation___DC5485.pdf_55024594.pdf
Supporting Information for Appraisal and Revalidation (GMC, 2011)	
Medical Appraisal Guide (NHS Revalidation Support Team, v4 March 2013)	

Quality Assurance of Medical Appraisers (NHS Revalidation Support Team, (2012)	
The GMC protocol for making revalidation recommendations: Guidance for Responsible Officers and Suitable Persons Fourth edition (May 2015).	

Key Dates	DATE
Ratification Date	
Review Date	1 year

Executive Summary Sheet	
Document Title:	Medical Appraisal and Revalidation Policy
Please Tick (☐) as appropriate	
	This is a revised Document within the Trust

What is the purpose of this document?

To outline the process required to manage and monitor enhanced appraisals and will ensure that all licens Doctors with a prescribed connection to Walsall Healthcare NHS Trust as a Designated Body.

What key Issues does this document explore?

- The appraisal process; the principles and process to ensure Doctors evidence their fitness to Practice
- Monitoring and tracking of performance
- Governance of the appraisal and revalidation process
- Quality Assurance
- GMC Revalidation
- Non engagement
- Supporting Information and evidence required for revalidation
- Appraiser performance and training
- Tracking and monitoring performance

Who is this document aimed at?

All Doctors with a prescribed connection to Walsall Healthcare NHS Trust to include all Consultants, SAS Doctors, Clinical Assistants, NHS Locum Doctors employed direct by the Trust and Trust Temporary Bank staff as outlined in **Section 2** (scope).

What other policies, guidance and directives should this document be read in conjunction with

1. 2003 Consultant Contract
2. 2008 Associate Specialist and Specialty Doctor Contract
3. Trust's Disciplinary and Management of Performance of Medical Staff Policy
4. Trust's Medical Job Planning Policy
5. Effective Governance to Support Medical Revalidation http://www.gmc-uk.org/static/documents/content/Governance_handbook.pdf
6. *Good Medical Practice* (GMC, 2006)
7. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2011) http://www.gmc-uk.org/static/documents/content/RT___Supporting_information_for_appraisal_and_revalidation___DC5485.pdf_55024594.pdf
8. *Supporting Information for Appraisal and Revalidation* (GMC, 2011)
9. *Medical Appraisal Guide* (NHS Revalidation Support Team, v4 March 2013)
10. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2012).
11. *The GMC protocol for making revalidation recommendations: Guidance for Responsible Officers and Suitable Persons* Fourth edition (May 2015).

How and when will this document be reviewed?

The policy will be subject to a review after 12 months. This review will be undertaken in conjunction with the Trust's Local Negotiating Committee.

CONTRIBUTION LIST

Key individuals involved in developing the document

Name	Designation
Mr Amir Khan	Medical Director
Mr Naj Rashid	Divisional Director for Medicine & Long Term Conditions
Mark Read	Medical Revalidation and Job Planning Manager
Jo Adams	
BMA rep	

Circulated to the following for consultation

Name/Committee/Group/	Designation
Medical Advisory Committee	
Local Negotiating Committee	
Trust Management Board	
All Doctors	

Version Control Summary

Significant or Substantive Changes from Previous Version
A new version number will be allocated for every review even if the review brought about no changes. This will ensure that the process of reviewing the document has been tracked. The comments on changes should summarise the main areas/reasons for change.

Version	Date	Comments on Changes	Author
V4	01/14	Review of previous appraisal programme	Wendy Bailes
V5	08/17	Replacing previous appraisal Policy	Mark Read

1.	**INTRODUCTION**
1.1	**Aims**
	This Policy will ensure that all licensed Doctors with a prescribed connection to Walsall Healthcare NHS Trust as a Designated Body undergo a high quality and consistent form of annual Medical Appraisal (**section 3.1**).
1.2	Objectives the objectives of the Policy; 1) To implement robust governance processes for facilitating the successful deployment of the Trust appraisal and GMC revalidation programme; 2) To ensure accurate and timely tracking and monitoring to ensure connected Doctor's compliance with the programme is ensured; 3) To ensure any issues or concerns are escalated in a timely manner so that appropriate action is taken by the Trust. 4) To provide appropriate assurance through effective reporting processes that connected Doctors are adhering to the GMC revalidation framework and GMC Good Medical Practice (2013).
	Walsall Healthcare NHS Trust has the following objectives for Medical Appraisal: 1) To support the delivery of safe, high quality, committed, compassionate and caring services to patients; 2) To help supervise and support its Doctors in achieving continual professional improvement; to support the process of Medical Revalidation; 3) To contribute to the achievement of the values and objectives of Walsall Healthcare NHS Trust.
2.	**SCOPE**
	This Policy applies to all licensed medical practitioners who have a prescribed connection to Walsall Healthcare NHS Trust as a Designated Body, including Consultants, SAS, Trust Doctors, honorary contract holders and all Trust employed training grade posts. All Trust employed locums with a prescribed connection to Walsall Healthcare NHS Trust should be included in the appraisal process. However, under the Responsible Officer Regulations, there is no prescribed connection for Locum Doctors operating through a limited or umbrella company. In respect of Trust Bank Doctors, the only Doctors who will be deemed to have a prescribed connection to Walsall Healthcare NHS Trust and therefore eligible for appraisal and revalidation with the Trust will be those Doctors who: • Do not already have a prescribed connection to another designated body; • Have no other primary source of employment and conduct the majority of their practice in Walsall Healthcare NHS Trust; • Undertake a minimum of 40 hours Bank work per month on average with Walsall Healthcare NHS Trust's Bank.
3.	**BACKGROUND**
3.1	**Medical Appraisal**
	Medical Appraisal has been a requirement for Consultants since 2001. Medical Appraisal is the appraisal of a Doctor by a trained appraiser, informed by supporting information defined by the GMC, in which the Doctor demonstrates that they are practicing in accordance with the GMC guidance Good Medical Practice across the whole of their scope of practice. In 2013 the NHS Revalidation Support Team published a piloted and tested model of medical appraisal, the *Medical Appraisal Guide*, which complies with the needs of revalidation. This guide was updated in 2014.
3.2	**Designated Body**
	A Designated Body is defined by the GMC as the organisation that provides the Doctor with an annual appraisal and helps them with revalidation. Any Doctor who is connected to the Trust as per GMC rules will be required to register their connection online via their GMC Connect account as soon as this connection arises. According to the GMC, the designated body that a Doctor is connected with will

	depend on: • the number of organisations that the Doctor practises in and where they spend most of their practice • the basis on which they are employed, such as whether they are employed, hold practising privileges or have another type of contract.
3.3	**Responsible Officer Regulations**
	The Medical Profession (Responsible Officers) regulations 2010 and the Medical Profession (Responsible Officers) (Amendment) regulations 2013 require each body designated under the regulation to appoint a responsible officer who must monitor and evaluate the fitness to practise of Doctors with whom the designated body has a prescribed connection. The Medical Director is the Responsible Officer of Walsall Healthcare NHS Trust. As described in the NHS Revalidation Support Team *Medical Appraisal Guide*, Medical Appraisal can be used for four key purposes: 1) To enable Doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in the GMC document *Good Medical Practice* and thus to inform the Trust's Responsible Officer's revalidation recommendation to the GMC; 2) To enable Doctors to enhance the quality of their professional work by planning their professional development; 3) To enable Doctors to consider their own needs in planning their professional development; 4) To enable Doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practise in. *NHS Revalidation Support Team Medical Appraisal Guide v4, March 2013 (re-issued with updated hyperlinks September 2014)*
3.4	**GMC Revalidation**
	Revalidation is the process by which licensed Doctors demonstrate to the GMC that they are up to date and fit to practise. Licensed Doctors have to revalidate usually every five years, by having an annual appraisal based on GMC core guidance for Doctors, *Good Medical Practice.* On the basis of this and other information available to the Trust's Responsible Officer from local clinical governance systems, the Responsible Officer will make a recommendation to the GMC concerning a Doctor's fitness to practise. The GMC will then consider the recommendation and decide whether to continue the Doctor's licence to practise. There is extensive guidance and information on the revalidation process available from many sources including the General Medical Council website (http://www.gmc-uk.org/Doctors/revalidation.asp) and the NHS England Revalidation webpage (http://www.england.nhs.uk/revalidation/).
4.0	**ROLES AND RESPONSIBILITIES**
4.1	**Responsible Officer (RO)**
	The Responsible Officer has overall responsibility for the effective implementation and operation of appraisals for all Medical Staff within the Trust (Consultants, SAS, Trust Doctors, honorary contract holders and all Trust employed training grade posts) and is personally accountable to the Board. The RO will make a recommendation to the GMC on a Doctor's fitness for revalidation based on an assessment of their practise through annual appraisals over 5 years. The RO will ensure that arrangements are in place so that appropriate information held by the Trust regarding each Doctor's practice within the organisation is made available to them on an annual basis and in a timely manner. Where a Doctor works for more than one organisation, ROs are responsible for ensuring that appropriate information is made available to the Doctor to take to their whole practice appraisal within their Designated Body. In addition to being accountable for the provision of medical appraisal, the responsible

	officer is also accountable for: • ensuring the provision of processes for supervision of the quality of medical practice; • intervening, should concern arise around a Doctors medical practice; • making recommendations about revalidation to the GMC for Doctors with a prescribed connection to the designated body; • Whilst retaining statutory responsibilities at all times, ROs will normally delegate many operational tasks to members of their team. Actions ascribed to the responsible officer in this policy should be taken to indicate the RO or person with appropriately delegated authority.
4.2	**Chief Executive Officer**
	The Chief Executive Officer of Walsall Healthcare NHS Trust is accountable to the Board for supporting the function of the responsible officers in respect of all their statutory duties, including the provision of medical appraisal as described by this policy.
4.3	**Medical Appraisal Lead (Divisional Directors)**
	The RO will put an appraisal support team (Revalidation Team) in place to manage the appraisal system on their behalf. In addition, Medical Lead Appraiser(s), and/or non-clinical manager(s) are accountable to the RO for providing leadership in respect of the medical appraisal process in their respective Divisions, in collaboration with the RO, appraisers and Revalidation Team. The Medical Appraisal Leads play a key role in assuring the performance and quality of the appraisal programme in their respective Division including: • Providing Final Sign Off on Allocate of all appraisal outputs in the revalidation cycle **no later than 12 weeks** before the Doctor's Revalidation Submission date; • Quality assuring all appraisals in their Division, using the recognised quality assurance tool Appraisal Summary and PDP Audit Tool (ASPAT) **(see section 13.4)** • Observing each appraiser in their Division conducting an appraisal once per annum **(see section 13.8)** and to complete an ***Appraiser Assurance Review Template*** (**see appendix 15**) for the appraiser's development; • Monitoring and actioning as appropriate Doctor's none compliance with the appraisal programme via the weekly **Appraisal and Revalidation Dashboard** • Responding to escalation at **Final Reminder Stage (see section 8.3)** • Escalating to the RO where deferral of revalidation may apply **(see section 7.1)** • Escalating to the RO where non-engagement may apply **(see section 7.3)** • Appraiser Performance review **(see section 13.9)** • Attend regional NHS England Lead Appraiser network meeting • Undertake appraiser refresher training **(see section 14.2)**
4.4	**Medical Appraisers**
	Medical appraisers are accountable to their Responsible Officer (via their Division's Medical Appraisal lead). They will be responsible for providing medical appraisals as described by this Policy, and for engaging with training, support and review processes as described in this Policy **(see appendix 10)** for a summary of the Medical Appraiser role). **Section 5.3** outlines the Professional Requirements of all Medical Appraisers;
4.5	**Clinical Directors**
	Clinical Directors as Clinical Managers have managerial responsibility for ensuring that Doctors in their specialty are complaint with the GMC requirements of revalidation and fit to practice. Appraisal compliance should be a key performance indicator, monitored monthly at Care Group meetings.

4.6	**Doctors**
	Doctors with a prescribed connection to the Trust are individually professionally accountable for their engagement with the medical appraisal process as described by this policy. Doctors are required to maintain their appraisal anniversary, or to request a formal postponement (**see section 6.2**) providing valid grounds for the request. Failure to do so could result in non-engagement, and the GMC withdrawing a Doctor's license to practise (**see section 7**).
4.7	**Medical Recruitment**
	A completed *Medical Practise Information Transfer Form* (MPIT) **(appendix 12)** will be requested from the Doctor's previous designated body's RO, once a Doctor has been provided with a formal offer of employment from the Trust. This form supports the appropriate transfer of information about a Doctor's practice from the Doctor's last responsible officer and other medical professionals, to ensure appropriate handover of any pertinent information to include the Doctor's previous appraisal.
4.8	**Medical Revalidation and Job Planning Manager**
	Is responsible for the effective implementation of the appraisal process and ensuring Trust compliance with GMC and national guidance with respect to Revalidation and Medical Appraisal. Also, for undertaking performance and quality audits and producing regular reports to ensure the organisation identifies performance concerns and achieves the successful deployment of the appraisal and revalidation programme, escalating concerns relating to Doctors noncompliance with the appraisal programme via the weekly Appraisal and Revalidation Dashboard, bi-monthly reports to the Revalidation Steering Group (RSG) and Medical Advisor Committee (MAC).
4.9	**Revalidation Administrator (Administrative Support)**
	Is responsible for supporting the administration of the appraisal process and e-appraisal system (Allocate), providing support to the Revalidation and Job Planning Manager and Trust Doctors as part of the Medical Appraisal process.
4.10	**Human Resources Department**
	Is responsible for communicating with the RO to ensure that the RO is aware of any Doctor where conduct and/or capability issues arise. This information should also be shared with the Director of Medical Education concerning any Doctor in training. Investigations will be monitored at the Maintaining High Professional Standards (MHPS) Decision Making Group;
5.0	**ASSIGNING APPRAISERS**
5.1	**Assigning Process**
	The Trust will maintain a database of appropriately trained Medical Appraisers. This will be maintained by the Trust's Medical Revalidation and Job Planning Manager. The Medical Revalidation and Job Planning Manager will have responsibility for assigning appraisers to Doctors on an annual basis and ensuring that appraisers are appropriately allocated as per **section 5.2.**
5.2	**Allocation Principles**
	The following principals must be adhered to ensure appropriate governance regarding the appraiser assignment process: 1) Appraisers are undertaking a minimum of four appraisals and a maximum of 5 appraisals per annum; 2) The Doctor to be appraised has been assigned at least 2 different appraisers in a 5 year revalidation cycle, 3) The Doctor to be appraised has not had the same appraiser for more than 2 consecutive years; 4) No reciprocal appraisals take place between Doctors within a 5 year period. 5) The Trusts Medical Director (MD) as the Responsible Officer will not be a Medical Appraiser; 6) The MD will have **two** separate appraisals: a Management Appraisal with the Trust's Chief Executive Officer for their Management role and a Medical Appraisal with an assigned NHS England appraiser;

	7) The Trust's three Divisional Directors will each have **two** separate appraisals: a Management Appraisal with the MD and their respective Director of Operations and a Medical Appraisal with an appropriately trained Trust Appraiser. 8) Clinical Directors will each have **two** separate appraisals: a Management Appraisal with their Divisional Director and a Medical Appraisal with an appropriately trained Trust Medical Appraiser.
5.3	**Appraiser Suitability and Conflict of Interest**
	There must be no potential conflict of interest or appearance of bias between a Doctor and their appraiser, to ensure the objectivity of the appraisal process. Also, to ensure achievement of all the purposes of appraisal stated earlier, the Doctor should be in agreement with the assigned appraiser. Appraisers must declare any conflicts of interest with their appraisee, for example: 1) A personal or family relationship; 2) Reciprocal appraisals if they have been assigned to appraise a Doctor who has appraised them in their own revalidation cycle; 3) An appraiser is receiving direct payment from a Doctor for performing their appraisal.
5.4	**Appraiser Professional Requirements**
	To be a Trust Medical Appraiser, it is a requirement for the Doctor to: 1) undertake formal Appraiser Training; 2) undertake refresher/top up training every 3 years (minimum) (**see section 14.2**) 3) attend the Trust's Appraisal Support Group (ASG) meetings at least twice a year (**see section 13.7)** 4) Attend annual 1:1 Performance Review meetings with Medical Appraisal Leads **(see section 13.9)** 5) understand the professional obligations placed on Doctors by the GMC; 6) understand the importance of appraisal for the Doctor's professional; development;
6.0	**EXEMPTIONS, POSTPONEMENT AND ADJOURNMENT OF APPRAISAL**
6.1	**Appraisal Exemption**
	In very few circumstances, the appraisal anniversary may not be adhered to e.g. if the Doctor is on long term sick leave. Before any decision is made to exempt a Doctor from their appraisal anniversary, advice should be sought from the Revalidation and Job Planning Manager as this can have implications for revalidation progression. If a Doctor is due to go on maternity leave, sabbatical or planned long term sick leave which will necessitate their absence from the workplace when their appraisal anniversary falls, the Doctor should plan to undertake their appraisal before this leave commences.
6.2	**Appraisal Postponement**
	A late or missed appraisal can have implications for revalidation progression in the 5 year cycle and could be deemed non-engagement (**see section 7**). If a Doctor wishes to postpone their appraisal date, they must obtain approval to postpone their appraisal from the Trust's Responsible Officer. The Doctor must put their request in writing by completing an *Appraisal Postponement Application Form* **(appendix 16)** to the Trusts Responsible Officer no less than **8 weeks** before the date of their appraisal expiry, clearly stating their reasons for making this request.
6.3	**Ongoing Processes**
	An ongoing process refers to participation in an ongoing local management or disciplinary process, the outcome of which is material to the RO's evaluation of the Doctor's fitness to practise and will need to be considered prior to making a recommendation. If the Doctor is subject to an ongoing process the Responsible Officer may agree to the appraisal being postponed for a period of time (subject to regular review) whilst this procedure is ongoing.

6.4	**Adjournment of Appraisal Meeting**
	Where it becomes apparent during the appraisal that there is a serious performance, health or conduct issue (not previously identified) that requires further discussion or investigation, the appraisal meeting must be stopped. The matter must be referred to the Trust's Responsible Officer to consider appropriate action that may need to be taken. Both appraiser and appraisee must recognise their professional duty to protect patients. The appraisal may be continued at a later date once the matter is resolved, but the appraisal process cannot override the basic professional obligation to protect patients from harm.
7.0	**REVALIDATION RECOMMENDATIONS**
	The GMC has a protocol in place for making revalidation recommendations: *Guidance for Responsible Officers and Suitable Person,* (May 2015). Regulation 11(2) (e) of the RO regulations lays down a specific statutory responsibility to make revalidation recommendations and these recommendations must be based on the RO's evaluation of a Doctor's ongoing fitness to practise **(see section 3.4).** The RO will make their recommendation via their Responsible Officer GMC Connect account, online. The RO must submit their recommendation to the GMC on or before the submission date. **Appendix 2** outlines the process flowchart governing revalidation recommendation.
7.1	**Doctors Under Statutory Notice of Revalidation**
	Six months before the revalidation submission date, the GMC invites the Doctor to confirm their revalidation details (including the identity of their RO and designated body) on GMC Online. **Four months** before the submission date: • The GMC will issue Formal Notice to the Doctor, informing them of the date by which the GMC must receive a recommendation about their revalidation. This is called the 'statutory notice period'. The beginning of the notice period is also reflected on GMC Connect; • The Medical Revalidation and Job Planning Manager will be responsible for notifying the Divisional Medical Appraisal Leads of all Doctors due to fall under statutory notice of revalidation in the next **four months** and this will also be monitored at the bi-monthly Revalidation Steering Group (RSG) **(see section 13.6)**. This will allow for the appropriate and timely planning of revalidation decisions; • **Three months** before the submission date: The Medical Appraisal Leads will review the outputs for each of the appraisals in the Doctor's current revalidation cycle no later than 12 weeks before the doctor's revalidation submission date, and where issues or concerns are identified with regards to the Doctors supporting information which may impact upon their successful revalidation, a meeting will be convened as per **section 7.3** chaired by the Trust's Responsible Officer.
7.2	**Where no concerns arise at Final Sign Of Stage**
	When reviewing and providing Final Sign Off for any Doctor due to revalidate, the relevant Medical Appraisal Lead will notify the RO in writing when it is identified that the Doctor meets the requirements of revalidation (based upon their supporting information provided). The RO will then make a positive recommendation to revalidate to GMC Connect, unless they are aware of any ongoing processes that may prevent them from making such a recommendation **(see section 7.4).** Following this, after receiving an RO's recommendation, the GMC will consider the recommendation and make a decision about the Doctor's revalidation

	The GMC will notify the RO and the Doctor when a decision has been made and the content of that decision.
7.3	**Where concerns arise at Final Sign Off Stage**
	Where issues or concerns are identified by the Medical Appraisal Lead with regards to a Doctor's appraisal portfolio and supporting information (i.e. omissions or insufficient supporting information) which may impact upon their successful revalidation, **a meeting with be convened 12 weeks before the revalidation submission date** with the Doctor and the Trust's Responsible Officer **(see appendix 6).** The Medical Appraiser Lead and Medical Revalidation & Job Planning Manager will also be present at this meeting to support the process. An **action plan** will be developed at the meeting, to address the issues identified by the Medical Appraisal Lead: • The outcome of this meeting will be formally communicated in writing to the Doctor. • It is the Doctor's responsibility to communicate any issues that may hinder or prevent the successful completion of the agreed action plan. • Failure to meet the action plan will likely result in a non-engagement referral being made to the GMC **(see section 7.6),** unless the Responsible Officer agrees that there are mitigating circumstances. Where it is identified that the issues or concerns cannot be addressed or rectified before the doctor's submission date is due (which may impact upon the RO's ability to make a revalidation decision) depending upon the circumstances, this could result in the RO making a deferral recommendation **(see section 7.5)** or deeming that the Doctor is a non-engaging doctor **(see section 7.6).**
7.4	**Recommendations to revalidate**
	If the RO makes a revalidation recommendation to the GMC, they are confirming that in their judgement the Doctor: • has participated in annual appraisal that considers the whole of their practice and reflects the requirements of the GMC's Good Medical Practice Framework for appraisal and revalidation, or where the Doctor is a trainee, participated in the assessments and curriculum requirements of their training programme; and • Has presented and discussed appropriate supporting information at annual appraisals in accordance with the requirements of the GMC's Supporting information for appraisal and revalidation, or where the Doctor is a trainee, undertaken and discussed the assessments and curriculum requirements of their training programme. • Is practising in compliance with any conditions imposed by, or undertakings agreed with, the GMC (where applicable) • Is practising in compliance with any conditions agreed locally (where applicable) • Has no unaddressed fitness to practise concerns identified by the local governance systems and processes in place.
7.5	**Recommendations to defer**
	Before a decision to defer a doctor's revalidation submission is made, the RO must first meet with the doctor as per **section 7.3.** Where there is insufficient evidence to support a recommendation about the medical practitioner's fitness to practise, the RO must: • Have identified the outstanding evidence required to make an informed decision about the medical practitioner's fitness to practise; • Be in a position to anticipate being able to make an informed recommendation about the medical practitioner's fitness to practise once the outstanding evidence has been collected. Where the medical practitioner is participating in an ongoing process:

	• I will consider the outcome of this process when making a recommendation about their fitness to practise. • I anticipate being able to make an informed recommendation about the medical practitioner's fitness to practise once the process is concluded. A letter confirming the meeting outcome and associated revalidation action plan for the Doctor will be issued **(appendix 7)**.
7.6	**Recommendations of Non Engagement**
	GMC Definition A Doctor is not engaging in the revalidation process where, in the absence of reasonable circumstances, they do not participate in the: 1) Local processes and systems that support revalidation on an ongoing basis 2) Formal revalidation process.
	Process If the Medical Appraisal Lead has highlighted concerns to the RO regarding Doctors suitability to be revalidated (i.e. they have not participated in local processes and systems that support revalidation on an ongoing basis) and as per **section 7.3** a meeting has been held and the RO deems the doctor to be non-engaging, an outcome of the meeting could be that the RO: 1) Informs the GMC via GMC Connect (online) if the Doctor is already **under statutory notice of revalidation**, that the Doctor has failed to participate in the local processes that underpin revalidation (see below); 2) Informs the GMC, having first contacted the Trust's GMC Employment Liaison Advisor that the Doctor has failed to participate in the local processes that underpin revalidation if the Doctor is currently **not under statutory notice of revalidation** (see below). The GMC will then issue a **non-engagement concern letter** to the Doctor (see **Doctors not under notice** below) The RO's decision will be communicated to the Doctor in writing **(see appendix 8)** and the associated revalidation action plan enclosed.
	Doctors under notice If a Doctor under notice (i.e. within Four months of their GMC revalidation submission date) does not complete a satisfactory annual appraisal on or before their appraisal anniversary, in keeping with the GMC revalidation standards, this could result in the Responsible Officer referring the Doctor to the GMC via GMC Connect as a non-engaging Doctor.
	Doctors not under notice The RO cannot submit a formal recommendation of non-engagement before the Doctor has been issued notice by the GMC as this sits outside of the formal revalidation process described in the License to practice regulations. However, an RO can still advise the GMC that they do not envisage being able to make a recommendation to revalidate the Doctor when it becomes due, on account of the Doctor's failure to engage or engage adequately in the appraisal and revalidation process. The RO will request that the GMC issue the Doctor with a **non-engagement concern letter**. The GMC will then write to the Doctor to remind them that they are obliged to participate in the ongoing processes that support revalidation in order to maintain their licence to practise. To do this, the RO will authorise the completion and submission of a GMC REV6 form "Request to send a non-engagement concern letter to a doctor" to the GMC Revalidation Support Team. http://www.gmc-uk.org/Template_Form_REV6_RDT_Request_for_GMC_to_send_a_non_engagement_concern_to_Doctor_DC3165.pdf_50534040.pdf If following the GMC non-engagement concern letter the Doctor is still not engaging with the processes that support revalidation, the GMC can bring forward the issue of

	notice to a Doctor. This will bring forward the submission date and the RO can then make a formal recommendation of non-engagement. Under regulation 4(3) (a) of the Licence to practise regulations, the GMC may withdraw a Doctor's licence where that Doctor has failed, 'without reasonable excuse', to comply with GMC revalidation guidance.
	Disciplinary Action Where a doctor is deemed to be a non-engaging Doctor by the Responsible Officer, this will be considered to be a Disciplinary matter that should be managed in accordance with the Trust's Policy *Disciplinary and Management of Performance of Medical Staff***.**
8.0	**MEDICAL APPRAISAL PROGRAMME**
8.1	**Appraisal Anniversaries**
	The Trust's annual Medical Appraisal programme runs from **1st April – 31st December** • All new starters will be required to undertake a Medical Appraisal within 3 months of starting in Post. • If the Doctor has already undertaken a Medical Appraisal previously at Walsall Healthcare NHS Trust they will retain their appraisal anniversary date which will remain consistent for all future appraisals. • An appraisal can be undertaken earlier than the Doctor's appraisal anniversary, but no sooner than 9 months from the date of their last appraisal. The new date of appraisal will then become the appraisal anniversary for all future appraisals.
8.2	**Doctor's responsibilities**
	It is the responsibility of the Doctor to make the necessary arrangements to ensure that they complete their appraisal **before** the date of expiry and to ensure that all of the necessary supporting information is supplied to enable them to meet GMC Revalidation requirements (**see section 9**). The Appraisal Meeting should be arranged by the Doctor at least **12 weeks** in advance of the appraisal expiry date. It is the responsibility of the Doctor to make arrangements with their appraiser and advise the Revalidation Team of the meeting date, time and location. The Doctor must complete their pre-appraisal supporting documentation on the Allocate system at least **2 weeks** before the date of their appraisal meeting and that all the necessary supporting information is uploaded to enable thir appraiser to review the appraisal portfolio before the meeting and if necessary, highlight any deficincies to the Doctor.
8.3	**Reminder Process**
	The Trust's Revalidation Team will assist in facilitating the appraisal reminder process as outlined below and in the *Appraisal Process Flowchart* **appendix 1**. **1) First Reminder (appendix 3)** The Doctor will receive a First Reminder **12 weeks** before their appraisal is due. It is the responsibility of the Doctor (appraisee) to advise the Revalidation team of the agreed date and time of the appraisal meeting. The meeting should be arranged in SPA time for those on the new Consultant contract (2003) and in flexible time for those on the old contract. **2) Second Reminder (appendix 4)** If after 4 weeks the Revalidation Team has not been notified of a planned appraisal date and time by the Doctor, then a Second Reminder will be issued, **8 weeks** before the date of appraisal expiry. The correspondence will be copied to the Doctors Clinical Director, for their investigation and action as part of the escalation process. **3) Final Reminder (appendix 5)** If after a further 4 weeks the Revalidation Team has not been notified of a planned

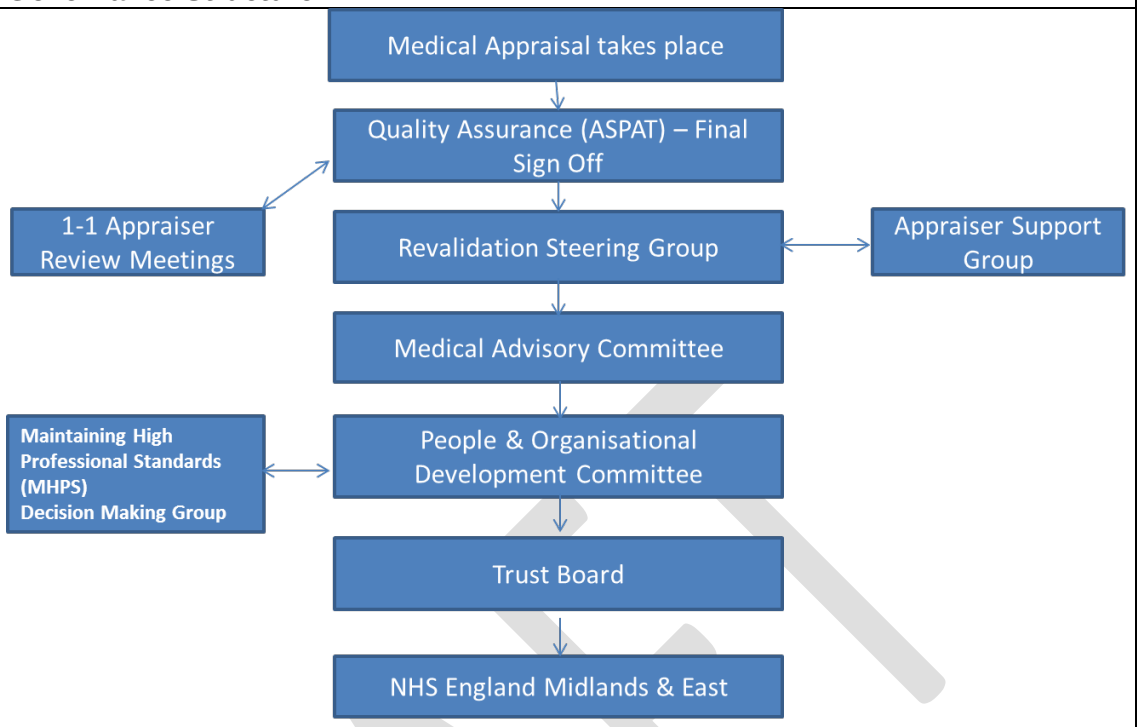
	appraisal date and time by the Doctor, then a Final Reminder is issued via e-mail **4 weeks** before the date of appraisal expiry. The correspondence will be copied to the relevant Divisional Director & Medical Lead Appraiser, for their investigation and action as part of the escalation process. **Section 8.4** outlines the process of escalation for any appraisals due to expire within 4 weeks, which do not yet have a confirmed appraisal meeting date booked.
8.4	**Missed Appraisals**
	Where the process outlined in **8.3** has been followed, if a Doctor's appraisal anniversary is **within 4 weeks** of becoming overdue, an investigation as to the reasons why the Doctor has not booked their appraisal will be carried out by the Medical Revalidation and Job Planning Manager. If the Doctor has **not** had a request to postpone their appraisal formally approved by the Trust's Responsible Officer in advance, and there are no known factors preventing the Doctor from completing a satisfactory appraisal on time (e.g. sickness absence, maternity leave, exclusion from work) the following escalation procedure will apply: **4 weeks from Appraisal Expiry Date:** • The matter will be escalated to the Doctor's Clinical Director who will be responsible for investigating with the Doctor concerned why they have failed to book their appraisal meeting; • Where no mitigating circumstances can be identified, the Divisional Director/Medical Lead Appraiser will be responsible for escalating this matter to the RO who will determine if the Doctor is a non-engaging Doctor **(see section 7.5)** • If the Responsible Officer deems the doctor to be a non-engaging Doctor **(see section 7.6)** this could result in Disciplinary action being taken against the doctor. • If the Doctor is currently under statutory notice of revalidation, then the RO will advise the GMC of the Doctor's non-engagement via GMC Connect online. • If the Doctor is currently **not under statutory notice of revalidation**, the RO will authorise the issue of a GMC Rev 6 form, notifying the GMC that the Doctor has failed to participate in the local processes that underpin revalidation. • The GMC will then issue a **non-engagement concern letter** to the Doctor (see **Doctors not under notice** below and section 7.6). The letter will be sent to any doctor whether under statutory notice or not, who has missed their appraisal anniversary without having had an appraisal postponement formally agreed by the RO. As outlined in **section 13**, **Weekly** The Divisional Director/Medical Lead Appraiser will receive a weekly Appraisal and Revalidation Dashboard identifying all appraisals due in the next 12 weeks and they will be responsible for ensuring that the Clinical Director has carried out the necessary investigation in cases where potential non-engagement risks are identifying; **Monthly** An exception audit of all missed appraisals will be completed monthly by the Medical Revalidation and Job Planning Manager. This will also detail the number of missed appraisals which had an appraisal date postponement approved by the Responsible Officer **(see section 6.2)** and any unapproved missed appraisals during this period. **Bi-monthly** The exception audit of all missed appraisals will be reported bi-monthly at both the Medical Advisory Committee (MAC) and the Revalidation Steering Group (RSG), along with overall appraisal compliance rates.

	Annually Approved missed and unapproved missed appraisals will form part of the *Quarterly appraisal report (Framework of Quality Assurance)* to NHS England's Regional Revalidation Team and annually as part of the internal annual Board Report on Revalidation **(see section 12.6).**
9.0	**SUPPORTING INFORMATION FOR APPRAISAL AND REVALIDATION**
9.1	**Doctor's responsibilities**
	It is the Doctor's responsibility to ensure that their appraisal portfolio meets the GMC *Good Medical Practice Framework for appraisal and revalidation.* The appraisal should cover a Doctor's whole practise, including any work performed privately, work performed for other healthcare organisations or NHS Trust's, any academic or teaching responsibilities or any other work including voluntary in their capacity as a Doctors and requires a licence to practise. The GMC document *Supporting information for appraisal and revalidation* (revised March 2012) outlines the six types of supporting information that Doctors will be expected to provide and discuss at their appraisal at least once in each five year cycle. These are: 1. Continuing professional development (CPD); 2. Quality improvement activity; 3. Significant events; 4. Feedback from colleagues **(see section 10.1)**; 5. Feedback from patients **(see section 10.2)**; 6. Review of complaints and compliments. A checklist is outlined in **Appendix 9.**
9.2	**Continuing Professional Development (CPD)**
	Most medical Royal Colleges and faculties have developed CPD schemes or guidance to support Doctors in maintaining and developing their professional standards in their specialty. The colleges and faculties require Doctors participating in these schemes to obtain a specified number of CPD credits over five years. A Doctor should aim to complete 250 CPD credits (250 hours) over a 5 year revalidation cycle, or 50 CPD credits per year. Trust Mandatory Training does not count as CPD, but this is required by all employees of the Trust. It is also a Trust requirement that the Doctor is fully compliant with Trust Mandatory Training requirements before their appraisal meeting takes place. Failure to do so will result in the appraisal being deemed incomplete, which could have implications for revalidation.
9.3	**Quality Improvement Activity**
	For the purposes of revalidation, a Doctor will have to demonstrate that they regularly participate in activities that review and evaluate the quality of their work. Quality improvement activities should be robust, systematic and relevant to the Doctor's work. They should include an element of evaluation and action, and where possible, demonstrate an outcome or change. Quality improvement activities could take many forms but examples of quality improvement activities include: 1. Clinical audit – evidence of effective participation in clinical audit or an equivalent quality improvement exercise that measures the care with which an individual Doctor has been directly involved; 2. Review of clinical outcomes – where robust, attributable and validated data are available. This could include morbidity and mortality statistics or complication rates where these are routinely recorded for local or national reports; 3. Case review or discussion – a documented account of interesting or challenging cases that a Doctor has discussed with a peer, another specialist

	or within a multi-disciplinary team; 4. Audit and monitor the effectiveness of a teaching programme; 5. Evaluate the impact and effectiveness of a piece of health policy or management practice. If the Doctor works in a non-clinical role they might find it helpful to discuss options for a quality improvement activity with their appraiser, or a relevant professional association.
9.4	**Significant Events**
	A significant event (also known as an untoward or critical incident) is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented. If the Doctor has been involved in a significant event in the past 12 months, they must evidence this on their appraisal forms and provide a brief description, clarify their personal involvement and the outcome of this event. This should include the Doctor's whole scope of practise including any private work or any other work undertaken in the capacity of a Doctor. Failure to disclose this information at appraisal could be considered a probity issue which could result in disciplinary action and potentially referral to the GMC in accordance with the Trusts Policy *Disciplinary and Management of Performance of Medical Staff***.**
9.5	**Complaints**
	A complaint is a formal expression of dissatisfaction or grievance. It can be about an individual Doctor, the team or about the care of patients where a Doctor could be expected to have had influence or responsibility. Complaints should be seen as another type of feedback, allowing Doctors and organisations to review and further develop their practice and to make patient-centered improvements. If the Doctor has been involved in a Complaint in the past 12 months, they must evidence this on their appraisal forms and provide a brief description, clarify their personal involvement and the outcome of this complaint. The Doctor does not need to record a complaint where their role was complaint investigator. This should include the Doctor's whole scope of practise including any **private work** or any other work undertaken in the capacity of a Doctor. Failure to disclose this information at appraisal could be considered a probity issue which could result in disciplinary action and potentially referral to the GMC in accordance with the Trusts Policy *Disciplinary and Management of Performance of Medical Staff.*
9.6	**Compliments**
	Where they have been received, the Doctor will need to provide a summary of any unsolicited compliments from patients, carers or colleagues in recognition of the quality of their work and/or of their team. The Doctor will also need to provide evidence of reflection, for example, how compliments have affected their professional practice.
10.0	**MULTISOURCE (360) FEEDBACK**
	Along with the other supporting information Doctors must collect **(see section 9),** multi-source helps Doctors reflect on how they work, and identify ways they can modify and improve their practice. Doctors will be required to undertake feedback from both colleagues and patients as follows: 1) Twice (minimum) in a 5 year revalidation cycle and it should form part of the discussion at appraisal; 2) Further/repeat feedback may be collected wherever this is deemed necessary by the Responsible Officer i.e. where concerns have been raised in previous feedback regarding the Doctor being appraised. The Multisource Feedback (MSF) or '360 degrees' process will be facilitated and administered by the Revalidation Team.

	The assessment is comprised of 2 questionnaires: one for patients and one for colleagues. The Revalidation Team will support and facilitate the distribution, collection and collation of the questionnaires. A Doctor should **not** distribute or collect their own feedback questionnaires. Completed Feedback summaries from both colleagues and patients will be accessible through Allocate at least **2 weeks** before the appraisal meeting date. If the feedback has identified any concerns, the Appraiser should discuss these with the Doctor at the appraisal meeting.
10.1	**Colleague Feedback**
	Colleague feedback should be collected from a variety of staff who the Doctor works with on a regular basis, to include: 1) Doctors of all grades; 2) Managers; 3) Nurses; 4) Allied Healthcare Professionals; 5) Clerical Staff. In the case of Divisional Directors and Clinical Directors/Leads, colleague feedback should also be sought from: 1) Divisional Directors: the Director of Operations, Clinical Directors and Leads and Care Group Managers for that Doctor's Division. 2) Clinical Directors/Leads: the Divisional Director, the Director of Operations and Care Group Manager for their Specialty. A minimum of **15** feedbacks should be collected from colleagues and this process.
10.2	**Patient Feedback**
	Patient feedback should be at the heart of a Doctors' professional development. The GMC recommend that Doctor's think broadly about who can provide feedback and it is recognised that, due to the nature of particular types of practice, it may not be appropriate for some Doctors to collect feedback from their patients. However, a Doctor might be able to collect feedback from families and carers. Some Doctors who do not have contact with patients will not be required to participate in a patient survey e.g. Microbiologists. If there is minimal contact with patients then the feedback process can be extended over a 12 month period. The Doctor will have to discuss with their appraiser if they do not think patient feedback can be collected due to the nature of their work. A minimum of **30** patient feedback forms should be collected.
10.3	**Medical Appraiser Feedback**
	It is a requirement that Doctors being appraised are asked for feedback on their experience of appraisal annually and the information obtained should be used to further develop appraisers' performance. The Medical Appraiser will be required to upload evidence on all their feedback as an appraiser during the past 12 months as part of their own annual appraisal process. The Medical Revalidation and Job Planning Manager will provide a report from Allocate, completed by the appraisee as part of the quality assurance process. If there are any specific concerns identified, these will be addressed with the Medical Appraiser by the Divisional Director & Medical Lead Appraiser. Any issues identified through appraisal feedback, including examples of good practise and areas for improvement, will be raised through the Revalidation Steering Group **(see section 13.7**) and appropriate actions identified. It will be the responsibility of the Divisional Director & Medical Lead Appraiser to address these concerns with the

	appraiser concerned.
10.4	**Trainee and Student Feedback**
	Clinical Supervisors and/or Educational Supervisors will also be required to collect feedback from students/trainees as part of a Doctors as teachers assessment to help them become better teachers, and to assist the Clinical Tutor**.**
11.0	**PERSONAL DEVELOPMENT PLAN (PDP)**
	The previous year's PDP needs to be discussed and also future PDP items agreed with your appraiser. The items can include Departmental and Trust objectives. The items must be SMART (specific, measurable, achievable, realistic and time limited). The Clinical Director should be given a copy of the agreed PDP. It is the responsibility of the appraisee to progress their PDP. It is the responsibility of the Clinical Director to progress the other agreed actions at departmental level to facilitate the agreed development objectives of the Doctor. Appraisers at their own appraisal will also consider their role as an Appraiser and their skills and include development action in the PDP for their role as necessary.
12.0	**APPRAISAL SUMMARY AND OUTPUTS**
	In all cases, the structured outputs of appraisal, including the Final Sign Off statements, should be those listed in the NHS Revalidation Support Team *Medical Appraisal Guide*. Appraisers should utilise the ***Appraisal Summary Preparatory Notes Template*** **(see appendix 13)** to ensure that the Appraisal Summary is sufficient, covers the Doctor's whole practise and is linked to supporting evidence that demonstrates the Doctor is meeting the requirements of GMC's Good Medical Practise and revalidation. The appraiser's statements should confirm that: 1) An appraisal has taken place that reflects the whole of a Doctor's scope of work and addresses the principles and values set out in Good Medical Practice. 2) Appropriate supporting information has been presented in accordance with the Good Medical Practice Framework for Appraisal and Revalidation and this reflects the nature and scope of the Doctor's work. 3) A review that demonstrates appropriate progress against last year's personal development plan has taken place. 4) An agreement has been reached with the Doctor about a new personal development plan and any associated actions for the coming year. The appraiser must remain aware when conducting an appraisal of their duty as a Doctor, as laid out in the GMC's *Good Medical Practice*. The appraisal summary should include a confirmation from the appraiser that they are aware of those duties. *"I understand that I must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times. If I have concerns that a colleague may not be fit to practise, I am aware that I must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary."* This provides the context for a further statement that: *"No information has been presented or discussed in the appraisal that raises a concern about the Doctor's fitness to practise."* The appraiser and the Doctor should both confirm that they agree with the outputs of appraisal and that a record will be provided to the responsible officer. If agreement cannot be reached the responsible officer should be informed. In this instance, the appraiser should still submit the outputs of the appraisal, but the responsible officer should take steps to understand the reasons for the disagreement.

13.0	**QUALITY ASSURANCE**
13.1	**Governance Structure**
	 ***Revalidation Governance Structure - Figure 1***
13.2	**Pre- Appraisal Forms**
	The pre-appraisal forms should be submitted on Allocate at least 2 weeks prior to their date of appraisal to enable their designated appraiser to review the supporting information. If supporting information is missing, or if the appraisal portfolio has not been completed to a satisfactory standard, the Appraiser will advise the Appraisee and of any actions or amendments required before the appraisal meeting takes place. Once the Appraisee and Appraiser are satisfied that the appraisal process is complete, they will each sign off the appraisal electronically on Allocate within **28 days** of the appraisal meeting date.
13.3	**Post Appraisal (Final Sign Off)**
	The Trust's Divisional Director & Medical Lead Appraisers will assess the appraisal portfolio to ensure that it has been completed to a standard that meets the requirements for revalidation before providing Final Sign Off electronically and any comments for the Responsible Officer's consideration for revalidation purposes. Quality issues or concerns identified with regards to the appraisal summary/outputs, the Medical Appraisal Lead will be evidenced on the Appraisal Summary and PDP Audit Tool (ASPAT) **see section 13.4.** Electronic Final Sign Off on Allocate should take place no later than **12 weeks** before the Doctor's revalidation submission date.
13.4	**Appraisal Summary and PDP Audit Tool (ASPAT)**
	The ASPAT **(appendix 13)** is a generic tool that is used to audit the appraisal summary and PDP. The ASPAT will be used by the Divisional Director & Medical Lead Appraisers when giving Final Sign Off, to review a minimum of 10% of all Medical Appraisals on an annual basis (10 appraisals per Division) It is the responsibility of each Divisional Director & Medical Lead Appraiser to bring ONE completed ASPAT to be reviewed and discussed at the bi-monthly Revalidation Steering Group (**see section 13.6**).

	In the event of any quality issues being identified during Final Sign Off review, these appraisals will also be brought to be reviewed and discussed at Revalidation Steering group by the Divisional Director & Medical Lead Appraiser and any actions, owners, and associated timelines identified in the associated action plan. Anonymised ASPAT feedback and points of learning will also be raised at the Appraisal Support Group meetings **(see section 13.7)** to ensure shared learning is cascaded to Medical Appraisers.
13.5	**Auditing and Monitoring Arrangements**
	KPI's will be monitored via the Weekly Appraisal and Revalidation Dashboard to the RO and Divisional Director & Medical Lead Appraisers. Key performance indicators (KPI's) are as follows: • Trust Appraisal compliance rate of 95%; • Appraisal compliance by Division and Department; • Audit of Missed Appraisals (approved missed and unapproved missed); • Audit of non-engagement recommendations; • Audit of current deferral recommendations • Quality of Appraisal Outputs; • Attendance at Appraiser Support Groups; • Refresher training compliance; The overall quality and compliance of the appraisal and revalidation programme will also be assured through regular reports to: **Bi-monthly** • Medical Advisory Committee regarding appraisal compliance rates by department and division, missed appraisals, non-engagement and overall appraisal programme performance and action plan; • People and Organisational Development Committee to provide assurance and compliance to national and local indicators; • Maintaining High Professional Standards (MHPS) Decision Making Group; **Quarterly** • NHS England - Quarterly appraisal report (for Framework of Quality Assurance) **Annually** • NHS England Annual Organisation Audit (AOA) (May); • Board Report with regards to Medical Revalidation. (August)
13.6	**Revalidation Steering Group (RSG)**
	The RSG will meet **bi-monthly** to discuss any revalidation and Medical Appraisal related issues for those Doctors connected to the Trust as a Designated Body. The Steering Group will Report to the Medical Advisory Committee and People and Organisation Development Committee **(see Figure 1 above).** Appropriate actions will be agreed by the Group where necessary; to ensure overall appraisal compliance and quality is maintained, that GMC Revalidation requirements are met and that appropriate arrangements are in place relating to the governance processes concerning the successful deployment of the Trust's Revalidation Programme. The group will report any appropriate actions required relating to the successful deployment of the appraisal and revalidation programme to the Appraiser Support Group meeting e.g. quality, training and development needs - see **section 13.8** The RSG will be minuted by the Medical Revalidation and Job Planning Manager. Please see **Appendix (17)** for Terms Of Reference for the RSG.
13.7	**Appraiser Support Group (ASG)**
	All Medical Appraisers will be members of the Appraiser Support Group (ASG) which will be chaired by one of the 3 Trust Divisional Director & Medical Lead Appraisers on

	a rotational basis. These meetings will be held **quarterly,** in line with the commencement of the annual leave year 1 April. The meetings will cover any issues and concerns to be addressed, as identified by the RSG **(see section 13.6).** This will include, but is not restricted to: appraiser allocations for the forthcoming year, any appraiser training and development needs, any anonymised issues or concerns identified through appraisal feedback, including examples of good practise or areas for improvement. The ASG will be minuted by the Medical Revalidation and Job Planning manager. It is a requirement that Medical Appraisers attend a **minimum of 2** ASG meetings per appraisal year. Noncompliance with this requirement will be monitored, tracked and reported to the Revalidation Steering Group by the Medical Revalidation and Job Planning Manager.
13.8	**Appraiser Performance Review**
	The Medical Revalidation and Job Planning Manager will sit in and observe all Trust Medical Appraisers perform an appraisal meeting at least once per appraisal year (having obtained in writing the consent of the appraisee Doctor). The 3 Divisional Director & Medical Lead Appraisers will meet with each Medical Appraiser within their Division a minimum of once per annual leave year, to provide feedback and review development needs. They will complete an ***Appraiser Assurance Review Template*** (**see appendix 15**) and a copy of this will be shared and retained by the appraiser and the Revalidation Team. These review meetings will be forward planned and diarised over the course of the appraisal year 1 April – 31 December. Where concerns arise regarding the performance or competency of an appraiser, **see section 14.**
14.0	**SELECTION AND TRAINING OF MEDICAL APPRAISERS**
14.1	**Selection**
	The process for the selection of appraisers will ensure that Doctors with the appropriate expertise, skills and commitment are selected for this role. The Medical Appraisal Leads should scope the number of appraisals that will be need to be undertaken and ensure there is a sufficient pool of trained appraisers within their respective Divisions to carry out these appraisals. If a Doctor wishes to become a Medical Appraiser, they should contact their Divisional Director & Medical Lead Appraiser who will arrange an interview, which will be supported by the Medical Revalidation and Job Planning Manager. The Doctor must meet the Person Specification for Medical Appraisers outlined in **appendix 11.**
14.2	**Training**
	New Appraisers The selection and training of new appraisers will be carried out as and when required. National guidelines (GMC, Revalidation Support Team, etc.) will be followed regarding approved training. **Existing Appraisers** It is a requirement to undertake top-up/refresher training every **3 years** from the date of completing formal Medical Appraiser Training.
15.0	**MANAGING MEDICAL APPRAISER PERFORMANCE CONCERNS**
	Where concern arises about the performance of a medical appraiser, which cannot be addressed by the normal processes described in the NHS Revalidation Support Team guidance on *Quality Assurance of Medical Appraisers* this will be managed according to the Trust Policy *Disciplinary and Management of Performance of Medical Staff* and in keeping with the contractual arrangement between the Trust and the appraiser in

	question.
16.0	**DOCTORS IN DIFFICULTY**
	In the event that the appraisal process indicates that a Doctor is 'in difficulty', the appraiser must escalate this to the relevant Clinical Director without delay, who will deal with the issues in accordance with the Trust's Policy *Disciplinary and Management of Performance of Medical Staff*. However, organisations need to deal with performance issues as they arise, and not wait until the annual appraisal. It may be appropriate to delay an appraisal under such circumstances. Arrangements should be made for the appraisal to be rescheduled as soon as possible. Where this is not possible, records must be kept and timescales clearly documented. Audits of any delayed or deferred appraisals will be carried out and summary information will be included in Appraisal and Revalidation reports to the Trust Board.
17.0	**DOCTORS SUBJECT TO DISCIPLINARY PROCEDURES**
	Annual Medical Appraisal should continue for all Doctors and must be kept separate from any performance, capability or disciplinary procedures. An appraiser should not appraise the Doctor concerned if they are directly involved in the ongoing process against the Doctor. Another appropriately trained appraiser should be assigned to the role of appraiser by the RO in these circumstances.
18.0	**LINKS WITH JOB PLANNING**
	Doctors should take their Personal Development Plan from their last appraisal to their annual job planning meeting to inform this discussion. Departmental objectives agreed in job planning should similarly inform a Consultant's PDP in a cyclical fashion. Please also refer to the Trust's Medical Job Planning Policy.
19.0	**LINKS WITH CLINICAL EXCELLENCE AWARD APPLICATIONS**
	Only Consultants with an appraisal and an agreed job plan within the preceding year are eligible to apply for Clinical Excellence Awards. Doctors who have not completed a satisfactory an annual appraisal by their specified appraisal anniversary date will **not** be eligible for routine pay progression or local clinical excellence awards unless postponement on exceptional grounds has been approved by the Responsible Officer.
20.0	**APPRAISAL RECORDS, CONFIDENTIALITY AND SCOPE OF ACCESS**
20.1	**Appraisal Records**
	Both the Trust and the appraisee will need to retain copies of the appraisal documentation. These will be retained on Allocate, from where they can be exported electronically where necessary/appropriate e.g. if the Doctor is leaving the Trust in order to take evidence to their next Designated Body.
20.2	**Confidentiality of Appraisal Information**
	The appraisal discussion is an important opportunity for a confidential open discussion between a Doctor and a trained appraiser. The detail of discussions during the appraisal interview would generally be considered to be confidential to the appraisee and appraiser. However, within the context of appraisal for revalidation, the appraiser will be reporting to the RO on the general outcomes of their appraisals. Therefore the appraiser will need to escalate any concerns about performance that arise during the appraisal discussion, in line with Trust relevant policies and guidelines. The RO will normally base their decision to recommend for revalidation on the basis of the appraisal outputs, i.e. the summary of discussion, the new personal development plan, and the appraiser's statements. However, the RO may view any relevant information to assure their recommendation about the Doctor's fitness to practise. In the context of appraisal this may on occasion include the completed full appraisal documentation and the Doctor's supporting information.

20.3	**Scope of Access to Appraisal Forms**
	Allocate access permissions will ensure that appropriate restriction of access to the appraisal portfolio forms is in place. **Pre-Appraisal Forms** The Doctor (appraisee) and their designated appraiser will have full access to the Pre-Appraisal Forms. The designated Allocate Revalidation System Operators – within the Revalidation Team - will have full access to these forms. **Post Appraisal Forms** The Doctor (appraisee) and their designated appraiser will have full access to the PDP and Appraisal Summary on Allocate. The Evaluation form will be restricted from the designated appraiser, but this can be accessed by the Trust's Divisional Director & Medical Lead Appraisers and Responsible Officer. The appraiser will be given an anonymised report on all their feedback as an appraiser during the past 12 months as part of the annual appraisal process. The designated Allocate System Operators – within the Revalidation Team – will have full access to these forms, also. The 3 Divisional Director & Medical Lead Appraisers will also have full access to the forms for final sign off purposes.
20.4	**Access for Quality Assurance and Revalidation**
	The Appraisal Summary and PDP may be reviewed at the Revalidation Steering Group as part of a quality assurance exercise to ensure consistency and quality of appraisal outputs and also, to identify any possible training needs with regards to appraisers (**see section 14.2**).
21.0	**APPRAISER INDEMNITY**
	It is appropriate for appraisers who are not acting negligently to be indemnified for their actions by the Trust. The Trust will provide explicit assurance of indemnity for the appraiser.
22.0	**APPRAISEE INDEMNITY**
	It is a Statutory requirement for doctors to have insurance or indemnity (GMC 2015) The Good medical practice framework for appraisal and revalidation (GMC, 2013) The Doctor being appraised should evidence at their appraisal whether they are covered by the private organisation's insurance or indemnity policy or whether they have arranged for their own personal insurance or indemnity. Indemnity for doctors employed by the Trust will be provided by a clinical negligence scheme.

Appendix 1: Annual Appraisal Flowchart

12 weeks

Prior to the Doctor's appraisal anniversary, the Revalidation Team issues a **FIRST REMINDER** confirming the name of appraiser.
The Doctor is responsible for arranging an appraisal meeting and advising medicalrevalidation@walsallhealthcare.nhs.uk of the arrangements

8 weeks

Prior to the Doctor's appraisal anniversary,
If the Doctor has not notified the Revalidation Team of the agreed appraisal date, a **SECOND REMINDER** will be issued

4 weeks

Prior to the Doctor's appraisal anniversary,
If the Doctor has not notified the Revalidation Team of the agreed appraisal date, a **FINAL REMINDER** will be issued.

2 weeks

Prior to the agreed appraisal date, the Doctor submits pre-appraisal documentation to appraiser via Allocate

1 week

Prior to agreed appraisal date, appraiser reviews pre-appraisal documentation and clarifies any necessary alterations with the Doctor. If necessary, Doctor and appraiser agree a new date.

APPRAISAL MEETING

Doctor and appraiser hold appraisal discussion.

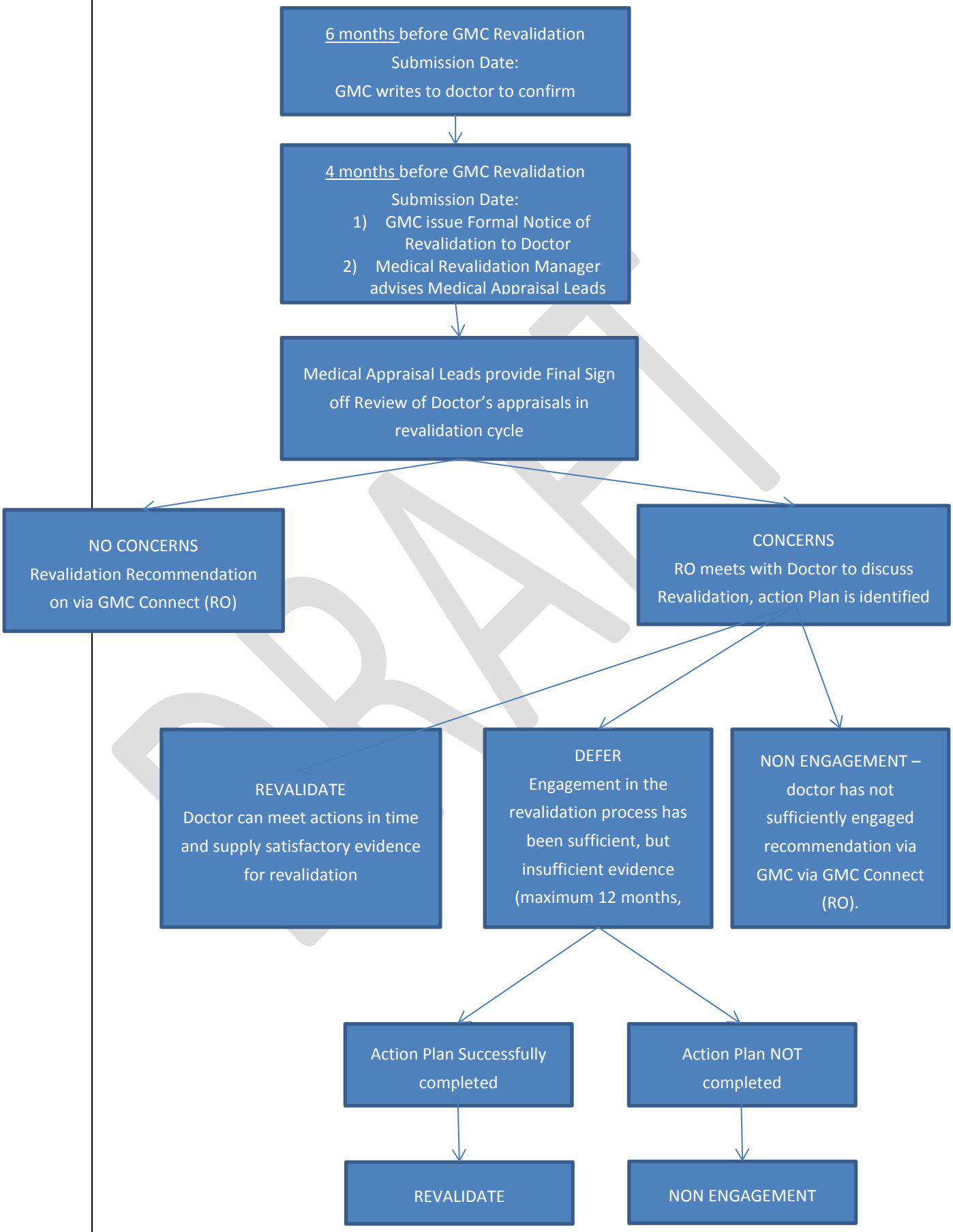
Appraiser and Doctor draft Appraisal summary and PDP.

28 DAYS POST APPRAISAL MEETING

No later than **28 days** after appraisal meeting, Doctor completed Evaluation and both Doctor and appraiser sign off agreed appraisal documentation, complete appraisal outputs.

* For every medical appraisal the structured outputs of appraisal including the final sign-off statements for the appraisal should be those listed in the Revalidation Support Team *Medical Appraisal Guide*

Appendix 2: GMC Revalidation Flowchart



Appendix 3: Appraisal Due - First Reminder Letter

Our Ref: [GMC NUMBER]

[Appraisee name/address]

[Insert date]

Dear [Appraisee],

First Reminder: Appraisal Due

Your appraisal is due in 12 weeks on [INSERT APPRAISAL ANNIVERSARY] and you need to be taking steps to prepare for your annual appraisal. Please contact your designated appraiser [INSERT APPRAISER'S NAME] as soon as possible and advise the revalidation team at medicalrevalidation@walsallhealthcare.nhs.uk what date and time you will be undertaking your appraisal meeting.

Please also ensure that all necessary pre-appraisal forms and supporting information is fully completed on Allocate at least **2 weeks** prior to your appraisal meeting. Supporting Information is outlined in the GMC document supporting information for appraisal and revalidation 2012 is required: http://www.gmc-uk.org/static/documents/content/Supporting_information_for_appraisal_and_revalidation.pdf

If for any reason you are unable to complete the appraisal meeting by the above date, you must complete an Appraisal Postponement Application form, no less than **8 weeks** before the date of your appraisal anniversary, to the Trust's Responsible Officer.

If you require any support or advice regarding the appraisal process, please do not hesitate to contact me on ext. [INSERT].

Yours sincerely,

[NAME]

Medical Revalidation and Job Planning Manager

Ext [INSERT].

Cc [Name of appraiser]

Appendix 4: Appraisal Due - Second Reminder Letter

Our Ref: [GMC NUMBER]

[Appraisee name/address]

[Insert date]

Dear [Appraisee],

Second Reminder: Appraisal Due

Further to the First Appraisal Reminder issued to you, you are yet to confirm what arrangements you have made with respect to your appraisal which is due in **8 weeks**' time on [INSERT APPRAISAL ANNIVERSARY].

You must contact your designated appraiser [INSERT APPRAISER'S NAME] and advise the revalidation team of the date and time you will be undertaking your appraisal meeting at medicalrevalidation@walsallhealthcare.nhs.uk

May I remind you that you need a license to practice and therefore it is your responsibility to meet all appraisal and revalidation requirements and ensure that all your documentation is completed in time in order to maintain your license to practise. Failure to complete your annual appraisal documentation to a satisfactory standard could result in a decision to advise the GMC that you are not engaging in the revalidation process, and that the Trust's Responsible Officer will not be in a position to recommend your revalidation on your submission date [INSERT DATE OF REVALIDATION]. This could result in your licence to practise being withdrawn by the GMC.

If you require any support or advice regarding the appraisal process, please do not hesitate to contact me on ext. [INSERT]

Your Clinical Director has bene copied into this correspondence for information and action.

Yours sincerely,

[NAME]

Medical Revalidation and Job Planning Manager

Ext [INSERT].

Cc [Name of appraiser]

[Clinical Director]

Appendix 5: Appraisal Due - Final Reminder Letter

Our Ref: [GMC NUMBER]

[Appraisee name/address]

[Insert date]

Dear [Appraisee],

Final Reminder: Appraisal Due

You have been previously notified that your appraisal is now due within **4 weeks** on **[INSERT APPRAISAL ANNIVERSARY]**.

Two reminders have now been issued to you by the Revalidation Team to remind you that your appraisal is due, but I have been advised that you are yet to confirm a planned appraisal meeting date. You have also not requested a formal Postponement of your appraisal as per the Medical Appraisal and Revalidation Policy.

I remind you that under GMC revalidation requirements you must participate in annual appraisal and that failure to participate in the local processes and systems that support revalidation on an ongoing basis constitutes non-engagement. Under regulation 4(3) (a) of the Licence to practise regulations, the GMC may withdraw a Doctor's licence where that Doctor has failed, 'without reasonable excuse', to comply with revalidation guidance.

You require a license to practice and it is your responsibility to meet GMC revalidation requirements in order to demonstrate you are fit to practise. These responsibilities are outlined in the GMC's "Meeting the GMC's requirements for revalidation".

I am therefore advising you that if you do not complete your appraisal on or before your appraisal anniversary, I will be advising the GMC that you have not engaged in the local appraisal and revalidation process as per Trust Policy and I will not be in a position to recommend you for revalidation on your designated submission date [INSERT DATE OF REVALIDATION]. This could also result in further action being taken against you, including your suspension from clinical duties and Disciplinary action.

Please contact the Revalidation Team on 6931/7631 to confirm your appraisal meeting arrangements as soon as possible.

Yours sincerely,

[NAME]

Medical Director and Responsible Officer

Cc [Relevant Divisional Director & Medical Lead Appraiser]

[Relevant Clinical Director]

[Medical Revalidation and Job Planning Manager]

Appendix 6: Invitation to Revalidation Meeting with RO

Our Ref: [GMC NUMBER]

[Appraisee name/address]

[Insert date]

Dear [Appraisee],

GMC Revalidation Submission

As you are aware, your revalidation submission date is [INSERT DATE OF REVALIDATION]. I have been advised by your Divisional Director & Medical Lead Appraiser that your appraisal portfolio and supporting evidence in your current revalidation cycle is insufficient to enable me to make a revalidation recommendation to the GMC.

I therefore have arranged a meeting to discuss this matter, and to identify any actions required in order for me to make a recommendation to the GMC by the above submission date.

I must advise you that an outcome of this meeting could be to a request to defer your submission date.

If however I deem that you have not participated in the appraisal and revalidation processes outlined in the Trust's Medical Appraisal and Revalidation Policy which underpins the GMC revalidation framework, then I will notify the GMC that I consider you to be a non-engaging doctor which could have implications for your licence to practise.

Yours sincerely,

[NAME]

Medical Director and Responsible Officer

Cc [Relevant Divisional Director & Medical Lead Appraiser]

[Relevant Clinical Director]

[Medical Revalidation and Job Planning Manager]

Appendix 7: Deferral of Revalidation Submission Letter

Our Ref: [GMC NUMBER]

[Appraisee name/address]

[Insert date]

Dear [Appraisee],

Your Revalidation Submission - Deferral Recommendation

As you are aware, your date of Revalidation [is]. I have made the request to the General Medical Council to defer your Revalidation decision date until [insert date] following the meeting held [INSERT DATE OF MEETING WITH RO].

Please note that this is a recommendation, and the decision to approve this request remains at the discretion of the GMC.

This decision has been made on the following basis:

Delete as appropriate:

- Exceptional circumstances owing to [delete as appropriate: maternity leave/prolonged sick leave/ sabbatical];
- Ongoing investigation;

To be inserted if the decision was owing to exceptional circumstances; Due to you not being able to complete the appraisal process at this time owing to the aforementioned circumstances, a date of completion will be agreed between yourself and the Trust's Responsible Officer upon your return to work. In the event that a return to work is unlikely within 2 months of your revised revalidation decision date, you must discuss this matter with the Trust's Responsible Officer.

To be inserted if the decision was owing to an ongoing investigation; As you are not in a position to have a revalidation recommendation made because you are at present subject to an active investigation, the appropriate period for deferral has been decided based upon the circumstances of the case [specify if this has been set by the GMC at the conclusion of a GMC investigation]. This matter will be reviewed as and when the aforementioned matter is concluded.

The agreed action plan is enclosed and I remind you that it is your responsibility to ensure that you are fit to practise and therefore, it is your responsibility to ensure that you meet the agreed actions in order to enable me to make a revalidation recommendation to the GMC by your next submission date.

Yours sincerely,

[NAME]

Medical Director and Responsible Officer

Cc [Relevant Divisional Director & Medical Lead Appraiser]

[Relevant Clinical Director]

[Medical Revalidation and Job Planning Manager]

Enc. Revalidation Action Plan

Appendix 8: Non-engagement

Our Ref: [GMC NUMBER]

[Appraisee name/address]

[Insert date]

Dear [Appraisee],

Your Revalidation Submission – Non-engagement Recommendation

As you are aware, your date of Revalidation [is]. I have advised the General Medical Council to that I deem you to be a non-engaging doctor, following the meeting held [INSERT DATE OF MEETING WITH RO].

I remind you that under GMC revalidation requirements you must participate in annual appraisal and that failure to participate in the local processes and systems that support revalidation on an ongoing basis constitutes non-engagement. Under regulation 4(3) (a) of the Licence to practise regulations, the GMC may withdraw a Doctor's licence where that Doctor has failed, 'without reasonable excuse', to comply with revalidation guidance.

You require a license to practice and it is your responsibility to meet GMC revalidation requirements in order to demonstrate you are fit to practise. These responsibilities are outlined in the GMC's "Meeting the GMC's requirements for revalidation".

The agreed action plan is enclosed and I remind you that it is your responsibility to ensure that you are fit to practise and therefore, it is your responsibility to ensure that you meet the agreed actions in order to enable me to make a revalidation recommendation to the GMC by your next submission date.

Yours sincerely,

[NAME]

Medical Director and Responsible Officer

Cc [Relevant Divisional Director & Medical Lead Appraiser]

[Relevant Clinical Director]

[Medical Revalidation and Job Planning Manager]

Enc. Revalidation Action Plan

Appendix 9: Supporting Information for Medical Appraisal Checklist

1. Significant event review and reflection
2. Complaints review and reflection
3. Audit Attendance, presentations and any other quality improvement activity.
4. CPD – both internal and external
5. Trust Mandatory Training Record
6. Meeting attendances (e.g. Grand Round, MDT)
7. Current Job Plan
8. Performance Indicators/ Quality dashboards
9. Previous PDP
10. Multisource Feedback (360) if required that year.
11. Independent Sector/Whole Practice Appraisal evidence

Appendix 10: Medical Appraiser Role - Summary of activities

- To prepare appropriately for the appraisal by reviewing the appraisee' s portfolio and contact the appraisee before the appraisal interview in good time should further information be required.
- To ensure that the post-appraisal PDP, summary and sign off is completed and submitted to the Responsible Officer as soon as it is agreed by both parties. The content should be an accurate and comprehensive summary of the appraisal discussion.
- To be available to the appraisee, if needed to discuss problems in meeting the identified requirements and using this opportunity to signpost the appraisee to other resources of help.
- To conduct each appraisal in accordance with the Trust's Policy and procedures which meets the GMC's requirements for appraisal and revalidation
- Both appraiser and appraisee must recognise their professional duty to protect patients. If during the appraisal process the appraiser believes that the appraisee may pose a risk to patients the appraisal should be suspended immediately and the Responsible Officer notified immediately using agreed Trust procedures. The appraisal may be continued at a later date once the issue is resolved. Nothing in the appraisal process can override the basic professional obligation to protect patients.
- To ensure that any information which raises concerns about patient safety are brought to the attention of the Responsible Officer.
- Stay up to date and remain aware of any changes to the appraisal process within the Trust by ensuring all communication from relevant managers and appraisal leads are read.
- Undertake continuing professional development appropriate to the role as an appraiser and document this in your personal development plan.
- Participate fully in the Trust's Quality Assurance process of the appraisal system by gaining feedback on your appraisal meetings. The appraiser will undertake to have this role included in their own appraisal to review their performance and structure their future development needs and results obtained from feedback will be included in their appraisal portfolio. The appraiser will submit information for scrutiny by external regulatory bodies as appropriate.
- Participate in the management and administration of the appraisal systems within the Trust, including the use of the Allocate e-appraisal system.

Appendix 11: Person Specification for the Medical Appraisers

Qualifications:

- Medical Degree (plus any Postgraduate qualifications required)
- GMC License to Practice
- Where appropriate entry on the GMC Specialist Register
- Completion of Appraisal Training

Experience:

- has been subject to a minimum of two medical appraisals not
- including those in training grades
- Experience in managing own time to ensure deadlines are met
- Experience of applying principles of adult education or quality
- improvement

Knowledge:

- Knowledge of the role of the appraiser
- Knowledge of the appraisal process and its links to revalidation
- Knowledge of educational techniques which are relevant to appraisal
- Knowledge of responsibilities of Doctors as set out in Good Medical
- Practice
- Knowledge of relevant Royal College specialty standards and CPD
- guidance
- Knowledge of health sector in which appraisal duties are performed
- Knowledge of local and national healthcare context
- Knowledge of Evidence Based Medicine and clinical effectiveness

Expertise, Skills and Aptitudes:

- Verbal communication and listening skills – including the ability to understand and summarise a discussion, ask appropriate questions, provide constructive challenge and give feedback;
- Effective written communication skills – including the ability to summarise a discussion clearly and accurately
- Objective evaluation skills
- Commitment to own ongoing education and development
- Ability to build rapport and maintain professional working relationships with professional colleagues and Stakeholders

Appendix 12 - Medical Practise Information Transfer Form (MPIT)

https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/mpit-form-1213.pdf

Appendix 13: Appraisal Summary Preparatory Notes Template

Doctor's name	
Date of appraisal	Click here to enter text.
Revalidation date	Click here to enter text.

SETTING THE SCENE AND SCOPE OF WORK

Click here to enter text.

SUPPORTING INFORMATION

Briefly list what is provided under the following headings – more detailed reference to parts of specific supporting information may be added to the narrative in the four Domain sections to evidence appraiser statements. Include an action plan for any required supporting information that is missing.

Continuing professional development (may include college recommendations)
Click here to enter text.

Quality improvement activity
For example:
- *Clinical audit*
- *Review of clinical outcomes*
- *Case review*
- *Audit teaching programme*
- *Evaluate health policy or management practice*

Click here to enter text.

Significant events (if applicable)
Significant events are reserved for the rare cases where there was a serious incident (for example unexpected death or permanent harm) and a significant untoward incident (SUI) process was initiated. The systems around SUIs are rarely activated in primary care but less serious significant event analyses may still be submitted for learning.
Click here to enter text.

Feedback from colleagues (5 yearly)
Click here to enter text.

Feedback from patients (where applicable and 5 yearly)
Click here to enter text.

Review of complaints and compliments
Click here to enter text.

Reference to any other clinical supervision/specialty appraisal also submitted/RO evidence
Click here to enter text.

LAST YEAR'S PDP

Was it completed? If not, document why not

Click here to enter text

When considering the appraisee's work in each of the domains please reflect on the following:

- *What went well?*
- *What could have been done better?*
- *How has this learning affected the Doctor personally?*
- *How has it improved their patient care?*
- *Did they objectively demonstrate this?*
- *Did they disseminate this learning to colleagues?*

Refer to the Doctor's strengths and areas for development

Domain 1: Knowledge, skills and performance

Attribute 1 - Maintain your professional performance
Attribute 2 - Apply knowledge and experience to practice
Attribute 3 - Ensure that all documentation
(including clinical records) formally recording your work is clear, accurate and legible

Click here to enter text.

Domain 2: Safety and quality

Attribute 1 - Contribute to and comply with systems to protect patients
Attribute 2 - Respond to risks to safety
Attribute 3 - Protect patients and colleagues from any risk posed by your health

Click here to enter text.

Domain 3: Communication, partnership and teamwork

Attribute 1 - Communicate effectively
Attribute 2 - Work constructively with colleagues and delegate effectively
Attribute 3 - Establish and maintain partnerships with patients Additional:

- *Teaching, training, supporting and assessing*
- *Continuity and coordination of care*

Click here to enter text.

Domain 4: Maintaining trust

Attribute 1 - Show respect for patients
Attribute 2 - Treat patients and colleagues fairly and without discrimination
Attribute 3 - Act with honesty and integrity

Click here to enter text.

Summarising Comments

Click here to enter text.

Appraiser:	Click here to enter text.
Date:	Click here to enter text.

Appendix 14: Appraisal Summary and PDP Audit Tool (ASPAT)

Appraiser identifier	Click here to enter text.
Doctor identifier	Click here to enter text.
Date of appraisal	Click here to enter a date.
Organisation	Click here to enter text.
Auditor (usually the senior appraiser)	Click here to enter text.

Scale:

* *Unsatisfactory*
* *Needs improvement*
* *Good*

Score each item out of two

1.1.1 Setting the scene and overview of supporting information

a) The appraiser sets the scene summarising the Doctor's scope of work	
b) The evidence discussed during the appraisal is listed *(not all senior appraisers feel that this is necessary, so if not required score 2)*	
c) There is documentation of whether the supporting information covers the whole scope of work	
d) Specific evidence is summarised with a description of what it demonstrates	
e) Objective statements about the quality of the evidence are documented	
f) All statements made by the appraiser are supported by evidence	.
g) Appraiser comments about evidence refer/fit in to the four GMC domains and associated attributes set out in the GMC guidance *Good medical practice framework for appraisal and revalidation*	.
h) Reference is made to whether speciality specific guidance for appraisal has been followed e.g. college recommendations for CPD and quality improvement activity *(this is not a GMC requirement so if the senior appraiser does not feel that this is necessary, score 2)*	
i) Reference to completion of locally agreed required training (e.g. safeguarding training, basic life support training) is made *(please insert agreed requirements, score 2 if none agreed)*	

1

Comments: Click here to enter text.

1.1.2 Reflection and effective learning

a) There is documentation of evidence showing that reflection on learning has taken place or that the appraiser has discussed how the Doctor should document their reflection	.
b) There is documentation of evidence showing that learning has been shared with colleagues or that the appraiser has challenged the Doctor to do so	
c) There is documentation of evidence showing that learning has improved patient care/practice or that the appraiser has explored how this might be taken further with the Doctor	
Comments: Click here to enter text.	

1.1.3 The PDP and developmental progress

a) There is positive recording of strengths, achievements and aspirations in the last year	
b) There is documentation of appropriate challenge in the discussion and PDP e.g. significant issues discussed and new suggestions made	
c) The completion (or not) of last year's PDP is recorded	
d) Reasons why any PDP learning needs that were not followed through are stated (*if the PDP was completed then score 2)*	
e) There are clear links between the summary of discussion and the agreed PDP	
f) The PDP has SMART objectives (specific, measurable, achievable, relevant, timely)	
g) The PDP covers the Doctor's whole scope of work and personal learning needs and goals	.

h) The PDP contains between 3-6 items	
Comments: Click here to enter text.	

1.1.4 General standards and revalidation readiness

a) The documentation is typed and uploaded onto an electronic toolkit in clear and fluent English	
b) There is no evidence of appraiser bias or prejudice or information that could identify a patient/third party information	
c) The stage of the revalidation cycle is commented on	
d) There is documentation regarding revalidation readiness relating to supporting information (e.g. states that feedback and satisfactory QIA are already done). Any outstanding supporting information/other requirements for revalidation are commented on with a plan of action to address them	
e) Appraisal statements (including health and probity) have been signed off or if not, an explanation given (*if signed off score 2)*	
Comments: Click here to enter text.	

TOTAL SCORE (OUT OF 50)	Click here to enter text.

General comments from the senior appraiser:

Click here to enter text.

Appendix 15: Appraiser Assurance Review Template

1.3 Using this template

It is good practice for the senior appraiser (or appraisal lead) to hold a periodic assurance review meeting with individual appraisers. This template is intended to guide this process and provide a record of the meeting for the appraiser and the appraisal office.

Whilst initially designed to support an assurance review meeting between an appraiser and their senior appraiser, this template can also be used alone by an appraiser as a self-review tool, or by an appraiser and a fellow appraiser as a peer-facilitated review tool, in a networking or buddying context.

The intended procedure is as follows:

* The reviewer or appraisal office part-populates the template, and prepares the appraiser's audit of appraisal outputs, Doctor feedback and any other relevant information, as available.
* The appraiser completes remaining items in Section A.
* The appraiser and reviewer hold the review meeting, structured along the lines of the information in the template.
* The appraiser and reviewer agree the content of Section B, and complete the sign-off in Section C.
* The appraiser and the appraisal office each retain a copy of the final template.

Note: Appraisers who are themselves licenced medical practitioners should present a copy of the completed template at their own medical appraisal, as supporting information indicating their participation in effective governance processes in relation to their appraisal work.

1.4 Section A

Appraiser's name: Click here to enter text.

Reviewer's name: Click here to enter text.
Reviewer's role: Click here to enter text.
Date of review meeting: Click here to enter a date.

1.4.1. General

Specialty: Click here to enter text.
Other roles: Click here to enter text.
Start date as appraiser: Click here to enter text.
Have you signed a contract/consultancy agreement? Choose an item.
Date of signature of contract/consultancy agreement: Click here to enter text.

Number of appraisals in the last year: Click here to enter text.
Number of appraisals you would like to do next year: Click here to enter text.

Scope of appraisal work (e.g. primary care, secondary care, private, responsible officer appraisals): Click here to enter text.

Review of appraisal work in the last year

1.4.2 Headlines

Looking at your last review's development themes/objectives in relation to your role as appraiser, to what extent did you get to fulfil these?
Click here to enter text.

As an appraiser, what do you consider you did well in the last year?
Click here to enter text.

What is your approach to preparation and appraisal summaries completion?
Click here to enter text.

What difficulties/ barriers have you come across as an appraiser?
Click here to enter text.

How well does your appraisal work fit in with your other professional duties?
Click here to enter text.

Do you have any helpful tips/good practice to share?
Click here to enter text.

Do you have any suggestions for appraisal workshop topics?
Click here to enter text.

How would you like your appraisal work to develop?
Click here to enter text.

1.4.3 CPD for your appraisal work

Local appraiser groups/appraiser network meetings attended: Click here to enter text.
Comments on these, and any other CPD activities you have undertaken in relation to your appraisal work; possible development plans:
Click here to enter text.

1.4.4. Quality improvement activity for your appraisal work

(Appraisal office should provide the audit of appraisal summaries and PDPs if available)
Comments on the audit of your appraisal summaries and PDPs and any other quality improvement activity relating to your appraisal work; possible development plans:
Click here to enter text.

1.4.5 Significant events in your appraisal work

(Consider, for example, unexpected concerns, interrupted appraisal, failure to agree outputs with Doctor)
Comments; possible development plans:
Click here to enter text.

1.4.6. Maintaining professional relationships with Doctors you have appraised

(Appraisal office to provide Doctor feedback if available,)

Comments on Doctor feedback provided by the appraisal office and any other feedback from the Doctors you have appraised; possible development plans:

1.4.7 Maintaining professional relationships with colleagues in your appraisal work

Comments; possible development plans:
Click here to enter text.

1.4.8 Your health in relation to your appraisal work

Comments; possible development plans:
Click here to enter text.

1.4.9 Maintaining probity in relation to your appraisal work

(Consider, for example, identification of conflict of interest or appearance of bias with Doctors
you are asked to appraise, delivering a professional appraisal through diligent preparation
and personal organisation.)
Comments, possible development plans:
Click here to enter text.

1.4.10 Complaints and compliments in relation to your appraisal work

(Appraisal office to provide information about complaints if available)
Comments; possible development plans:
Click here to enter text.

1.4.11 Any other comments before the discussion

Reviewer: Click here to enter text.
Appraiser: Click here to enter text.

1.5 Section B

1.5.1 Comments/summary following discussion Reviewer: Click here to enter text.
Appraiser: Click here to enter text.

Personal development themes for your appraisal work
Click here to enter text.

Actions by reviewer/appraisal office
Click here to enter text.

1.6 Section C

1.6.1 Sign-off

We agree that the above is an accurate summary of the review discussion and agreed
personal development themes/actions.

Signatures: May be agreed by e-mail if both parties consent, in which case names sufficient:
Click here to enter text.

Date of sign-off: Click here to enter a date.

Walsall Healthcare NHS
NHS Trust

Appendix 16 – Appraisal Postponement Application Form

Section A Doctor's details and request for postponement	
Doctor's name:	Click here to enter text.
GMC number:	Click here to enter text.
Telephone number(s):	Click here to enter text.
Mobile:	Click here to enter text.
Practice:	Click here to enter text.
Home:	Click here to enter text.
Email:	Click here to enter text.
Doctor's appraisal month:	Click here to enter text.
Date of last appraisal:	Click here to enter text.
Name of last appraiser:	Click here to enter text.
Revalidation due date:	Click here to enter text.
Reason for request for postponement of appraisal:	Click here to enter text.
Proposed date for next appraisal:	Click here to enter text.
Date of request:	Click here to enter text.
Section B Local decision	(for office use only)
Name of person considering request:	Click here to enter text.
Position:	Click here to enter text.
Postponement agreed:	☐ Yes ☐ No
Comment:	Click here to enter text.
Agreed new appraisal due date:	Click here to enter text.
Date of decision:	Click here to enter text.

Walsall Healthcare NHS
NHS Trust

Appendix 17 – Revalidation Steering Group Terms of Reference

Revalidation Steering Group (RSG)

Terms of Reference

1.0 Purpose

To discuss any revalidation related issues and issues regarding Medical Appraisal for those Doctors connected to the Trust as a Designated Body. Appropriate actions should be agreed by the Group where necessary; to ensure overall appraisal compliance and quality is maintained, that GMC Revalidation requirements are met and that appropriate arrangements are in place relating to the governance processes concerning the successful deployment of the Trust's Revalidation Programme.

2.0 Remit

1. To provide an update in terms of overall appraisal compliance dashboard (rates by Trust, Division and Department);
2. To highlight any issues which may hinder appraisal compliance, explore the reasons why and agree any action(s) and responsibilities;
3. To highlight any Doctors requiring revalidation in the next 120 days (under notice)
4. To highlight and discuss any issues which may impact on Doctors revalidation
5. To highlight any potential non-engagement issues
6. To highlight any potential deferrals and issues
7. To quality assure Random Sample of 5 anonymised Appraisals and Personal Development Plans using recognised Quality Assurance Tool (ASPAT)
8. To highlight any issues regarding quality assurance around training, education and support for Medical Appraisers
9. To update any changes due to be implemented with regards to the Appraisal and Revalidation programme.

3.0 Membership

Mr Amir Khan - **Chair**

Mr Najam Rashid – **Vice Chair,** Divisional Director, Medicine and Long Term Conditions

Mr N Turner – Divisional Director, Surgery

Dr L Holland– Divisional Director, Women's and Children's & Clinical Support Services

Mr Mark Read– Medical Revalidation and Job Planning manager

Mrs Jo Adams - Business Manager, Medical Directorate

4.0 Frequency

To meet bi-monthly

5.0 Quorate

- Chair **or** Vice Chair (in the Chair's absence)
- 1 Divisional Director
- Medical Revalidation and Job Planning Manager to take notes and actions at the meeting

6.0 Agenda

1.	**Apologies**
2.	**Minutes of previous meeting**
3.	**Action Log**
4.	**Appraisal position statement (dashboard)** • **Overall rate of compliance** • **Departmental compliance** • **Divisional Compliance** • **Appraisal Postponement Applications (if applicable)**
5.	**Revalidations Due in next 120 days** **Deferrals** • **Currently deferred** • **Potential deferrals (issues, concerns)** **Non engagement** • **Current** • **Potential (issues, concerns)**
6.	**Quality Assurance of Appraisals** • **ASPAT Tool review of 10 randomly selected appraisal summaries and PDP's**
7.	**Appraiser Support Group** • **feedback from ASG** • **matters to raise at next ASG**
8.	**Training & Performance** • **new medical appraisers** • **current medical appraisers** • **Appraiser 1-1 review compliance**

9.	**Any Other Business**
10.	**Date and Time of Next Meeting**

6.0 Notes and Live Action Sheet

- To be completed by a member of the Revalidation Team;
- Circulated within **5 working days** of RSG meeting,
-
- Update of any actions to be circulated **5 working days prior** to the next RSG

RATING	PROGRESS
	YET TO COMMENCE
	BEHIND SCHEDULE
	SOME PROGRESS
	ON SCHEDULE
	COMPLETED

NOTES / ACTION LOG	
[MEETING TITLE]	
Date:	
Attendees:	
Apologies:	
Notes:	

AGENDA ITEM	ACTION	INDIVIDUAL(S) RESPONSIBLE FOR ACTION	ACTION(S) PROGRESS	ACTION DEADLINE	PROGRESS RATING
1					
2					
3					

4					
5					
6					
7					
8					
9					

8.0 Management and Accountability

The Trust's Medical Director as the Responsible Officer is accountable, as part of the Responsible Officer Regulations [1] as set out in statute, for ensuring that the designated body has all systems and processes in place, including those of clinical governance, underpinning the responsible officer's recommendation to the GMC on a Doctor's fitness to practise, and that these are functioning effectively.

9.0 Governance Reporting Arrangements

Bi-monthly

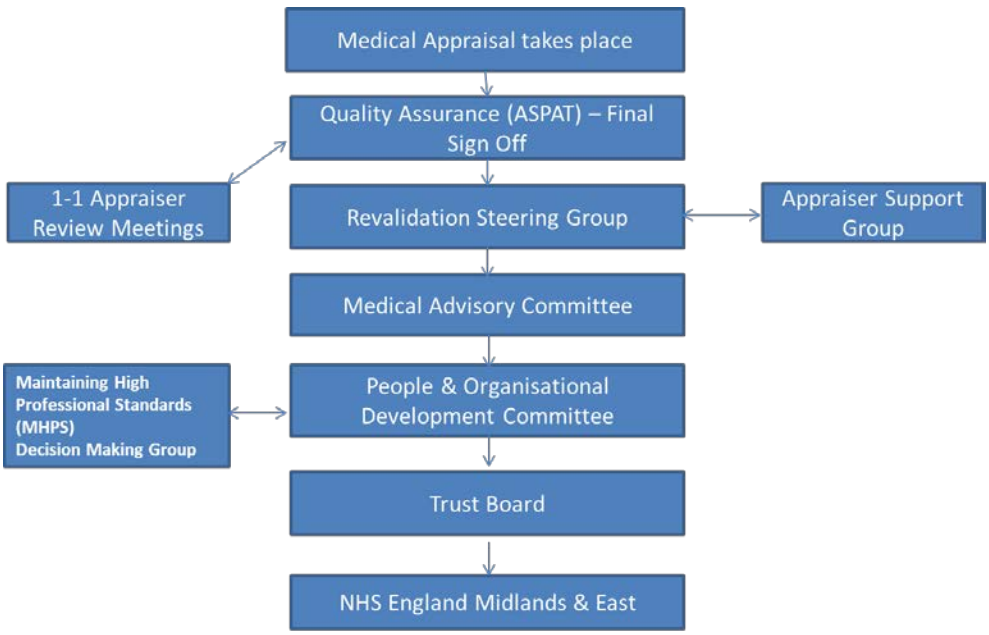
- Reports to Medical Advisory Committee regarding appraisal compliance by department and division, missed appraisals, non-engagement and overall appraisal programme performance and action plan
- Report to People and Organisational Development Committee to provide assurance and compliance to national and local indicators
- Report to MHPS Group

Quarterly

- NHS England - Quarterly appraisal report (for Framework of Quality Assurance)

Annually

- NHS England Annual Organisation Audit (AOA) (May);
- Board Report with regards to Medical Revalidation. (August)



Revalidation Governance Structure - Figure 1

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

MEETING OF THE TRUST BOARD–Thursday 2nd August			
Hospital Mortality			**AGENDA ITEM: 11**
Report Author and Job Title:	Mrs J Adams Business Manager to the Medical Directorate	**Responsible Director:**	Mr Amir Khan Medical Director
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	**In Month Performance** • HSMR March 2018 110.50 • SHMI December 2017 127.25 **Year to Date 2017/18** • HSMR March 2018 101.06 • SHMI December 2017 104.23 SHMI has not been updated since December to a provider data issue **Reviewing and Learning** Work continues to be undertaken to embed the National Quality Board guidelines using a Structured Judgement Review approach. Completion of reviews continues to prove challenging. Work is being undertaken to develop an options appraisal for implementing the role of the Medical Examiner to support with a qualitative approach to reviewing deaths, identifying lessons learnt, supporting bereaved families and carers, ensuring medical certification is completed appropriately and developing working relationships with the trust coroner. A revised approach, supported by the clinical governance and patient safety teams, is to be developed to ensure specialty ownership of reviews, lessons learnt and action plans to support in embedding changes in practice and process, shared learning and improved patient outcomes. **Key Points for consideration and Action** • Review of HSMR outliers • Review of deaths for patients admitted with a fractured neck of femur • Develop the Medical Examiner role • Triangulation of operational data with mortality data for Q3 and Q4 • Review of a patient transferred to ED • Review of a patient post chemotherapy		

Recommendation	Members of the Trust Board are asked to: 1. NOTE the Trust's current hospital mortality performance and associated learning points and actions to be taken	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Quality and Safety- to identify lessons learnt from hospital deaths and amend practice and process to improve clinical outcomes, patient experience, reduce hospital deaths and improve mortality performance. Shared learning and improve education and training for clinical staff. Reduce Hospital Mortality Assure performance against SHMI Ensure correct coding to assure appropriate income is received Collaborative working with the CCG to support the implementation and desired outcomes of the Living Longer in Walsall Strategy Implementation of revised national regulations in relation to MCCD	
Resource implications	Ineffective coding resulting in loss of income Reduce LOS	
Legal and Equality and Diversity implications	Reducing mortality rates Compliance to the NHS standard contract requirements Complying with the NQB recommendations, Learning from Death Compliance with DoH Reforming death certification	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☐	

Mortality Report
Trust Board August 2018

1. PURPOSE OF REPORT

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

2. DETAILS

How We Are Performing

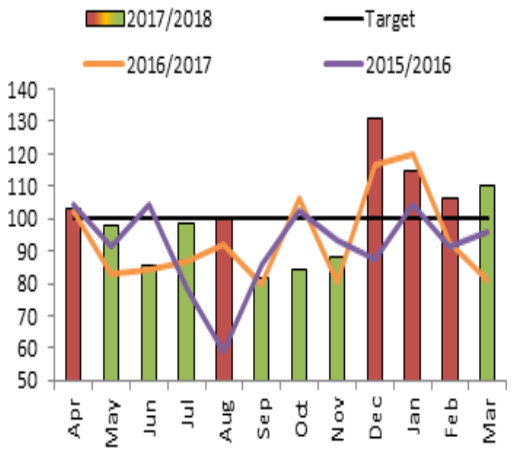
The Trust performance against the two key national indicators for mortality Hospital Standardised Mortality Rate and Standardised Hospital Mortality Index has been variable during the year 2017/18 (Appendix 1). SHMI is not available after December 2017.

Performance in month for the current reporting period as below identifies that HSMR started to rise significantly in December and January reflecting a significant rise in deaths and reflective of a similar trend seen in previous years. This reflects a similar trend for regional peers. HSMR continued to demonstrate a level above 100 for February and March reflected in deaths for those 2 months, higher than the previous year but similar to that of the year before. This has resulted in an end of year HSMR above 100
Similarly SHMI has demonstrated a rise reporting above 100 for 3 consecutive months and rising above 100 for YTD

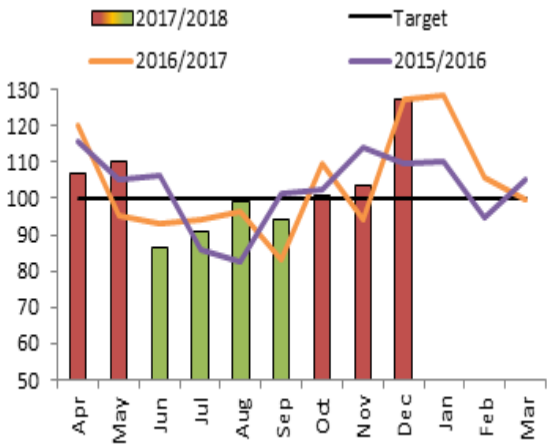
Walsall Healthcare Hospital Mortality – Headline Indicators

Measure	Period (latest available)	Month	Year to Date	Comment
HSMR (index)	Mar 2018	110.50.	101.06	End of year rebasing shows a HSMR above 100 for 4 consecutive months and an end of year outturn above 100
SHMI (index)	Dec 2017	127.25	104.23	SHMI has reported as over 100 for 3 consecutive months and rising above 100 YTD, SHMI remains unreported since Dec 2017
Crude Mortality Rate/ 1000 bed days	June 2018	5.6	N/A	Crude mortality for has fallen significantly since December and January
Actual Deaths (no.)	June 2018	85	253	

HSMR Performance 2016-2018



SHMI Performance 2016-2018



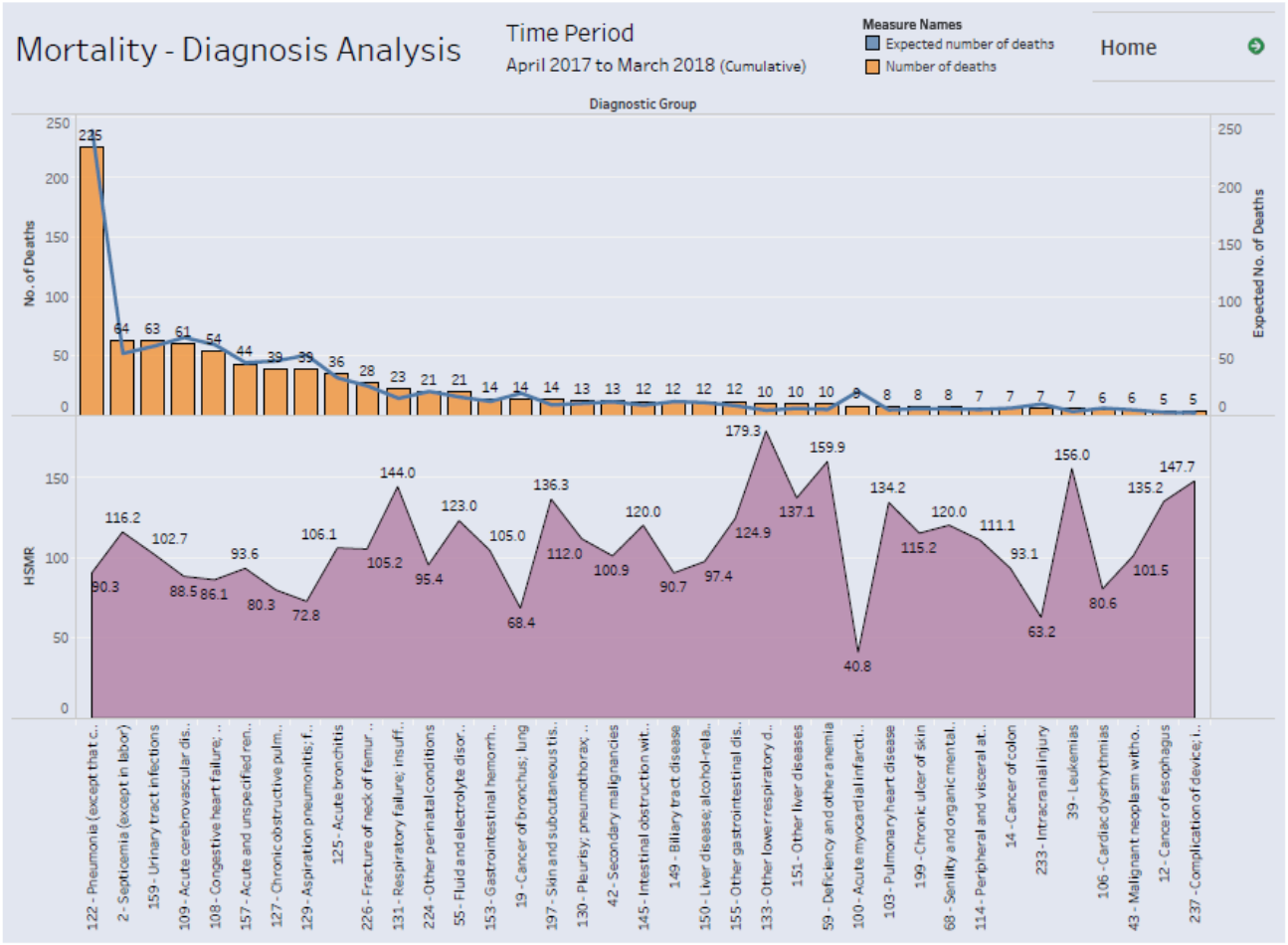
Regional Comparison

The diagrams, Appendix 2, show the Trust performance for HSMR compared to other Trusts within the region for 2017/18. With a number of Trusts showing a seasonal rise for the winter period

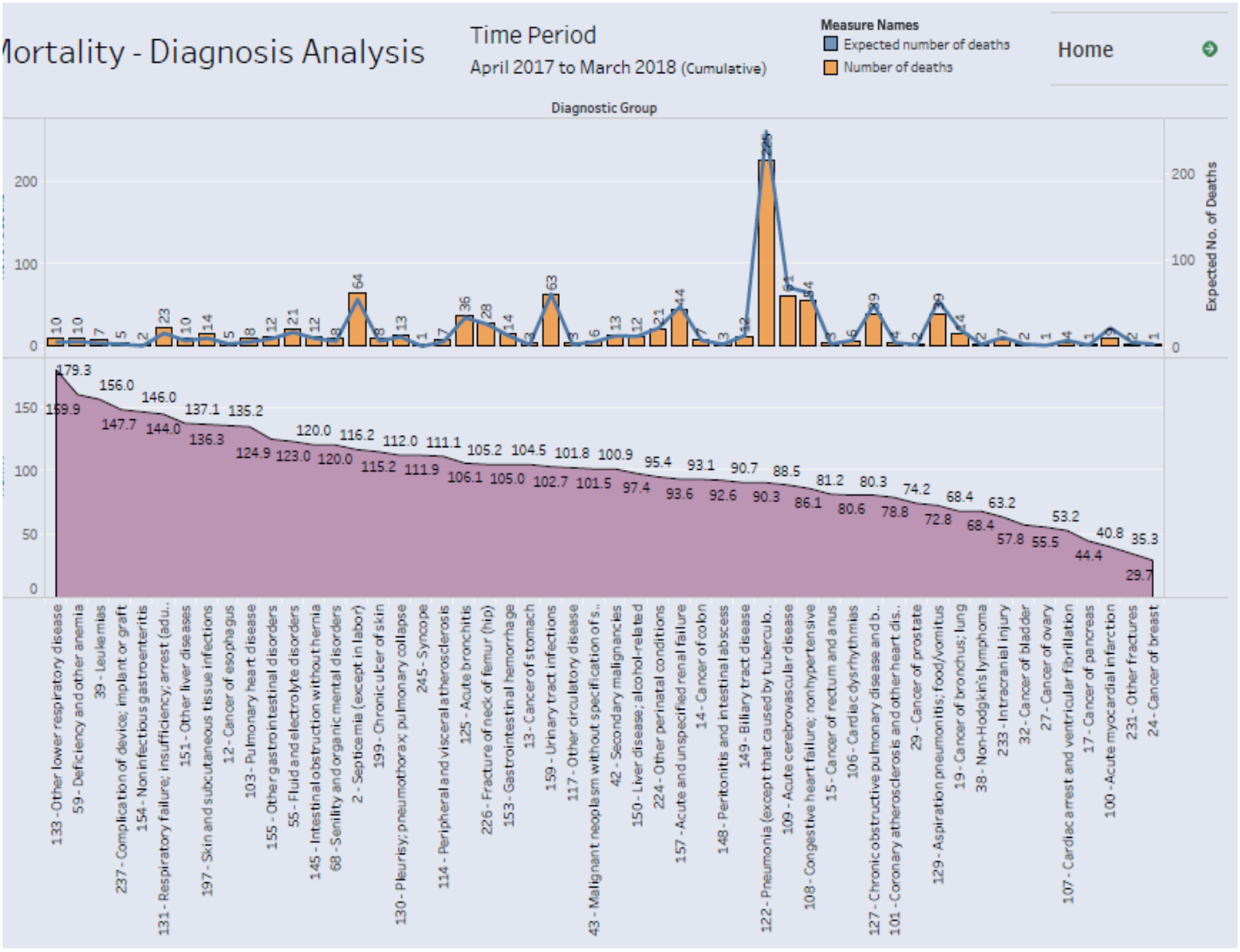
Diagnosis Specific Triggers and Alerts, CuSum

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

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



The following diagram identifies the highest HSMR by diagnostic group.



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

A CuSum trigger for overall performance is set at 5, the trust performance for CuSum is currently 1.96 rising from 0.00 since November 2017.
The highest CuSum occurred in February.

These relate to HSMR outliers for fluid and electrolyte imbalance, 1 death relating to colon cancer, respiratory disease related deaths and a HSMR outlier of fracture neck of femur.
The majority of the high CuSum and subsequent high crude mortality percentages relate to respiratory related diseases and the HSMR outliers which are currently being reviewed.

Key Data Themes

Respiratory related diseases continue to contribute significantly to the numbers of deaths and higher HSMR based on observed greater than expected.

HSMR Outliers

Deaths coded as fluid and electrolyte imbalance demonstrate a significantly higher HSMR than expected to December 2017 recorded as double the expected rate. The trust has subsequently received notification from Imperial College London, who routinely analyse Hospital Episode Statistics HES to advice of the abnormal trend.

Having undertaken a preliminary review of these patients the patient record identified patients with multiple comorbidities, advanced malignant disease, frail elderly and a number in nursing home environments. Outputs from those patients who had a RCP SJR of the death indicate a good level of care.
The clinical coding department have subsequently undertaken a review of the coding of this group of patients, consulted with clinicians and peers and have made some adjustments to the final coding categories.
HSMR outliers for Q4 relate to small numbers of patients referenced to a less than 1 expected death giving a subsequent high HSMR ratio.

During January in month there are 2 significant HSMR outliers relating to 2 patients. Both patients were emergency admissions and had significant progressive underlying disease which would have contributed to their deaths.
A clinical review has been requested for the patient who died whilst in the medical division. The patient who died in the surgical division has been reviewed by the clinical team who determined overall care as of a good standard. Neither patient was referred to the coroner.

February outliers relate to fracture neck of femur, reporting 5 with a HSMR ratio of 425.
All the patients have had a primary mortality review; a deep dive MDT review is to be requested.

During March HSMR outliers again relate to significantly small actual compared to expected deaths. The highest HSMR being 575.56 relating to a death for which a coding review has been requested.
The clinical coding team will continue to monitor HSMR outliers to address any coding issues. Any clinical triggers will be escalated to the teams through the mortality review process, RCA findings or following post mortem or subsequent coroner investigation.

Outlying HSMR are an important “smoke signals” when identifying trends and triggers that may identify key areas to focus review of deaths and determine any lessons that can be learnt in conjunction with individual reviews, local data and other national benchmark data. It should also be considered that documentation and subsequent clinical coding can also contribute to trends. In these particular cases it may be that the cause of death may have been attributed to fluid and electrolyte imbalance as a result of an underlying disease.
Clinical coding will be undertaking a review of these patients’ records to ensure clinical coding is representative of the cause of death and monthly reviews of all subsequent outlying groups of diagnosis.

Top 10 Diagnostic Groups

Diagnosis groups		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Running Total
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	Deaths	14	12	10	13	20	8	10	8	27	32	25	20	199
	HSMR	92.05	106.2	90.73	100.29	138.43	79.88	92.61	55.32	141.08	93.24	96.09	121.72	
2 - Septicemia (except in labor)	Deaths	13	18	11	10	5	8	10	16	21	20	10	11	153
	HSMR	82.09	117.43	62.25	106.14	43.03	59.89	69.81	112.99	125.47	120.89	76.07	99.91	
109 - Acute cerebrovascular disease	Deaths	6	8	5	4	6	5	4	3	5	6	8	6	66
	HSMR	130.6	195.35	110.66	80.82	105.13	90.85	102.18	108.12	83.85	142.59	115.73	108.4	
129 - Aspiration pneumonitis; food/vomitus	Deaths	5	2	3	4	6	3	8	3	3	4	6	2	49
	HSMR	177.43	61.86	99.67	58.16	121.9	65.24	128.31	66.51	125	79.95	121.43	110.88	
127 - Chronic obstructive pulmonary disease and bronchiectasis	Deaths	5	8	3	7	0	1	1	1	9	4	5	3	47
	HSMR	104.87	205.75	102.09	230.42		42.68	31.93	38.4	161.27	70.85	131.5	69.07	
108 - Congestive heart failure; nonhypertensive	Deaths	4	4	4	6	5	2	1	2	6	4	2	4	44
	HSMR	96.55	67.88	81.56	161.12	131.02	57.9	29.72	88.83	163.73	119.27	48.53	97.36	
157 - Acute and unspecified renal failure	Deaths	4	1	7	2	2	2	2	4	3	3	3	6	39
	HSMR	118.31	29.74	131.77	48.33	67.46	50.93	102.47	102.59	79.6	82.5	87.7	131.86	
131 - Respiratory failure; insufficiency; arrest (adult)	Deaths	2	4	4	2	1	1	1	2	0	4	4	8	33
	HSMR	125.51	190.19	182.49	93.01	593.15	118.21	122.31	169.25		336.66	138.28	193.5	
55 - Fluid and electrolyte disorders	Deaths	2	3	0	2	1	1	0	3	6	5	2	4	29
	HSMR	295.48	232.55		237.7	222.72	174		159.63	384.47	413.09	285.04	373.83	
125 - Acute bronchitis	Deaths	3	0	1	1	3	3	1	3	3	4	6	0	28
	HSMR	134.82		94.56	95.25	206.34	231.01	173.65	154.05	248.35	163.68	206.32		

Diagnosis groups		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Running Total
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	Deaths	14	16	11	18	15	12	16	17	26	35	22	23	225
	HSMR	73.58	92.08	62.66	84.97	77.18	66.63	100.43	84.9	98.5	119.29	112.28	90.44	
2 - Septicemia (except in labor)	Deaths	24	17	20	18	15	19	24	37	31	18	22	36	281
	HSMR	51.12	94.71	136.45	99.31	160.09	119.46	154.04	62.77	174.11	161.2	117.7	105.17	
109 - Acute cerebrovascular disease	Deaths	4	8	5	4	7	6	8	5	2	7	1	4	61
	HSMR	80.27	122.97	75.4	48.93	77.73	97	172.66	88.97	62.29	115.39	32.43	82.45	
108 - Congestive heart failure; nonhypertensive	Deaths	10	5	1	3	5	0	5	3	9	1	3	9	54
	HSMR	126.04	93.7	29.59	58.59	160.36	0	104.63	47.42	145.53	22.48	62	115.28	
157 - Acute and unspecified renal failure	Deaths	7	4	2	4	5	2	5	4	4	2	4	1	44
	HSMR	204.12	92.52	74.97	122.1	104.34	62.2	145.06	75.36	117.26	57.53	117.71	15.94	
129 - Aspiration pneumonitis; food/vomitus	Deaths	5	1	5	1	4	3	0	3	2	5	7	3	39
	HSMR	126.64	40.54	85.2	47.13	55.93	69.81		58.12	42.76	125.99	120.86	62.04	
127 - Chronic obstructive pulmonary disease and bronchiectasis	Deaths	5	1	2	3	5	4	1	2	4	4	5	3	39
	HSMR	157.85	32.01	45.12	68.82	154.15	149.55	34.52	79.94	64.43	53.96	102.29	82.04	
125 - Acute bronchitis	Deaths	2	0	4	2	4	2	3	4	7	6	1	1	36
	HSMR	97.39		151.87	69.89	203.06	74.16	140.09	135.38	144.86	124.06	33.85	52.22	
131 - Respiratory failure; insufficiency; arrest (adult)	Deaths	1	0	0	1	0	1	3	3	4	6	1	3	23
	HSMR	150.88			113.66		285.64	118.97	171.5	193.12	433.63	86.37	108.36	
55 - Fluid and electrolyte disorders	Deaths	0	3	2	0	1	2	3	0	2	4	3	1	21
	HSMR		237.11	154.84		56.38	230.15	140.93		185.43	151.33	157.58	52.1	

Specialty Groups

Grp By	(01) Apr	(02) May	(03) Jun	(04) Jul	(05) Aug	(06) Sep	(07) Oct	(08) Nov	(09) Dec	(10) Jan	(11) Feb	(12) Mar	Total
ACCIDENT AND EMERGENCY	0	0	1	1	0	0	2	1	0	0	1	0	**6**
CARDIOLOGY	4	3	2	3	3	4	4	4	5	3	6	9	**50**
COLORECTAL SURGERY	0	0	0	0	0	0	0	1	1	1	0	0	**3**
DIABETIC MEDICINE	1	1	7	1	9	3	7	3	9	5	3	11	**60**
ENDOCRINOLOGY	4	1	1	1	1	2	2	4	0	2	2	1	**21**
GASTROENTEROLOGY	4	8	7	2	7	4	13	7	12	7	4	11	**86**
GENERAL MEDICINE	20	22	18	18	22	18	20	20	44	56	43	34	**335**
GENERAL SURGERY	9	3	6	10	8	4	4	8	9	6	6	2	**75**
GERIATRIC MEDICINE	30	29	25	23	23	15	18	16	27	23	25	17	**271**
GYNAECOLOGICAL ONCOLOGY	0	0	0	0	0	0	0	0	0	0	0	1	**1**
GYNAECOLOGY	0	0	0	0	1	0	0	0	1	1	0	0	**3**
NEPHROLOGY	0	8	1	2	2	1	2	1	3	4	5	3	**32**
PAEDIATRICS	0	0	0	0	0	0	0	0	0	0	1	0	**1**
REHABILITATION	1	1	0	0	0	0	0	0	3	4	1	3	**13**
RESPIRATORY MEDICINE	14	11	8	14	7	7	6	10	14	11	8	8	**118**
TRAUMA AND ORTHOPAEDICS	2	5	3	4	3	1	6	3	4	5	5	7	**48**
UROLOGY	0	0	0	0	0	1	0	0	1	2	0	2	**6**
WELL BABIES	1	2	0	1	5	1	1	2	1	3	2	1	**20**
ZZZ Treatment not known	0	0	2	0	0	2	1	0	5	6	1	3	**20**
Total	**90**	**94**	**81**	**80**	**91**	**63**	**86**	**80**	**139**	**139**	**113**	**113**	**1169**

Year Financial	Grp By	(01) Apr	(02) May	(03) Jun	Total
Year 2018/19	CARDIOLOGY	4	3	5	**12**
	COLORECTAL SURGERY	0	1	0	**1**
	DIABETIC MEDICINE	2	7	4	**13**
	ENDOCRINOLOGY	1	0	0	**1**
	GASTROENTEROLOGY	8	3	7	**18**
	GENERAL MEDICINE	31	21	31	**83**
	GENERAL SURGERY	7	5	9	**21**
	GERIATRIC MEDICINE	20	21	13	**54**
	GYNAECOLOGICAL ONCOLOGY	0	1	0	**1**
	NEPHROLOGY	0	0	2	**2**
	REHABILITATION	1	2	3	**6**
	RESPIRATORY MEDICINE	6	9	3	**18**
	TRAUMA AND ORTHOPAEDICS	3	2	7	**12**

UROLOGY	0	1	0	**1**
WELL BABIES	3	2	1	**6**
ZZZ Treatment not known	4	0	0	**4**
Total	**90**	**78**	**85**	**253**

Our Process for Learning from Hospital Mortality

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

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

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

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

Going forward it is proposed that the business case for an ME role be developed using a two tier approach to reviewing the deaths that occur in the trust.

It is proposed that the ME role would provide support and teaching for junior staff to ensure effective and timely completion of death certificate, liaise with all bereaved families supported by the bereavement team, undertake an initial review of all deaths occurring in the trust, identify all deaths requiring a formal review, liaise and support the clinical teams in ensuring effective and timely reviews are undertaken to ensure that issues in care or process that may have contributed to a death are identified , acted on and lessons are learnt. Develop a close working relationship with the coroner. In addition the role would support the national ME agenda and delivery of objectives, bereaved families and the objectives in relation to engaging with families

as determined in the NQB guidelines. This role would support in the national death investigation agenda. Appendix 9

This role would require additional funding approximately £140k for the ME role and £50k for administrative support

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

Flags Applied	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
1. All deaths where bereaved families and carers or staff have raised a significant concern about the quality of care provision	3	5	4	5	7	11	3	5	1	3
2. All patients with a learning disability	0	0	0	0	1	1	1	0	TBC	TBC
3. All patients with a mental health illness	0	0	0	0	0	0	0	0	TBC	TBC
4. All maternal deaths	0	0	0	0	0	0	0	0	0	0
5. All children and young people up to 19 years of age	0	1	2	0	0	0	0	0	1	0
6. All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work	0	0	0	0	0	0	0	0	0	0
7. All 0-1 day LOS who are not receiving specialist palliative care	11	13	12	8	21	13	23	22	12	14
8. All patients admitted out of hours who die within 5 days, excluding those receiving specialist palliative care	46	14	20	14	23	15	34	34	27	18
9. All elective surgical patients	0	1	0	2	0	2	0	1	0	1
10. All none elective surgical patients	10	13	11	3	8	10	11	15	13	11
11. All unexpected deaths/ coroner reported	-	-	-	-	5	19	21	TBC	TBC	13
12. Deaths in critical care	8	5	5	6	15	10	8	15	8	14
13. A random selection of 20% of those other than listed above	6	8	8	6	10	7	6	9	13	10
14. 20 patients per month to be reviewed by the palliative care team to review EOL care	20	20	20	20	20	20	20	20	20	20
15. All deaths were an internal indicator is flagged readmissions within 30days	9	7	10	8	12	7	12	10	8	13
16. All deaths were an internal indicator is flagged readmissions >4 in 12 months	13	10	10	5	6	14	23	18	15	19

Flags Applied	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1. All deaths where bereaved families and carers or staff have raised a significant concern about	2	4	2									

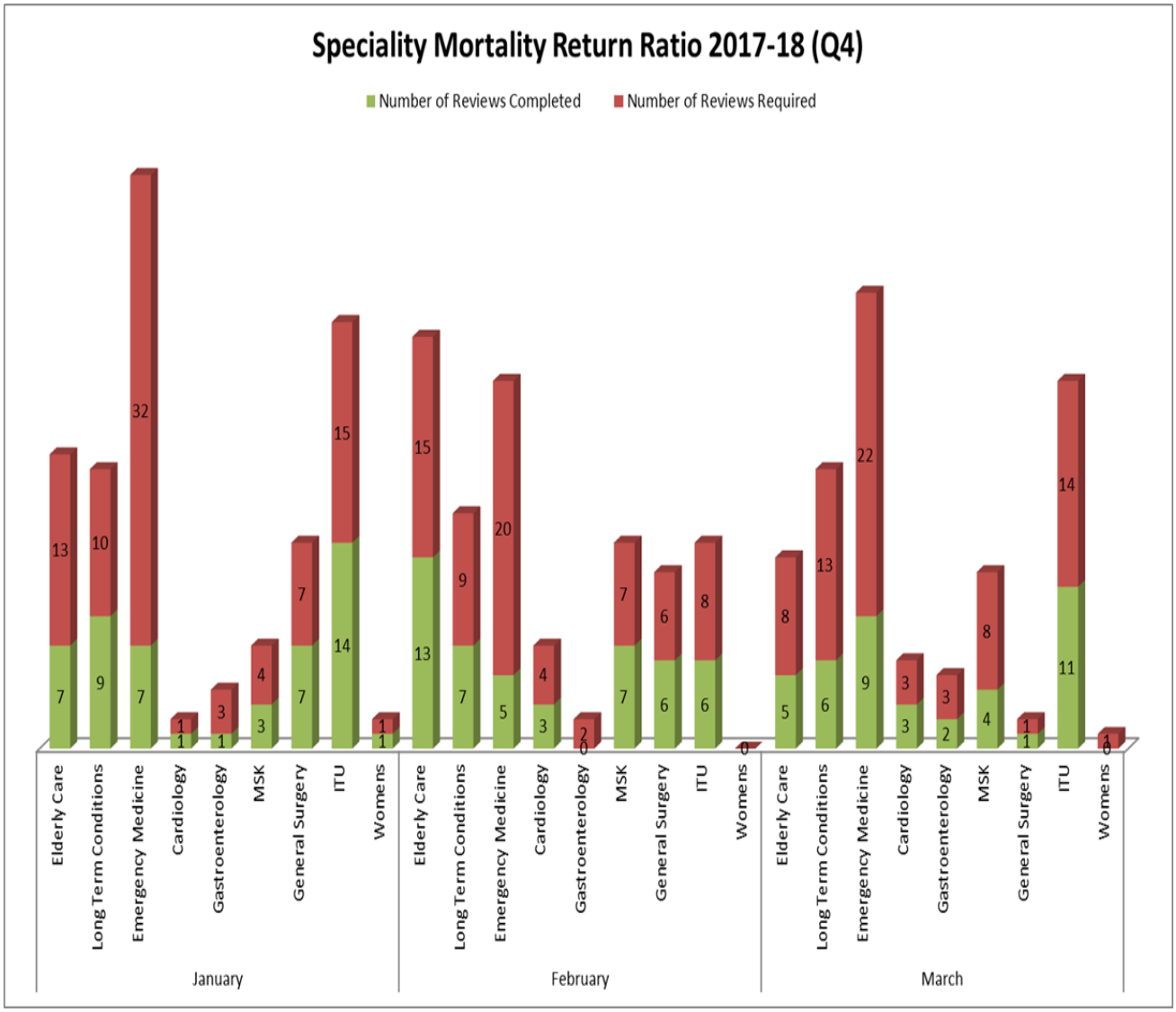
the quality of care provision												
2. All patients with a learning disability	0	0	0									
3. All patients with a mental health illness	0	0	0									
4. All maternal deaths	0	0	0									
5. All children and young people up to 19 years of age	0	0	0									
6. All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work	0	0	0									
7. All 0-1 day LOS who are not receiving specialist palliative care	14	14	7									
8. All patients admitted out of hours who die within 5 days, excluding those receiving specialist palliative care	31	15	21									
9. All elective surgical patients	1	0	0									
10. All none elective surgical patients	11	10	12									
11. All unexpected deaths/ coroner reported	0	0	1									
12. Deaths in critical care	13	2	5									
13. A random selection of 20% of those other than listed above	7	11	9									
14. 20 patients per month to be reviewed by the palliative care team to review EOL care	20	20	20									
15. All deaths were an internal indicator is flagged readmissions within 30days	12	9	7									
16. All deaths were an internal indicator is flagged readmissions >4 in 12 months	8	10	10									

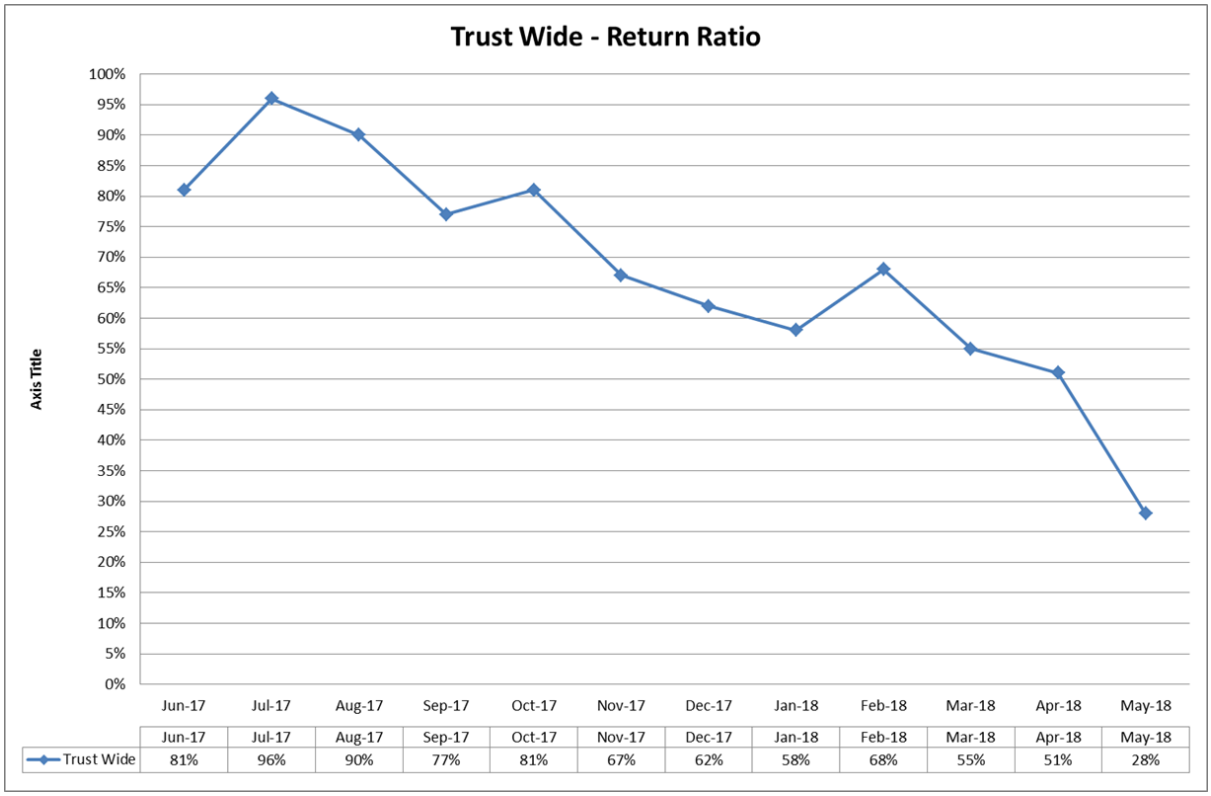
June 2017		July 2017	
Total Number of Deaths	80	Total Number of Deaths	81
Total Number to be Reviewed	62	Total Number to be Reviewed	62
August 2017		September 2017	
Total Number of Deaths	88	Total Number of Deaths	62
Total Number to be Reviewed	52	Total Number to be Reviewed	35
October 2017		November 2017	
Total Number of Deaths	86	Total Number of Deaths	80
Total Number to be Reviewed	68	Total Number to be Reviewed	51
December 2017		January2018	
Total Number of Deaths	133	Total Number of Deaths	139
Total Number to be Reviewed	103	Total Number to be Reviewed	88
February 2018		March 2018	
Total Number of Deaths	113	Total Number of Deaths	113
Total Number to be Reviewed	70	Total Number to be Reviewed	71

April 2018		**May 2018**	
Total Number of Deaths	90	Total Number of Deaths	78
Total Number to be Reviewed	57	Total Number to be Reviewed	40

June 2018		July 2018	
Total Number of Deaths	85	Total Number of Deaths	
Total Number to be Reviewed	55	Total Number to be Reviewed	
August 2018		**September 2018**	
Total Number of Deaths		Total Number of Deaths	
Total Number to be Reviewed		Total Number to be Reviewed	
October 2018		**November 2018**	
Total Number of Deaths		Total Number of Deaths	
Total Number to be Reviewed		Total Number to be Reviewed	
December2018		**January 2018**	
Total Number of Deaths		Total Number of Deaths	
Total Number to be Reviewed		Total Number to be Reviewed	
February 2018		**March 2018**	
Total Number of Deaths		Total Number of Deaths	
Total Number to be Reviewed		Total Number to be Reviewed	

Performance for reviews by specialty





Key themes

Respiratory related diseases continue to contribute significantly to the numbers of deaths and higher HSMR based on observed greater than expected.

Deaths due to pneumonia reported a significant rise during the winter months
Deaths within acute medicine and elderly care continue to see the highest prevalence during the winter months

The number of deaths as reported internally in December, January, February and March have risen significantly compared to the same period last year with December reporting a HSMR of 131.87 and January 112.82. This has since started to fall during Q4.
Deaths have remained high for the months of February and March with a rise in numbers in Gastroenterology and Diabetic specialties. These deaths are to be reviewed by the clinical leads.

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

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

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

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

An MDT review of 17 of this group of patients has been undertaken. Appendix 7
The following themes were identified. Appendix 7

- 8 patients were admitted from NH
- 12 patients were from out of the area or had no registered GP identified
- 6 patients had a pre admission DNAR in place, a higher percentage than that of the previous year.
- The reviewing team identified key areas for further discussion and work, quality of documentation, recognition of the dying patient and advanced care planning across acute and community providers.

A review of ED deaths has been undertaken which identifies similar issues in relation to the late presentation of elderly patients with DNAR in place and the challenges of determining the deteriorating or dying patient.
A review undertaken by the critical care team also identified a number of issues relating to appropriate identification of the dying patient and the importance of communicating with relatives and carers and discussing the possibilities reversibility of a chronic and life threatening condition.

A further more detailed review was undertaken of one of these patients which identified similar issues as a clear advanced care pathway was not documented and was subsequently transferred to ED from Swift Ward where she died

The trend analysis determined by the triggers predetermining the cohorts of patients to be reviewed must be used in conjunction with the review of the individual patients care to determine care or system issues.
The trigger trend analysis, number of deaths, deaths by specialty and diagnostic trends and the national benchmarking data demonstrated through HSMR and SHMI can only be used as a guide as to which deaths we should be reviewing.

This suggests that the critical element to enable us to learn from deaths, identify issues in care or process that are more likely to have contributed to a death is robust case by case review and a robust system for developing action plans and a governance to support changes in practice and process.. It is also essential to review the whole pathway including community care pre admission and post discharge from community teams and GPs.

Internal and external performance data is factual analysis and does not necessarily determine a problem in care but provides a smoke signal as to where to look.
As a health care organisation we are required to assure that the care we provide is optimal and does not contribute to any patient deaths. This can only be achieved through robust analysis of care pathways, care given and identification of areas of care that can be improved upon and sharing areas of good practice

Triangulation of operational and none clinical data

An exercise has been undertaken to analyse operational data to determine any Trends that may co relate to the trusts HSMR and SHMI performance during the period July 2017 to February 2018.
This data demonstrates a number of qualitative trends. Appendix 10

The data demonstrates a number of trends through the winter period, a rise in 4 or more readmissions, emergency readmissions, a rise in deaths for those patients with an age range between 81 and 90 years of age, a rise in ED breaches.
As standalone metrics these do not demonstrate an issue in care or process.
To understand if any of the quantitative and national benchmarked metrics represent an issue in care through review and scrutiny of deaths occurring in the trust is essential.

Acting on Learning

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

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

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

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

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

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

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

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

October 2017	Review of a shared care death JA 100065728. Steis 2017/714529	This death was recorded as an SI and managed via the SI framework. The death was subsequently reported to the coroner	An RCA has been completed, the coroner's report is complete	RCA action plan attached. Action plan completed and coroners recommendations addressed.  Remedial Action Plan 2017-14529.docx	SA	**November 2017 complete**
November 2017	Review of a sepsis related death IM 100112855 STEIS 2017/29009	The death was reported on safeguard by the ICT reported as an SI	An RCA has been undertaken , outcome has been considered to be unavoidable Lessons learnt action plan development in progress	Due date for report 22 February 2017	LR	**March 2018**
November 2017	Patient AS	Death of a patient in MLTC. Recorded within safeguard, possible HCAI.		This has been recorded via safeguard, to be reviewed as SI. Reviewed not SI	SA	**February 2018 complete**
January 2018	Patient. SH. SI number 83455. Unit number 300440921	Medical patient died of a ruptured aneurysm during transfer to another provider		This has been recorded as an SI and an RCA is to be undertaken. RCA complete 25/1. Coroner 27/3. No PFD served. RCA actions to be monitored through RMC	SA	**March 2018 Complete**
January 2018	Patient BT SI number 2018/898 Unit number 300718440	Surgical patient. Deteriorating patient and escalation processes followed by the team are to be reviewed		This has been recorded as an SI and an RCA is to be undertaken w/c 26/2. Outcomes and action being monitored through RMC. RCA complete 5/4	JR	**March 2018 complete**
January 2018	Review of ED deaths	Review of all deaths occurring in ED between Oct-Dec 2017. Identified	Issues relating to poor documentation to be taken to the ED quality group in	Further review to be presented . Reviews presented. Issues discussed relating to late	DC	**March 2018 Complete**

		poor documentation	February Further review of 2 patients to be undertaken to provide more detail relating to the timeline of care. 100052183 100096746	presentation , ceiling of care , DNAR in place on arrival		
January 2018	Pt 300799748	Patient receiving chemotherapy , review to be undertaken		Presentation by the oncology team identified key issues and recommendations. Key message relates to optimising time for referring to the oncology team for MDT discussion and advice regarding acute medical condition in conjunction with oncology treatment or clinical condition relating to oncology treatment. Key action to communicate oncology referral process and guidelines to all key staff.  Oncology Mortality Review.pptx	NA/NA	**March 2018 Complete**
February 2018 MLTC	Review of deaths admitted out of hours with a LOS of 0-1 day			Similar trend to the previous year with an increased prevalence of patients presenting with a DNAR, late presentation and challenging decision of dying or deterioration. Frail elderly patients with previous admissions and multiple co morbidities. Information to be		**April 2018 Complete**

				shared with CCG  Review of Deaths Occurring during Dec		
February 2018	PT VS 300615177 steis 2018/912	Fracture following a fall		SI, RCA undertaken, referred to coroner. Inquest to take place 4 July. A verdict of an accident,contributed to by neglect. A deep dive of fracture neck of femur patients has been requested for deaths during February		~~**April 2018**~~ **July 2018 August 2018**
February 2018	PT MS 300502778 Steis 2017/28914	Shared care urology and Gynae		SI,RCA, referred to coroner PFD notice served Actions to be monitored through RMC		**April 2018 complete**
March 2018	Review of HSMR outliers fluid and electrolyte imbalance as alerted by RIC London for the period October 2017 to December 2017	HSMR outlier		The group of patients have been reviewed, areas to be addressed, documentation at point of entry regarding FCE. The clinical coding department will review all records to ensure coded accurately. Review of patient records demonstrates a group of patients with multiple underlying comorbidities. Clinical coding has been reviewed , a number of adjustments have been made to coding outcomes as appropriate for those patients with AKI relating to an underlying diagnosis		**April Complete**
March 2018	Patient BT SI 2018/898	Surgical patient		RCA undertaken , issues relating to escalation,		**March complete**

				contemporaneous record keeping and response for senior surgical review. Actions from RCA to be monitored through RMC.		
May 2018	Review of HSMR outlier x 2 for January 2018	HSMR outliers for colon cancer and ALD		Initial review of outliers demonstrates significant disease progression		**May complete**
May 2018	Review of a patient transferred from Swift Ward to ED who subsequently died	Limited evidence of advanced care plan and discussions with the family.		To be shared at grand round	EW	**June 2018**
May 2018	Patient CW nhs no 4547185905 S 2017/29015	Relative complaint and RCA		Relative complaint relating to care and unclear diagnosis , RCA undertaken following SI relating to infection control and escalation concerns., external review requested. Lessons learnt : improve MDT working and communication and subsequent documentation, early involvement of critical care, poor documentation, increased training in sepsis and deterioration, improve cannula care, improve communication with the family.	RCA actions being managed and monitored through RMC. Complaint from family on-going , external case review requested	**August 2018**
June 2018	Review of critical care deaths	Presentation by Dr Karavi		 Mortality review of ICU 1 day deaths.pp Presentation identified lessons learnt in relation to escalation to the critical care outreach team , discussions		**Complete July 2018**

				with families relating to advanced care pathways for those patients with possible EOL care needs.		

Conclusion

Year to date HSMR has risen to above 100 rising to 131.87 for the month of December and falling to 112.81 for the month of January and falling again for February and March resulting in a YTD. Performance of 101.06. SHMI has reported at above 100 for 3 consecutive months resulting in a rise of above 100 year to date but has not been reported since month 9.
Primarily there are no significant CuSum concerns, CuSum has risen to 1.96 predominantly relating to respiratory disease related deaths and a number of HSMR outliers currently being reviewed.
An alert form the Imperial College London has identified an outlying HSMR relating to electrolyte and fluid imbalance as a cause of death. Initial review has not demonstrated any areas of concern. A review of the coding for these patients will be undertaken.
Outliers of HSMR for January do not identify any initial areas of concern.
Respiratory disease related deaths contribute significantly to the total deaths seen.
Initial findings of review of high HSMR diagnostic groups and the deaths occurring in December and January admitted out of hours with a short LOS demonstrate trends relating to, frail elderly patients and those with end of life requirements. A number of patients were determined as dying, DNARCPR in place, these trends were reflected following review of patients admitted, deaths in ED and also deaths occurring in critical care.

Following the review of deaths and lessons learnt for the reporting period and as part of the Trust's submission for the Annual Account Appendix 8. Specific themes relate to

- the quality of documentation
- communication for internal referrals
- escalation and management of the deteriorating patient
- Management of the dying patient and development of advanced care pathways across the acute and community settings
  including discussions with families

The actions arising from these issues are being addressed via the SI framework and monitored through the Risk Management Committee.

WMQRS will be undertaking a review of practice relating to sepsis and the deteriorating patient during August and September

A trust wide process for internal referrals has been implemented

In addition a trust wide, specialty specific audit of medical and nursing documentation will be undertaken in response to findings from Learning from Death processes and to a CQC regulatory breach alert.

Performance for undertaking reviews of deaths remains below the required level presenting challenges in determining , evidencing and acting on any issues in care or system and subsequently assuring that the trust is sighted

on reducing SHMI and HSMR or evidencing that this performance is not as a result of quality of care across the health economy. The evidence suggests that there are several strands of work to be undertaken across the health economy to reduce avoidable admissions, earlier presentation, advanced care pathways and joint working with community teams to support anticipatory care of elderly patients at risk during the winter period.

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

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

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

Recommendations

- Undertake a review of patients with fracture neck of femur during February. Mr Selzer and the T&O team. August 2018
- Review trends relating to February and March deaths for Gastroenterology and Diabetes.
- Review HSMR outliers on a monthly basis. JA/NW monthly on going
- To achieve 100% reviews as per cohorts each month all care groups
- Escalate to DDs and CDs poor performance in reviewing deaths. Clinical audit team. On going
- Align the actions to address poor documentation to the CQC PCIP work relating to documentation. AHK/KB August 2018
- Undertake a trust wide documentation audit AHK/KB
- The Executive support the implementation of the ME role, mortality lead, mortality reviewers, associated administration support and the associated cost pressure. Develop a paper for the ME role NA/JA. July 2018
- Ensure mortality reviews are a standing agenda item at care group quality meetings and actions are developed and monitored through the divisional quality teams.
- Triangulate December and January mortality analysis with operational performance data. JA July 2018

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

- Going forward the Trust will align to the NQB Learning from death recommendations reviewing key cohorts of patients. This may not be 100% of the total deaths but the Trust will be working towards reviewing 100% of the selected cohort.
- From June 2017 the revised cohort of patients has been selected for review commenced
- A further revision of the cohorts selected will be applied for deaths occurring in August to incorporate multiple admissions in year and those readmitted within 30 days of a previous discharge.

- A nominated trust Lead for Mortality has been identified. The Trust is represented at the BCA Learning from Deaths forum.
- Specialty leads have been identified to lead on mortality
- Training provided by the RCP has been secured for October and November for 11 clinicians. The SJR tool will be revised further
- Work has been completed on the development of a trust policy this has been circulated internally and externally to the trust appendix 3. A further revision has been undertaken following a peer comparison exercise
- Robust governance will be implemented within specialties to ensure the clinical leads are taking ownership of learning from deaths and reviewing, identifying issues, developing action plans and sharing learning through the Mortality Surveillance Group.
- Work is continuing with the clinical governance and patient safety teams to ensure all deaths under review via the safeguarding framework are captured within the reporting process
- Collaborative work is being undertaken with the information services and performance team to develop robust reporting systems. A suite of reports has been developed to contribute to the monthly mortality paper and presentation to the Mortality Surveillance Group to communicate themes and performance to the clinical teams Appendix 6
- The Trust continues to develop and embed a robust process for monitoring and reporting deaths aligning to national recommendations including engagement with Dudley and Walsall Mental Health Trust to develop a method of notification of deaths within the trust for patients with a mental health illness.
- Collaborative work is being undertaken with the CCG to share learning from mortality reviews to contribute to reducing deaths in hospital, support care closer to home, reduce inappropriate admissions and reduce LOS. The findings of reviews of deaths in hospital will be able to contribute to the commissioners' strategy of reducing death in Walsall.

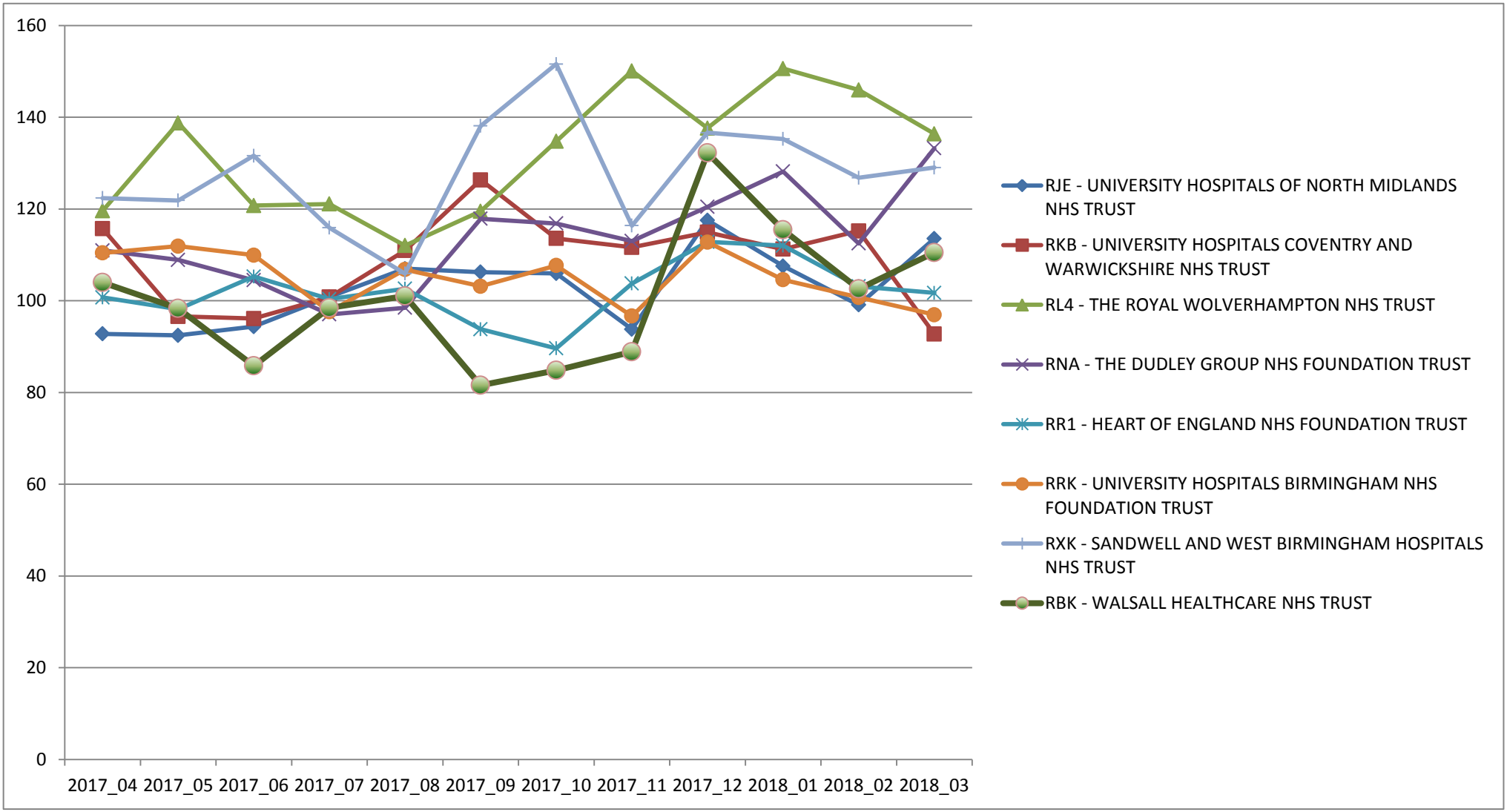
Appendix 1

	Bed days	Hospital Inpatient Deaths	Per 1000 bed days	HSMR Spells (discharges)	Deaths HSMR Basket	Expected HSMR Deaths	Excess Deaths	HSMR	Deaths in hospital	Deaths 30 days discharge	Total deaths	SHMI Monthly	SHMI adjusted Palliative Care	Crude Mort D/Di
Jul-15	**17685**	**65**	**3.68**	**1663**	**62**	**79.16**	**-17.16**	**78.32**	**63**	**38**	**101**	**86.09**	**73.79**	**3.73%**
Aug-15	**15254**	**45**	**2.95**	**1566**	**37**	**62.67**	**-25.67**	**59.03**	**42**	**41**	**83**	**82.81**	**73.32**	**2.36%**
Sep-15	**16789**	**85**	**5.06**	**1729**	**70**	**81.91**	**-11.91**	**85.46**	**83**	**38**	**121**	**101.40**	**86.63**	**4.05%**
Oct-15	**17663**	**99**	**5.6**	**1778**	**85**	**84.2**	**0.8**	**100.95**	**96**	**32**	**128**	**103.17**	**89.15**	**4.78%**
Nov-15	**17236**	**92**	**5.33**	**1796**	**86**	**91.83**	**-5.83**	**93.65**	**91**	**51**	**142**	**114.10**	**99.12**	**4.79%**
Dec-15	**18155**	**110**	**6.06**	**1969**	**92**	**105.53**	**-13.53**	**87.18**	**108**	**46**	**154**	**109.60**	**95.77**	**4.67%**
Jan-16	**17524**	**114**	**6.5**	**1891**	**101**	**96.77**	**4.23**	**104.37**	**113**	**41**	**154**	**110.12**	**100.38**	**5.34%**
Feb-16	**17481**	**98**	**5.61**	**2042**	**89**	**97.61**	**-8.61**	**91.18**	**95**	**26**	**121**	**94.78**	**81.88**	**4.36%**
Mar-16	**17324**	**110**	**6.35**	**1911**	**92**	**96.06**	**-4.06**	**95.77**	**106**	**32**	**138**	**105.23**	**92.23**	**4.81%**
Apr-16	**17536**	**104**	**5.93**	**1992**	**90**	**87.98**	**2.02**	**102.3**	**102**	**49**	**151**	**117.71**	**105.47**	**4.52%**
May-16	**15519**	**72**	**4.7**	**2050**	**63**	**76.13**	**-13.13**	**82.75**	**70**	**33**	**103**	**92.97**	**83.13**	**3.07%**
Jun-16	**17807**	**79**	**4.43**	**2120**	**70**	**83.35**	**-13.35**	**83.98**	**76**	**36**	**112**	**90.45**	**78.27**	**3.30%**
Jul-16	**16733**	**84**	**5.02**	**2033**	**69**	**79.52**	**-10.52**	**86.77**	**82**	**33**	**115**	**96.97**	**82.12**	**3.39%**
Aug-16	**17065**	**83**	**4.86**	**2072**	**75**	**81.65**	**-6.65**	**91.85**	**83**	**36**	**119**	**100.44**	**83.85**	**3.62%**
Sep-16	**15761**	**69**	**4.37**	**2100**	**64**	**80.46**	**-16.46**	**79.54**	**65**	**36**	**101**	**92.00**	**77.66**	**3.00%**
Oct-16	**17014**	**94**	**5.5**	**2124**	**81**	**76.2**	**4.8**	**106.3**	**93**	**38**	**131**	**115.37**	**98.38**	**3.81%**

Nov-16	16416	80	4.8	2371	66	82.18	-16.18	80.31	78	43	121	96.90	85.32	2.79%
Dec-16	18008	132	7.3	2249	116	99.37	16.63	116.74	130	49	179	133.21	114.77	5.06%
Jan-17	17177	141	8.2	2192	122	101.8	20.2	119.84	140	49	189	132.76	116.82	5.24%
Feb-17	16094	88	5.46	2060	77	82.8	-5.8	92.99	83	47	130	109.00	93.9	3.88
Mar-17	17041	96	5.16	2381	87	107.95	-20.95	80.59				103.32		
16/17	-	1122	-	25744	980	1039.4	-59.4	94.29	-	-	-	107.40	-	3.8
Apr-17	15924	90	5.65	1884	82	78.31	3.69	104.71	88	42	130	106.68	93.41	4.35
May-17	13785	94	6.82	2218	80	81.8	-1.8	97.8	90	54	144	110.10	96.33	3.61
Jun-17	17629	81	4.59	2101	71	83.34	-12.34	85.19	80	37	117	86.40	75.8	3.38
Jul-17	15495	80	5.16	2036	71	72.9	-1.9	97.39	79	34	113	90.69	80.42	3.49
Aug-17	16025	91	5.67	1844	76	75.83	0.17	100.22	90	40	130	99.28	88.91	4.12
Sep-17	14422	63	4.36	1701	58	71.74	-13.74	80.85	62	55	117	94.05	83.8	3.41
Oct-17	14871	86	5.7	1766	66	78.42	-12.42	84.16	84	51	135	101.03	89.68	3.74
Nov-17	15082	80	5.3	1912	68	77.21	-9.21	88.07	76	51	127	103.66	90.43	3.56
Dec-17	16400	133	8.1	1765	117	89.2	27.8	131.16	136	35	171	127.25	115.6	6.57
Jan-18	17231	131	7.6	1874	124	108.06	15.94	114.75	0					6.51
Feb-18	16284	106	6.5	1712	101	95.11	5.89	106.19	0					
Mar-18	16833	107	6.3	1679	89	80.55	8.45	110.5	0					
YTD		1142						101.06				104.23		4.25
Apr-18	16733	90	5.3											

May-18	**15118**	**78**	**5.1**											
Jun-18	**15124**	**85**	**5.6**											

Appendix 2


160
140
120
100
80
60
40
20
0
2017_04
2017_05
2017_06
2017_07
2017_08
2017_09
2017_10
2017_11
2017_12
2018_01
2018_02
2018_03
RJE - UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
RKB - UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
RL4 - THE ROYAL WOLVERHAMPTON NHS TRUST
RNA - THE DUDLEY GROUP NHS FOUNDATION TRUST
RR1 - HEART OF ENGLAND NHS FOUNDATION TRUST
RRK - UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
RXK - SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
RBK - WALSALL HEALTHCARE NHS TRUST

APPENDICES
(list any appendicies)

Appendix 4
Community report and action plan


Mortality Report.docx


Action Plan - Mortality Review.odt

Appendix 4.


Mortality Report.docx

Appendix 5


Mortality Screening Review.pdf

Appendix 6


MortalityReporting_Pub201804.pdf

Appendix 7

Review of Deaths Occurring during Dec

Appendix 8

Annual Quality Account Mortality 201

Appendix 9

https://www.rcpath.org/asset/6AF88A4F-1ECE-4851-AD18C0EC4055F2F4/

Appendix 10

JA_MortalityReview_ 20180618.xlsx

MEETING OF THE PUBLIC TRUST BOARD – 2nd August 2018			
Freedom to Speak Up: Walsall Healthcare NHS Trust Self Review			**AGENDA ITEM: 12**
Report Author and Job Title:	Freedom to Speak Up Guardians Kim Sterling, Valerie Ferguson, Shabina Raza	**Responsible Director:**	Interim Director of Human Resources and Organisational Development Louise Ludgrove
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	Sir Robert Francis' review of whistleblowing in the NHS, 'Freedom to Speak Up' (FTSU), was published in February 2015. It set out a number of principles that NHS organisations should adopt in order to ensure that NHS staff are encouraged and supported to share concerns and states that is the responsibility of every NHS Trust to appoint a Freedom to Speak up Guardian (FTSUG). WHT recruited three FTSUGs to advise and support members of staff if they wish to raise a concern. NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up to help boards create a culture that is responsive to feedback and focused on learning and continual improvement. Since our last report, FTSUG team has been extremely challenged and these difficulties are set out here. The team is now re-established and the FTSUGs have produced this report to highlight a new action plan for Speaking Up in WHT. The Speaking Up agenda assists the trust to meet key priorities of improving patient safety and developing the culture of the organisation.		
Recommendation	That the Trust Board notes the report and approves the action plan and pledge to become more visible to Walsall Employees and commit to re-launching Speaking up.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline			
Resource implications			
Legal and Equality and Diversity implications			

Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Freedom to Speak Up: Walsall Healthcare NHS Trust Self Review

Sir Robert Francis' review of whistleblowing in the NHS, 'Freedom to Speak Up' (FTSU), was published in February 2015.

'Freedom to Speak Up 'concluded that the NHS does not consistently listen or act on concerns raised by whistle-blowers and that some individuals have suffered appallingly for raising concerns. It set out a number of principles that NHS organisations should adopt in order to ensure that NHS staff are encouraged and supported to share concerns.

Effective speaking up arrangements are important to help to protect patients and improve the experience of NHS workers. The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question.

NHS Improvement and the National Guardian's Office (NGO) have published a guide (see Appendix 1) setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

The self-review tool accompanying the guide (see Appendix 2) enables trust boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Speaking Up agenda goes someway to enable the trust to meet key priorities of improving patient safety and developing the culture of the organisation.

Challenges at WHT

- Multiple changes at board level including CEO, Director of HR/OD, Director of Governance, and Head of Nursing
- Resignation of NED for Speaking up
- Resignation of one of FTSU Guardians (FTSUGs)
- Protected time for one of the FTSUGs denied
- Delays in recruitment to FTSU Guardian and NED

- Initial plans for FTSUGs including promotional work put on hold as there has only been one FTSUG in post
- The NED vacancy and absent FTSUG has hindered fostering engagement with senior leaders and line managers to progress their commitment to Speaking Up
- It has proved difficult for the FTSUGs to co-ordinate their activities alongside their clinical workloads and to consistently maintain records of their Guardian activities, because of the issues outlined above.
- quantitative and qualitative data collection issues
- Reduction in the number of concerns brought to FTSUGs

With these difficulties, the Speaking Up agenda has stalled and it has not been possible to effectively meet the standards set out in the Guidance for Trust and Foundation Trust Boards on Freedom to Speak Up.

What has worked well at WHT

- FTSU Guardians meet bimonthly with both Chair of board and CEO to discuss common themes and obstacles to the role being carried out effectively.
- Continued support for FTSUGs from the Interim Director of HR and OD.
- Access to the CEO to escalate patient safety concerns promptly.
- Action by divisional leads to change systems of work following concerns raised via FTSUGs
- Continued presence at trust induction for new employees

Areas to be considered for development

The review indicators taken from the self-review tool have been used as the basis for a revised action plan on Speaking for WHT (see Appendix 3).

Recommendations

That the trust board notes the report and approves the action plan and pledge to become more visible to Walsall employees and commit to re-launching Speaking Up.

Appendix 1

Freedom_to_speak_ up_guidance_May201

Appendix 2

FTSU_self_review_to ol_May2018.docx

Appendix 3

Action Plan

Review Indicator (National Guardians Office)	**Actions required for Development**	**Date for Review**
Leaders are knowledgeable about FTSU	NGO bulletin summary to be forwarded to board and CEO Wider involvement of board and VSMs through more frequent reporting	As received
Leaders have a structured approach to FTSU	Re-establish Openness and Transparency Working Group on a temporary basis to write vision statement and incorporate into strategy.	6 months

	Group membership to include board members, FTSUGs, Director of HR, NED for speaking up, Staff Side. CEO and board incorporate their commitment to speaking up in a trust video for use at staff meetings and trust induction.	6 months
Leaders need to be confident that wider concerns are identified and managed	Guardians to establish protocol for working with Clinical Divisions	9 months
Leaders actively shape the speaking up culture	Signing a pledge to be more visible to Walsall employees and commit to re launching speaking up Training for board members. Boardwalks, attendance at staff meetings Each board member holds their colleagues to account on speaking up	6 months
Leaders are clear about their role and responsibilities	Identify a new NED to support the FTSUGs/Speaking Up	Immediate
Leaders are confident the wider concerns are identified and managed	Develop feedback system to inform board regularly	6 months
Leaders receive assurance in a variety of forms	FTSUGs assist with formation (or relaunching) of employee support groups Set up evaluation process for FTSU	9 months
Leaders engage with all relevant stakeholders Leaders are focused on learning and continual improvement	Collaborative work with Engagement Lead. FTSUGs to report on Case Reviews	6 months As they are published
HR and OD	Training for managers – compassionate training Roll out Mandatory HEE FTSU training via ESR	12 months 12 months

	Collaborative work to share intelligence Ensure that FTSUG has support of HR staff and access to information for triangulation of data	6 months
Executive Lead for FTSU	Reinforcement of divisional heads commitment to Speaking Up and enforce FTSUGs protected time.	6 months
Medical Director and Director of Nursing	Collaborative work so that FTSU is on the agenda for in house medical conferences. Ensure that learning is operationalised within their teams/departments and share outcomes with guardians	6 months

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	FTSUGs meet bimonthly with both Chair of board and CEO to discuss common themes and obstacles to the role being carried out effectively.	Wider involvement of board and VSMs through more frequent reporting	Trust board
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.		Obtain a slot at forums where VSM meet eg Divisional team meetings SNAG	

They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Not met		
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Needs to be developed	Leadership conference	
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Partially. Initiated at the former Openness and Transparency SG		
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Revised when FTSUGs came into post		Raising Concerns at Work (Whistleblowing policy) available through Trust intranet
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian)and it aligns with existing guidance from the National Guardian.	Partially		
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative	Not met		

and quantitative measures.			
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Not met		
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.			
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Not met		
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Yes		
Other senior leaders support the FTSU Guardian as required.	Partial	More readily initiate feedback to FTSUG on the progress of investigations.	

		Give appropriate feedback to person who has disclosed concern. Response rates within timeframe set out in Speaking up Policy	
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.			
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Met		
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.			Attendance at inductions, team meetings, ward rounds,Daily Dose

			inserts To deliver training as mandatory? HEE resource
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Not met	FTSUGs assist with formation (or relaunching) of employee support groups	
Speak up issues that raise immediate patient safety concerns are quickly escalated	Met		Direct access to CEO
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Not Met		
Lessons learnt are shared widely both within relevant service areas and across the trust			
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented			
FTSU policies and procedures are reviewed and improved using feedback from workers			

The board receives a report, at least every six months, from the FTSU Guardian.	Not met		
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	Engagement Strategy		
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Not met		
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).			
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.			
Reviews and audits are shared externally to support improvement elsewhere.			

Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture			
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Met		Regional Network of FTSUGs
Senior leaders request external improvement support when required.			
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.			
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.			
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.			

Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.			
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Not yet		
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.			Implementation of evaluation process
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and			

objective; recommendations are designed to promote patient safety and learning; and change will be monitored			
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.			Inclusion in induction programme
Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Met		
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.			
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.			
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Partially met		Demonstrate commitment to Speaking up by measuring trust against recommendations

			following NGO case reviews. Sharing the learning
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Met		Diarised meetings for the short to medium term
Executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.			Forwarding emails
Overseeing the creation of the FTSU vision and strategy.	Partially met		
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Met	Recruitment of FTSUG following resignation	Stakeholder event with unseen presentation
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Partially met	Reinforcement of divisional heads commitment to Speaking Up and allow FTSUGs protected time.	

		One of guardians denied access to the role by departmental lead/manager	
Ensuring that a sample of speaking up cases have been quality assured.	Not met		
Conducting an annual review of the strategy, policy and process.	Not met		
Operationalising the learning derived from speaking up issues.			
Ensuring allegations of detriment are promptly and fairly investigated and acted on.			
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.			
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.		Circulate information as it arrives from NGO	
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up		Presentation to the board	

strategy.			
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual mprovement.			
Role-modelling high standards of conduct around FTSU.			
Acting as an alternative source of advice and support for the FTSU Guardian.	Partially		
Overseeing speaking up concerns regarding board members.	Not applicable as yet		
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.			

Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.			
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.		Training for managers – compassionate listening	
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Met		
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Met		
Ensuring learning is operationalised within the teams and departments that they oversee.			

MEETING OF THE PUBLIC TRUST BOARD – 2nd August 2018			
FINANCE REPORT M3 (JUNE)			**AGENDA ITEM: 13**
Report Author and Job Title:	Tony Kettle Deputy Director of Finance	**Responsible Director:**	Russell Caldicott
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	The Trust has attained its planned deficit of £5.6m for the first quarter of 2018/19. However, there are risks associated with the following: • Overspends as a consequence of temporary workforce costs (Nursing & Medical) • CIP delivery profiled into the later half of the financial year including the stretch target of £2.5m to deliver the enhanced plan, improvement of bed occupancy impacting on patient flow and outpatients productivity The Trust will encounter cash difficulties should the current run rate continue and has therefore sought to mitigate the risk of non-delivery of the financial plan through development of a Financial Recovery Plan. The Trust continues to investment in capital projects during 2018/19 (Maternity, ICCU & Emergency Department)		
Recommendation	Members of the Trust Board are asked to: To inform members of the Trust's financial performance for the year to June 2018 (M03) and risks to delivery of the deficit plan for the year of £10.6m. Noting and endorsing the recommendations 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."	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

Finance Report June (M03)

1. PURPOSE OF REPORT

To inform members of the Trust Board of the financial performance of the Trust for the year to date June 2018 (M03)

2. BACKGROUND

The Trust has adopted a financial plan for the 2018/19 financial year that delivers an £10.6m deficit (after PSF). The key component for achievement being delivery of a £15.5m Cost Improvement Programme and mitigation of overspends incurred in the 2017/18 financial year (largely associated with use of temporary workforce).

3. DETAILS

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

- Deficit of £5.6m in YTD (on plan)
- CIP delivered £1.9m YTD (£1.1m non-recurrent) of the £2.4m target
- Temporary workforce costs for June totalled £1.85m (£0.3m higher than June 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 £15.5m 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 (FRP) produced

4. RECOMMENDATIONS

Members are asked to note the reported performance to month 3, the risks to delivery of the planned deficit for the financial year and the development of an FRP to ensure delivery of the 2018/19 financial plan.

APPENDICES

Finance Report June (M03)

Walsall Healthcare NHS
NHS Trust

2018/19 Finance Report
June 2018 (Month 3)

Becoming your partners for first class integrated care

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

Key Messages

Financial **Month 3 plan.**	• The Trust plan is to deliver an £15.6m operational deficit, £10.6m net of Provider Sustainability Fund (PSF) • At month 3 the Trust has a deficit of £5.6m and is on plan • CIP delivery is profiled towards the end of the financial year, temporary workforce exceeding historic levels • The Trust is required to improve on the current run rate significantly to deliver the planned deficit for the year
CIP	• The Trust's Cost Improvement Target for the year is £15.5m (£2.5m higher than the initial plan) • YTD month 3 savings delivered totals £1.9m (£2.4m plan) of which £1.1m was non-recurrent • Increased births delivered at the Trust will off-set £0.35m of the non-recurrent delivery
Bank, Agency & Locum	• Spending on temporary workforce is £1.85m for the month (£0.3m higher than June 2017) • Nursing £0.1m and Medical £0.2m higher than prior year
Capital Developments	• Maternity works continue at pace and the ICCU development is set to open in November 2018 • The Trust is seeking additional capital allocations to support backlog maintenance and equipment purchase

Financial Risks	• CIP Delivery for the financial year requires traction on the 'Improvement Work-streams' with shortfalls driven by:
	  • Patient flow (seeking to improve bed occupancy)
	  • Outpatients delivery of the additional planned activity through productivity gains
	  • Attainment of additional savings schemes to off-set the increased outturn target of £2.5m
	• Overspends in month 3 (largely driven by temporary workforce) giving a run rate risk

Management of the financial risks	• The development of a Financial Recovery Plan (FRP) owned throughout the Trust presented to Performance, Finance & Investment Committee, components being:
	  • Monthly income & expenditure trajectories (by Division & expense category)
	  • Temporary workforce annual expenditure profile (medical and nursing focus)
	  • Mitigations with lead Executive accountable officer that include sale of assets
	  • Monitoring and control mechanisms
	  • Communication strategy
	• The Trust's delivery of the financial plan/outturn has been rated as red (the requirement for an FRP supporting this rating) and delivery at pace of the agreed measures is now a priority to ensure delivery of the financial plan

Summary Financial Performance to June 2018 (Month 3)

Financial Performance - Period ended 30th June 2018

Description	Annual Budget	Budget to Date	Actual to Date		Variance
	£'000	£'000	£'000		£'000
Income					
NHS Activity Revenue	228,269	56,462	56,453		(9)
Non NHS Clinical Revenue (RTA Etc)	586	285	269		(16)
Education and Training Income	6,924	1,762	1,798		36
Other Operating Income (Incl Non Rec)	12,614	2,917	2,922		5
Total Income	**248,393**	**61,427**	**61,442**		**15**
Expenditure					
Employee Benefits Expense	(174,566)	(43,067)	(43,713)		(646)
Drug Expense	(8,377)	(4,486)	(4,444)		42
Clinical Supplies	(17,564)	(4,480)	(4,642)		(162)
Non Clinical Supplies	(15,544)	(3,957)	(4,114)		(157)
PFI Operating Expenses	(5,079)	(1,299)	(1,283)		16
Other Operating Expense	(23,269)	(5,796)	(4,951)		844
Sub - Total Operating Expenses	**(244,400)**	**(63,085)**	**(63,147)**		**(62)**
Earnings before Interest & Depreciation	**3,992**	**(1,658)**	**(1,705)**		**(47)**
Interest expense on Working Capital	51	13	11		(2)
Interest Expense on Loans and leases	(8,114)	(2,349)	(2,406)		(57)
Depreciation and Amortisation	(6,560)	(1,640)	(1,514)		126
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(14,623)**	**(3,976)**	**(3,909)**		**67**
Total Expenses	**(259,024)**	**(67,061)**	**(67,056)**		**5**
RETAINED SURPLUS/(DEFICIT)	**(10,631)**	**(5,634)**	**(5,614)**		**21**
Adjustment for Gains on Donated Assets			(2)		(2)
Adjusted Financial Performance (Control Total)	**(10,631)**	**(5,634)**	**(5,616)**		**18**

Financial Performance

- The total financial position for the Trust at M3 is a deficit of £5,616k and is on plan resulting in the Trust being able to receive Provider Sustainability funds (PSF) totalling £0.7m
- The contracted income is on plan after adjustment for delivery of income CIP schemes (elective activity above contracted levels). However, the Trust is below contracted activity for Obstetric (births) and is not delivering the outpatients productivity targeted within the plan
- 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
- The main area of overspending is pay owing to the continued use of high cost temporary staffing in Medical and Nursing. The overspending on non-pay relates mainly to non delivery of CIP in month

CIP 2018/19 Delivery

- The Trust's Annual Cost Improvement Programme requirement is £15.5m (including the £2.5m to attain the enhanced outturn for the financial year).
- YTD month 3 savings delivered totals £1.9m (£2.4m plan) of which £1.1m was non-recurrent
- Key risks are outpatient productivity, the improvement in bed occupancy and the additional £2.5m increase in target to attain the financial plan

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding is £1.1m
- The Trust's agreed borrowing for 2018/19 is £10.6m, reflecting the deficit plan. The interest payable on increased borrowing adds to the future savings requirement

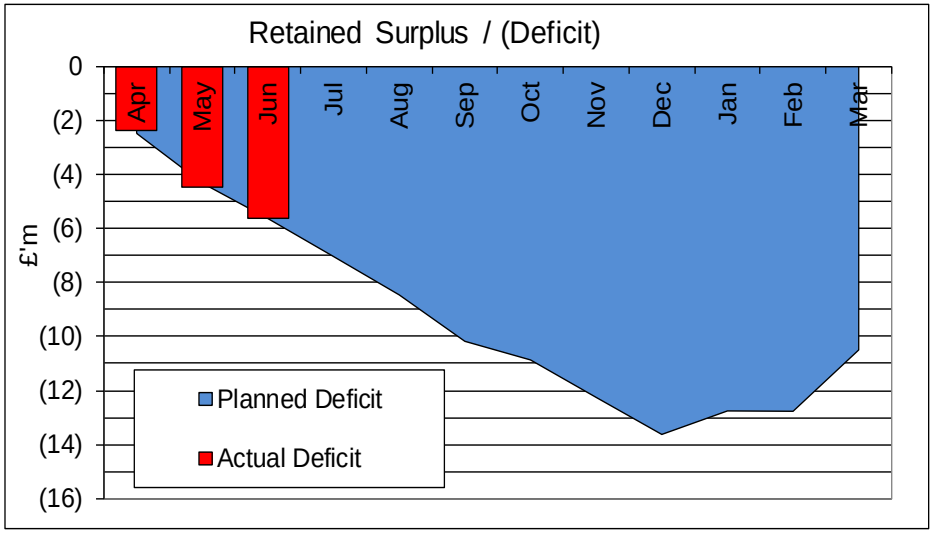
Capital

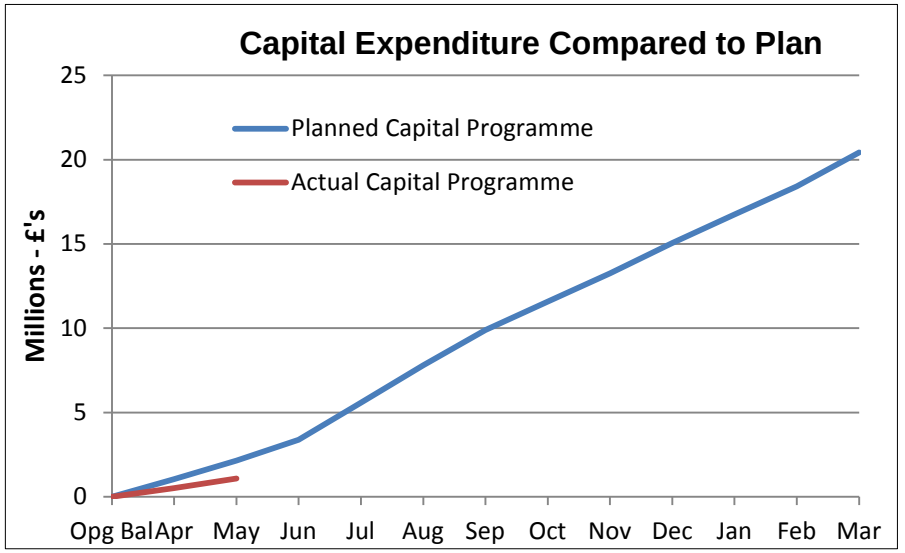
- The year to date capital expenditure is £2.5m, with the main spends relating to ICCU with the development set to open in November 2018 (£1.4m) and Maternity (£0.4m) following commencement of the multi-million pound development.

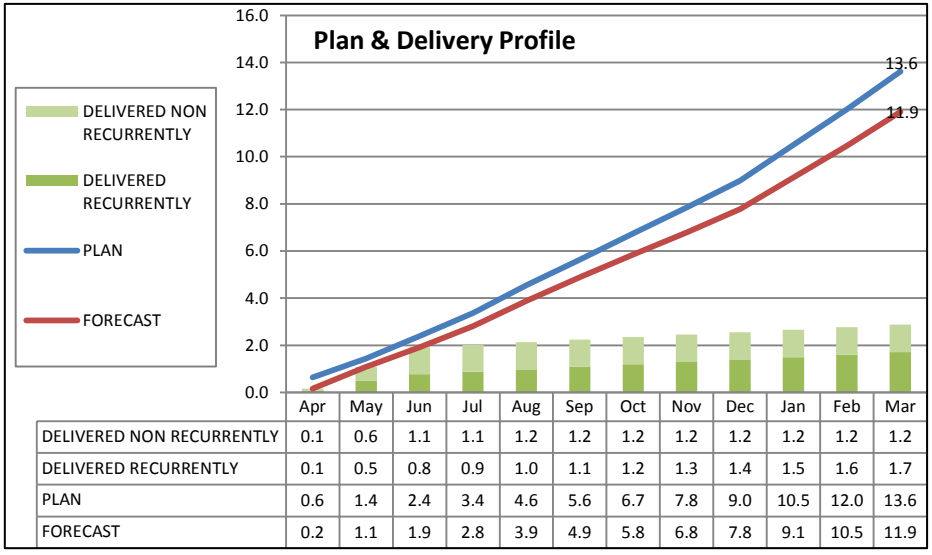
Temporary Workforce

- Total expenditure on temporary workforce is £1.85m (June 2018). Agency reducing by £0.1m off-set by an increase in Bank by £0.1m and £0.3m higher than historically
- Medical locum expenditure is the highest in the previous 12 months, though agency medical reduced in month

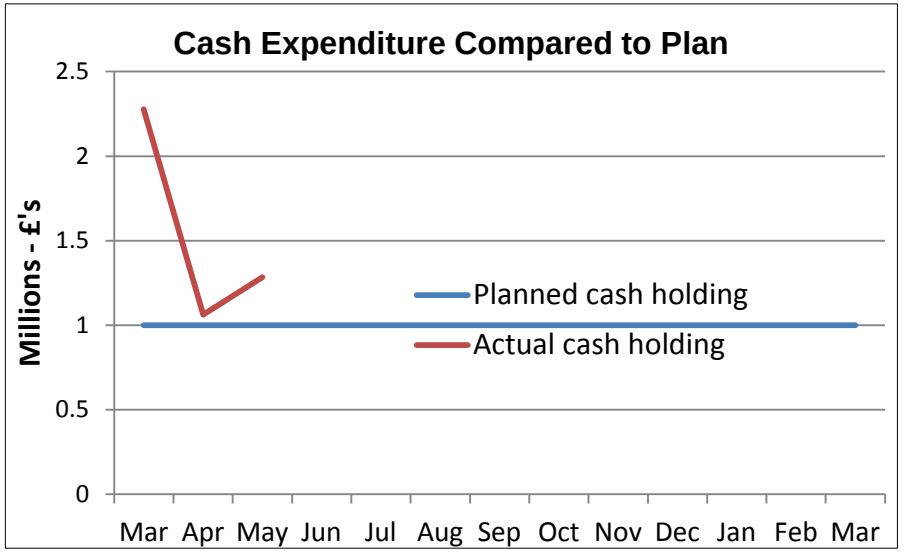
Overall Summary and RAG Assessment continued



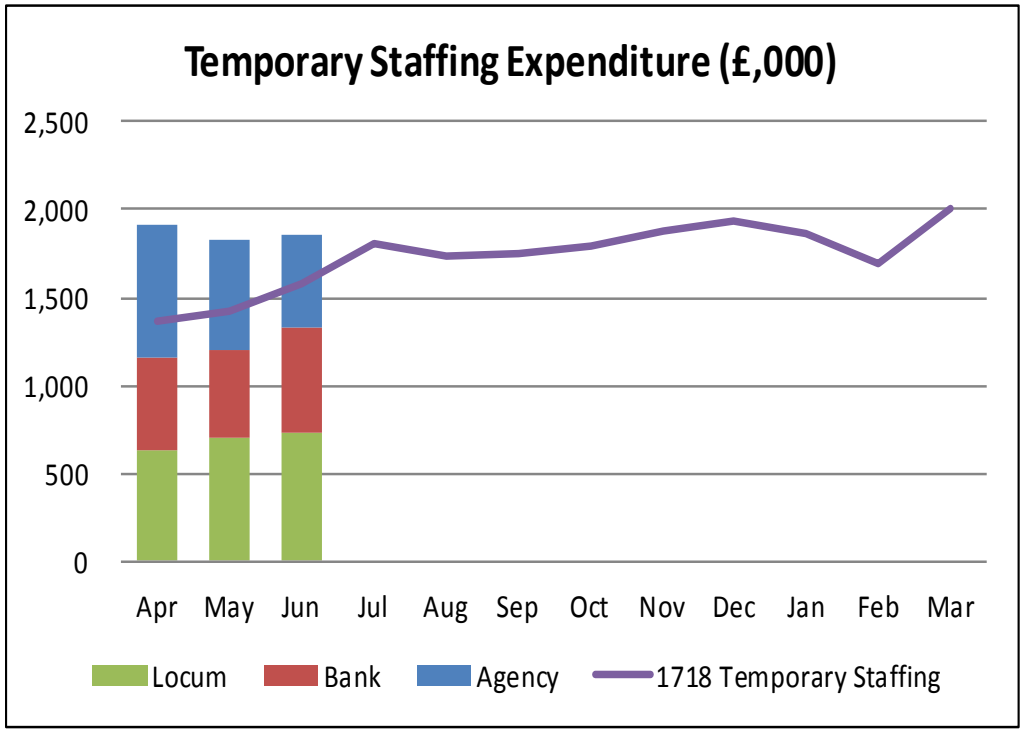




	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.1	0.6	1.1	1.1	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2
DELIVERED RECURRENTLY	0.1	0.5	0.8	0.9	1.0	1.1	1.2	1.3	1.4	1.5	1.6	1.7
PLAN	0.6	1.4	2.4	3.4	4.6	5.6	6.7	7.8	9.0	10.5	12.0	13.6
FORECAST	0.2	1.1	1.9	2.8	3.9	4.9	5.8	6.8	7.8	9.1	10.5	11.9



TEMPORARY EXPENDITURE 2018/19

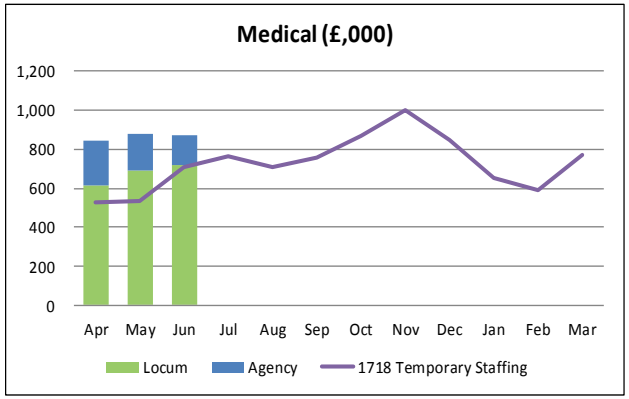


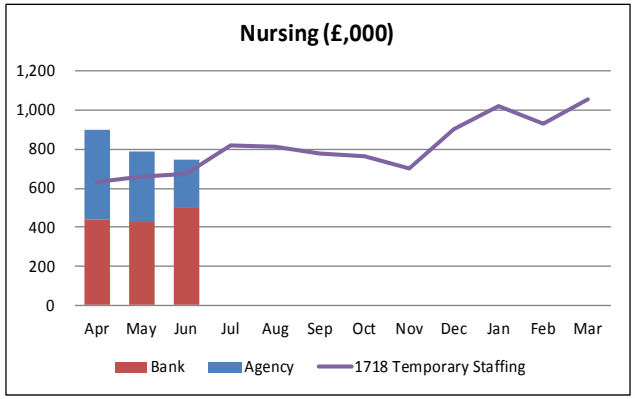
Commentary

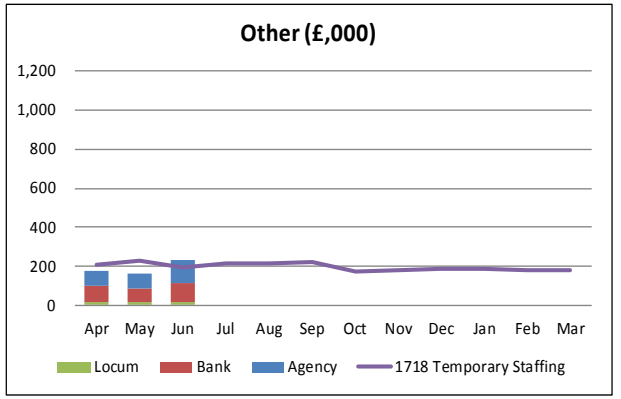
- Temporary staff costs totalled £1.85m in June 2018 (£1.83m May 2018), of which agency is £0.523m.
- The NHS Improvement target for the Trust is to spend no more than £6.5m on agency in 2018/19. This is a £0.5m reduction on 17/18's target and £1m reduction on 17/18's outturn.
- The Table below shows an annual forecast for temporary workforce spending, though early in the financial year to forecast the trend is for expenditure to exceed 2017/18 levels.

Description	2018/19		*2017/18*
	YTD June £000's	Annual £000's	*Annual £000's*
Temporary worker	5,594	23,450	*20,830*
Agency	1,899	7,596	*7,503*

- Total spend in June 18 (£1.85m) is significantly higher than the same period last year (£1.57m June 2017).







Capital Programme

Capital Schemes 2018/19	Annual Plan 2018/19 £'000	Year-to-Date Budget 2018/19 £'000	Year-to-Date Actual 2018/19 £'000	Year-to-Date Variance £'000
Estate				
Life cycle – estate maintenance	1,101	273	582	(309)
Integrated Critical Care Unit	2,907	1,548	1,385	163
Maternity	3,907	1,229	375	854
Accident & Emergency	2,000	0	11	(11)
Medical Equipment Replacement	516	83	31	52
Information Management & Technology				
Hardware & Software	100	25	54	(29)
Total Mobile	100	25	104	(79)
Capital Loan Support (Equipment & Estates)	1,500	0	0	0
Total Cost of Capital Schemes	**12,131**	**3,183**	**2,542**	**641**

Commentary

- The Trust's capital expenditure totals £2,542k as at the 30th June 2018, £641k below the plan mainly due to the delays in the commencement of the Maternity scheme and the ICCU scheme.
- The capital programme totals £12m in month 3 and reflects investment within the maternity scheme and A&E scheme.
- The A&E scheme has been given a high priority by the Black Country STP, and the NHSi have endorsed the Strategic Outline Case (SOC). The Outline Business Case is being reviewed by the regulator.
- The Trust are applying for additional capital loan support for estate maintenance, medical equipment and IT development. The value totals £1.5m and is identified at the bottom of the table.

Statement of Financial Position

Statement of Financial Position	as at 31/03/18	as at 30/06/18	Movement
	£000	£000	£000
Non-Current Assets			
Property, plant & Equipment	138,291	139,345	1,054
Intangible Fixed Assets	1,311	1,342	31
Total Non-Current Assets	**139,602**	**140,687**	**1,085**
Current Assets			
Receivables & pre-payments less than one Year	17,214	20,163	2,949
Cash (Citi and Other)	2,277	1,096	(1,181)
Inventories	2,277	2,511	234
Total Current Assets	**21,768**	**23,770**	**2,002**
Current Liabilities			
NHS Payables less than one year	(7,817)	(2,696)	5,121
Payables less than one year	(22,885)	(29,175)	(6,290)
Borrowings less than one year	(60,740)	(69,499)	(8,759)
Provisions less than one year	(432)	(432)	-
Total Current Liabilities	**(91,874)**	**(101,802)**	**(9,928)**
Net Current Assets less Liabilities	**(70,106)**	**(78,032)**	**(7,926)**
Non-current Assets			
Receivables greater than one year	1,054	1,758	704
Non-current liabilities			
Borrowings greater than one year	(127,859)	(126,935)	924
Total Assets less Total Liabilities	**(57,309)**	**(62,522)**	**(5,213)**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	58,318	58,718	400
Revaluation	16,023	16,023	-
Income and Expenditure	(131,650)	(131,650)	-
In Year Income & Expenditure	-	(5,613)	(5,613)
Total TAXPAYERS' EQUITY	**(57,309)**	**(62,522)**	**(5,213)**

Commentary

Non Current Assets

- The movement year to date is due to depreciation and amortisation being greater than the capital expenditure incurred to date.

Current Assets

- Receivables have increased by £2.95m since 31st March 2018. Invoiced debtors has increased by £0.17m net in month and primarily reflects the invoicing for cancer drugs, M1 maternity pathways and mandate underpayments.
- Cash is £1.2m lower than the balance at 31st March 2018 as the Trust attempts to reduce the level outstanding creditor balances.

Current Liabilities

- Payables have increased slightly reflecting the delays in cash settlement of creditor invoices. The Trust has taken deficit loan support totalling £7.2m in year at the end of June.

Provisions

- The balance of provisions has remained unchanged in May and reflects the non-clinical provisions held by the NHSLA, and a fines provision.

Tax Payers' Equity

- Income & Expenditure reflects the current deficit of £5,613k 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)	(3,222)
Depreciation and Amortisation	1,514
Donated Assets Received credited to revenue but non-cash	(58)
Fixed Asset Impairments	0
(Increase)/Decrease in Trade and Other Receivables	(3,654)
Increase/(Decrease) in Trade and Other Payables	1,226
Increase/(Decrease) in Stock	(234)
Increase/(Decrease) in Provisions	0
Interest Paid	(2,403)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	(6,831)
Cash Flows from Investing Activities	
Interest received	11
(Payments) for Property, Plant and Equipment	(2,495)
Receipt from sale of Property	0
Net Cash Inflow/(Outflow)from Investing Activities	(2,484)
Net Cash Inflow/(Outflow) before Financing	(9,315)
Cash Flows from Financing Activities	8,134
Net Increase/(Decrease) in Cash	(1,181)
Cash at the Beginning of the Year 2017/18	2,277
Cash at the End of the Month	1,096

Commentary

Cash Flow

- The Trust made an adjusted operating deficit of £3,222k (excluding interest charges) at the end of June and received cash of £1,514k 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) to off-set the impact on trade receivables
- The Trust spent a total of £2,495k in relation to payments for outstanding capital projects from 2017/18 and current 2018/19 projects
- The Trust has received a total of £7.2m against the temporary borrowing loan facility by the end of June to support working capital payments

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD – 2nd August 2018			
Performance and Quality Report			**AGENDA ITEM: 14**
Report Author and Job Title:	Alison Phipps - Head of Performance & Strategic Intelligence	**Responsible Director:**	Russell Caldicott – Director of Finance & Performance
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☐		
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.		
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	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.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Walsall Healthcare NHS
NHS Trust

Performance and 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 declined to 87.73% compared to 89.70% in May. June's performance exceeded the trajectory of 86%.
- **Ambulance Handover:** The number of delayed ambulance handovers totalled 75 compared to 42 in May. There were no ambulance handovers over 60minutes.
- **Cancer** – All cancer metrics achieved in May. Unvalidated results for June show non achievement of 62 day referral to treatment from consultant upgrade.
- **18 Weeks Referral to Treatment Incomplete: Target 92%:** June's performance further improved to 89.00%.
- **Diagnostic waits:** 99% target continued to achieve (99.79%).
- **HSMR (HED) & SHMI -** March HSMR rate was 110.50. No SHMI data available due to a national data issue. 85 deaths were recorded in June.
- **Infection Control** – There were no cases of C Difficile and 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 0.50 and 0.07 respectively for May (unvalidated).
- **Falls** - The rate of falls per 1000 bed days improved to 3.57 from 5.62 in May 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, Adult Safeguarding Level 1 and 3 and Children's Safeguarding Level 1 and 3. Trajectories have been established to achieve by end of Q1.
- **Open Contract Performance Notices** – Eight contract performance notices remain open.
- **DNA rates**: Slightly improved in June to 10.59% from 11.03% in May but 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: 26th July 2018

APPENDICES

Performance & Quality Report

Walsall Healthcare NHS
NHS Trust

Performance & Quality Report

Trust Board

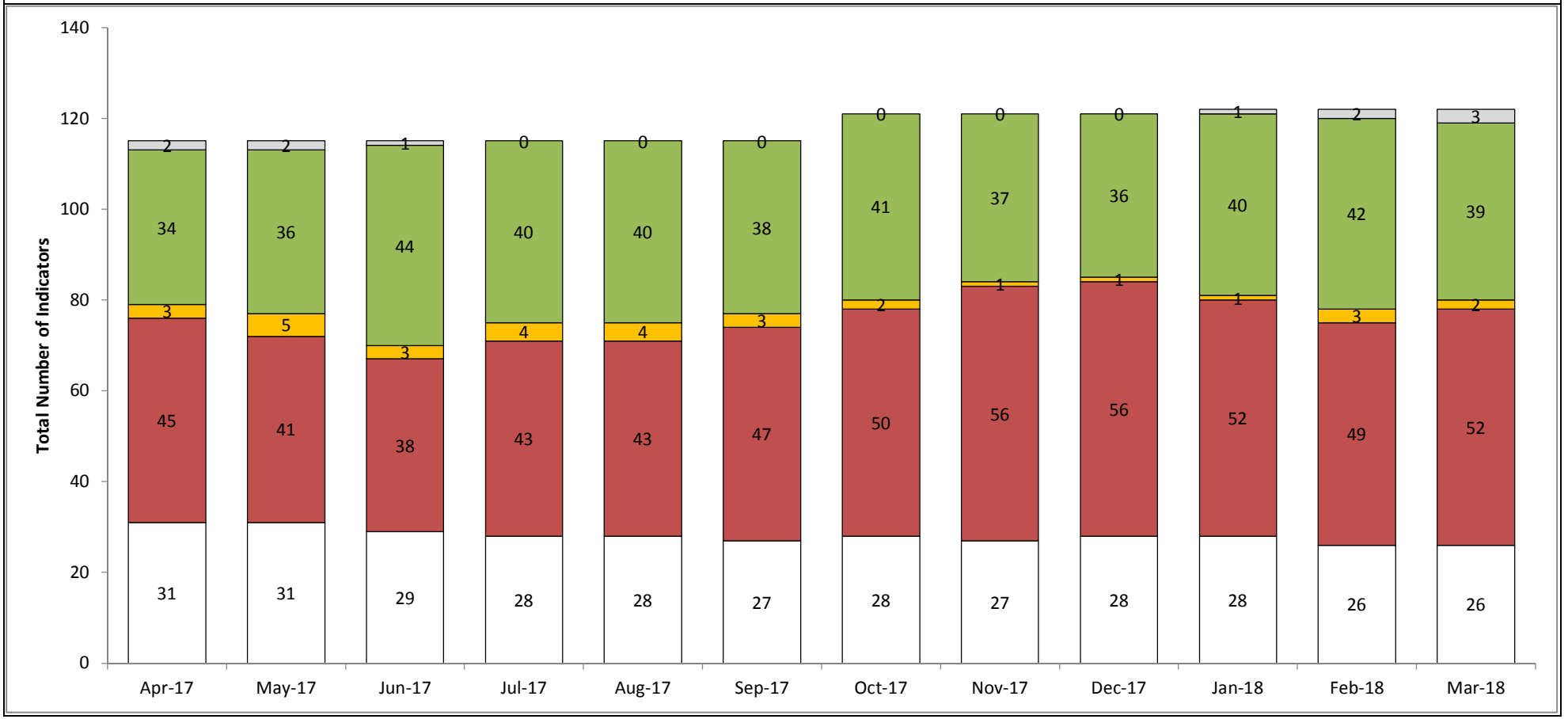
July 2018
(June 2018 Results)

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

Becoming your partners for first class integrated care

Contents

TRUST PERFORMANCE FRAMEWORK



Indicators with No Targets

Failing to meet Target or Major Variance from Plan

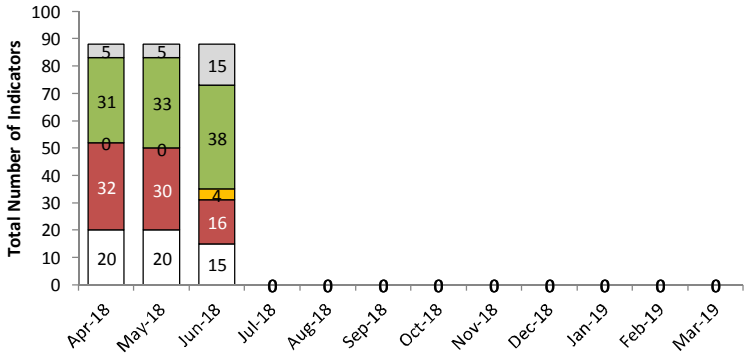
Minor Variance from Plan

Achieving Target or On Plan

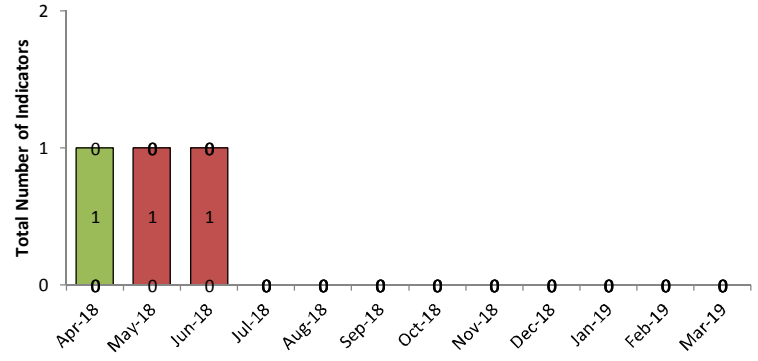
Indicators reported in Arrears or not yet available in Month

TRUST STRATEGIC VALUES FRAMEWORK

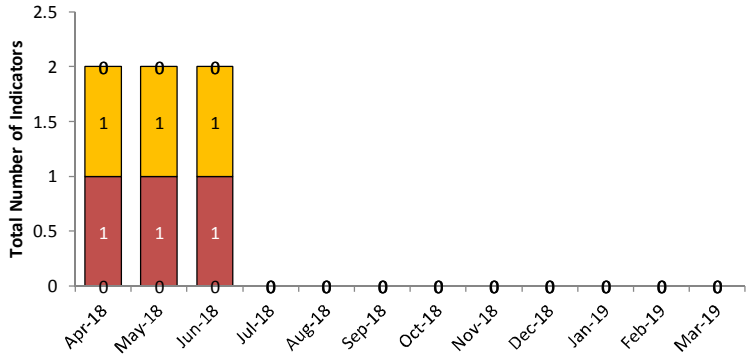
Provide Safe, High Quality Care Across All Our Services



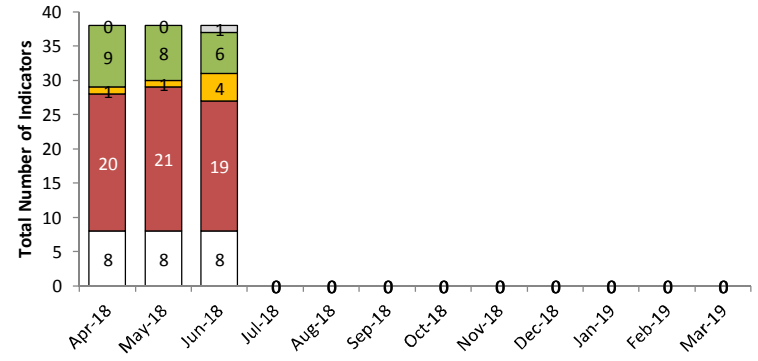
Care For Patients At Home Whenever We Can



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



Use Resources Well To Ensure We Are Sustainable



Indicators with No Targets

Failing to meet Target or Major Variance from Plan

Minor Variance from Plan

Achieving Target or On Plan

Indicators reported in Arrears or not yet available in Month

Walsall Healthcare NHS
NHS Trust

Quality and Safety Committee

Becoming your partners for first class integrated care

Quality & Safety Committee – Key Messages

Please refer to dashboard and exception pages for further detail

Quality & Safety Committee

PERFORMANCE ACHIEVED – OF NOTE: There were no cases of C Difficile reported. Trust Wide Safety Index- % of medication incidents resulting in harm reported performance of 9.38% in May. There were no medication incidents at level 3 or above reported for May. Midwife to Birth Ratio achieved at 1:26.2. Friends and Family reported an improvement in the following areas; inpatients achieved 97% against a 96% target, post natal maternity achieved 100% and post natal community achieved 100%. Safeguarding training level 1 and 3 compliance exceeded the respective 95% and 85% targets for both adults and children's.

PERFORMANCE NOT ACHIEVED: There were 5 sleeping accommodation breaches during June. HSMR declined to 110.50 in March from 106.19 in February. C Section rates increased to 30.53% in June. Emergency Readmissions within 30 days did not achieve in May with performance of 11.07%. EDS compliance declined to 90.83% in June. Dementia improved slightly to 68.42% in May, against a target of 90%, however methodology to determine performance of this metric is still under review. Four FFT areas failed to achieve in June, there were no responses received for maternity birth. Three of the training metrics narrowly failed to achieve in June but all showed significant improvement compared to May.

TO NOTE:
The number of deaths increased in June to 85. Two new metrics have been included to show the number of Hospital acquired avoidable pressure ulcers per 1000 bed days and the number of community acquired pressure ulcers acquired per 10000 CCG population. There were 6 Hospital & 1 Community serious incidents in June.

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 286 births in June.

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE 2018-2019

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no	Sleeping Accommodation Breaches	3	2	8	3	0	5	8	0	66	N
no..	HSMR (HED)	114.75	106.19	110.50					100.00		N
no..	SHMI (HED)								100.00		BP
no	Number of Deaths in Hospital	139	112	113	90	78	85	253		1166	BP
%..	% of patients who achieve their chosen place of death	63.04%	57.78%	57.69%	54.05%	58.93%	73.81%	62.22%			
no	MRSA - No. of Cases	0	0	0	1	0	0	1	0	0	N
no	Clostridium Difficile - No. of cases	0	0	0	3	2	0	5	17	11	N
%..	% of patients screened for Sepsis (IP & ED) (CQUIN quarterly audit)	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 (one month in arrears)				0.99	0.50					
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired Avoidable per 10,000 CCG Population (one month in arrears)				0.03	0.07					
no	Pressure Ulcers - (category 2, 3 & 4's) - Hospital	15	17	20	27	20	19	66			
no	Pressure Ulcers - (category 2, 3 & 4's) - Community	17	14	14	14	14	9	37			
no	Falls - Total reported	88	83	95	89	85	54	228		1026	BP
no..	Falls - Rate per 1000 Beddays	5.11	5.10	5.64	5.32	5.62	3.57		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	1	0	0	4	0	0	4	0	8	BP
no	Falls - Avoidable Falls resulting in severe harm or injury	1	0	0							BP
no	Falls - Unavoidable Falls resulting in severe harm or injury	0	0	0							BP
%..	VTE Risk Assessment	91.30%	93.18%	95.49%	96.34%	96.28%	96.50%	96.37%	95.00%	88.49%	N
no	National Never Events	0	0	1	0	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	13	12	14	11	6	31		123	L
no	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	8	4	5	8	5	1	14		77	L
no	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	22	24	18	28	27	24	79		262	L
no	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	16	4	8	6	6	3	15		89	L
%..	% of incidents resulting in moderate, severe harm or death as a % of total incidents	3.31%	2.89%	2.33%	3.17%	3.07%	2.77%	3.01%		2.78%	L

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE 2018-2019

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
%..	Deteriorating patients: Percentage of observations rechecked within time	88.72%	90.27%	90.52%	91.20%	93.46%	94.48%	93.02%	85.00%		
%..	Medication Storage Compliance (one month in arrears)	89.00%	89.00%	91.00%	92.80%	91.10%		91.10%			
%..	Controlled Drug Compliance (quarterly audit)			71.00%							
%..	% of Pharmacy Interventions made based on charts reviewed	22.62%	22.49%	13.00%	14.00%	12.00%	12.00%				
%..	Trust-wide Safety Index - % of medication incidents resulting in harm (one month in arrears)	30.59%	20.00%	17.54%	20.75%	9.38%		13.42%	12.00%		BP
no	No. of reported medication incidents level 3, 4 or 5 (one month in arrears)	1	1	3	1	0		1	0		
no..	Midwife to Birth Ratio	1:24.8	1:22.4	1:26.3	1:29.8	1:29.2	1:26.2		1:28	1:26.3	N
%..	One to One Care in Established Labour	98.98%	99.43%	99.48%	99.06%	100.00%	100.00%	99.68%	100.00%		N
%..	C-Section Rates	27.34%	26.61%	31.80%	27.06%	27.12%	30.53%	28.19%	30.00%		
%..	Instrumental Delivery	14.36%	9.09%	10.03%	9.48%	8.09%	8.04%	8.55%	10.00%		
%..	Induction of Labour	32.01%	31.85%	30.39%	32.01%	32.68%	39.30%	34.56%			
%..	NHS Safety Thermometer - Maternity - Women's Perception of Safety	82.60%	100.00%	94.30%	100.00%	90.50%	91.30%		92.00%		
%..	NHS Safety Thermometer - % Harm Free	95.29%	95.70%	94.75%	95.93%	94.21%	94.73%		94.00%		BP
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	10.44%	10.18%	10.26%	11.27%	11.07%		11.17%	10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	91.63%	91.84%	89.51%	83.45%	92.29%	90.83%	88.82%	100.00%	89.33%	N/L
%..	Dementia Screening 75+ (Hospital) (Internal audit Dec17 onwards) (one month in arrears)	79.55%	72.12%	78.26%	66.22%	68.42%		67.33%	90.00%		N
%..	Compliance with MCA 2 Stage Tracking	71.00%	77.00%	77.00%	55.00%	81.00%	69.00%		100.00%		
no	Complaints - Total Received	24	23	33	26	32	29	87		291	BP
%..	Complaints - Percentage responded to within the agreed timescales	100.00%	100.00%	90.32%	87.50%	93.55%	93.94%	92.50%	70.00%		BP
no	Clinical Claims (New claims received by Organisation)	10	14	8	9	19	12	40		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	9.96%	9.20%	9.13%	9.79%	10.70%	10.67%				
%..	Friends and Family Test - Inpatient (% Recommended)	93.00%	97.00%	94.00%	96.00%	95.00%	97.00%		96.00%		N
%..	Friends and Family Test - Outpatient (% Recommended)	91.00%	91.00%	92.00%	92.00%	92.00%	91.00%		96.00%		N
%..	Friends and Family Test - ED (% Recommended)	75.00%	79.00%	76.00%	79.00%	76.00%	75.00%		85.00%		N
%..	Friends and Family Test - Community (% Recommended)	97.00%	99.00%	97.00%	97.00%	98.00%	98.00%		97.00%		N

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE 2018-2019

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
%..	Friends and Family Test - Maternity - Antenatal (% Recommended)	97.00%	0.00%	81.00%	90.00%	91.00%	80.00%		95.00%		N
%..	Friends and Family Test - Maternity - Birth (% Recommended)	100.00%	100.00%	100.00%	100.00%	90.00%	0.00%		96.00%		N
%..	Friends and Family Test - Maternity - Postnatal (% Recommended)	97.00%	100.00%	96.00%	97.00%	91.00%	100.00%		92.00%		N
%..	Friends and Family Test - Maternity - Postnatal Community (% Recommended)	99.00%	100.00%	98.00%	100.00%	94.00%	100.00%		97.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	98.84%	98.80%	96.56%	98.59%	98.29%	98.22%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	69.07%	70.90%	75.97%	76.07%	77.51%	84.47%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	95.51%	93.10%	93.86%	94.14%	93.35%	99.76%		95.00%		
%..	Adult Safeguarding Training - Level 2 Compliance	63.80%	66.37%	70.09%	74.57%	79.13%	83.88%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	71.85%	74.09%	77.64%	78.06%	80.55%	87.48%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	96.28%	94.06%	92.12%	91.61%	92.00%	99.77%		95.00%		
%..	Children's Safeguarding Training - Level 2 Compliance	74.03%	73.84%	73.25%	75.49%	76.74%	82.10%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	68.87%	67.48%	71.07%	73.72%	87.10%	90.62%		85.00%		L
	RESOURCES										
no	Total Births	280	253	289	306	309	286	901		3603	L

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

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

Becoming your partners for first class integrated care

Performance, Finance & Investment Committee – Key Messages

Please refer to dashboard and exception pages for further detail

Performance, Finance & Investment Committee

PERFORMANCE ACHIEVED – OF NOTE: All cancer measures achieved in May and provisional figures for June show achievement of all seven national targets. There were no ambulance handovers delayed by more than 1 hour.

PERFORMANCE NOT ACHIEVED: The ED 4 hour performance declined to 87.73% however exceeds the 86% improvement trajectory. ED median waiting time increased in June. The number of delayed ambulance handovers totalled 75 compared to 42 in May. The provisional Cancer 62 day consultant upgrade performance for June is currently not achieving the local target of 85%. Incomplete 18 weeks RTT for June continued to improved to 89.00% which exceeds the improvement trajectory of 85.50%. The number of open contract notices increased by 1 to 8.

TO NOTE: For May'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 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 narrowly failed to achieve the internal target of no more that 7% recording a result of 7.12%.

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 improved from 11.03% in May to 10.59% in June. Average length of stay improved however narrowly failed to achieve the 7.01 target reporting 7.08 days. DTOC did not achieve and declined to 4.87% in June compared to 2.97% the previous month. The average number of medically fit patients throughout the month; based on a weekly snapshot average, was 85 which exceeds the target of 80 . The average length of stay for medically fit patients (from point they became medically fit) reduced to 8 days but exceeded the target of 5 days.

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

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)	82.68%	82.81%	81.23%	87.22%	89.70%	87.73%	88.25%	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)	181	178	187	167	152	160		120		
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	59.73%	71.31%	70.36%	80.95%	80.65%	76.24%	79.29%	85.00%	65.80%	BP
no	Ambulance Handover - No. of Handovers completed between 30-60mins	259	108	144	42	37	75	154	0	1836	N
no	Ambulance Handover - No. of Handovers completed over 60mins	37	21	9	1	5	0	6	0	236	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	95.16%	96.61%	97.90%	93.45%	93.98%	96.36%	94.59%	93.00%	95.45%	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	94.12%	96.55%	100.00%	94.00%	95.38%	94.12%	94.58%	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	98.82%	100.00%	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%	92.31%	100.00%	97.37%	90.00%	98.03%	N
%..	Cancer - 62 day referral to treatment of all cancers	87.36%	85.71%	87.69%	83.33%	85.58%	85.37%	84.67%	85.00%	88.05%	N
%..	Cancer - 62 day referral to treatment from consultant upgrade	90.91%	79.52%	86.89%	92.54%	86.67%	71.43%	84.82%	85.00%	86.20%	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	82.48%	83.69%	84.74%	85.89%	88.33%	89.00%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	1	0	0	0	0	0	0	0		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Admitted	1	0	1	1	0	0	1	0		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Not Admitted	0	1	0	0	1	0	1	0		N
%..	Diagnostic Waits - % waiting under 6 weeks	99.54%	99.66%	98.06%	99.05%	99.57%	99.79%	99.45%	99.00%	99.06%	N
%..	Elective Cancellations - No. of last minute cancellations on day of operation or after patient admission	0.19%	0.35%	0.39%	0.09%	0.35%	0.08%	0.17%	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)	326	225	258	212	205					

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
%..	% of RN staffing Vacancies	9.96%	9.20%	9.13%	9.79%	10.70%	10.67%	0			
no	No. of Open Contract Performance Notices	6	6	7	7	7	8		0	7	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	6.71%	6.18%	6.87%	6.80%	7.68%	7.12%	7.23%	7.00%	6.76%	BP
	RESOURCES										
%..	Booking Utilisation (booked as a percentage of capacity)	90.13%	90.41%	92.87%	93.17%	94.97%	93.84%	94.03%	90.00%	89.90%	L
%..	Outpatient DNA Rate (Hospital and Community)	12.11%	11.27%	10.73%	10.47%	11.03%	10.59%	10.71%	8.00%	12.16%	
no..	New to follow up ratio - WHT	2.04	2.01	2.04	2.09	1.88	1.94		2.14	1.99	BP
%..	Theatre Utilisation - Touch Time Utilisation (%)	58.16%	63.60%	70.73%	80.91%	83.76%	82.63%	83.26%	75.00%		
no..	Length of Stay	7.50	7.59	7.59	8.24	7.22	7.08	7.50	7.01	7.22	BP
%..	Delayed transfers of care (one month in arrears)	3.11%	3.44%	3.63%	2.97%	4.74%	3.74%	3.80%	2.50%	2.56%	L
no	Average Number of Medically Fit Patients				98	87	85		80		
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only				21	26	30				
no	Average Number of Medically Fit Patients - Trust				49	42	39				
no..	Average LoS for Medically Fit Patients (from point they become Medically Fit)				8.61	10.57	8		5		
no	Hospital beds open at month end	532	514	519	488	470	465				L
%..	Day case rates	90.32%	88.44%	86.78%	88.31%	90.25%	89.27%	89.33%		88.14%	BP
%..	Bank & Locum expenditure as % of Paybill	7.29%	7.42%	10.31%	7.93%	8.39%	9.07%	8.46%	6.30%	7.67%	L
%..	Agency expenditure as % of Paybill	5.39%	4.51%	3.68%	5.15%	4.33%	3.57%	4.35%	2.75%	4.32%	L
£	Surplus or Deficit (year to date) (000's)	-£20,395	-£23,257	-£23,267	-£2,386	-£4,509	-£5,616	-£5,616		-£23,267	L
£	Variance from plan (year to date) (000's)	-£3,622	-£4,238	-£2,511	-£2,483	-£186	-£18	-£18		-£2,511	L
£	CIP (£) (000's)	£7,213	£7,826	£10,900	£168	£1,080	£1.9	£1.9		£10,900	L
%..	CIP % delivered (year to date)	72.30%	74.80%	99.10%	6.90%	11.00%	19.00%	19.00%	100.00%	99.10%	L
£	Income variance from plan (year to date) (000's)	£640	-£927	-£2,306	£236	£106	£15	£15	£0	-£2,306	L
£	Expenditure - Variance from Plan (year to date) (000's)	£3,991	-£3,389	-£222	-£154	-£331	-£62	-£62	£0	-£222	L
£	Cash Against Plan (variance) (000's)	£73	£121	£128	£1,004	£1,280	£100	£100		£128	L
£	Capital spend YTD (000's)	£6,674	£7,438	£9,662	£506	£1,100	£2,500	£2,500		£9,662	L

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-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) (one month in arrears)	8730	8712	9073	8750	9643		18393			BP
no	Total Elective Activity (Contracted)	250	250	322	284	251	301	836		3725	L
no	Total Non Elective Activity (Contracted)	61	62	39	31	26	21	78		578	L
no	Total Outpatient attendances (Contracted)	15932	18388	20094	19133	21458	20047	60638		230583	L
no	Total Day Case Activity (Contracted)	2089	1812	1847	1776	2147	2154	6077		22253	L
no	Total Emergencies Activity (Contracted)	2815	2551	2682	2459	2559	2561	7579		31847	L
no	Total ED Attendances Type 1 Pbr (Excl Badger) (Contracted)	6551	5984	6606	6193	6688	6586	19467		74003	L
no	Total AHP Activity (Contracted)	1811	1866	1799	1665	1789	1794	5248		21600	L
no	Total Critical Care Days (Contracted)	990	895	829	1008	919	980	2907		11242	L
no	Total Unbundled Chemo Delivery Activity (Contracted)	323	318	353	341	378	323	1042		3975	L
no	Total Maternity Pathway	881	766	801	1041	934	928	2903		11712	L
no	Total Community Contacts (Contracted)	23589	27787	27787	29198	29926	23897	83655		361113	L
no	Total Births	280	253	289	306	309	286	901		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: Safeguarding training level 1 and 3 compliance exceeded the respective 95% and 85% targets for both adults and children's.
PERFORMANCE NOT ACHIEVED Mandatory training reported 83.06% compliance against a target of 90%. Three of the Safeguarding metrics failed to achieve in June.

NONE APPLICABLE
There are no specific Care at Home metrics identified for inclusion within the dashboard for this committee

PERFORMANCE NOT ACHIEVED: Sickness absence declined from 4.71% in May to 4.97% in June. PDR's compliance improved in June to 83.41% .

FINANCE: Turnover remains within the agreed tolerance of the 10 % target. Please refer to Finance report for further details.

Walsall Healthcare NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 2018-2019

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	% of RN staffing Vacancies	9.96%	9.20%	9.13%	9.79%	10.70%	10.67%	10.67%			
%..	Mandatory Training Compliance	78.14%	77.61%	76.61%	76.99%	78.76%	83.06%	83.06%	90.00%	76.61%	L
%..	PREVENT Training - Level 1 & 2 Compliance	98.84%	98.80%	96.56%	98.59%	98.29%	98.22%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	69.07%	70.90%	75.97%	76.07%	77.51%	84.47%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	95.51%	93.10%	93.86%	94.14%	93.35%	99.76%		95.00%		
%..	Adult Safeguarding Training - Level 2 Compliance	63.80%	66.37%	70.09%	74.57%	79.13%	83.88%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	71.85%	74.09%	77.64%	78.06%	80.55%	87.48%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	96.28%	94.06%	92.12%	91.61%	92.00%	99.77%		95.00%		
%..	Children's Safeguarding Training - Level 2 Compliance	74.03%	73.84%	73.25%	75.49%	76.74%	82.10%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	68.87%	67.48%	71.07%	73.72%	87.10%	90.62%		85.00%		L
	VALUE COLLEAGUES										
%..	Sickness Absence	6.23%	5.00%	5.65%	5.06%	4.71%	4.97%	5.10%	3.39%	5.30%	L
%..	PDRs	78.24%	79.47%	78.17%	80.55%	82.42%	83.41%	83.41%	90.00%	78.17%	L
	RESOURCES										
%..	Bank & Locum expenditure as % of Paybill	7.29%	7.42%	10.31%	7.93%	8.39%	9.07%	8.46%	6.30%	7.67%	L
%..	Agency expenditure as % of Paybill	5.39%	4.51%	3.68%	5.15%	4.33%	3.57%	4.35%	2.75%	4.32%	L
no	Staff in post (Budgeted Establishment FTE)	4100	4116	4095	4125	4114	4125	4125			L
%..	Turnover	8.77%	8.89%	9.13%	9.83%	9.92%	10.33%	10.33%	10.00%	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

Walsall Healthcare NHS
NHS Trust

Exception Pages

Becoming your partners for first class integrated care

	Year Standard	Monthly Trajectory	Jun-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%	86.00%	87.73%	88.25%	▼	
Ambulance Handover - Percentage of handovers completed within 15mins of arrival	85.00%		76.24%	79.29%	▼	

Contractual Financial Penalties (LCA)	YTD £	ED	£0
		Amb	£36,800

What is driving the reported underperformance?

ED Overall		Apr-18	May-18	Jun-18
Type 1 Attenders		6193	6688	6654
Type 3 Attenders		3323	3671	3566
WiC Attenders		3329	3545	3200
Breaches (Type 1)		1640	1423	1627
Trolley Waits >12Hours		0	0	0
Median Wait		167	152	160
Ambulance Handover (WMAS)	<15mins	2090	2176	1986
	15-30	449	480	544
	30-60	42	37	75
	>60	1	5	0
	No Time	31	61	57
	Total	2613	2759	2662
ED Reattenders		6.80%	7.68%	7.12%

- Average attendances per day were 222 compared to 216 (May)
- Average breaches per day were 54 compared to 46 (May)
- Average number of ambulances to ED per day was 87, compared to 89 (May).
- There were over 90 ambulance arrivals to ED on 17 days during the month, comparable to the previous month and 3 days where the Trust saw over a 100 ambulances to ED which is a decrease compared to May (6).

Benchmarking

ED 4 Hour - (June 2018) - National position = 99/133 Trusts & Regional position = 8/14 Trusts.

Ambulance - (June 2018) - Regional position = 3/14 Trusts.

Contractual Status

ED 4 Hour - CQN/First Exception report remains open. The Trust has signed up to the sustainability fund programme committing to achieve the trajectories as detailed.

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 June a fine of £15,000 will be incurred.

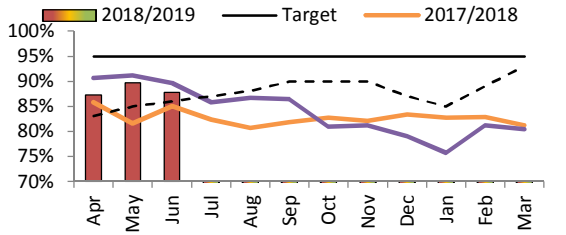
What actions have we taken to improve performance?

New Actions:

- A new process is in place to review the Super-Stranded 21 day patients on a regular basis for Medical specialities. A 7 day LOS process is also being drafted.
- Intermediate Care Services are now working closely with ED and Acute to support avoidance of social admissions.
- Ward processes within each ward have been audited against SAFER standards with each area now developing plans to meet all standards mandated from the Executive Team
- Frequent Attenders have been reviewed within an MDT to wrap around care plans for those attending within 7 days.
- Process changes to Ambulance Handovers continue with new IT being installed to maximise quick handovers

Continuing Actions:

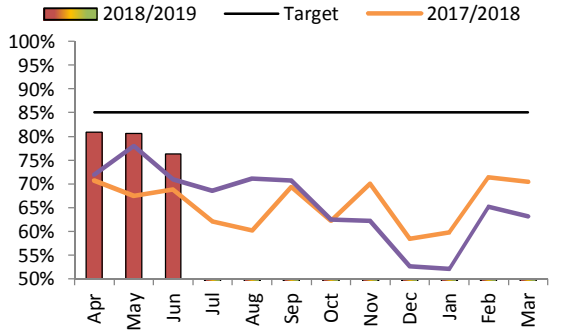
- Improvements group continue to meet regularly
- Rapid Assessment and Treatment continues to be consistent in ED
- Ward Managers continue to attend Capacity Meetings throughout the day with the newly established Discharge Plans that are produced.
- The Discharge Lounge continues to open from 9am (weekdays) to enable patients to move from wards earlier.
- Regular escalations continue with Health & Social Care to review the Medically Fit lists and continue to remove and reduce delays to discharge and Multi Disciplinary Meetings continue to manage Frequent Attenders coming to ED.



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%	93.00%

Ambulance Handover



Expected date to meet standard	ED 4 Hour - achieved trajectory Ambulance - to be agreed ED Reattenders - July 2018
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Year Standard	Monthly Trajectory	Jun-18	YTD	Change on last month	Year End Forecast
	92.00%	85.50%	89.00%		▲	

What is driving the reported underperformance?

Performance results (Validated June 2018):
The Trust achieved 89.00%, which is a further improvement compared to 88.33% in May, and is also ahead of the recovery trajectory of 85.50%. The number of patients waiting over 18 weeks has reduced again by 84 compared to May.

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

		Apr-18	May-18	Jun-18
PTL Size		14695	14702	14832
No. over 18 Weeks		2074	1716	1632
No. over 52 Weeks		0	0	0
Clock Stops	Total	5730	6582	6162
	Admitted	868	1058	1104
	Not Admitted	4862	5524	5058
Specialties achieving 92%		9	11	10

Performance of Divisions (target 92%):
- MLTC achieved 88.89% compared to 88.89% in May.
- Surgery achieved 87.13% compared to 86.22% in May.
- WCCSS achieved 98.33% compared to 97.63% in May.

Benchmarking:
For May, the Trust ranked 71st out of 128 Acute Trusts nationally who submitted information and 9th out of 14 Trusts regionally. 76 Acute Trusts reported breaches of over 52 weeks.

Contractual status:
Contract Query Notices remain open with WCCG and NHSE.
The Trust has signed up to the sustainability fund programme committing to achieve a year end reduction on the PTL size.

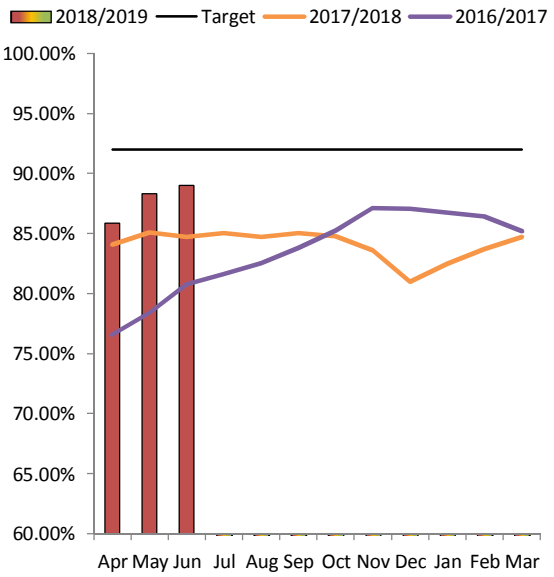
What actions have we taken to improve performance?

Data Quality:
- Historic cashing up is being addressed by using the Robotic software to automate the process.
- Validators continue to work on duplicate and 'attended' status access plans.
- KPIs are in place for the reception team for clinic outcoming, with a view to ensuring fully booked are actioned on the day and DNA reviews take place in clinic.
- ERS rollout for new appointment bookings has made good progress over the last 6 months. Paper switch off commenced during July, with a view to full electronic bookings by October 18 per the national contractual requirement.

Capacity Improvements:
- WLI clinics in place to support cancer delivery and long waiters in RTT.
- Demand and capacity models have been refreshed by Care Groups and shared with CCG.
- Focus continues to reduce DNA levels and improve service booking rates.
- Work to commence on reviewing clinic templates and assessing new to review ratios, during July.

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 £** £0



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**
87.20%	88.10%	87.20%	87.20%	88.10%	89.30%

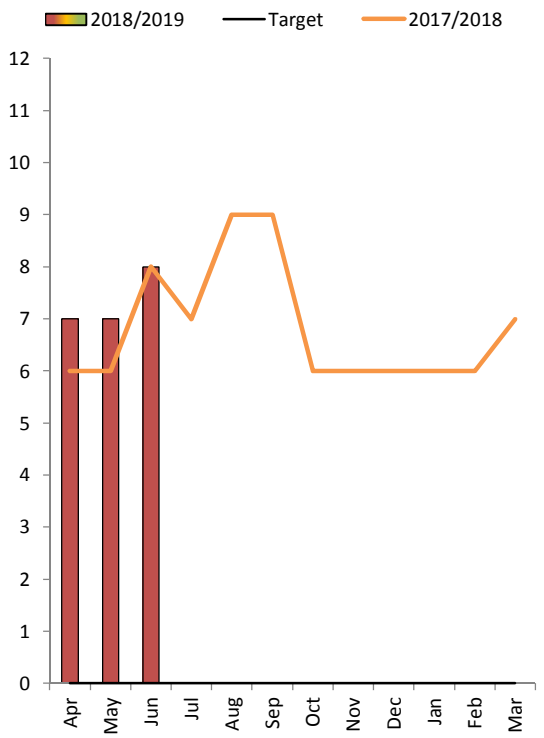
Expected date to meet standard	Achieve trajectory 85.50% for June.
Lead Director	Chief Operating Officer

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	Jun-18	YTD	Change on last month	Year End Forecast
Total number of Open Contract Performance Notices	0		8		▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties for numbers open - applied to individual performance areas.	YTD £	
As at 30th June 2018, there are 8 formal contract notices outstanding. A notice for Imaging Infection Control was received from WCCG during June, the remaining 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	Jun-18	YTD	Change on last month	Year End Forecast
Outpatient DNA Rates	8.00%	9.00%	10.59%	10.71%	▲	
Booking Utilisation (booked as a percentage of capacity)	90.00%		93.84%	94.03%	▲	

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

Performance Results

Outpatient DNA rates are the number of outpatient appointments where the patient 'Did Not Attend' against the total number of outpatient appointments.
The Trust failed to achieve the internal trajectory of 9% with performance of 10.59%.
Divisional performance is as below:-
MLTC - 10.64% (Jun) (compared to 11.74% in May)
SURG - 9.82% (Jun) (compared to 9.92% in May)
WCCSS - 11.28% (Jun) (compared to 11.70% in May)

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 - 94.57% (Jun) (compared to 97.46% in May)
SURG - 94.81% (Jun) (compared to 93.43% in May)
WCCSS - 91.30% (Jun) (compared to 95.96% in May)

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 complete for services suitable for this style of booking.

- Call Centre software went live.

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

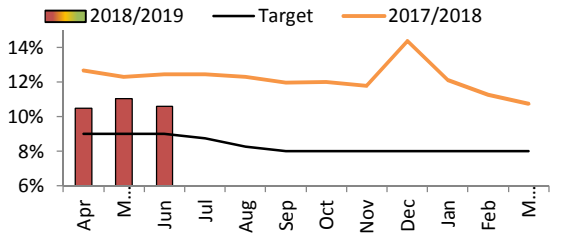
- Specialty plans under development to look at specific issues with DNAs for services above the 9% standard.

- Collaborative work as started to look at 2 week wait DNAs.

- 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. Paper switchoff roll out commenced in July.

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

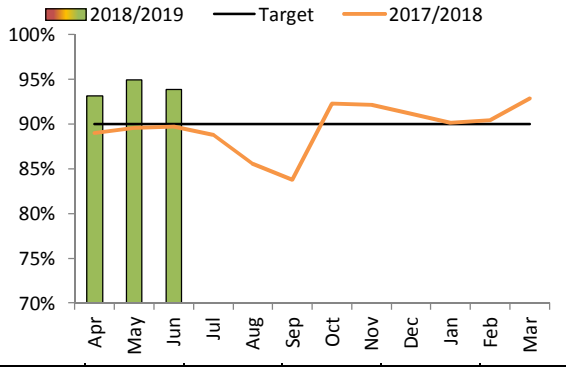
- This metric is covered within the Outpatients Improvement Programme, the Executive Lead is the Chief Operating Officer and the Operational Lead is the Corporate Director.



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 - July 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	Jun-18	YTD	Change on last month	Year End Forecast
	7.01		7.08	7.50	▲	

What is driving the reported underperformance?

Performance results:

Overall performance for LoS in June was 7.08 days. This is further improvement compared to 7.22 days reported in May. 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 May	Ave LoS June	% LoS <72hr	% LoS of "0"
MLTC	8.32	8.46	57.26%	26.14%
SURG	6.14	6.07	67.78%	29.99%
WCCSS	3.71	2.04	95.09%	64.97%

The average LoS for Division of Surgery and Women's, Children's and Clinical Support Services improved during June and remains below the target of 7.01 days. Medicine and Long Term Conditions LoS slightly declined during June from 8.32 days to 8.46 days.

Benchmarking:

No formal national reports.

Contractual status:

No contractual requirements apply.

What actions have we taken to improve performance?

Continuing Actions:-

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

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

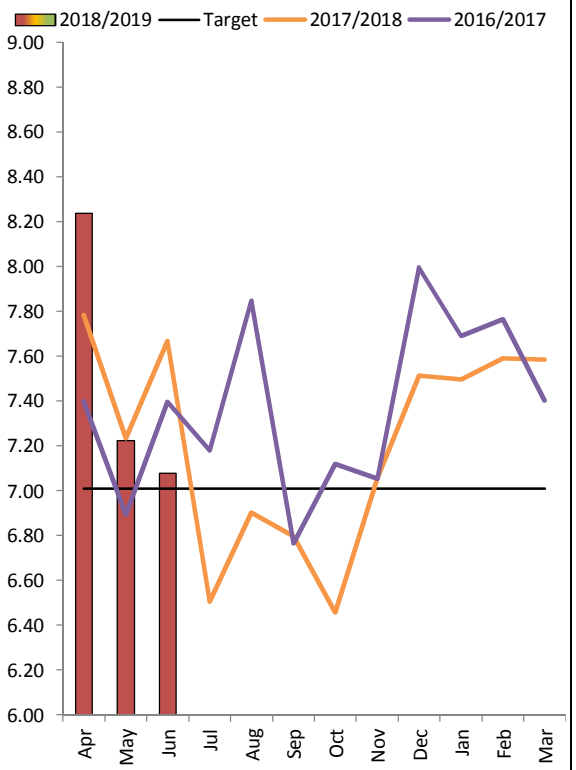
- One works stream is focused on ward processes, namely: twice daily multidisciplinary board rounds, review of the 'sick & quick' patients; discharge planned for next day; use of discharge lounge in the morning.

- There is a weekly review on the acute medical wards of the stranded 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	

Walsall Healthcare NHS Trust

	Year Standard	Monthly Trajectory	Jun-18	YTD	Change on last month	Year End Forecast
The number of beds days relating to patients who were classified as a delayed discharge taken as a snapshot on the last Thursday of the month	2.50%		3.74%	3.80%	▲	
Average Number of Medically Fit Patients	80		0		▲	

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

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 for 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 June with performance of 3.74%. This is an improvement in performance compared to 4.74% reported in May.

MFFD Performance results:

Internal metric: Medically Fit For Discharge are patients who have had 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 (Walsall patients only)
- The average number of medically fit patients awaiting health (all including out of area)
- 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.

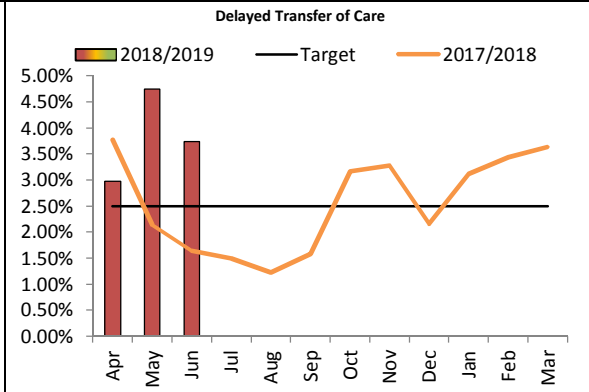
Latest benchmarking shows, 581 bed days were impacted in May 2018 from delayed transfers taken at the snapshot position. This ranks the Trust 60th out of 133 Trusts nationally and 6th out of 14 Trusts regionally.

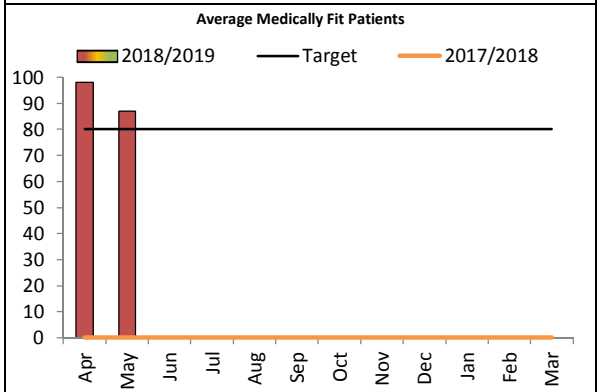
Continuing actions:

- 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. This is currently being implemented.
- The ICS team have developed a system of managing referrals via a Tier system which is working well and now focusing on A&E admission avoidance.
- 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. This has been sucessful and the number of staff working in community has increased to ensure flow on the community pathways to speed discharge up in hospital.

DTOC is now recorded daily rather than monthly and May was the first month a daily count was submitted to UNIFY. This has shown an increase.

- CHC assessments (DSTs) completion in the community is working well and the majority of DST assessments now take place in community.
- ICS model is continuing to develop training and guidance for the acute wards on discharge planning. This plan is in place and ICS staff attend acute trust meetings to ensure the pathways are well known. ICS managers attend patient flow meetings.
- 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. All wards have access to ICS leaflets and ICS held a stand at the Trust Leadership day in July 2018.
- DTOC audit has been completed, awaiting recommendations and feedback. No formal feedback received.
- ICS team have developed community therapy pathways in order to facilitate discharges sooner and conduct therapy assessments in the community. This is in place and working well.





Expected date to meet standard	DTOC - To be agreed Medically Fit - To be agreed
Lead Director	Chief Operating Officer

g underta	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Sleeping Accommodation Breaches	Year Standard	Monthly Trajectory	Jun-18	YTD	Change on last month	Year End Forecast
	0		5	8	▼	

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

Performance results:

There were 5 patient breaches reported within the Trust during June. This is a decline in performance as no breaches were reported in May. A trajectory for 2018/19 has been agreed.

For the 5 patient breaches reported in June the length of breach incurred for each patient was between one and two days. The patients breached on 13th, 14th, 21st and 22nd June. There were 4 patients from Walsall CCG and 1 patient from Sandwell and West Birmingham CCG.

Bed capacity issues within the Trust continue to impact on the timely step down of patients from the Critical Care Unit. As regionally agreed, the rules which apply within HDU are that a patient on critical care should only be counted as a breach if another patient is ready to step down whilst the first patient is still there. Patients should be transferred within 12 hours of decision to step down.

Performance is impacted upon by Estates configuration of the unit at present as there is no area for ring fenced step down beds.

Benchmarking:

Latest benchmarking for May shows that 43 out of 137 Acute Trusts reported sleeping accommodation breaches.

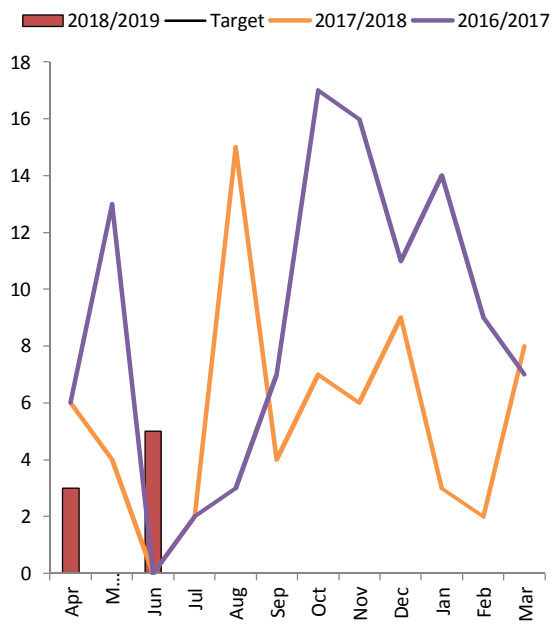
Contractual status:

Mixed Sex Accommodation is a contractual indicator in 2017/18 with a financial penalty attached of £250 per patient involved, per day impacted upon.

* In compliance with the recommendation of the NHS national emergency pressures panel the CCG has temporarily suspended sanctions for this metric.

Continuing actions:

- Agreement has been made with Walsall CCG to extend the 4 hour step down tolerance to 12 hours which is in line with other Trusts, with effect from January.
- RCA documents are completed for reported breaches which all needed stepdown to Medical beds. The RCA documents are tabled at Divisional Quality Meetings for discussion/learning to prevent future breaches.
- The critical care outreach team have transferred over to the Surgery Division. Once the team has been fully establishedmbeded they will produce a procedure to support the patient flow process.
- A trajectory of no more than 42 breaches for the period quarter 2 to quarter 4 inclusive has been agreed wirh WCCG.
- The business case for the new Intensive Critical Care Unit was approved by NHSI in March 2017, this will have single sex accommodation. The project started in April and the anticipated date for completion is Winter 2018.
- Mixed Sex Accommodation breaches are a specific risk on the Critical Care Risk Register.
- All breaches are raised as an incident on the Safe Guard System.
- The critical care unit continues to focus on operating a "push" model.
- Emphasis of the importance of the critical care step downs continues within bed bureau.



Trajectory to be agreed with WCCG					
Apr	May	Jun	Jul	Aug	Sept
				15	
Oct	Nov	Dec	Jan	Feb	Mar
	15			12	

Expected date to meet standard	Due to limitations with Estates and capacity pressures, on occasion breaches may be unavoidable
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

HSMR (HED) SHMI (HED)	Year Standard	Monthly Trajectory	Mar-18	YTD	Change on last month	Year End Forecast
	100		110.50	101.06	▼	
	100					

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

Performance results:

Hospital Standardised Mortality Ratio (HSMR) compares a Healthcare provider's mortality rate with the overall average rate. The Trust receives this information from the HED system but historically received this from Dr Foster. Due to methodology differences, each system returns a different result. The latest published results report that HSMR was 110.50 for March 2018. For the financial year 2014/15 HSMR was 95.96, for 15/16 was 92.21 and for the financial year 2016/17 HSMR was 94.17. Previous months have been refreshed to reflect the latest published results.

HED publish a metric defined as the number of excess deaths within the HSMR, it is the difference between the expected deaths and actual deaths. For April 2017 to March 2018 (ytd) there were 12 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.

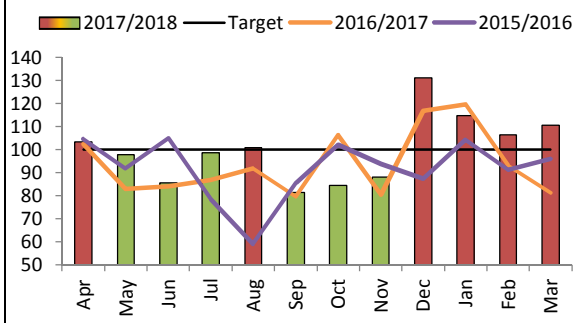
New actions:

- Review the trends identified relating to February and March deaths for Gastroenterology and Diabetes.
- Undertake a review of patients with fracture neck of femur recorded during February.

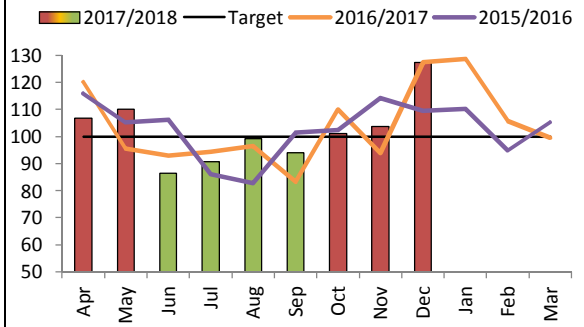
Continuing actions:

- 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.
- 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	Jun-18	YTD	Change on last month	Year End Forecast
CDiff - Total number of cases of Clostridium Difficile recorded in the Trust	17	1	0	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
				CDiff
				MRSA £10,000

Performance results:

CDiff:

There were no cases of C.Difficile attributed to Walsall Healthcare NHS Trust during June 2018.

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

Benchmarking:

CDiff:

Data published one month in arrears by Health Protection England confirms that for May 2018, there were 2 cases of hospital attributable C.Difficile toxin at Walsall Healthcare. This compares to 0 cases at Dudley and 5 cases at Wolverhampton.

MRSA:

Data published one month in arrears shows there were no cases of MRSA recorded regionally for May 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 no C.Difficile cases reported in June 2018.

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

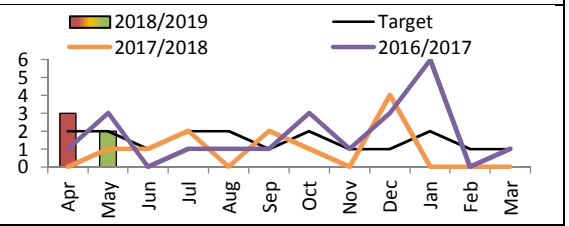
Deep cleans have been completed on ASU, and ward 9.
Deep cleans have been completed on AMU and ward 2.

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.

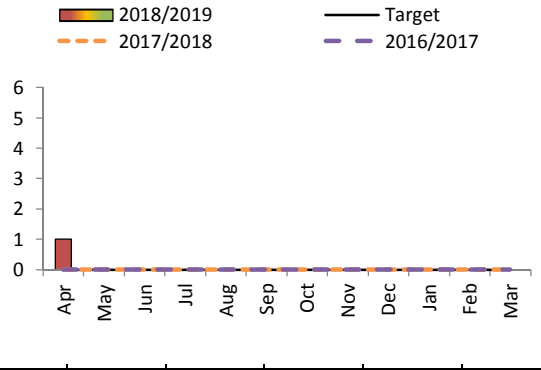
MRSA - improvement work for care of peripheral vascular devices continues throughout the Trust.
- Work continues with the Continence and Urology services to improve the care of urinary catheters. This will be monitored via the NHS Safety Thermometer.
- The Infection Control nurses continue to follow 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	C-Diff - currently meeting standard
Lead Director	Medical Director

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
Avoidable Hospital per 1000 bed days			0.50		▲	
Avoidable Community per 10,000 CCG Population			0.07		▼	

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*
Apr-18	Cat 2	19	*7*	6	*0*
	Cat 3	2	*2*	1	*0*
	Cat 4	0	*0*	0	*0*
	Unstage	6	*4*	7	*1*
*May-18	Cat 2	16	*6*	9	*1*
	Cat 3	1	*0*	1	*0*
	Cat 4	0	*0*	0	*0*
	Unstage	3	*0*	4	*1*
*Jun-18	Cat 2	16	*5*	7	*0*
	Cat 3	0	*0*	1	*0*
	Cat 4	0	*0*	0	*0*
	Unstage	3	*1*	1	*0*

*Figures for these months are still being validated - please note there are 5 PU's for April still awaiting final validation but initial discussions have already taken place with the wards involved.

There were 41 PU related incidents reported in April.

The highest reported area of prevalence continues to be on patients heels. There have been 8 incidents confirmed as avoidable in April.

Contractual status:

2 year CQUIN for 2017-19 worth approx. £258K per year aimed at improving the assessment of wounds. The Trust achieved year 1. National targets published for year 2.

What actions have we taken to improve performance?

Continuing actions: -

Ward/ Team Actions Taken for avoidable 3/4 & unstageable:

1 avoidable community incident was due to a delay in the request for equipment. Discussed with team team.

There were a variety of reasons for the Acute avoidable incidents. These included delays in providing an air mattress which was attributed to confusion of the new process for 2 incidents on ward 15. Others included; poor documentation, lack of initial body map, limited evidence for repositioning and heel protection not in place.

Education

The TV team continue to work through competencies with the community link nurses. Many have been completed

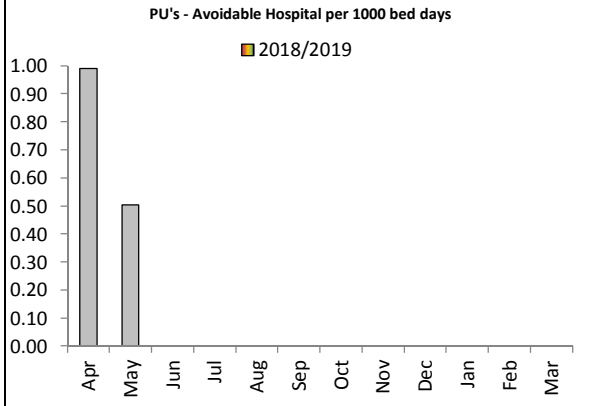
Equipment

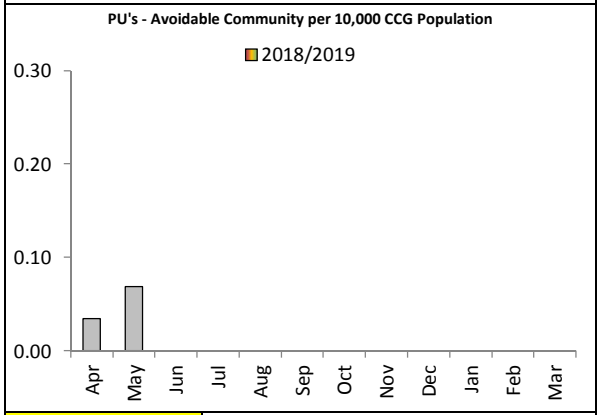
TV are investigating the implementation of pillows with blue pillow cases across the hospital to alert nurses the patient is at risk of heel damage and pillows are there to be used to elevate. Awareness posters have been developed and will be ditributed to wards as soon as availability of blue pillow cases and extra pillows is confirmed. TV are working with podiatry to investigate other potential options when pillows may not be effective.

Ward 15

TV are working with ward 15 to pilot SKIN bundle documentation and possibly introducing blue pillows. The team will support the ward (at least 8 hours per week) in patient care and traininig on the ward whilst delivering patient care. The aim is to provide intensive support for 3 months to increase staff knowledge and confidence and improve PU prevention,documentation and reduce incidents.

Contractual Financial Penalties | **YTD £**





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	Jun-18	YTD	Change on last month	Year End Forecast
Falls - Number of Falls reported			54	228	▲	
Falls - Rate per 1000 Bed Days	6.63		3.57		▲	

What is driving the reported underperformance?

Performance results:

There were 85 falls reported during June 2018, equating to a rate of 3.64 falls per 1000 beddays for the month which is an improvement compared to 5.62 in May and achieves the Trust target of 6.63.

Based on Calendar Month		Apr-18	May-18	Jun-18
Count of Falls	Total	89	85	54
	MLTC	72	72	48
	Surgery	15	11	4
	WCCSS	0	2	1
	Comm / Corporate	2	0	1
	Other	0	0	0
Rate per 1000 beddays - All Falls		5.32	5.62	3.57
Rate per 1000 beddays - Moderate & Severe Falls		0.24	0.07	0.07

There were 6 reported incidents of patients falling more than once in June which is less than in May (13). In total these patients had 16 falls. The highest no.of falls were reported on Ward 15 (10 falls), Ward 04 (7 falls), Ward 29 (6 falls) & Ward 03 (5 falls)

There was 1 fall resulting in moderate or severe harm (on Midwifery led unit - patient suffered injury to head).

NHS Safety Thermometer results for May show performance of 0.40% 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?

Continuing actions:

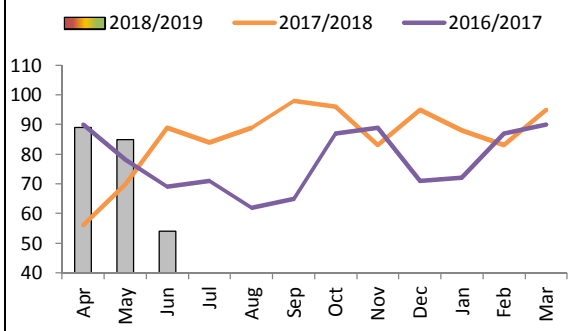
- Training programme continues with face to face training at ward level, this includes the use of bedrails. This training is evaluating well.
- Monthly falls audits continue.
- Falls dashboard is shared with all wards and is monitored via the ward review process.
- All incidents relating to falls are recorded within the Safeguard system.

– Moving and handling training includes Falls scenarios and includes completion of the falls and bedrail assessments.

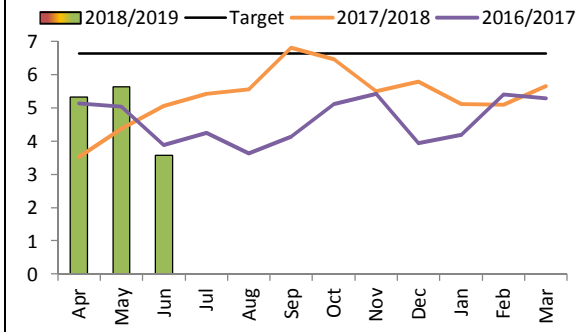
- A monthly monitoring meeting is held between the Corporate Senior Nurse and the Performance & Information Team. This meeting ensures there is a robust process for tracking and chasing outstanding RCA's for falls and ensures action plans are in place for all avoidable incidents and lessons learnt are 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

C-Section Rates	Year Standard	Monthly Trajectory	Jun-18	YTD	Change on last month	Year End Forecast
	30.00%		30.53%	28.19%	▼	

What is driving the reported underperformance?

Performance Results

Performance of 30.53% in June was a decline compared to 27.12% the previous month. This is the first time this financial year the target of 30% has not been achieved.

		Apr-18	May-18	Jun-18
Total	Number	82	83	87
	%	27.06%	27.12%	30.53%
Elective	Number	30	35	33
	%	9.90%	11.44%	11.58%
Emergency	Number	50	48	54
	%	16.50%	15.69%	18.95%

There were 87 c-sections recorded in the month which is a slight increase compared to 83 in May. There were 285 deliveries reported in June which is a decrease compared to 306 the previous month.

Benchmarking (published annually):

Latest benchmarking (based on 2015/2016 performance) ranks the Trust 109th out of 116 Acute Trusts who submitted data. Regionally, the Trust ranked 8th out of 10 Trusts.

Contractual Status:

No contractual requirements apply.

What actions have we taken to improve performance?

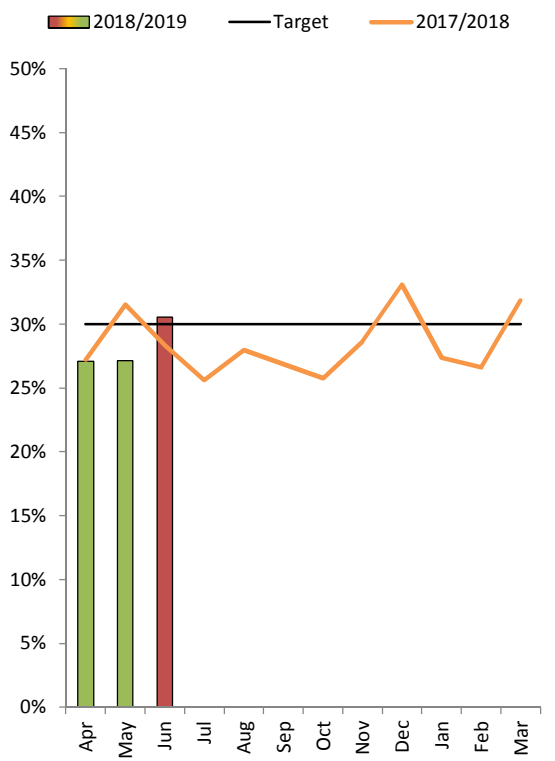
New Actions:-

- The unit has implemented the use of statistical process charts for Caesarean section rate review which reassures that this is normal variation in month. This has been agreed with the Maternity Oversight Committee. The rate will continue to be monitored and reported monthly.

Continuing Actions:-

- C-sections continue to monitored on a daily basis
- C-sections continue to be discussed at monthly meetings including the Maternity Oversight Group which includes representatives from Walsall CCG, CQC, NHSI and NHSE.

No Contractual Financial Penalties | **YTD £**



Expected date to meet standard	To be confirmed.
Lead Director	Director of Nursing

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Emergency Readmissions Within 30 Days

Walsall Healthcare NHS Trust

% of Emergency Readmissions within 30 Days of a discharge from hospital	Year Standard	Monthly Trajectory	May-18	YTD	Change on last month	Year End Forecast
	10.00%		11.07%		▲	

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 May was 11.07% which is a slight improvement compared to 11.27% in April 2018 but doesn't achieve the internal target of 10%.

There were 606 emergency readmissions in May, of which, 62 were related to GAU cohort.

Of the patients who were re-admitted in May:-
- Approximately 23% of the readmissions were aged under 30 (a decrease compared to 25% in April).
- Approximately 36% of the readmissions were aged over 70 (an increase compared to 35% in April).

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

For those patients discharged in the month who were an emergency readmission within 30 days, the average length of stay of the readmission was 4.0 which is a decrease compared to 4.3 in April.

Benchmarking:

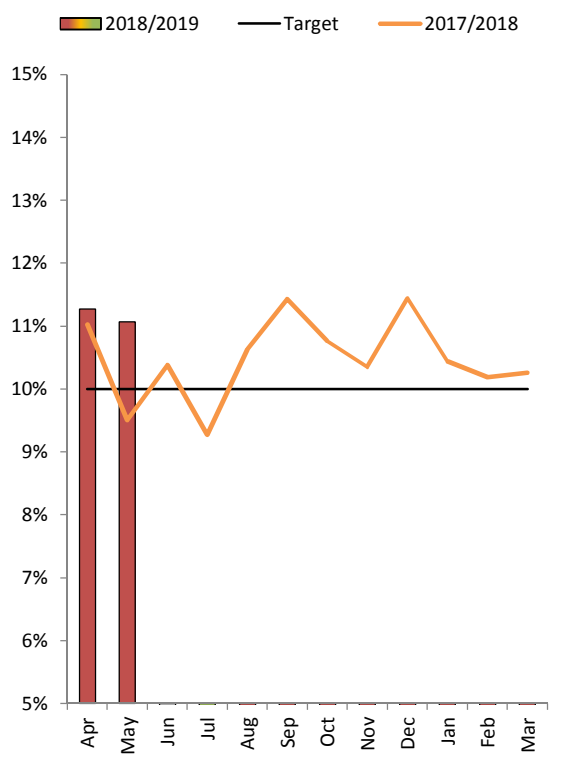
There are no formal national reports published for this metric.

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	Jun-18	YTD	Change on last month	Year End Forecast
Number of EDS completed within 48 hrs of the point of patient discharge	100.00%		90.83%	88.82%	▼	

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

Performance results:

This indicator measures the percentage of EDS completed within 48 hours of the point of patient discharge. Performance has declined in June to 90.83% compared to 92.29% in May and is below the locally agreed target of 95%.

Divisional performance for June 2018 was as follows:-
- Surgery: 87.39% (89.61% in May)
- MLTC: 92.06% (94.17% in May)
- WCCSS: 92.84% (92.73% in May)

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

Benchmarking:

No national or regional benchmarking available for this measure.

Contractual status:

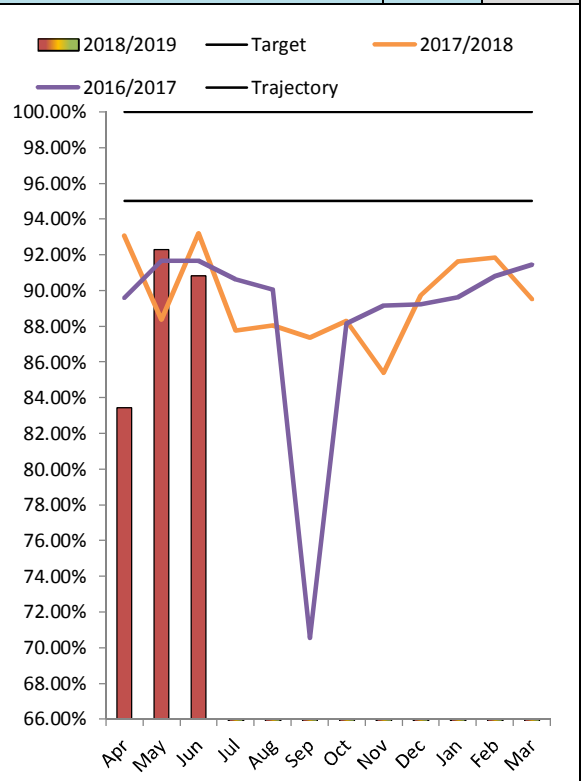
The NHS contract states when transferring or discharging a Service User from an inpatient or daycase or accident and emergency service, the Provider must within 24 hours following that transfer or discharge issue a Discharge Summary to the Service User's GP and/or Referrer and to any third party provider, 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 trustwide documentation audit is due to take place as part of the CQC PCIP which will include reviewing discharge summaries. This will be supported by NHS Improvement.
- 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 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	May-18	YTD	Change on last month	Year End Forecast
	90.00%		68.42%	67.33%	▲	

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 services. The target for all 3 requirements (screen, assess and refer) remains at 90%.

During May 2018 the Trust failed to achieve the 90% screening target for patients aged 75 years and over with performance of 68.42%. This is an improvement compared to the reported result in April 2018 (66.22%).

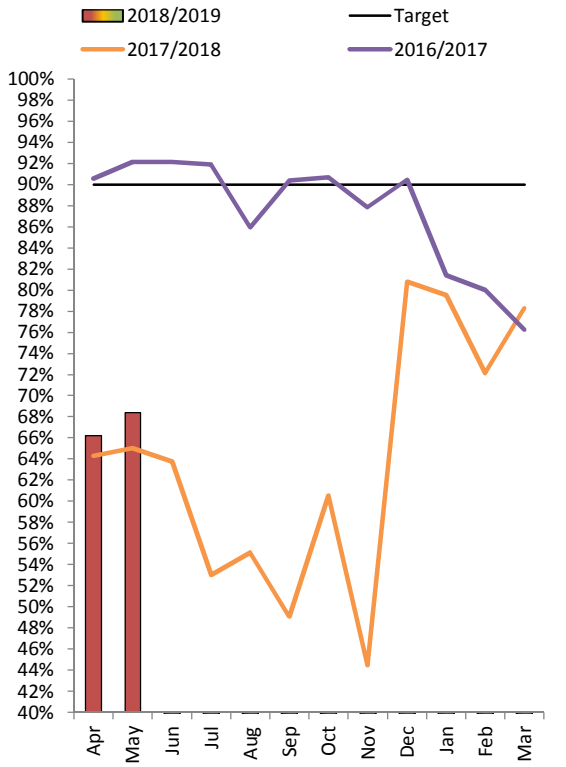
In agreement with WCCG and the Trusts executive lead, the reporting methodology has changed to utlising an audit approach rather than against the full cohort as it was not possible to capture the assessments for all applicable patients due to electronic system limitations.

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	

Walsall Healthcare NHS
NHS Trust

Compliance with MCA Stage 2 Tracking	Year Standard	Monthly Trajectory	Jun-18	YTD	Change on last month	Year End Forecast
	100.00%		69.00%		▼	

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

Performance Results

The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The MCA is designed to protect and restore power to those vulnerable people who lack capacity.

The test of mental capacity is essential in ensuring that people who lack capacity are protected. There is a two-stage test of capacity in order to decide whether an individual has the capacity to make a particular decision.

The percentage of patients with 2 stage test completed is based on a monthly audit of DNACPR decision making. Figures for June show performance of 69%.

Benchmarking:

No formal national reports.

Contractual Status:

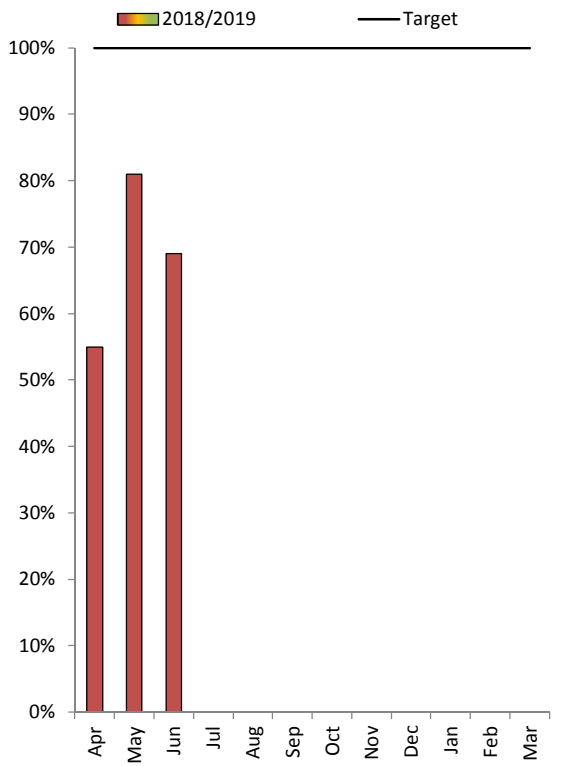
No contractual requirements apply.

New Actions:-

- MCA and form completion to be included in upcoming consent audit.
- MCA audited monthly when auditing DOLs referrals by safeguarding Adult Team, results to be fed back through DQT and to Ward areas and clinicians at the time of audit.
- Senior Quality Nurse to attend CQC preparation meeting 31st July to speak about legality and compliance with MCA.

Continuing Actions:-

- Audit continues monthly with results shared with Medical Director and Divisional Medical Directors for escalation where MCA has not been completed.
- Mandatory Training continues with bespoke sessions as requested.
- Escalation regarding compliance with mandatory training through divisional leadership.
- Included within the audit of care of patients with Dementia and escalated if concerns.



Expected date to meet standard	To be agreed
Lead Director	Director of Nursing

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Friends & Family Test (All Services)

Walsall Healthcare NHS Trust

Friends & Family Test - ED (% Recommended) Friends & Family Test - Inpatient (% Recommended)	Year Standard	Monthly Trajectory	Jun-18	YTD	Change on last month	Year End Forecast
	85.00%		75.00%		▼	
	96.00%		97.00%		▲	

What is driving the reported underperformance?

Performance results:

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

Measure	Target	May	June
Inpatient	96%	95%	97%
Outpatient	96%	92%	91%
ED	85%	76%	75%
Community	97%	98%	98%
Maternity-Antenatal	95%	91%	80%
Maternity-Birth	96%	90%	0%
Maternity-Postnatal Ward	92%	91%	100%
Maternity-Postnatal Community	97%	94%	100%

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

Benchmarking:

For ED, the latest benchmarking (May) ranks the Trust 122nd out of 129.

For Inpatients, the latest benchmarking (May) ranks the Trust 97th out of 131.

Contractual status:

NHS standard contract applies but no contractual financial penalties.

What actions have we taken to improve performance?

Inpatients:

- MLTC and Surgery division have now received some ipads for doing their FFT, these are currently with the IT team for setup. The devices will either complement or in some areas replace the use of paper surveys.

Use of tablet devices increases patient participation in the feedback process, makes surveys more accessible and improves the quality of qualitative and quantitative information collected.

ED:

- The Volunteer Service has recruited two more new volunteers to support improving patient's experience of this area.

Outpatients:

- Regular FFT data trends now included in the new OP key performance indicators dashboard. A new poster campaign to promote capaturing mroe postive experience via FFT is planned for Aug/Sep 2018. 'What matters to you' campaign is also being soft launched on OPD areas to enrich the qualitative data collection.

Maternity:

- Teams are being encouraged to increase their response rates, spread use of ipads. A maternity service app, similar to the paediatric app, is being explored. Birth did not register any responses in June.

Community:

- Adult Community Teams moving to FFT via Total Mobile devices in a phased manner and later switching to an offline app which works without wifi or mobile signals.

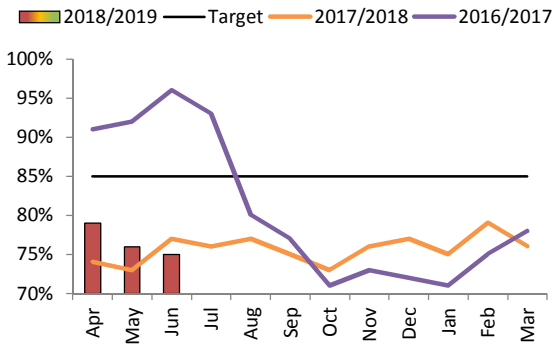
Continuing actions:

- 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.

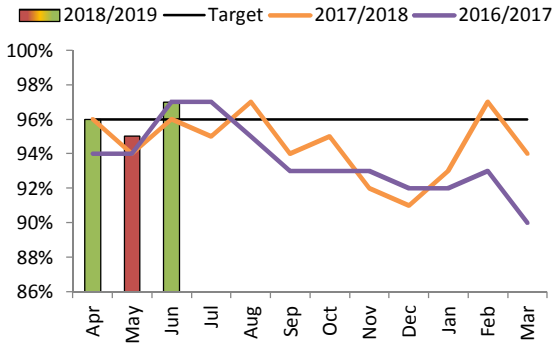
No Contractual Financial Penalties

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

	Year Standard	Monthly Trajectory	Jun-18	YTD	Change on last month	Year End Forecast
Adult Safeguarding Training - Level 3 Compliance	85%		87.48%		▲	
Children Safeguarding Training - Level 3 Compliance	85%		90.62%		▲	

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 June for both Adults and Children.

Based on Calendar Month	Target	May-18	Jun-18
PREVENT Level 1 & 2	85%	98.29%	98.22%
PREVENT Level 3	85%	77.51%	84.47%
Adult Safeguarding Level 1	95%	93.35%	99.76%
Adult Safeguarding Level 2	85%	79.13%	83.88%
Adult Safeguarding Level 3	85%	80.55%	87.48%
Children Safeguarding Level 1	95%	92.00%	99.77%
Children Safeguarding Level 2	85%	76.74%	82.10%
Children Safeguarding Level 3	85%	87.10%	90.62%

Of the 8 key training areas tracked above, 7 have shown improvement in June compared to May. Of the 6 areas of safe guarding training 4 have achieved the target in June, with level 2 training narrowly missing achievement. Focused work continues to achieve compliance in all areas.

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.

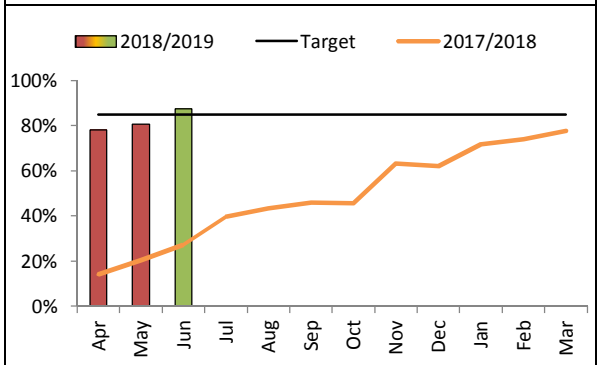
What actions have we taken to improve performance?

Continuing actions:

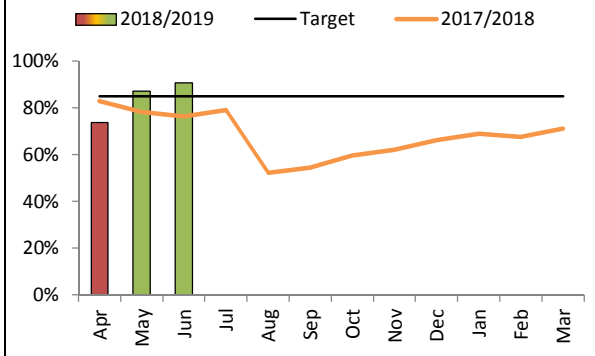
- Screensaver reminding staff of the importance of safeguarding training.
- Divisions to take accountability for staff training compliance and to receive reports naming staff who are non-compliant.
- Statistics included within the Board Performance Report.
- Staff requiring Level 3 training (face to 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	Safeguarding Level 3 achieved in June Adults and Children
Lead Director	Director of Nursing

National Contract	X		X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Mandatory Training Compliance	Year Standard	Monthly Trajectory	Jun-18	YTD	Change on last month	Year End Forecast
	90.00%		83.06%	83.06%	▲	

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

Performance status:
Mandatory training compliance levels in June have improved to 83.06% compared to 78.76% reported in May. A rise of 4.30% month on month. This represents a rise of 4.50% since the end of Q4 17/18 and a rise of 0.24% compared to the same period last year.

8 of the 8 core mandatory competences saw compliance increase by up to 8% month on month.

The largest improvement owed to Safeguarding Children Level 1, whereby compliance rose by 7.77% month on month.
The majority of divisions experienced a fall in compliance levels over the past month, of between 0% and 12%.

Women's, Children's & Clinical Support Services holds the highest level of divisional compliance, at 90%; which is 0% below the Trust target for Mandatory Training compliance.
Medicine & Long-Term Conditions holds the lowest levels of compliance, at 72%; this is 18% below agreed target levels.

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

Contractual status:
No contractual requirements apply.

New Actions:
- Learning & Development have produced guides on how to access e-learning; these are available on the Intranet, improving the experience of users

- Short Videos have been created and are available on the Intranet

- Facilitated E-Learning workshops are continuing, offering 1-1 advice for any colleagues struggling to access training.

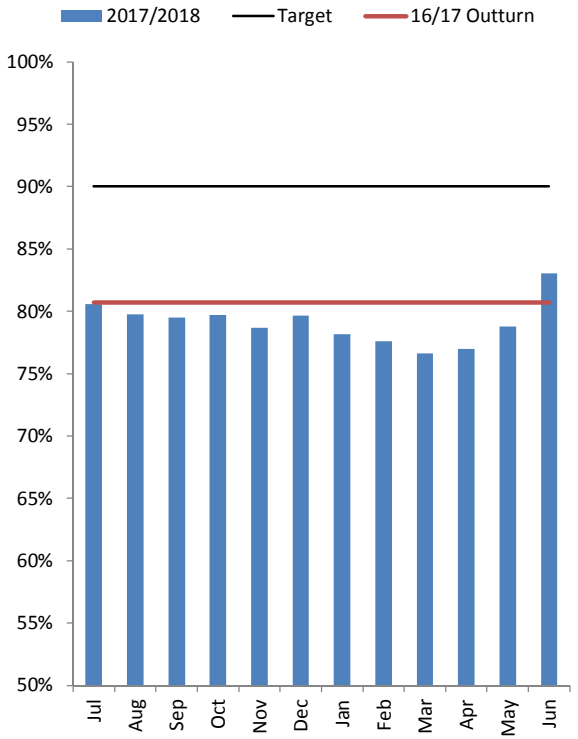
- Learning & Development colleagues have been visiting departments to give training and advice.

- Daily dose messages have been sent out, with a planned Daily dose dedicated to Mandatory Training

- Departments can have dedicated e-Learning Champions.

- We are reviewing the processes of competence requirements and plan to remove them all and re-load them. The time frame for this is October.

- Posters to be delivered to departments for those who do not access e-mails.



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

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Sickness Absence	Year Standard	Monthly Trajectory	Jun-18	YTD	Change on last month	Year End Forecast
	3.39%		4.97%	5.10%	▼	

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

Performance status:
Sickness levels declined in June with performance of 4.97% compared to 4.71% in May 2018 and did not achieve the target of 3.39%. This represents a rise of 0.33% compared to same period 2017/18.

Monthly short-term sickness during June 2018 totalled an estimated cost of £173k and long-term sickness totalled an estimated cost of £261k.

There were 159 long-term episodes of sickness during June 2018. 18 LTS cases extend to 6 months or more.
The largest cause of absence during June 2018 was Anxiety/stress/depression/other psychiatric illnesses - 1390 FTE Days across 83 episode(s) including 51 long-term.
The second largest cause of short-term absence was Other musculoskeletal problems - 746 FTE Days across 66 episode(s) including 20 long-term.
The sickness absence during the past 12 months stands at 5.31%, 1.92% above the Trust target.

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

Contractual status:
No contractual requirements apply.

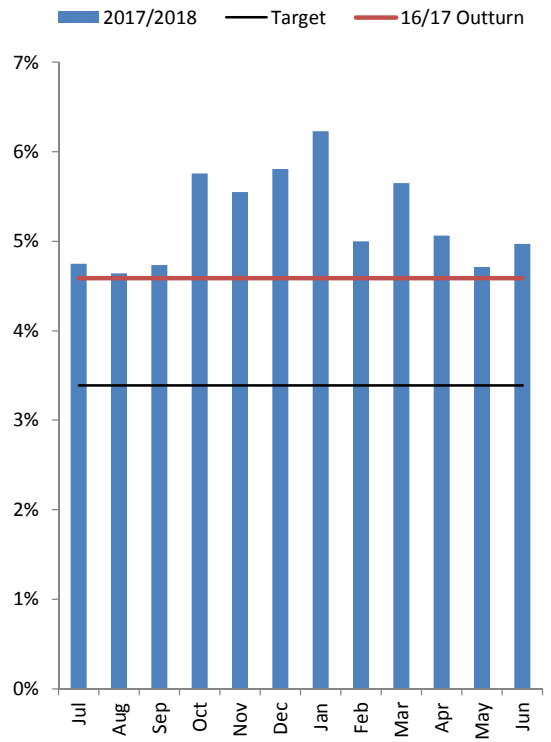
New Actions
- The Trust has begun a 90 day program utilising the 'Health and Well-Being Framework' commissioned by NHS Employers.

- The framework, which began in May 2018, is an interactive tool, which sets out actionable steps and also provides guidance on how an organisation can deliver on their Health and Well-Being plan. The Trust completed the diagnostic tool to assess where the organisation is against the framework.

- NHS Employers acknowledge that there are 3 health areas of concern; Mental Health, MSK & Healthy Lifestyles.

- Interventions fall in to 2 prevention and self-management, target support. This work will be monitored and supported by the Health and Well-Being Steering Group.

- Session offering Mental Health support for colleagues will take place over the next month; including targeted bespoke sessions for teams with serious concerns.



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	Jun-18	YTD	Change on last month	Year End Forecast
	90.00%		83.41%	83.41%	▲	

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 June 2018 was 83.41%, an increase on May's 82.42%. This represents a rise of 0.64% month on month.

119 Band 7 & above colleagues required an annual appraisal at the end of June 2018, resulting in a 79% compliance rate for this group.

The majority of divisions experienced a rise in compliance levels over the past month, of between 1% and 2%.

The Women's, Children's & Clinical Support Services division has the highest level of compliance at 89.06%.

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

Contractual status:
No contractual requirements apply.

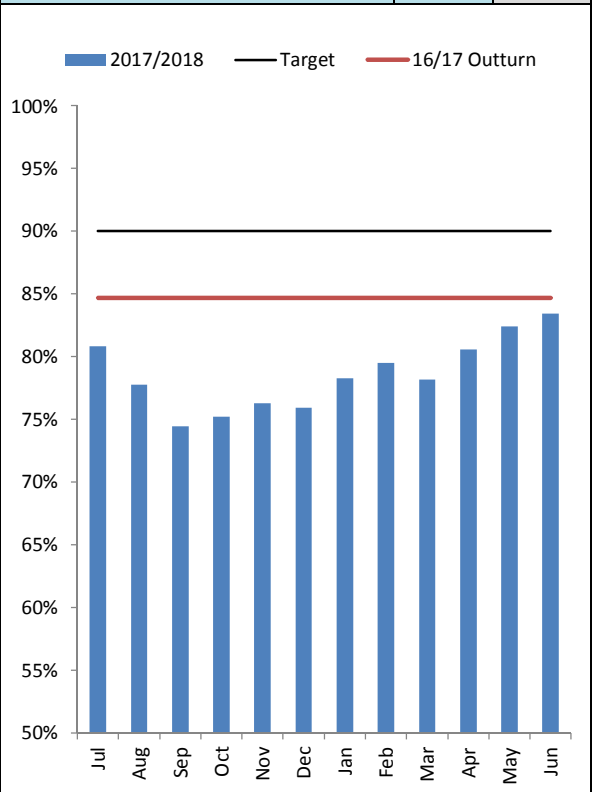
New Actions:
- Training sessions for Appraisers are on-going and are published in the Trust Training Bulletin.

- 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 when it is launched in September 2018.

- The publication of HR KPI league tables, with the performance of services ranked in a meaningful and engaging way, is being tabled for Q2 18/19.

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



Expected date to meet standard	TBC (pending review)
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS
NHS Trust

CQUINs

Becoming your partners for first class integrated care

2017/18 CQUIN SCHEMES - Status as at 30th June 2018 (values based on initial contract)

	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	£257,685	£64,421	£64,421	£32,211	£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
						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**
						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)
						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	£257,685	£64,421	£64,421	£64,421	£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.**
						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.**
						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
						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	£257,685		£64,421			**Personalised care and support planning: to introduce the requirement of high quality personalised care and support planning** **QTR 2: (end of Sept 17)** Submission of a plan to ensure care & support planning is recorded by providers. Status: Agreed with WCCG definition of long term conditions. Plan created. Linking into the Total Mobile
						b. Plan produced but recording system not in place = 50% of proportion of CQUIN value
						c. Plan produced and recording system put in place = 100% of proportion of CQUIN value Risk: none. **Confirmed by WCCG Achieved.**
				£38,653		**QTR 3**: identify the number of patients as having multiple LTCs and who will be prioritised for personalised care and support planning (establishment of cohort) compared to the total number of patients served Q3 submitted to WCCG. There were 241 patients identified (100% of the community matrons caseload)
					£77,306	**QTR 4a:** To confirm that proportion of relevant staff have undertaken training in personalised care and support planning. **Status:** 87.5% of staff trained **Confirmed by WCCG Achieved**
					£77,306	**QTR 4b:** To confirm the number of patients identified for the cohort who have one or more LTCs and have been assessed as having a low activation level **Status: Confirmed by WCCG Achieved.** There were 8 patients who scored zero who now require personalised care plans.
Sub totals	£257,685	£0	£64,421	£38,653	£154,611	
Preventing ill health by risky behaviours – alcohol and tobacco DoN	£276,091	£69,023				**Preventing ill health by risky behaviours – alcohol and tobacco** **QTR 1: each element worth 33% of Q1** **a)** completing an information systems audit; b) training staff to deliver brief advice, c) collect baseline data (on elements a) to e)) Risk: **Confirmed by WCCG Achieved**
			£3,451	£3,451	£3,451	Tobacco screening: Percentage of unique adult patients who are screened for smoking status AND whose results are recorded **Q2 Confirmed Achieved Q3 Confirmed Achieved . Q4 target = 90% Achieved 97%**
			£13,805	£13,805	£13,805	Percentage of unique patients who smoke AND are given very brief advice **Q2 Confirmed Achieved Q3: Achieved. Q4 target 80%. Achieved 88%.**
			£17,256	£17,256	£17,256	Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication. **Q2 Confirmed Achieved. Q3 achieved. Q4 target 60%. Achieved 88%**
			£17,256	£17,256	£17,256	Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems **Q2 Confirmed Achieved Q3 achieved. Q4 target 90%. Achieved 91%.**
			£17,256	£17,256	£17,256	Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral. **Status:** Q2 submitted and expected to achieve. Monthly audits continue (10 patients per ward) close monitoring of compliance and follow up with wards who are not performing the audit in full or have low compliance. Meeting arranged with WCCG during December to agree improvement trajectories. **Q2 & Q3Confirmed Achieved by WCCG. Q4 target 85%. Achieved 100%.**
Sub totals	£276,091	£69,023	£69,023	£69,023	£69,023	

Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) MD	£257,685	£8,053	£8,053	£8,053	£8,053	**Timely identification of sepsis in emergency departments** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis The indicator applies to adults and child patients arriving in hospital as emergency admissions A minimum of 50 records per month after exclusions for ED. 90% Target. Sliding scale 50-89% = 10%. **Status:** The audit methodology of NEWs scores continues not to identify the full required number of patients and continues to be time consuming. A centralised database is being created during Q3 to support the audit process. Risk: **Q1 achieved 95.33%. Q2 achieved 94.85% Q3: 95.77% Achieved. Q4 achieved 93.59%**
		£8,053	£8,053	£3,221 £4,832	£8,053	**Timely identification of sepsis in acute inpatient settings** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis. The indicator applies to all patients on acute in-patient wards. A minimum of 50 records per month after exclusions for Inpatients. 90% Target. Sliding scale 50-89% = 10%. **Status**: as ED. Risk: **Q1 achieved 90%. Q2 achieved 90.91%. Q3: 88.73%. partial achievement 10%.** Q4 achieved 90.48%.
		£3,221 £4,832	£3,221 £4,832	£3,221 £4,832	£8,053	**Timely treatment for sepsis in emergency departments** The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour. Applies to adults and child patients arriving in hospital as emergency admissions. 90% Target. Sliding scale 50-89% = 10% **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:** Expected to **Achieve**
			£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**:**Expected to achieve.**
	£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				£12,610 £12,610	**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 **Status**: **50% Achievement**
	£12,993				£6,496 £6,496	**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:** 50% Achievement SACT failed to achieve.
Sub totals	£76,427	£6,305	£6,305	£12,802	£51,015	
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	£6,305	£30,926	£31,741	£83,211	
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	£364,759	£757,506	£342,344	1,465,042	
Confirmed Lost	£310,079	£9,664	£9,664	£46,707	£244,045	Confirmed non achievement
	10.6%	2.6%	1.3%	13.6%	16.7%	
Confirmed Achieved	£2,555,151	£355,095	£747,842	£295,638	£1,156,576	Agreed by Commissioners as Achieved
	87.2%	97.4%	98.7%	86.4%	78.9%	
Forecast to achieve						
Forecast at risk	£64,421				£64,421	Risk to achieving (Awaiting Public Health England to validate AMB submission)
	2.2%				4.4%	
Totals	£2,929,652	£364,759	£757,506	£342,344	£1,465,042	

Walsall Healthcare NHS
NHS Trust

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
- DNACPR – Do not attempt cardiopulmonary resuscitation
- 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
- MCA – Mental Health Capacity Act
- MD – Medical Director
- MDT – Multi Disciplinary Team
- MFS – Morse Fall Scale
- MHRA – Medicines and Healthcare products Regulatory Agency
- MLTC – Medicine & Long Term Conditions
- MRSA - Methicillin-Resistant Staphylococcus Aureus
- MSG – Medicines Safety Group
- MSO – Medication Safety Officer
- MST – Medicines Safety Thermometer
- MUST – Malnutrition Universal Screening Tool

KPI Monitoring - Acronyms

N

- NAIF – National Audit of Inpatient Falls
- NCEPOD – National Confidential Enquiry into Patient Outcome and Death
- NHS – National Health Service
- NHSE – NHS England
- NHSI – NHS Improvement
- NHSIP – NHS Improvement Plan
- NOF – Neck of Femur
- NPSAS – National Patient Safety Alerting System
- NTDA/TDA – National Trust Development Authority

O

- OD – Organisational Development
- OH – Occupational Health
- ORMIS – Operating Room Management Information System

P

- PE – Patient Experience
- PEG – Patient Experience Group
- PFIC – Performance, Finance & Investment Committee
- PICO – Problem, Intervention, Comparative Treatment, Outcome
- PTL – Patient Tracking List
- PU – Pressure Ulcers

R

- RAP – Remedial Action Plan
- RATT – Rapid Assessment Treatment Team
- RCA – Root Cause Analysis
- RCN – Royal College of Nursing
- RCP – Royal College of Physicians
- RMC – Risk Management Committee
- RTT – Referral to Treatment
- RWT – The Royal Wolverhampton NHS Trust

S

- SAFER – Senior review - All patients will have an expected discharge date - Flow of patients - Early discharge – Review
- SAU – Surgical Assessment Unit
- SDS – Swift Discharge Suite
- SHMI – Summary Hospital Mortality Indicator
- SINAP – Stroke Improvement National Audit Programme
- SNAG – Senior Nurse Advisory Group
- SRG – Strategic Resilience Group
- SSU – Short Stay Unit
- STP – Sustainability and Transformation Plans
- STS – Short Term Sickness
- SWBH – Sandwell and West Birmingham Hospitals NHS Trust

T

- TACC – Theatres and Critical Care
- T&O – Trauma & Orthopaedics
- TCE – Trust Clinical Executive
- TDA/NTDA – Trust Development Authority
- TQE – Trust Quality Executive
- TSC – Trust Safety Committee
- TVN – Tissue Viability Nurse
- TV – Tissue Viability

U

- UCC – Urgent Care Centre
- UCP – Urgent Care Provider
- UHB – University Hospitals Birmingham NHS Foundation Trust
- UTI – Urinary Tract Infection

V

- VAF – Vacancy Approval Form
- VIP – Visual Infusion Phlebitis
- VTE – Venous Thromboembolism

W

- WCCG/CCG – Walsall Clinical Commissioning Group
- WCCSS – Women's, Children's & Clinical Support Services
- WHT – Walsall Healthcare NHS Trust
- WiC – Walk in Centre
- WLI – Waiting List Initiatives
- WMAS – West Midlands Ambulance Service
- WTE – Whole Time Equivalent

MEETING OF THE PUBLIC TRUST BOARD – Thursday 2nd August			
Information Technology Update Q2 2018			**AGENDA ITEM: 15**
Report Author and Job Title:	Daren Fradgley Director of Strategy and Improvement	**Responsible Director:**	Daren Fradgley Director of Strategy and Improvement
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	This briefing paper aims to give an update on the trust's IT current initiatives, strategic direction, plans and next steps. The trust digital strategy is currently being updated and due for completion in September/October. The focus is being clinically-led through weekly engagement and working from our Chief Clinical Information Officer Dr Javad This paper outlines the engagement approach, Electronic Patient Record Journey, IT Improvement projects and challenges for 18/19.		
Recommendation	Board members to NOTE and discuss the contents of this paper as an update on IT activities either in progress or planned for 18/19		
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.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

Walsall Healthcare NHS
NHS Trust

Information Technology Update
Q2 2018

1. PURPOSE OF REPORT

This briefing paper aims to give an update on the trust's IT current initiatives, strategic direction, plans and next steps.

The Trusts digital strategy is currently being updated and due for completion in September/October 2018. The focus is being clinically-led through weekly engagement and working from our Chief Clinical Information Officer Dr Javad

This paper outlines the engagement approach, Electronic Patient Record Journey, IT Improvement projects and challenges for 18/19.

2. DIGITAL NEEDS ASSESSMENT

Staff engagement is key to the success of finding the most appropriate Electronic Patient Record (EPR) and technology for the organisation and one that is future proofed to take us on our next journey of an Electronic Health Record (EHR). The Trusts strategy of wider partnership working also needs to be considered with the need to share a whole record across partners and pathways of care.

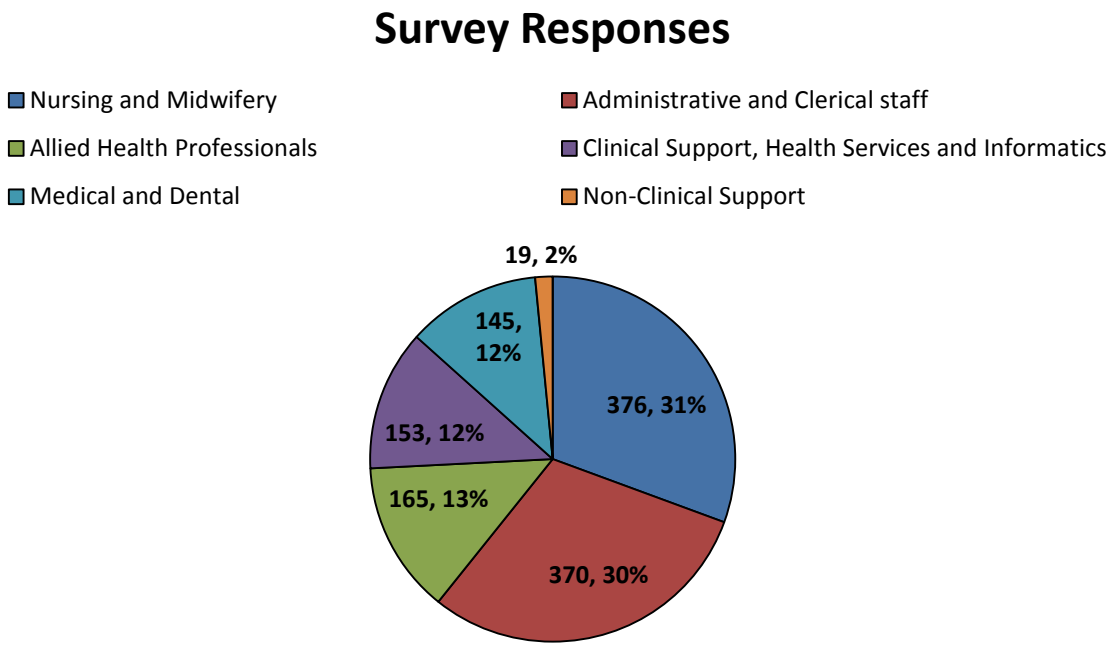
A trust-wide Digital Needs Assessment was conducted by engaging colleagues between 7th June and 29th June 2018.Views were gained from every service, site and role including evening, night and weekend colleagues. Staff were asked about what they need from our clinical systems as well as commenting on the system themselves. The word all below shows the breath of the consultation. The graphic below shows the span of the survey returns.

The survey itself was also collected using new technology deployed by the Trust. QR codes were visible around the Trust, on emails and on devices so that staff could route to an electronic survey that was tailored to their role.

The newly-appointed Trust Chief Clinical Information Officer (CCIO) is being used to assist coordinating the clinical requirements and conversations together with requirements from staff that use our IT and systems from an administrative and technical perspective.

The CCIO played a vital role in promoting the completion of the survey resulting in 1228 staff participating, 1048 responded to using our clinical portal, Fusion and 724 using our Patient Administration System, Lorenzo.

The engagement plan and approach to



The results are currently being analysed to input into our digital and EPR strategy. There will be opportunity where some quick wins and improvements can be made immediately or in the near future from existing systems and functionality. Examples of this are integrating record reporting from the Clinical Measurement Unit and scanning into Fusion, our clinical portal, external letters, both of which are underway

It should also be noted that not all the feedback received related to our current systems but more importantly about the gaps that can be addressed – application development and digital pagers to name but two.

3. EPR JOURNEY

The Executive will shortly commence the process of considering a variety of options as to the next steps to present to Board members relating to our EPR journey. This will be facilitated through the Trust Management Board.

The Trust has received formal notification from the Department of Health and Social Care of the expiry of the funded Lorenzo service under the CSC Local Service Provider Contract in March 2020. To comply with this notice and allow suitable time for a decision, and if appropriate, deployment programme, the Executive have asked for the options to be ready by October 2018.

Current position

Lorenzo – PAS system

Lorenzo became the Trusts Patient Administrative System (PAS) back in March 2014 on a 6-year contract centrally funded until March 2020. Phase one commenced with the building of the core PAS / Admin with phase 2 being the deployment of clinical functionality such as reports and requests, EPMA and Maternity. Unfortunately, most of the clinical functionality in Lorenzo was not deployed due to it not being ready at the time and the Trust electing to stay with Fusion or an alternative specialist/departmental system i.e. BadgerNet for Maternity service. This decision resulted in the Trust using two core systems instead of one.

Fusion+ - Clinical Portal

Fusion was deployed in 2002 and is the Trusts Clinical Portal covering 450,000 patient records with over 3000 users. The portal is used across the Health Economy by Acute and Community staff, all Walsall GP practices and out of area GPs, Voluntary partners, Partner Trusts as well as Social care and Mental Health colleagues.

Fusion was upgraded to Fusion+ with the roll out commencing 16th October 2017. The new version gives a new look and feel to the systems with more tabulated searching and capacity to build mobile applications. Updated architecture now gives a fully supported version and platform on which to build richer functionality.

Future State – EPR Direction

Given the limited progress of phase 2 of the Lorenzo program, the Trust remains on two core systems as previously described. It should be considered moving forward whether this configuration is optimal for our operation. To understand this, a review of what an EPR definition has been undertaken and is noted below.

An electronic patient record (EPR) is a structured collection of patient medical information, both clinical and administrative data, stored accurately electronically in order to provide patient information to clinicians across the Healthcare Economy.

Below describes the high level functions of a PAS and EPR with Fusion + fulfilling some of the functionality of what is described as an EPR but not all given the existence of Lorenzo.

PAS – Patient Administrative System LORENZO	EPR – Electronic Patient Record
Manages the main activity of the trust capturing encounters, managing waiting lists and all associated pathway and RTT information. High level functions such as:- - Referral To Treatment management (RTT) - Inpatient Bed Management - Outpatient Appointment Management - Emergency Department Management - Contact Management - Coding and Grouping (Procedures / Investigations / Diagnosis) - Commissioning Data Sets - eRS integration	Augments the administrative activity captured in PAS with clinical content and ideally additional information from other healthcare providers such as Primary Care, Social Care and Mental Health. High level functions such as:- - Order Communications and Results Reporting - Integrated Care Pathways - Observations and Notes - Clinical Assessments - GP clinicals - eDischarge process - Current Medications - Immunisations - Problems and Existing Conditions

At this point it is suggested that we use these views to build an options appraisal limited to the following three options.

Key Considerations

Retain current PAS Lorenzo, Trust Clinical Portal Fusion+

When reviewing the retention of Lorenzo, evidence from clinician's needs to be considered as well as if the current state will be maintained or whether it is enhanced to include additional functionality. The known gaps need to be addressed i.e. A&E, CMU, Patient Vital Statistics/Immunisations and internal referrals/requests (list not exhaustive)

Contract negotiations would be required to renegotiate the contract cost from 2020 accepting that the Trust has not deployed all elements of the system – some of which remain in development.

Commitment and investment is also required to address some of the current solution gaps i.e. workflow/eform solution application platform, a patient portal to allow patient access and additional support for areas such as CMU and interfacing with other systems such as ORMIS Theatres.

New PAS product, retain Trust Clinical Portal Fusion+

In this scenario the Trust would need to understand the benefits of replacing the PAS system only to work alongside Fusion+. The Trust will need to procure plan and deploy a new system to ensure continuity of critical clinical services post March 2020.

Whilst Fusion would be retained in this option, a full rebuild of the infrastructure that it resides on will be required to ensure that speed and access issues are resolved. It should be noted that

some of these issues are not system related today but relate to the clients that the software sits on.

Full EPR, complete new platform (replacement of Lorenzo, Fusion+)
A single partner approach or multi agency approach will need to be considered learning from other Trusts that have followed this route. This could be phased over a longer period of time doing an element at a time.

NEXT STEPS for EPR

- Results of the Digital Clinical Needs Assessment in outlining the findings and proposed next steps in August.
- Match the needs assessment to the capabilities or planned future capabilities of the current systems that the Trust operates.
- Establish a clinical focus/user groups and future engagement programme to understand the future needs assessment of system users. There are already 300 people that have committed to participating in the process further. (August-September)

4. **TRANSFORMATIONAL PROJECTS STARTING IN 18/19**

-

There are several major transformational projects in line with the strategic direction and Trusts paper-free journey. This include:

Community Mobile Working (Total mobile)

We have successfully implemented community mobile working using Total Mobile where staff use tablets in their everyday work to record the patients care. This provides access to the shared record from all the Trusts systems. Where community staff have all the relevant information at their fingertips electronically.

We are currently building the case to extend this across Children's Community Services to make our entire community workforce digital. Further integration with our GP colleagues through EMIS is currently underway so that a primary care record can be accessed and edited at the patients side.

Emergency Department

Working together, ED and Informatics have investigated an eForm solutions to enable real-time data capture by the Clinicians. eForm solutions enable paper forms to be electronically recreated, designed to capture, validate and share data with other IT systems. This pilot project starts in August and uses mobile technology to fulfil the requirements of ED pathway. If this is successful, then consideration for a wider roll out will be explored. This project is being sponsored by the ED team and coordinated by IT.

Patient Flow

A Patient and Asset Tracking System business case is being finalised. There has been delay with this process due mainly to affordability of the system. However, progress is now being made. This platform will represent a more integrated, sophisticated approach to patient flow, moving away from simpler siloed components, such as bed management, case management, transport, and staff assignment. Through the establishment of a Coordination Centre, the platform will allow the users to analyse patient flow, use predictive models to anticipate

downstream demand, monitor pathways, coordinate patient placement within the acute and community setting, sensor-track resources and patients, and adjust resources in real-time to changing circumstances. This deployment is considered essential to efficiently manage our operation. To this extent, additional options are being explored as contingency incase the primary approach is not successful. There is a large level of clinical support and ambition for this piece of work.

Outpatients

Through the Outpatients Improvement Programme a pilot for Self-Check-in is being considered for Q4. This principle of arrival and booking in is now becoming commonplace in other sites and will change the way in which our clinics are organised on the day.
Delivery of Paperless Outpatient Clinics is also being piloted with a view of how we can have reduced and then remove the use of paper records from our day to day operations.
Implementation of Virtual Clinics Programme is in progress. This will enable clinicians to book follow-up calls with patients without bringing them back into clinic.

Digitalisation of Patient Records (Electronic Document Management)

A business case has been completed and is now about to commence the approvals process. The Trust generates about 83,000 pieces of paper per week from clinical activities and this content needs to be safely stored and made available for later use. The rate at which paper is being generated means that the existing records store which is currently full would have to move more active records to local storage incurring increased charges in retrieval when these patient come back into contact with the Trust. In addition to this, logistics of moving records, timeliness of access and information governance are all areas that require addressing. The deployment of an electronic record would start to resolve these issues and is complementary to an refreshed systems approach.

Deployment of a new Business Intelligence System

Work is well underway to look at options for procurement of a Business Intelligence system so that the Trust can change the way in which its builds up the information and intelligence picture for the future. Work around this will be coordinated in three phases.

- Organising the data within our systems so that we can see all elements of the Trust Operation.
- Displaying the data using the BI platform in a way that a picture can be built, and trends can quickly be identified
- Develop teams to use the data to inform the decisions that are taken in the future.

Other improvement projects for delivery in 18/19 include

- **Office365** for collaboration and back office efficiencies. (Collaborative working, virtual meetings)
- **Managed Print Service** reducing the amount a paper produced. This will be achieved by a follow me printing approach
- Enhancements in the capture of ***nurse observations & SEPSIS through VITALPAC***
- Development of the new ***Black Country Pathology System*** within the Trust
- Implementation of ***End of Life (EPACCS) system*** across the health economy
- Development of the ***Shared Care Record*** across STP. Initially across Walsall/Wolverhampton and started with the End Of Life record outlined above.

- replacement of **Digital Dictation** with enhanced workflow features
- **Maternity (Badgernet)** enhancements for end to end maternity pathway
- Through the new **eforms/workflow/app** platforms
    - Internal Referrals (electronic referrals)
    - Bleep and Notification Capability
    - Inpatient Booking and Patient Consent Forms
- Available through the EPR Clinical Portal
    - **External Correspondence** from other providers
    - **Results Acknowledgements for** Clinicians
    - Integration of **CMU systems and results**
    - **Operating Notes** available to all users through Clinical Portal(Fusion)
    - **Consultant Dashboard/Splashboard**
- **Therapies System Review**
- **Chemotherapy (eChemocare)** New Software with enhancements
- **PACS System** Re-Provision

5. OTHER IT PLANNED ACTIVITIES OVER NEXT 36 MONTHS

IT infrastructure transformational projects

- Move from Desktop based computing to Tablet/Laptop/Mobile platform
- Review of Cloud Technologies
- BYOD (Bring your Own Device)
- Paper-free meetings
- Single Sign on
- Password self-reset
- VDI for A&E

IT life-cycle projects

- Overall Trust Life-cycling Strategy
- Cyber-Security Review
- New Trust Network (HSCN Wide Area Network Migration)
- Manor Telephony (depending on Network repatriation decision)
- Server/Storage migration
- Windows Server 2008 to 2016 migration
- Windows 10 upgrade
- WIFI cart replacement – mobile working
- Direct Access/VPN
- Active Directory Migration

6. RECOMMENDATIONS

Board members are asked to NOTE the information within this report

Report Author: Daren Fradgley- Director of Strategy and Improvement
Date of report: 20/07/2018

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD – Thursday 2nd August			
Partnership Update August 2018			**AGENDA ITEM: 16**
Report Author and Job Title:	Daren Fradgley Director of Strategy and Improvement	**Responsible Director:**	Daren Fradgley Director of Strategy and Improvement
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	Paper updates Board Members on the key partnership working undertaken this month. This includes the following • Admission avoidance workshop • Place Based Teams • Partnership Governance • Black Country STP • Partnership measures • MDT progress table		
Recommendation	Board members to NOTE and discuss the contents of this paper .		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses the mitigations mapped out in the care at home and partnership risks in the BAF		
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.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

Walsall Healthcare NHS
NHS Trust

Partnership Report

August 2018

1. PURPOSE OF REPORT

This report is the monthly update on partnership activities that the Trust has been involved in. It is not designed to be a complete list but establish the key highlights and next steps.

2. ADMISSION AVOIDANCE EVENT

As part of the admission work that is being sponsored through the A&E delivery Board, a workshop was held with partners across the system to understand what opportunities exist working together.

The workshop was focused on a patient that struggles to get access to services and ends up in A&E. The partners within the workshop were tasked with looking at the patient journey and exploring what services or interventions could be put in place to provide a better pathway for the patient.

A variety of opportunities were exposed that where complimented with the current Walsall Together work, in particular, the strength of the Place Based Teams and Rapid Response. It was apparent through the discussion that our example patient could easily miss those services if not known to the community or weren't referred at the time of requesting. Equally the need to share records across providers to see previous episode or care records was a particular weakness.

Whilst there were a variety of short and medium-term actions that can and will be taken before winter pressures commence, the need for a care coordination service to navigate the patient to the right service and access to a shared care record were considered essential next steps in the planning process. This was supported by previous work that I had reported in last month's report in our visit to Rotherham.

A more focused visit is now planned to visit Rotherham to look at these two functions and see what knowledge, skills and technology can be transferred to Walsall. Equally the team from Rotherham are visit Walsall in October to look at our Intermediate care and place based services.

3. PLACE BASED TEAMS

During this month the Chief Executive and myself have visited a further two community teams to explore how the Walsall Together work is bedding in. Teams in the North were passionate about the progress they had made with Social Care on a joint referral process. Both professional groups are meeting frequently and working from the same room. What was equally impressive during the visit was the fact that they spoke as if they were one team

and highlighted numerous examples collaborative problem solving. The thinking was mature enough to highlight gaps in services that should provide support for drug and alcohol abuse. A conversation on behalf of the teams is now being had with the commissioners to see how we respond to these issues highlighted.

Estates continued to be a challenge in the East, North and South of the borough but options for resolution are becoming clear and being explored with partners. The Walsall Together program has been adapted to look at Estates and IT to respond to the issues as we move forward

The work on developing the MDT's with primary care continues at a sensible pace given the challenges experienced. Another two practices are about to come online and are noted in the appendix to this paper. The project team is now looking at how we scale up the MDT's to cover as many practices as possible in the next 6 months. This will require some use of technology together and some wider collaborative meetings. The teams from any of the partners do not have the capacity to service 50+ MDT's a month so the next stage of planning is critical to future progress. The project team are now working through this with a variety of options being considered

4. PARTNERSHIP GOVERNANCE

Over the past 12 months, several partnership groups have been running concurrently working on Walsall Together – these include the Provider Board and the Partnership Group that has been overseeing Intermediate Care Services and Place Based Teams. A decision has now been taken to merge these groups together into the Provider Board that will align provider oversight and promote consistent thinking in the Walsall Together business case. A series of workshops have been planned to establish future governance arrangements for the Host Provider Model and the associated delegated authorities of the partners. This model will be consulted through the Trust Board and will be at the core of any future thinking.

The Walsall Together Board which has both provider and commissioners present will retain program oversight. A monthly pack on progress will be provided but will only work within the delegated authority provided to complete the Walsall Together business case and progress the current partnership schemes underway. Until established otherwise, all other governance matters will route through the Trusts established Committee and Board Structures. An additional review of how the program is overseen within the Trust is underway with the relevant Executive Directors and if any variations are proposed then this will be established through next month's Board governance cycle.

5. BLACK COUNTRY STP

The design work on developing the next stage of the wider partnership plan is coming to an end. It has revealed that each of the four Places in the Black Country have strong and developing plans. The Walsall Together plan in some regards is ahead of most in terms of

thinking and next steps. Subject to the approval of a Host Provider model later this year, Walsall will be in a very strong position in the Black Country. However, learning can still be achieved and all of the boroughs have committed to sharing ideas on how to manage the populations we serve. The services that we can provide as a wider partnership of providers and commissioners still requires additional work and thinking. An overarching STP strategy is now in final draft and will shortly be shared for comments.

The Trusts review of services and their future sustainability is now going through a consistency check and will provide the roadmap for working at scale with other providers in the Black Country.

6. PARTNERSHIP MEASURES

Work has commenced both internally and with partners to establish a key set of metrics to monitor progress towards a formal Walsall Together proposal. A proportion of these metrics will also look at key partnership working in place today. To align the thinking with the integrated performance dashboard these measures will be included in the new draft report and developed over the next few months and tested through the committee structures.

In parallel with this, a set of system outcome measures are in development, lead by the CCG and the Council. The first draft has been produced and is currently being shared for comment with system leaders. The ambition being that outcome measures become the performance metric for Walsall Together moving forward.

7. RECOMMENDATIONS

Board members are asked to NOTE the information within this report

Report Author: Daren Fradgley- Director of Strategy and Improvement
Date of report: 20/07/2018

MDT Summary - Last Updated 25th July 18				
Key		**Covered by GP Led MDT's**		
Blue	MDT Running - Fully	**% GP covered**	**16%**	
Green	MDT's Running	**% Total Practices covered**	**15%**	
Amber	MDT's Planned	**% Population covered**	**19%**	
Red	MDT's To be agreed			
Pilot - Phase One				
Locality	**Practice Name**	**Time & Date**	**Status**	**Comments**
West 1	Bentley Med Centre Berkley Practice Stroud Practice	**Monthly** Every 3rd Mon at 13:00hrs	Running	Running well, MDT's have been well attended.since Aug 17
West 2	Lockfield Surgery	**Monthly** Every 2nd Tuesday at 11:30hrs	Running	Running well, MDT's have been well attended.
East 2	Northgate Practice	**Bi-Monthly** Every 3rd Tues at 12:30hrs	Running	Running well, MDT's have been well attended. Monthly meetings now set for 3rd Tue Bi-monthly
East 2	Portland Practice	**Bi-Monthly** Every 3rd Tues at 13:30hrs	Running	Running well, MDT's have been well attended. Meetings now bi-monthly due to GSF.
west 2	Moxley Practice	**Monthly** Every 3rd Wed at 11:30hrs	Running	Another very good MDT. Practice going to talk to two other practices and see if they want to join this MDT. Monthly meetings to be set for 3rd Wed every month
North	Pinfold St Mary's Surgery	**Monthly** Last Thurs of every month, attached to monthly MDT meeting so date of meeting wont always be rolling date 1.30pm-2pm	Running	MDT meeting on the 17th May was well attended, practice felt halfan hour was enough time for them, even though the meeting lasted an hour.
North	Pinfold Bloxwich Practice	**Bi-Monthly** Next meeting confirmed 22nd Aug @ 12:15hrs	Running	2nd meeting went well, 3rd meeting planned for August, GP looking to see if practice can attach MDT to existing PBT and St Mary's MDT, GP wanted August's MDT meeting in his office, and asked for only those services that have input into his patients to attend.
South 2	Brace Street	**Monthly** Every 1st Tues at 13:00hrs	Running	First meeting was well attended, GP stated that he thinks the MDT is really useful.
East 1	Parkside Practice	**Bi-Monthly** Every 4th Wed (bi-monthly) at 13:00hrs	Running	First MDT took place on the 25th July, very well attended only 1 service not in attendance due to illness.
South 1	Pleck HC	Awaiting date and time for first meeting	Planned	Meeting went ahead on the 8th May with practice manager, practice will be contacting MDT Co-ordinator with a suitable rolling date and time, and have confirmed they will be taking part.
East 2	Collingwood Practice	Awaiting date and time for first meeting	Planned	Meeting went ahead on the 21st May with practice manager and GP, practice will be contacting MDT Co-ordinator with a suitable rolling date and time, and have confirmed they will be taking part.

MEETING OF THE PUBLIC TRUST BOARD – 2nd August 2018			
Quality & Safety Committee Highlight Report			**AGENDA ITEM: 17**
Report Author and Job Title:	Kara Blackwell, Acting Director of Nursing	**Responsible Director:**	Professor Russell Beale, Non-Executive Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The report provides a highlight of the key items discussed at the most recent Quality & Safety Committee meeting held on the 26th July 2018 together with the confirmed minutes of the meeting held on 29th June 2018 (appendix 1). Key items discussed at the meeting were: • The process for QIA's needed to be reviewed for consideration at the next Quality Committee • The discussion in relation to how we maximise the opportunity for clinical engagement of staff in relation to Walsall Together • The positive highlights from the MLTC presentation The meeting held on the 26th July 2018 was quorate and chaired by Professor Beale.		
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		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

Walsall Healthcare NHS
NHS Trust

Quality & Safety Committee Highlight Report

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 26th July 2018

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

The Role of the Trainee Nursing Associate

The Associate Director of Nursing provided a presentation of the Trainee Nursing Associates and the following points were noted:

- The trust had been a pilot for the role
- The 19 TNAs will qualify and register with the NMC in January 2019
- There needed to be an acknowledgement and celebration of these TNAs when they qualify as they will be the first across the Country alongside the other pilot sites
- There needs to be clear communications across the Trust in relation to how these newly qualified TNAs will be integrated into the workforce

Performance and Quality Report

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

- There had been no C. Diff cases reported in June 2018
- The HSMR had reduced
- Safeguarding training performance, whilst the Trust had seen significant improvements over the last few months and was compliant with level 1 and 3 Adult and Children Safeguarding and Level 2 Adult Safeguarding at the end of June 2018, it did not achieve the Level 2 Children's training and was just below the 85% target
- The monthly Divisional review Process was now in place and would help drive the accountability for performance against key quality and safety KPIs
- There was a reduction in the number of falls in June 2018
- Re-admission rates remained higher than trajectory

Mortality Report

The reported was presented and discussion highlighted the following key points:

- HSMR for the year remains high, although positioned well regionally. Areas highlighted included fluid electrolyte balance

- In relation to Mortality Reviews these were not being achieved in all specialities. A paper in relation to the recruitment of a medical examiner as per national guidance is being developed. The possibility of partnership working in relation to this would be explored.

Monthly Safe Staffing Report

The following key points were noted and discussed:

- Fill rates remained above the 90% target and were 96.72% in June 2018
- CHPPD were 7.4 but the Trust remained below the national median and in the lowest quartile
- The daily acuity tool alongside the risk assessment had commenced
- The reporting of NICE (2015) staffing Red Flags had started to be collected as part of the risk assessments, these would provide information on the impact of gaps in staffing on patient care and would be reported in future staffing reports

Progress Update on the Emergency Care Improvement Programme

The committee was provided with an update on the Emergency Improvement Programme and the Winter Plan. The recent workshop on the frailty assessment pathways was outlined and the progress in relation to implementation of Red to Green and Safer. There was a discussion about the pressures which meant that closure of beds was difficult as part of the financial recovery plan. It was highlighted that the Financial Recovery Plan and suggested schemes included in this would need an enhanced Quality Impact Assessment. It was agreed that these schemes requiring an enhanced QiA should come to the next Quality Committee for discussion to ensure the balance between quality impacts and financial impacts were correct. The QiA process needed further strengthening and it was agreed that this would be developed and presented at the next Committee.

Update on the Patient Care Improvement Programme

The report was presented and the following items discussed:

- Risks around consistently achieving the safeguarding training and the issues around documentation
- The planned outcomes workshop on 4th September 2018
- The multi-professional quality audits being planned to commence later in August 2018. A smaller scale documentation audit had been planned for week commencing 30th July 2018
- MCA/DNACPR required further actions to ensure improvements were made and sustained
- The planned check and challenge sessions with the Care Groups in relation to the self-assessments they had undertaken as part of the CQC prep work

Risk Management Report

The Risk Management Committee and Escalation report outlined:

- There had been 7 Sis reported in June 2018

- The number of Pressure Ulcer Sis had reduced but all reported related to unstageable pressure ulcers.
- There remained outstanding actions from previous Sis which needed to be actioned and closed as soon as possible
- The proposal for a Patient Safety Committee and Patient Safety Report were discussed. The proposal was being discussed with the CEO and Chair but the aim would be to enable wider cross Divisional learning from Sis

Equipment Replacement Programme

The planned equipment replacement programme achieved within the current financial constraints was presented:

- The programme had prioritised some equipment that must be replaced due to changes in guidance
- The proposal for leasing some equipment requiring replacement such as that needed in radiology
- The list had been agreed with the Divisions

Presentation from Division of Medicine and Long Term Conditions

The Division of Medicine and Long Term Conditions presentation included:

- An update on the CQC self-assessment and the actions being taken in relation to outstanding PCIP items
- The improvements in relation to observations recorded on Vital Pac which were now >90%
- The work undertaken in relation to “the aggregation of marginal gains” including end PJ paralysis, open visiting, activity sessions on MFFD/Elderly care ward
- The recent video produced as part of the enhanced collaborative care work with NHS Improvement which was awarded best video
- Areas of ongoing concern included staff recruitment, pressure ulcers on heels and the ED environment

The committee also discussed the understanding of the “Walsall Together” work for staff in the Division; it was agreed this needed strengthening and more focused engagement with the clinical teams so they were able to understand their part in this.

3.0 Conclusion/Recommendations

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

- The process for Quality Impact Assessments needed to be reviewed for consideration at the next Quality Committee
- The discussion in relation to how we maximise the opportunity for clinical engagement of staff in relation to Walsall Together
- The positive highlights from the MLTC presentation

Appendix 1

MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON THURSDAY 28TH JUNE 2018 AT 9.00 A.M ROOM 10, MLCC, WALSALL MANOR HOSPITAL

Present:	Professor R Beale	Non-Executive Director (Chair)
	Mrs A Baines	Associate Non-Executive Director
	Ms K Blackwell	Acting Director of Nursing
	Ms J Davies	Director of Governance
	Mr P Gayle	Non-Executive Director
	Mrs V Harris	Non-Executive Director
	Mr A Khan	Medical Director
	Mr P Thomas-Hands	Chief Operating Officer (Item 47/18 onwards)
	Mrs J White	Interim Trust Secretary
In Attendance:	Mrs C Gilbert	Divisional Director of Nursing, Surgery (Item 58/18 only)
	Mr N Turner	Divisional Director, Surgery (Item 58/18 only)
	Mrs A Winyard	Divisional Director of Operations, Surgery (Item 58/18 only)
	Miss S Garner	Executive Assistant (minutes)
Apologies:	Mr R Beeken	Chief Executive

42/18 Welcome and Introductions

Professor Beale welcomed everyone to the meeting and introduced Mrs Baines who was an Associate Non-Executive Director and a new member of the Committee.

43/18 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

44/18 Declarations of Interest

There were no declarations of interest.

45/18 Minutes of the Meeting Held on Thursday 31st May 2018

Resolution

The minutes of the meeting held on 31st May 2018 were agreed as a true and accurate record.

46/18 Action Sheet and Matters Arising

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

- 234/17 Ms Blackwell confirmed that discussions were ongoing with the NHS Improvement lead regarding the dementia submission. The Trust's request to submit data from a point prevalence audit had been rejected by Unify; however, other trusts were submitting this data. The dementia audit continued to be undertaken but data was not currently being submitted, this had been agreed with the CCG.
- 29/18 The Improvement Consultant had been working on the quality audit process and the final audit tool was due to be agreed on Monday. A meeting was taking place to engage with the lead nurses and consultants for each ward this week and the tool would be rolled out through July.
- 37/18 The increase in the number of formal complaints per 10,000 spells for elective activity would be picked up as part of the quarter 1 complaints report.

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

47/18 Performance & Quality Report

Mr Khan presented the performance & quality report and the following points were noted:

- There were no mixed sex accommodation breaches during May
- There had been 5 C. difficile cases reported to date against a trajectory of 17 for the year. A deep cleaning programme had been agreed for all wards.
- The HSMR rate was now improving after a period of increased incidence throughout December and January.
- Performance for the dementia screening assessment had decreased, this was being addressed with the 'quality champions', lead nurse and consultant for each ward.

Mr Thomas-Hands joined the meeting.

Mr Gayle recognised a decrease in FFT performance for outpatients and inpatients. It was noted that work was ongoing in the outpatients department to increase FFT responses and a request for charitable funds had been completed to purchase some iPads for the inpatient wards for completion of the survey. The matron for the outpatient areas was also providing feedback to the specialty teams to improve ownership and identify any areas for improvement.

There was a discussion about delays in ambulance handover and how this impacted quality. Ms Blackwell advised that there were a

number of elements in the Emergency Department that impacted patient experience including poor communication in relation to waiting times and the environment and lack of space. Mr Thomas-Hands confirmed that Walsall had been identified as the second best performing Trust in relation to improving handover times.

Concerns were raised regarding safeguarding training compliance. Ms Blackwell advised that this was now being monitored on a daily basis and latest figures showed that the target for level 1 and 3 adult and children training had been achieved. The target for level 2 training had been negotiated to 85% with the CCG and further work was being done to achieve this. Professor Beale was concerned regarding the lack of response from staff to complete their training and it was agreed that staff should be held responsible for not completing their training and this should be raised in staff appraisals. Mr Khan highlighted that he would be discussing levels of training required for consultants with the divisional directors. There was a further suggestion to delay pay progression for staff who had not completed their training, however, there were also concerns about how this may affect staff culture. Mr Gayle agreed to raise this for discussion at the People & Organisational Development Committee.

There was a discussion about pressure ulcers and the difficulties in benchmarking these as they were recorded differently in different organisations, e.g. the recording of a pressure ulcer as hospital acquired ranged from 6 hours post admission to 72 hours making comparison between organisations more difficult. NHS Improvement had released a new definition and measurement framework for implementation in April 2019 which would aid comparison in the future. **PG**

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

48/18 Progress Update on the Emergency Care Improvement Programme

Mr Thomas-Hands highlighted that the work on the Emergency Care Improvement Programme had supported in the development of the Winter Plan which had been approved at this week's A&E Delivery Board. The final version had been circulated to members for discussion. A progress report on the ECIP would be provided at the next meeting. **PTH Jul 18**

Resolution
The Committee received the update on the Emergency Care Improvement Programme and a progress report would be provided at the next meeting.

49/18 Winter Plan

Mr Thomas-Hands presented the Winter Plan which had been developed following some analysis of the previous three winters and the actions identified to ensure safety of the Trust's bed base throughout the next winter period. The plan outlined the likely admitted bed demand expected in 2018/19 and mitigating actions being taken across the health economy to support the plan. Members were also advised of plans to maintain a staffed ward throughout the year to avoid the negative impact of 100% bed occupancy and the related impact this had on the quality, safety and patient experience of care. Mr Thomas-Hands confirmed that the plan had been fully supported by all partners at the A&E Delivery Board this week and the CCG had provided assurance that the 111 service had been strengthened in readiness for winter. A summary of next steps was provided including the workstreams being supported by the Emergency Care Improvement Programme and the risks associated with the plan.

Members were assured that the plan had been developed and shared with the committee at this early stage; however concerns were raised in relation to current clinical workforce gaps and the impact this would have on the plan. Mr Khan agreed that this would be a risk for the organisation; however, the plan had been developed with input from the clinical teams.

Ms Davies highlighted that the views of the committee should be re-focused and was concerned that discussions had been very performance driven. The purpose of providing the report to the committee was to focus on driving better quality and patient experience.

Resolution
The Winter Plan was received and noted by the Committee.

50/18 Update on the Patient Care Improvement Programme and Regulatory Breaches

Ms Blackwell presented the report on the Patient Care Improvement Plan which included an update on the regulatory breaches and 'must' and 'should' do actions highlighted in the previous inspection. Good progress was being made against these breaches; however, further work was required particularly in relation to documentation. Work was ongoing to explore an electronic solution to monitor the whole PCIP and individual action plans were being updated by each division until this was in place.

Resolution
The Update on the Patient Care Improvement Programme and Regulatory Breaches was received and noted by the Committee.

51/18 Maternity Oversight Committee Update

The committee received the Maternity Oversight Committee update which provided an update on the section 29A warning notice. The following points were noted:

- 100% of women received 1-1 care in labour in May
- There was 1 shift in May which did not have an Enhanced Midwifery Care (EMC) competent midwife on duty (previously reported as HDU trained). There would be 29 staff members with the EMC competency by the end of June and 2 would be rostered onto each shift to address this.
- The team presented a proposal for presenting C-section rates using statistical process charts (SPC's) in future.

Concerns were raised regarding the increase in sickness levels in the department and members asked whether any themes had been identified. Ms Blackwell confirmed that the main reasons for sickness were cold, flu and stress (work and non-work related) and there was a process in place to ensure that sickness was being managed appropriately.

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

52/18 Trust Quality Account 2018-19

The Committee received the final Quality Account which had been shared with stakeholders for comment. The draft version had also been shared with the Audit Committee and the Quality & Safety Committee and the Trust Board had delegated responsibility to the committee for formal approval due to the tight deadline for submission. Mrs White identified that the final audit opinion was being agreed with the partner today and would be inserted into the document prior to publication. Any concerns as a result of this would be flagged to the committee chair; however, this would be unlikely as the external auditors had been engaged in the whole development process.

The Chair queried why there had been a delay in the auditors providing their opinion and it was confirmed that there had been a lack of communication between the auditors and the Trust in relation to the signature of the director responsibility which was required prior to the opinion being shared with the Trust.

Members approved the Quality Account for publication once the audit opinion had been inserted.

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

53/18 Equipment Replacement Programme

Mr Khan apologised that the report on the Equipment Replacement Programme had not been provided in readiness for the meeting. He confirmed that the list of equipment had been reviewed and a prioritisation exercise was being undertaken to identify equipment to be replaced this year. This would also include a review of risks associated with equipment not being replaced.

The chair raised concerns at the lack of progress with this and that the list of equipment had not been provided within the agreed timeframe. It was noted that this issue was an area of focus for the executive team and was being discussed on a regular basis at the CQC Preparation Steering Group and the Trust Management Board. Mr Khan provided assurance that the report would be provided at the next meeting.

AK
Jul 18

Resolution
The Committee received and noted the update on the Equipment Replacement Programme and it was agreed that the report would be provided at the next meeting.

54/18 Risk Management Committee Information & Escalation Report

Ms Blackwell presented the Risk Management Committee Information and Escalation report and the following points were highlighted:

- Two patients' suffered harm following gynaecology surgical procedures. There were no commonalities identified between the cases as the procedures and surgeons were completely different. The RCA process was being undertaken.
- Pressure ulcer reporting had decreased during May 2018 (9 incidents compared to 17 incidents in April 2018).

It was noted that the governance process for reporting of serious incidents was being reviewed. Incidents had previously been discussed at the Risk Management Committee and it had been agreed that the committee would manage risks only in future and incidents would be reviewed in a separate forum to enable them to be discussed in detail and identify lessons to be learnt. The Committee would receive a separate SI report in future.

Mrs Harris queried whether lessons to be learnt had been identified in relation to the intra-uterine death. It was noted that a chair was yet to be identified for the RCA investigation which would identify learning points, however, Ms Blackwell agreed to discuss with the Divisional Director of Midwifery to identify whether there were any immediate actions that could be taken.

KB

Resolution

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

55/18 Monthly Nursing & Midwifery Quality & Staffing Report

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

- 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
- There was a significant reduction in the use of temporary staffing and a 26% reduction in agency cap breaches
- The daily acuity tool was implemented on 25th June 2018, further work continued to embed its use into the daily decision making around the deployment of staff

Mr Gayle identified that the 90% fill rate had not been achieved for ward 9 and queried what impact this would have had. Ms Blackwell identified that changes had been made to the establishment on ward 9 and the ward had been identified as an outlier because it had been running with 2 Registered Nurses instead of 3 at night. The impact on quality of care including number of falls with harm was being reviewed and the staff, who were very experienced, had suggested the reduction in Registered Nurses and that basic nursing care could be provided by CSW's.

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. The Chair and other committee members raised concerns regarding the modification of the tool which had not been communicated to the committee or the board previously. It was agreed that clear guidance should be provided to the committee on the agreed process for utilising the tool in future.

It was recognised that there had been some improvements identified in relation to quality of care being provided as a result of the reduction on vacancies. Ms Blackwell agreed to include the impacts in quality in future reports. **KB**

<u>Resolution</u> **KB**
The Committee received and noted the Monthly Nursing & Midwifery Quality & Staffing Report.

56/18 Quarterly Health & Safety Report

Ms Davies shared the quarterly Health and Safety report with the committee and confirmed that an internal audit had been commissioned to look at health and safety for the Trust. It was noted that compliance with training was poor for the divisional teams and the corporate areas and a baseline and actions to improve would need to be agreed. The new Head of Health & Safety would commence in post in September and would be taking these actions forward.

Concerns were raised regarding an incident whereby a member of staff had been injured by a paediatric patient requiring a tier 4 mental health bed and this had not been reported as a serious incident. Ms Davies clarified that the incident would have been reported on the Trust's safeguard system and it would then be investigated through the RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) process and would not meet the criteria for a serious incident. There was a further debate about whether assaults on staff should be reported as a serious incident and it was also recommended that all RIDDOR incidents and learning points should be reported to the committee in future. Mr Gayle confirmed that health and safety had previously reported into the People & Organisational Development Committee and it had been requested that this be moved to the Quality & Safety Committee. Ms Davies agreed to work with the new Head of Health & Safety to develop a proposal for reporting to the committee and suggested that she attend the October meeting to present. Members requested that a review of RIDDOR reporting be undertaken in the meantime to ensure lessons were being learnt. It was also agreed that this would be added to the terms of reference for the internal audit.

JD Oct 18

<u>Resolution</u>
The Committee received and noted the Health & Safety Committee report and it was agreed that a proposal for reporting incidents would be presented in October 2018.

57/18 Annual Complaints Report

Ms Blackwell presented the Annual Complaints report 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
- There had been an improvement in the response rates
- The Complaints team were currently pulling together a work plan for 2018-2019 which included the further roll out of the customer care approach which would be delivered in the Emergency Department, a medical ward and surgical ward following the launch of the new Trust Values in July 2018.

Resolution
The Committee received and noted the Annual Complaints Report.

58/18 Presentation from the Division of Surgery

The Chair welcomed the Surgery Divisional team to the meeting and a presentation was provided. The following points were noted:

- An update on ratings of the previous CQC inspection was provided including the PCIP actions being taken by the division. Further clarification was provided on the must and should do actions being taken following the inspection.
- The divisional red risks were highlighted, particularly in relation to the ability to provide a 24/7 critical care outreach service. The service had previously been reduced following a CIP scheme and a proposal to increase resources in the team was being presented at the Trust Management Board for approval during the following week. The committee endorsed this decision from a quality and patient safety perspective and it was agreed that an update on the proposal would be provided at the next committee meeting.
- A discussion took place about Registered Nurse vacancies within the division and it was noted that there was a risk in relation to the number of vacancies on ASU (9.41 WTE). Job offers had been made to overseas nurses and there was a time delay in getting these in post. Safety and quality of care was being monitored closely and performance remained good. The Chair suggested that learning from practice in surgery areas be shared across other nursing teams. **PTH Jul 18**
- A new matron had been recruited in theatres and there was good engagement with the pharmacy team addressing medication incidents and documentation.
- The Theatre workstream continued at pace and changes had been made to the care group team to support with this. There remained some issues within the team particularly in relation to the number of vacancies and the impact temporary staffing was having on efficiency. The Chair raised concerns in relation to the variance with the number of sessions booked and it was noted that there were a number of consultant vacancies in gynaecology therefore lists were not being filled at the moment. An update was provided on knife to skin rates and an improvement in this would not be expected due to the anaesthetic cover currently provided. Mr Khan highlighted that the Trust had not been identified as an outlier for this.
- An update was provided on the OPD workstream and it was noted that there had been a reduction in DNA rates in surgery and improvements had been seen in service bookings. Further work was ongoing to improve DNA rates across the rest of the organisation and discussions were ongoing with the CCG about how 2-week wait appointments were communicated by

GP's. Discussions were also ongoing with the CCG to run virtual clinics.

- Actions were being taken to drive staff engagement as a result of poor staff survey results received within the division and the engagents were working with the teams on elements most important to them.

Members thanked the division for their presentation and congratulated them on the good work being undertaken. The divisional team left the meeting.

Resolution
The Divisional presentation was received and noted by the Committee.

59/18 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 5th July 2018:

- 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 this would have with the planning taking place earlier in the year
- The approval of the Quality Account
- The local modification of the Safer Nursing Care Tool Audit (SNCT)
- The learning from Health and Safety incidents including the RIDDOR reported staff incidents, and whether all incidents where staff had been assaulted resulting in injury were reported as serious incidents

60/18 Any Other Business

There was no other business.

61/18 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.

62/18 Date & Time of Next Meeting

Thursday 26th July 2018, 9:00am
Meeting suite A, MLCC

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD – 2nd August 2018			
Performance Finance and Investment Committee Highlight Report			**AGENDA ITEM: 18**
Report Author and Job Title:	John Dunn, Committee Chair	**Responsible Director:**	Russell Caldicott, Director of Finance & Performance
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	The Committee: a) received a comprehensive presentation from the WCCSS Division that outlined financial performance to date and the plans for the remainder of the year. b) received a detailed presentation covering the forecast financials for 2018/19 and the plan to mitigate the projected overspend c) made recommendations on the Imagining Business Case and Contract Award for Theatres Application (ORMIS).		
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.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

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 25 July 2018 together with the approved minutes of the meeting held on 27 June 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 - WCCSS

A comprehensive presentation that outlined financial performance to date and the plans for the remainder of the year. Overall performance for Q1 was on track, income was adverse to plan but compensated by reduced costs. Cost Improvement plans were on track to "deliver across the board". Questions were raised about achieving higher patient volumes within the resource capacity, this would be explored further in divisional performance reviews.

Financial Recovery Plan

A detailed presentation covering the forecast financials for 2018/19 and the plan to mitigate the projected overspend.

The plan was well structured and contained the very detailed Project Initiation Documents behind each initiative covering implementation risk and impact on patient services. The overall plan mitigated the projected overspend of £11m albeit with some work to be finalised on the Amber and red rated initiatives.

Revised plans for implementation and monitoring and control were discussed.

The plan will have a Trust wide launch in August.

A full report will be presented at the Private Board.

Investment Appraisal

The committee made recommendations on the following items:

Imagining Business Case- recommendation to the Board; adoption of the case to commence in the 2019/20 financial year

Theatres Application (ORMIS) - recommendation to proceed for board approval

4. RECOMMENDATIONS

The Board is recommended to DISCUSS the content of the report and raise any questions in relation to the assurance provided.

APPENDICES
Minutes

Walsall Healthcare NHS
NHS Trust

MINUTES OF THE PERFORMANCE FINANCE AND INVESTMENT COMMITTEE HELD ON WEDNESDAY 27th JUNE 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 D Fradgley	Director of Strategy & Improvement
	Mr A Khan	Medical Director
	Mr P Thomas-Hands	Chief Operating Officer
	Mrs J White	Interim Trust Secretary
In Attendance:	Mr J Cook	Regional Productivity Director (up to Item 020/18 only)
	Mrs K Boffey	Senior Delivery and Improvement Lead NHSI (up to Item 020/18)
	Mrs A Winyard	Divisional Operations Director – Surgery (Item 024/18 only)
	Mr W Goude	Consultant Orthopeadic Surgeon (Item 024/18 only)
	Mrs C Keeling	Matron – Outpatients (Item 024/18 only)
	Mr Q Zada	PMO Director
	Mrs K Blackwell	Acting Nurse Director (Item 026/18)
	Mrs C Dawes	Executive Assistant (Minutes)
Apologies:	Ms J Davies	Director of Governance

The Chair welcomed everyone and opened the meeting and apologies were noted.

ACTION

017/18 **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

018/18 **Declarations of Interest**
There were no declarations of interest.

019/18 **Minutes of the Meetings held on 30th May 2018**

Resolution:
The minutes of the meeting held on 30th May 2018 were approved as an accurate record.

A change to the running order of the agenda was noted, the committee business would follow the presentation on the Model Hospital from Mr Cook, Regional Productivity Director for East & West Midlands.

The committee welcomed Mr Cook and Mrs Boffey and introductions were made.

020/18 Presentation on the Model Hospital

Mr Cook and Mrs Boffey attended to give a presentation on the Model Hospital data and metrics used by NHS Trusts across the country. The information presented was pertaining to Walsall Healthcare NHS Trust performance in comparison to other Trusts. A log-in could be requested from NHS Improvement to use the Model Hospital as a tool for managing our business.

Mr Zada arrived at this point in the meeting.

The key messages were highlighted as follows:

- The Model Hospital is arranged by compartments (clinical services/ operational/people/patient experience)

- The Quality/Efficiency Matrix identifies different CQC segments of trusts, the bubble size indicates the Cost Weighted Output expressed as Weighted Activity Units (WAUs)

- The national average cost per WAU was £3,500 (this relates to how much healthcare activity can be bought)

- The Trust's WAU was below £3,500 in some areas - which was quite productive – this was good but difficult to make savings. (Average cost per WAU multiplied by 73,609 WAUs

- The breakdown per WAU highlighted higher than average WAUs in a number of areas (pay and non-pay costs and by specialty)

- A number of areas of opportunity were highlighted for improvement using 2016/17 data including Obs & Gynae, Breast Surgery, ENT, Urology, Nursing and AHPs and Estates & Facilities.

- The Trust's Reference Costs submitted had been used to collate the data in the report

Comments and Questions

Mr Beeken commented the data presented and the areas highlighted were consistent with what the organisation was aware off and working to make improvements in with assistance from the PMO and Director of Finance.

Mr Fradgley said it was helpful to see the whole picture and sequence to enable us to have conversations with staff groups and use the data to make decisions to deliver better outcomes for patients.

Mr Dunn commented the Trust was mid-point in some areas from the comparisons with other trusts and the data was helpful in identifying areas where improvements could be made to improve our position.

It was noted the key action was to get the right skill set for delivery of our 2018/19 financial plan for the next year and to how to engage with the Care Groups on how they will meet the challenges ahead.

Mr Dunn thanked Mr Cook for the excellent presentation.

Mr Cook and Mrs Boffey left the meeting at this point.

Actions:

- Presentation to be shared with the Care Groups.
- External assistance being sought for the PMO team
- Opportunities for the Trust to be quantified and brought back to PFIC following presentation to Medical Advisory Committee **RC**

Resolution:
The Committee:

- **Received and noted the content of the Model Hospital Presentation**
- **Noted the presentation to be shared with Care Groups**
- **External assistance being sought for the PMO team**

021/18 Matters Arising and Action Sheet

The Committee received the status of the following actions:

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

022/18 Financial Plan 2018/19

The Director of Finance and Performance gave an overview the 2018/2019 Financial Plan following acceptance of the NHSI Control Total by the Trust Board. The following highlights were noted:

- The Trust adopted a financial plan for 2018/19 financial year that delivers an £18.6m deficit. The key component for delivery being delivery of a £13m Cost Improvement Programme and mitigation of overspends incurred in the 2017/18 financial year.

- The Trust adopted a revised financial plan that resulted in an operational deficit of £15.6m which then releases Provider Sustainability Funds to the Trust of £5m, resulting in the deficit plan now set at £10.6m for 2018/19.

- The key risks to delivery of the plan were temporary workforce expenditure and CIP delivery

- Month 1 and 2 indicated high risk to delivery due to continued high temporary workforce costs and back phasing of the savings programme

- There were organisational and financial benefits associated with the delivery of the 2018/19 financial plan (outturn £10.6m) not least the ability to draw down central capital cash to facilitate the development of

an Emergency Department (OBC costed at £36m), with reductions in interest premiums and additional fines protection key additional benefits.

- Additional risks to delivery were contract challenge, CQC and Winter Planning

The Director of Finance and Performance presented a breakdown of the 2018/19 Financial Plan Submission by month that had been aligned to the 2018/18 Control Total.

The Director of Finance stated that the Trust was facing the following pressures:

- Overspends
  - Medical temporary workforce currently exceeds prior year
  - Nursing temporary workforce exceeds prior year levels
- CIP
  - The additional targeted CIP to deliver the control target has not been delivered in plans, so this remains a risk
  - The targeted productivity increases from Outpatients additional activity in hours is not delivering to plan
  - The movement to enhance bed occupancy rather than close beds has impacted on the patient flow scheme (£1m)

The Director of Finance forecast the impact of current expenditure trends and reductions in CIP delivery to result in a risk to outturn of approximately £11m and urgent action is required to mitigate the risks and deliver the agreed financial plan. If the Trust does not mitigate then a re-forecast would be required.

The Chair highlighted his concerns that the Trust Board had adopted the revised control total and was so far away from delivery with the plans not yet in place to mitigate the risk to delivery and the Quarterly Review with NHSI was scheduled within the next couple of weeks.

The Chair noted the size of the challenge and asked for the urgent completion of a full 2018/19 Financial Recovery Plan within the next two weeks.

Mr Heer commented on his disappointment that there was still not a defined financial recovery plan and asked that each Executive take ownership of the headline schemes placed before Committee within the report and note risks to delivery, timeframes for start of the initiatives and profile the financial benefits and KPI's for the remainder of 2018/19 as part of the FRP.

It was requested an Extraordinary Performance, Finance & Investment meeting be arranged within the next couple of weeks to receive an updated Financial Recovery Plan, the Chair requested the plan presented underpinned the plans, the risks associated with each scheme, Patient impact and timescales for delivery and to understand the impact. **RC**

Resolution:
The Committee:

- **Received and noted the content of the continued risk to attainment of the 2018/19 financial plan and disappointment that the mitigations had not been fully profiled into a Financial Recovery Plan** **RC**
- **Requested completion of a full and detailed financial recovery plan be produced** **RC**
- **Requested an urgent extraordinary meeting be arranged within the next couple of weeks with the sole agenda item being to review the financial recovery plan** **RC**

023/18 Financial Performance - 2018/2019 Month 2 Report

The Director of Finance and Performance outlined the 2018/2019 Financial position for Month 2 and highlighted the following:

- The Trust was reporting a deficit of £4,488k against a deficit plan of £4,323k, resulting in an unfavourable YTD deficit of £165k.

- The contracted income showed an unfavourable variance to plan of £100k, the under-performance occurring in clinical support and out of area emergencies. This was a net of the over-performance on elective that had generated CIP recurrently in month 2 in excess of £200k.

- 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 £331k YTD. The main area of overspending was pay owing to the continued use of high costs temporary staffing in Medical (£358k) and Nursing (£782k).

- The Trust Board adopted a revised deficit plan of £10.6m for the financial year (after receipt of £5m Provider Sustainability Funds - PSF)

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

- The CIP plan for M2 was £1,432k (11% of the target) and actual delivery wass £1,080k (8.3% of target), resulting in an under achievement of £352k YTD. In addition, of this total £555k was delivered non-recurrently, though an element of non-recurrent delivery reflects the delays in the Trust increasing obstetric activity to cap and will be off-set by recurrent income delivery).

- A continued reliance on non-recurrent delivery will place increased pressure on future financial sustainability.

- The Trust's planned cash holding in accordance with borrowing requirements wass £1m. The actual cash holding wass £1.28m.

- 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 wass circa £2.3m payable in 2018/19.

- The year to date capital expenditure was £1.1m, with the main spends relating to ICCU (£0.7m), Estates Lifecycle (£0.17m), Maternity (£0.07m) and Community Mobile technology (£0.1m).

- Total expenditure on temporary workforce wass £1.828m (May 2018) representing a £86k reduction on the April total. The Trust continued to spend resource in excess of historic performance £1.42m May 2017) and was driving levels of overspend within the Divisions.

Questions and Comments

The Chair summarised by noting the continued high workforce expenditure and divisional overspend and that a capital bid had been submitted to the STP for the ED development. The Private Trust Board would receive a paper to address the nursing workforce element.

Resolution:
The Committee:

- **Received and noted the content of the Finance Report.**
- **Mr Dunn to inform Trust Board of the significant risk to delivery of the financial plan and urgent requirement for mitigations and a Financial Recovery Plan** **JD/RC**
- **The Financial Recovery Plan focus upon Medical expenditure above historic levels** **AK**
- **Nursing expenditure to be reported to Private Trust Board** **KB**

Mrs Winyard, Mr Goude and Matron Keeling joined the meeting at this point.

024/18 Outpatient Deep Dive

Mrs Winyard, Mr Goude and Mrs Keeling attended to give a presentation on the Outpatients Workstream and the following highlights were noted:

- The position 18 months ago was high % DNA rate, issues with data quality, RTT was not being reported and CQC rated as Requires Improvement

- Significant improvement had been made within the Outpatients Workstream and in May 2018 the DNA rate was at 10% (Surgery 9%) as a result of a text messaging service

- Central bookings had increased the utilisation from 80% to 100%,

48/24 hour backfilling process for short notice cancellations, with improved escalation to the care groups.

- Improved processes for out-coming of clinics, fully booked patients, E-outcome development and cleaning of duplicate access plans had significant improved data quality.

- The follow-up backlog in 2017 was 53,000 patients showing overdue follow-up appointments. Robotic software used for lettering process and out-coming. The position in May 2018 was 4,000 patients waiting.

- Return to RTT reporting in November, improved access to services, increasing referrals from non-Walsall CCG and confidence returning in services – RTT now reporting 88.433% (4% ahead of trajectory). It was anticipated the position would be 89% in July.

- CQC rating of Requires Improvement in 2017 – now rated as Good for Caring, Safety and Well Led.

- Focus was now on working with 27 Specialties identified by KPMG to find sustainable improvements

- New project support will help the workstream and give confidence to achieve delivery moving forward

The Chair noted how important achievement of this workstream objectives was to enhance patient experience and support the financial plan, so asked if any help or assistance was required. Mrs Winyard confirmed no further support was required to deliver the workstream, the chair asked other members of the presenting group if they were in agreement with the statement and Matron Keeling mentioned further support at ground level would enhance delivery e.g. in the call centre and a new location to enable the merging of the booking teams. It was agreed the new Admin Review Lead Keith Dibble) should be involved in taking this forward with assistance from the Director of Strategy & Improvement via the Space Utilisation Group. **DF**

Ms Blackwell joined the meeting at this point.

The Chief Operating Officer confirmed that senior operational support for the workstream had now been agreed.

Mr Dunn thanked the team for their presentation and acknowledged the positive work being undertaken to improve performance which has given him confidence to assure the Trust Board.

Resolution:
The Committee:

- **Received and noted the content of the Outpatient Workstream presentation**
- **Noted assistance would be sought from the Admin Review Lead**

to work with the team to provide support

Mrs Winyard, Mr Goude and Matron Keeling left the meeting at this point.

025/18 Improvement Programme Update

Mr Zada presented the Cost Improvement Programme update for month 2 and the following key messages were noted:

- The Cost Improvement Programme for 2018/19 was £13m. The month 2 delivery was £1.08m against a plan of £1.4m resulting in an adverse variance of £352k)
- £587k non-recurrent savings
- Temporary workforce costs for May were £1.8m (£0.4m higher than May 2017)
- 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.

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**
- **Continued focus was needed to close the CIP gap and this would need to feature heavily within the Financial Recovery Plan to be presented to members** **RC/QZ**
- **The enhanced focus to be taken forward, in particular in regard to the change in stance on closing beds, Mr Zada to identify mitigations through further engagement with the Divisions and Executive** **QZ**

026/18 Review of Nurse Bank Pay Rates

The Acting Director of Nursing was welcomed to the meeting to present a report outlining the impact of the RN pay rate increase approved by the Trust Board in July 2017 and the key outcomes were noted:

- There had been a marginal take up of bank staff
- The Trust incurred costs of between £400k and £500k per annum as a consequence of increasing the bank rate.
- The Trust cap compliance data evaluated the number of shifts filled with above Tier1 Agencies. The number of shifts had reduced by over 50%, although this cannot be attributed to the bank rate increases alone and correlates with reductions in additional capacity beds open and the e-roster work being undertaken.

The chair summarised by noting the Trust Board had approved the increase to the Nurse Bank Rates and although there had been some improvement, the full benefits had not been realised in additional workforce and further work was required to mitigate the increased costs.

SH noted the resolution of the Board had not been complied with, as the reduction in CSW posts had not been actioned as was agreed in the paper to the Board to finance this increase, with further debate on why would we keep the rate at the increased levels if only marginal gains were made on use of Bank?

KB stated the review of ward based establishments was ongoing and as a consequence no reduction in CSW's can be actioned at this time. This would be picked up by the report produced on staffing requirements, with an update to Board and a further paper to be presented to PFIC. KB

Resolution:
The Committee:

- **Received and noted the content of the report**
- **Noted further work required to mitigate costs**
- **Noted the debate over reduction in CSW's to resource the increase in bank rate for RN to be covered within the wider review of ward based establishments**

027/18 Constitutional Standards Operational Update

Mr Thomas-Hands gave an overview of the Constitutional Standards relating to Emergency Department, Elective Access and Cancer. The key messages were highlighted as:

Emergency/Urgent Care:

- May performance had increased to 89.70% against a target of 85%.
- Medically Fit for Discharge (MFFD) list is reducing.
- May saw continued high levels of ambulances to ED (90+ ambulance arrivals on 17 days in month).
- Admissions per day remained at 86 in May.
- There were no 12 hour breaches.
- Closer integrated working across the site encouraged by ECIP working.

Elective Access:

- Performance in May was 88.33% against a trajectory of 84.2%, which was a continued improvement against the April 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 May

- There were no 52 week breaches in May.

Cancer:

- All national cancer measures achieved in April with exception of 62 day referral to treatment cancers Initial un-validated performance for May shows achievement of all cancer measures.

Diagnostics:
April performance was 99.57% 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.**

028/18 Performance and Quality Report by Exception

The Performance and Quality Report was taken as read.

Resolution:
The Committee:

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

029/18 Ultrasound Business Case

The Chief Operating Officer presented the Business Case for The non-obstetric ultrasound service that provides support to outpatient, A&E and Inpatient care pathways, and is an integral diagnostic procedure for a large number of clinical specialities. He advised that due to the increased demand and pressures on physical capacity there was a need for urgent and specialist outpatient ultrasound scans to be accommodated in the inpatient scan room, in order to avoid 18 week 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 was poor. Additional capacity is also provided by the breast imaging machine which is not ideal with regard to its location.

It was noted that due process had been followed and the committee agreed to recommend approval to the Trust Board as it was outside of committee delegated authority.

Resolution:
The Committee:

- **Received and noted the content of the report.**
- **Agreed to recommend approval of the business case to the Trust Board at its July meeting**

030/18 Gastroenterology Business Case

The Chief Operating Officer gave an overview of Phase 2 of the Gastroenterology Business Case for the recruitment of specialist nurses and a pharmacist 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 committee were in support of the business case and approval was given to proceed.

Resolution:

The Committee:

- **Received and noted the content of the Gastroenterology Business Case**
- **Approved the business case**

031/18 Walsall Together – Consultancy Commission

The Director of Strategy & Improvement gave an overview of the Consultancy Commission for Walsall Together report advising legal advice had been taken and due process had been followed.

The committee agreed to recommend approval to the Trust Board.

Resolution:

The Committee:

- **Received and noted the content of the report**
- **Agreed to recommend approval of the business case to the Trust Board at its July meeting**

032/18 Refurbishment Costs of Wilbraham Court and New Man Court

The Director of Strategy & Improvement gave an overview of the freehold properties and current occupancy advising that as part of the Estates Strategy a review of all premises had been undertaken. The estimated market value of each property, together with the potential opportunities for sale, the risks and recommendations were presented for discussion and approval to move to the next stage. Funds from property sales could be utilised to cover refurbishment costs of other properties.

The committee debated the options put forward and suggested alternative options on leasing were to be explored but endorsed the recommendations to Trust Board.

Resolution:

The Committee:

- **Received and noted the content of the report**
- **Requested alternative options on leasing be explored**
- **Agreed to recommend proposals to the Trust Board**

Mr Beeken left the meeting at this point.

033/18 Committee Terms of Reference

The committee received and noted the updated Terms of Reference.

The Medical Director expressed concern the Chief Executive was no longer a member of the committee. It was noted the Terms of Reference had previously been agreed by the Executive Team and concerns should be taken up directly with him.

The Director of Finance & Performance suggested the replacement of specific amounts with referral to the Scheme of Delegation document to eliminate the need to amend the Terms of Reference should amounts be changed.

034/18 ANY OTHER BUSINESS

There was no other business discussed.

035/18 Date of Next Meeting

The next meeting of the Committee would be held on of **Wednesday, 25th July 2018 at 2p.m.** in Room 10, Manor Learning and Conference Centre, Walsall Manor Hospital.