Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 6 SEPTEMBER 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.	Patient Story	Learning		Verbal	**10.00**
CHAIR'S BUSINESS					
2.	Apologies for Absence	Information	Chair	Verbal	**10.30**
3.	Declarations of Interest	Information	Chair	ENC 1	**10.35**
4.	Minutes of the Board Meeting Held on 2 August 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	Director of Nursing	ENC 6	**11.05**
9.	CQC Preparedness Update	Information	Director of Nursing	ENC 7	**11.15**
10.	Well Led Action Plan	Discussion	Chief Executive / Chair	ENC 8	**11.20**
VALUE COLLEAGUES					
11.	Pulse Check		Chief Executive	Verbal	**11.30**
BREAK – TEA/COFFEE PROVIDED					**11.40**
RESOURCES					
12.	Integrated Performance Report	Discussion	Director of Finance & Performance	ENC 9	**11.55**
PARTNERS					

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
13.	Partnership update	Information	Director of Strategy & Improvement	ENC 10	**12.10**
GOVERNANCE AND COMPLIANCE					
14.	Risk Appetite	Approval	Director of Governance	ENC 11	**12.20**
15.	Board Assurance Framework and Corporate Risk Register	Approval	Director of Governance	ENC 12	**12.30**
16.	Annual objectives update	Discussion	Director of Strategy & Improvement	ENC 13	**12.40**
17.	Strategy Committee Terms Of Reference	Approval	Director of Governance	ENC 14	**12:50**
18.	EPRR	Approval	Chief Operating Officer	ENC 15	**13:00**
19.	Quality and Safety Committee Highlight Report and Minutes	Information	Committee Chair	ENC 16	**13.10**
20.	Performance, Finance & Investment Committee Highlight Report & Minutes	Information	Committee Chair	Verbal	**13.15**
21.	People & Organisational Development Committee Highlight Report & Minutes	Information	Committee Chair	Verbal	**13.20**
22.	**QUESTIONS FROM THE PUBLIC**				**13.25**
23.	**DATE OF NEXT MEETING** Public meeting on **Thursday 4 October 2018** at 10.00 a.m. at the Manor Learning and Conference Centre, Manor Hospital				
24.	**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 – 6 SEPTEMBER 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 September 2018

Name	Position/Role at Walsall Healthcare NHS Trust	Interest Declared
Ms Danielle Oum	Chair	Board Member: WM Housing Group
		Board Member: Wrekin Housing
		Chair Healthwatch Birmingham
		Committee Member: Healthwatch England
Professor Russell Beale	Non-executive Director	Director, shareholder: CloudTomo- security company – pre commercial.
		Founder & minority shareholder: BeCrypt – computer security company.
		Director, owner: Azureindigo – health & behaviour change company, working in the health (physical & mental) domains; producer of educational courses for various organisations including in the health domain. .
		Academic, University of Birmingham: research into health & technology – non-commercial.
		Spouse: Dr Tina Newton, is a consultant in Paediatric A&E at Birmingham Children's Hospital & co-director of Azureindigo.
		Journal Editor, Interacting with Computers.
		Governor, Hodnet Primary School.
		Honorary Race Coach, Worcester Schools Sailing Association.
		Non-executive Director for Birmingham and Solihull Mental Health Trust with effect from January 2017.
Mr John Dunn	Non-executive Director	No Interests to declare.
Ms Paula Furnival	Associate Non-executive Director	Executive Director of Adult Social Care, Walsall Council.
		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 Alan Yates	Associate Non-executive Director	Director Sustainable Housing Action Partnership Director Energiesprong Uk Director Liberty Developments LTB Trustee Birmingham and Country Wildlife Trust Executive Director Accord Housing Association 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
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.
Dr Karen Dunderdale	Director of Nursing	No Interests to declare.
Ms Jenna Davies	Director of Governance	No Interests to declare.

Report Author: Jackie White, Interim Trust Secretary
Date of report: 3 September 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 2ND AUGUST 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 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
Mr A Yates	Associate Non-Executive Director
Mrs L Ludgrove	Interim Director of Organisational Development and Human Resources
Mr D Fradgley	Director of Strategy & Improvement
Mrs J White	Interim Trust Secretary
Miss J Wells	Senior Executive PA (Minutes)

Members of the Public 0
Members of Staff 6
Members of the Press / Media 0
Observers 2

091/18 Staff Story

The Medicine and Surgery Patient Safety Teams attended the meeting to inform members that they had won the HSJ Patient Safety Awards in the Clinical Governance & Risk Management category.

The team gave a presentation of the work they had undertaken which had resulted in their achievement which had focused upon;

- Engagement with both colleagues and families
- Sharing information in relation to incidents and risks
- Providing training
- Holding regular confirm and challenge meetings with divisions
- Sharing lessons learnt
- Embedding an open and positive patient safety culture across the medicine and surgery divisions.

The award was won in partnership with the divisions.

The team were now working to sustain current developments in patient safety whilst always looking for innovative ways to improve processes.
Future projects included implementation of a multi-disciplinary forum which addressed learning from incidents and human factors; working collaboratively with the QI Academy.

Ms Oum congratulated the team on an excellent achievement and queried whether any work with the Community and Women's and Children's had been undertaken. The team confirmed that they had shared the concept with all divisions and work was underway.

Mrs Furnival thanked the team for their work and updating the board members of the good work being done, adding that the transparency and engagement within their work stood out.
Using patient stories as a platform when engaging with divisions was very impactful.

Professor Beale congratulated the team for the award win. The work was a good example of pushing decision making away from the board for teams to make their own decisions.

Mr Caldicott thanked the team for the excellent work they had done which had filtered across all areas. Mr Caldicott asked how it could be built upon as an overall communication.
The team advised that they were working on a communications strategy to share lessons learnt.

Mr Heer queried what the impact looked like, noting the work had been done within their own teams and without board assistance.

Mr Khan observed that the team had worked alongside clinical teams, spending time with them and embedded themselves in which was an important element for success, raising incidents, learning from them and providing support.

091/18 Apologies for Absence

Apologies were noted from Mr R Beeken, Chief Executive and Ms J Davies, Director of Governance

Ms Oum welcomed Caroline Bell, CQC Inspector & Relationship Manager for the Trust and Lucy Land from Healthwatch.
Ms Oum also welcomed Mr Alan Yates, Associate Non-Executive Director who would become a member of the Performance, Finance and Investment Committee.

092/18 Declarations of Interest

Ms Oum informed that her declaration should read MW Housing.
Mr Heer would update his declaration for the next meeting.

093/18 Minutes of the Board Meeting Held in Public on 5th July 2018

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

094/18 Matters Arising and Action Sheet

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

206/17 Risk Management – The Board Assurance Framework would be reviewed at the Trust Board meeting in September.

Resolution

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

095/18 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.

096/18 Chief Executive's Report

Mr Caldicott presented the report in Mr Beeken's absence which was taken as read but alerted members to the emphasis of the leadership day.

Ms Oum reminded members that the new values had been launched. A behavioural framework would be built around the new values with a view to transforming culture.

Mr Heer was pleased to see the refreshed values but asked how progress would be monitored going forward and the measure of impact upon the organisation.

Mr Caldicott replied that the development of the values framework would assist.

Ms Oum advised that the values and behaviours should be seen throughout all aspects of the Trust and asked members to be mindful of this whilst visiting departments.

Mrs Ludgrove stated that Simon Johnson, Staff Engagement Lead would be attending the Board meeting in September with a detailed update.

The Behaviour framework was almost complete. The Trust aimed to build the values into staff processes such as appraisals, induction etc.

Mr Heer asked that leading catalysts were accelerated by the use of additional resource or changes and the best use of communications and technology to make an impact.

Resolution

The Board received and noted the content of the report.

097/18 Monthly Nursing and Midwifery Safer Staffing Report

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

- Care hours during June were 7.4. Though this was a slight improvement upon the previous month, the Trust remained below the national average of 7.9.
- The daily acuity tool had embedded into daily practice.
- NICE Red flags had been added to the risk assessment and data on the impact of staffing gaps in relation to patient care would be included from July.

Ms Oum stated that the report was too long and lacking in the precision and focus necessary to support board assurance.

Mr Dunn observed that the overall fill rate was reported at 97% against a target of 90%, querying how it could be balanced.
Ms Blackwell replied that quantifying the right establishment formed part of a triangulated review that would be complete the following week. A draft report would be shared at the Quality and Safety Committee. **Q&S**

Professor Beale stated that the Trust did not appear to have the right amount of patient care time and asked what the reason for it was.
Ms Blackwell advised that figures did vary by speciality but would be outlined within the report once complete.

Mr Thomas-Hands advised that the medical division ward was ward 10 and not ward 14 as outlined within the paper. It was recognised that E-roster compliance was good.

Ms Oum asked to be clear that though establishment was under review, what assurance there was that it was operating safely.
Ms Blackwell replied that risk assessments took place when there were staffing shortfalls. Matrons reviewed staffing gaps on a morning and evening, moving staff where appropriate.

Ms Oum noted that it was Ms Blackwell's last Board meeting as Acting Director of Nursing and thanked her for the huge amount of work that she had done.

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

098/18 CQC Preparedness Update
The CQC Preparedness paper was taken as read.

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

099/18 Responsible Officer Revalidation and Appraisal Report
Mr Khan advised that the report had been reviewed by the Quality and Safety Committee.
Mr Khan wished to assure the board of the revalidation and that the Trust met the requirements. The performance highlights were:

- 96% of doctors had been appraised between April 2017 and March 2018, which was an improvement upon the previous year.
- 11 doctors were recommended for revalidation
- 9 doctors were deferred due to insufficient supporting information.

Mr Gayle reminded of the importance to ensure that appraisals were taking place but queried what assurance was in place that appraisals were undertaken.
Mr Khan replied that there was a 5 year cycle, during which 5 appraisals would take place to include patient and colleague feedback at least once. The Trust also repeated that process.

Ms Baines queried whether there was any impact upon patient care if staff were not revalidated.
Mr Khan advised that deferrals did not mean that the doctors did not have a licence to practice.

The report was approved.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Approved the Revalidation and Appraisal Report.**

100/18 Learning from deaths report

Mr Khan presented the report, informing that it had been reviewed at the Quality and Safety Committee. The following key points were highlighted:

- HSMR Year to date was 101.06
- SHMI Year to date was 104.23, though no data was available from December due to a provider data issue.
- The Trust had received notification from Imperial College London, advising in an abnormal trend of deaths coded as fluid and electrolyte imbalance. The Trust had completed a review, which included patient care and the feedback had been supplied to the college.
- Timely reviews of deaths had been of concern due to availability to conduct the reviews and provide feedback. A paper regarding Medical Examiners would be reviewed at the Mortality Review Group later in the week, followed by the Executive Team Meeting. Medical Examiners would be mandatory from next year and the Trust needed to make investment.

Ms Oum stated that the report was overlong and insufficiently focused so that it did not support board assurance, adding that there was a need to be clear on the areas to be improved upon and requested clarity on how soon a succinct set of recommendations would be presented.

Mr Khan replied that the Mortality Review Group would review the proposals initially and would then progress through the relevant committees this month.

Mr Heer questioned the impact of the lack of availability of the SHMI data. Mr Heer also asked for underlying trends to be incorporated through the use of technology and resource going forward.

Mr Dunn advised that it was difficult to understand the key issues and lessons learnt. There needed to be a plan to improve which set out key milestones.
Mr Khan suggested that the topic featured at a Board Development session and inclusion at the Clinical Senate.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Agreed to feature Learning from Deaths at a Board Development session.**
- **The Learning from Deaths Report and proposals would come back to a later Trust Board meeting following the Committee cycle.**

101/18 Freedom to Speak Up Guardians Report

Mrs Ludgrove presented the report and welcomed Shabina Raza and Val Ferguson, members of the Freedom to Speak Up team to the meeting. The report was last reviewed the previous year. Mrs Ludgrove acknowledged that it had been a challenging year and thanked the team for their dedication and commitment to the role.

Ms Oum reiterated the importance of the FTSU function in addressing national concerns following the Francis Report into Mid Staffs and in addressing Trust priorities around improving staff culture and enabling colleagues to raise concerns. Ms Oum asserted the importance of the Board owning and supporting the FTSU agenda
Ms Oum introduced the Guardians to the Non-Executive Director Committee Chairs and encouraged the Guardians to approach them at any time for assistance; they would link back to Ms Baines as the Non-Executive Lead.

Mrs Harris agreed that it was important to strengthen feedback and asked whether any recent communications about the team had been issued to staff.
Mrs Ludgrove replied that there was a focus on relaunching the Guardian role and to refresh the level of understanding.
Mrs Harris queried whether there was any peer support available.
Ms Raza informed that there was a network and good practice was shared between other Trusts.

Mr Gayle queried whether there were any themes.
Ms Raza advised that there had been themes previously. Moving

forward focus was aimed at engagement and patient safety and work would better progress now that the team was back to full establishment.

RB/JW/AB

Ms Oum asked that the team met with Mr Beeken, Ms Baines, Ms Davies and Ms Griffiths, Director of People and Culture (when in post) to discuss issues and to ensure they were addressed.

Mr Yates queried whether the 6 month review time frame should be shortened.
Ms Oum agreed and advised that the action plan would be reviewed.

Ms Oum advised that it would be Mrs Ludgrove's last Trust Board meeting prior to her departure and thanked her for her help and assistance during her time at the Trust.

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

102/18 Financial Performance Month 3

The Financial Performance for month 3 was reviewed and the following key points were highlighted;

- The Trust was committed to deliver the financial plan but to not compromise patient safety.
- Key risks were current run rate and temporary staffing.
- A financial recovery plan had been developed which was driven through divisions and owned by the Executives who were supportive of the plan.
- Sustainable service delivery was of importance and focus was on capital investments to make improvements.

Ms Oum informed that a quality impact assessment would be reviewed at the Quality and Safety Committee. Ms Oum and Mr Dunn as the Chair of the Performance, Finance and Investment Committee would be attending the Quality and Safety Committee later in the month.

Mr Heer noted that the recovery plan incorporated the quality impact and though it was a good plan, the execution of it would be the challenge.

Mr Dunn endorsed the plan which was solid and underpinned and was impressed by the involvement of divisions. Mr Dunn asked to ensure that it is launched, balanced and all understood the issues faced. Mr Dunn clarified balanced in terms of not compromising safety standards.

Mr Fradgley advised that wider discussions had launched and were utilising the key priorities, of which finance was one of. The first stage of the plan launched the previous day and a number of engagement events had been planned throughout August which

underpinned the willingness and desire of the organisation and next steps. The topic would also be covered during the CEO Brief the following week.

Ms Baines queried whether commissioners had to agree to fund any additional work that needed to be done.
Mr Caldicott advised that there may be a dispute which would be debated.

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

103/18 Performance and Quality Report Month 3

Mr Thomas-Hands presented the Performance and Quality Report for month 3 and highlighted the following key points:

- 4 hour A&E performance had declined to 87% compared to 90% during May. Decontamination of wards had affected flow.
- Ambulance times had increased but not above 1 hour.
- 18 weeks had achieved.
- There was a risk to RTT due to annual leave and sickness.
- Diagnostic waits delivered.

Mr Thomas-Hands added that July had been a difficult month for 4 hour admissions. Acuity and discharge figures had risen. RTT for July looked to show improvement. Did not attend rates in Outpatients was decreasing.

Mr Gayle referenced the Friends and Family Test Outpatients figures and observed that they did not appear to be improving. Mr Gayle queried what was being done in order to improve.
Mr Thomas-Hands replied that the figures were puzzling. The Trust were working with Commissioners. Mr Thomas-Hands advised that the DNA rate was quite high within cancer clinics.

Mr Dunn advised that the performance within cancer clinics was one often taken for granted and it should be recognised that the Trust had been delivering on its targets consistently for quite some time. Outpatients and Theatres did have a comprehensive set of KPIs which were monitored each week.

Ms Oum acknowledged that diagnostic waits were also consistently good but queried whether there were any barriers hindering the ability to reduce DNA rates.
Mr Thomas-Hands informed that the Trust was not a national outlier but cancer DNAs were quite high. A review by speciality needed to be undertaken to establish whether appointments were being offered to patients who did not want them.
Ms Oum requested an update at the next Board meeting.

Mr Heer stated that the Friends and Family Test dashboard was incomplete.
Ms Oum replied that work was underway to address the IT error.
Mr Fradgley advised that the IT department were reviewing business intelligence system dashboards. A Board Development session would focus on dashboards in the near future.

Ms Oum asked that exception reports included dates aspired to. **RC**

Mrs Furnival observed that the prevent training and safeguarding trajectories for quarter 1 had not achieved.
Mrs Ludgrove replied that mandatory training was consistently failing as a KPI and there was a national problem with ESR upon where they were recorded. There was 77% compliance against a 90% target achieved in March 2018. Training was being refreshed for the current year with compliance at the end of May 2018 being 82%.
Ms Blackwell confirmed that the Trust had only failed to achieve Level 2 Children's. Prevent had been achieved.

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

104/18 IT Update

Mr Fradgley presented the update following a complete review within IT, outlining leadership changes and revised structure.
A Digital Needs Assessment had been undertaken with staff and a strategy was being built from the results.
Mr Fradgley added that a decision needed to be made in relation to the Patient Administrative System supplier (PAS).

Ms Oum asked how the feedback from staff was gathered.
Mr Fradgley replied that there were working groups in each area with project board monitoring. Total Mobile reviews took place every 3 months.

Mr Khan advised that the Trust knew and understood the need to invest in technology though finances hindered it moving forward.
Ms Oum agreed that the Trust did need to invest and ensure the board clearly understood the advances.
Mr Caldicott stated that there were clear efficiencies with IT and in turn that could generate savings. Business cases needed to be clear and concise with benefits that could be derived from investment.

Mrs Harris queried whether the Trust had the right IT structure, noting that there were big projects to implement, therefore a need to ensure that resources and the right technical knowledge and engagement was in place.
Mr Fradgley advised that a Future Strategy was being drafted.
There were gaps in capability but additional resource could be sought to obtain an objective view.
Conversations with Walsall Together were taking place in regard to interfacing different systems.

Ms Oum queried when the next IT update would be presented.
Mr Fradgley replied that it would likely be October. A separate paper regarding PAS and EPR would also likely be reviewed at the October board meeting.
Ms Oum asked for lessons learnt from the last implementation of PAS be built in. **DF**

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

105/18 Partnership Update

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

- An Admission Avoidance event was hosted the previous month with an integrated approach focused on patient journey.
- Place based teams work was progressing. It was apparent that there was a fundamental gap between alcohol and drug use particularly in the north of the borough resulting in a review of coding in order to capture those patients appropriately.
- Black Country STP design work of the wider partnership plan was coming to an end. An overarching STP strategy was in final draft and would be shared for comments shortly.

Ms Oum reiterated the importance of influencing the focus of the STP.

Mrs Furnival stated that there had some good conversations with the council cabinet, stroke rehabilitation move and the embedding of joint arrangements.

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

106/18 Quality and Safety Committee Highlight Report and Minutes

Professor Beale presented the highlight report from the most recent meeting held on 26th July 2018, together with the approved minutes of the meeting held on 29th June 2018. The following key points were highlighted;

- The process for QIA's would be reviewed for consideration at the next meeting review.
- Divisions did not appear to be engaged with Walsall Together and were ensure of what it meant. Communications to be issued to maximise the opportunity for clinical engagement.
- The division of Medicine and Long Term Conditions attended the meeting giving a positive update and showcased their video of part of their collaborative care work with NHS Improvement, which was awarded Best Video.

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

107/18 Performance, Finance & Investment Committee Highlight Report and Minutes

Mr Heer presented the highlight report of the meeting held on 25th July 2018, together with the approved minutes of the meeting held on 27th June 2018.

Mr Heer advised that the key issues had been covered earlier in the Agenda. The Committee had reviewed financial recovery in detail and further discussion would take place during the private section of the meeting.

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

108/18 Questions from the Public

Lucy Land, Healthwatch commented that she had enjoyed attending her first Trust Board meeting at Walsall Healthcare and observed a good sense and grip of the issues faced. Lucy formed part of Walsall Together Healthwatch and would attend future board meetings.

109/18 Date of Next Meeting

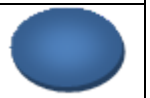
The next meeting of the Trust Board held in public would be on Thursday 6th September 2018 at 10:00a.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

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** Executive team have reviewed the Corporate Risk Register and a copy is on the agenda	
	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** Interim Trust Secretary met with all Executive team members to update the Corporate Risk Register. There is further work to do but this is discussed in the Board paper	
	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** A draft BAF has been developed and is on the 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 presented to the Quality & Safety Committee in August. Verbal update to be given at Board	
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	

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
				in place to agree this action	
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	Meeting held with Garry Perry and shared learning examples across health and care	
101/18 Freedom to Speak up Guardians Report	FTSU Guardians to meet with Mr Beeken, Ms Bains, Ms Davies and Catherine Griffiths, Director of People & Culture (when in post) to discuss issues raised and to ensure that they were addressed.	Director of Human Resources	04/10/2018	Meeting to be arranged once Catherine Griffiths in place	Not started yet
103/18 Performance & Quality Report month 3	Exception reports to include trajectories	Director of Finance	06/09/2018	**Complete Included in Performance Report**	
104/18 IT Update	Consideration for future PAS direction	Director or Strategy & Improvement	04/10/2018	**Not due. On Agenda for October Meeting**	

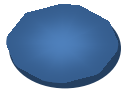
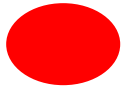
ENC 3

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.

MEETING OF THE PUBLIC TRUST BOARD – 6th September 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 ☒		

Chair's Update

PRIORITY OBJECTIVES FOR 2018/19

1. **Continue our journey on patient safety and clinical quality through a comprehensive improvement programme**
   The Trust welcomed Enable East to conduct a mock inspection and look forward to receiving their feedback.

   I attended the Quality & Safety Committee to hear updates in relation to the Annual Plan Objectives, Quality Impact Assessment and the Patient Care Improvement Programme.

2. **Improve our financial health through our robust improvement programme**
   Regular communication with NHSI is taking place in relation to the Trust's financial monitoring.

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

   I chaired the interview panel for the SEN Community vacancy.

   I would like to take the opportunity to welcome Dr Karen Dunderdale, Director of Nursing to the Trust.

   Colleagues continue to be generous in accommodating me to work shadow and visit services. This month I visited the Pain Management Service and Security.

Meetings attended / services visited

Security
Pain Management Service
Quality & Safety Committee
Human Resources
Engagement Lead

RECOMMENDATIONS
The Board are asked to note the report

Danielle Oum

September 2018

MEETING OF THE PUBLIC TRUST BOARD – Thursday 06 September 2018			
Chief Executive's Report			**AGENDA ITEM: 7**
Report Author and Job Title:	Richard Beeken, Chief Executive Officer	**Responsible Director:**	Richard Beeken, Chief Executive Officer
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 August 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 and in collaboration with other Trusts

3. DETAILS

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

The important work of the organisation, both to prepare for CQC re-inspection and to bed in the delivery of the "fundamentals of care" on an ongoing basis, continues. Last week, I feel our decision to invite the not for profit organisation, Enable East, to undertake an observational inspection of our hospital services was vindicated, with respect to both of these objectives. The verbal feedback was presented to an extraordinary meeting of the Trust Management Board, to which non-executive directors were invited.

The feedback following the one week inspection was frustrating, in that it shows that the excellent and often exceptional, work of many teams and individuals, continues to be undermined by a lack of consistent delivery of the fundamentals. Positive feedback included:

- Impressive clinical leadership in difficult day to day circumstances in ED, Gynaecology and Outpatients
- Compassionate care delivery in medical and older people's inpatient services
- Good management of sub-optimal environments in many places, particularly through reduction in visible "clutter"
- Largely consistent adherence to Trust policy on medicines management and storage

Concerns were raised about the following fundamentals, to name a few:

- Smoking and smoking related litter in main entrances
- Some front line staff remained unaware of key upcoming service developments in their area, leading to concerns about the two way communication between senior leaders and the front line
- Capacity management and internal escalation policy need urgent revision and more discipline instilling in its approach
- Too much reliance on the Trust safeguarding lead by front line staff, exposing their own inconsistent knowledge of safeguarding requirements/expectations
- Poorly filed and protected paper health records and inadequate ward clerk resource on many wards
- Inconsistent sickness management

The Trust will receive a formal report, two weeks from the date of inspection. We have already started to tackle many of these compliance issues through a systematic process of CQC inspection preparation. However, I am now emphasising that individual staff need to draw upon their own professionalism and teamwork, to ensure that these fundamentals are delivered sustainably.

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

We have now welcomed our new Director of Nursing, Karen Dunderdale, to the team. Karen has significant experience both as a Director of Nursing and as a Deputy CEO and we are already seeing the benefit that her clarity of thought and high professional standards, brings to us. Her two key immediate objectives will be to co-produce clear recommendations on nurse establishment with the Director of Finance and to visibly lead the response of our clinical services to ensure the fundamentals of care are consistently embedded.

In order to develop clinical leaders of the future, both within medical and nursing professions, we are in the process of discussing a proposal from the West Midlands NHS Leadership Academy. Their proposal is to undertake a detailed diagnostic of the individual leadership development requirements of all our

aspirant or existing Clinical Leaders, in order that a tailored programme of personal development can then be enacted. The intention will be to produce a larger cohort of such aspirant leaders, given that we continue to struggle to fill our key leadership vacancies at such a critical time for delivery in the organisation.

The executive team continue to sponsor and lead our summer "roadshows", in which an open invitation is given to staff to attend discussion groups about how we can deliver our four key priorities for the year and what barriers may be preventing progress against these. There has been some good feedback about the level of participation and the quality of the discussion in these forums, with a particular focus on bringing our new values to life to assist in delivery of our strategic objectives.

3.3. Improve our financial health through our robust improvement programme

Given our concerning performance at month 4, particularly with respect to expenditure on supplementary staffing, our decision as a Board to develop and implement a financial recovery plan, even at this relatively early stage of the year, seems justified. Critical to its success will be the ongoing intensity of its oversight, including that by non-executives; a stepping up of professional accountability for delivery and weekly oversight by NHSI's West Midlands team. I will be seeking hard evidence from executive colleagues regarding the control and approvals processes we have in place for both nursing and medical staff temporary spend, in particular the risk assessment and redeployment process which takes place before requests for temporary staffing are even made.

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

Impressive partnership working continues within the borough of Walsall as we continue to pull together the Walsall Together business case for integrated care. KPMG are assisting us in this task and Walsall Healthcare are procuring their input on behalf of the statutory partners in the borough. Due to delays in receiving NHSI approval for this facilitation support and because the contractual, commercial and corporate governance elements require more Board/governing body/cabinet input than thus far given, there is a risk that the business case may not be presented to all the partner's governing bodies until early December. We have yet to evaluate the impact of this on the critical path to intended delivery of a host provider model. I will inform the Board of such risks as and when they are evaluated and clear.

The Black Country STP has requested that all acute hospital Trusts produce a sustainability review and recommendations, similar to those which are being

developed at Walsall Healthcare and which will be presented to our Board. The Dudley Group FT have shared their work, Royal Wolverhampton will shortly follow and Sandwell & West Birmingham have committed to hitting the consensus deadlines on this also. Once available, our respective CEOs, Medical Directors and STP strategy leads can take an initial view on how and where, further clinical service integration can take place, to secure resilience and certainty of core service provision for the longer term, in the context of severe workforce challenges and facilities constraints which all Trusts face to a greater or lesser extent. The STP Health Leaders forum will oversee this work.

4. RECOMMENDATIONS

Board members are asked to note the report.

NEW NATIONAL GUIDANCE, REPORTS AND CONSULTATIONS

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

No	Document	Guidance/ Report/ Consultation	Lead
1.			
	Managing conflicts of interest — a contractual obligation It's a contractual obligation for all trusts to comply with last year's guidance to help organisations manage conflicts of interest. Trusts should publish the interests of decision-making staff at least once a year. NHS England recently conducted a survey of published registers, which found only 5% of acute trusts and 20% of community and mental health trusts publish the required registers	Action	Director of Governance / Interim Trust Secretary
	Consultation on contracting arrangements for Integrated Care Providers (ICPs) The 12-week consultation provides more detail about how the proposed ICP contract would underpin integration between services, how it differs from existing NHS contracts, how ICPs fit into the broader commissioning system, and which organisations could hold the ICP contract. The previous iteration of this draft contract was referred to as the draft Accountable Care Organisation (ACO) contract.	Consultation	Director of Strategy & Improvement
	Implementing local best value biologic medicines programmes NHS England and the Commissioning Support Units have produced an interactive toolkit and supporting materials, including the Best Value Biologics implementation plan and template patient letters and FAQsopens in a new window. These resources focus on adalimumab because the NHS is expecting four new biosimilar versions of Humira (adalimumab) to become available when its patent expires in mid-October.	Resources	Medical Director
	Alert issued on need for safe and timely management of hyperkalaemia (high level of	Action	Medical Director

	potassium in the blood) A Patient Safety Alert has been issued with resources to support the safe and timely management of hyperkalaemia. Hyperkalaemia — a higher than normal level of potassium in the blood — is potentially a life-threatening emergency. Timely identification, treatment and monitoring — during and beyond initial treatment — is essential. The resources will help Trusts ensure clinical staff have easily accessible information to guide prompt investigation, treatment and monitoring options for hyperkalaemia.		
	Developing the long-term plan for the NHS The NHS has been asked to set out a long-term plan for the future by the autumn, setting out our ambitions for improvement over the next decade, and our plans to meet them over the five years of the funding settlement. NHS England want to make sure the provider sector that has to deliver the plan is strongly built into this. Working groups are now being established — bringing together local and national system leaders, partners and stakeholders to shape the final plan. The Trust can find the workstreams on our website, and we will keep the Trust updated as this process develops.	Information	Director of Strategy & Improvement
	Purchase price index and benchmark tool (PPIB) year 3 licence PPIB is a unique and powerful tool for the NHS which ensures we capitalise on our purchasing power. It identifies cost savings which can be reinvested into patient care. Since its initial release, the tool has come to inform local procurement teams' daily purchasing decisions and contract negotiations — and provides great insights. The deadline for raising a purchase order was in July — if the Trust didn't raise one for the year 3 licence, please do so immediately or the Trust risk losing access to the tool.	Action	Medical Director / Director of Finance & Performance
	First patient-level information and costing system (PLICS) public view prototype launched NHS England have developed the first PLICS public view tool with NHS Digital . Now anyone can review high-level information about activity	Information	Director of Finance & Performance

	and costing of acute NHS services, based on the 2016/17 acute PLICS collection and linked Hospital Episode Statistics data. NHS England welcome the Trust feedback on this tool, its content, functionality and layout to further improve this prototype in future releases. Our 2017/18 PLICS collection is underway, which will include acute, mental health, ambulance and community services.		
	Dementia Friendly Hospital Charter re-launch The National Dementia Action Alliance (DAA) has revised its Dementia Friendly Hospital Charter , which now includes a section on volunteering within hospitals. To launch this revised charter, the DAA is holding an event at University College London Hospitals (Euston) on Monday 3 September. This half-day event will see a range of speakers presenting on various aspects of work around dementia within hospitals. This event is aimed at the following healthcare professionals: • dementia leads • chief nurses • trust chief executives • trust dementia team members For questions, please contact sarah.tilsed@alzheimers.org.uk.	Action	Director of Nursing
	Patient Safety Alert: resources to support safer bowel care for patients at risk of autonomic dysreflexia A patient safety alert has been issued signposting the Trust to resources to support safer bowel care for patients at risk of autonomic dysreflexia. Please use the resources to review local clinical policy and guidance relating to bowel assessment and management, and to review local training and education provision — particularly around the care of patients with neurogenic bowel dysfunction resulting from spinal cord injury or severe neurological conditions, meaning they depend on routine interventional bowel care.	Action	Medical Director
	Pilot new incident recording and learning system NHSI are seeking expressions of interest for trusts to become pilot sites for the first version of	Action	Director of Nursing / Director of

	the new patient safety learning system, which will replace Strategic Executive Information System (STEIS) and the National Reporting and Learning System (NRLS). Participating organisations will have direct influence over the design of the new system, and organisations of all kinds, sizes, and digital/safety maturities are encouraged to participate.		Governance
	NHS England NEWS2 champions network NHS England recently issued patient safety alert asking all acute trusts and ambulance trusts to adopt NEWS2 by March 2019. As part of this, all acute and ambulance trusts must nominate a NEWS2 champion to work with NHS England as part of a network to effectively adopt and implement NEWS2 within their organisation. Nominated champions will have access to an online forum, webinar series and information on the latest NEWS2 developments.	Action	Director of Nursing
	Changes to agency price caps for Agenda for Change staff Following the recent approval of the new Agenda for Change contract, NHS I have amended the agency price caps in line with the uplift to Agenda for Change rates. This is designed to ensure continued compliance with the Agency Worker Regulations. The change only applies to those staff on Agenda for Change contracts, and therefore the current agency price caps for medical and dental staff still apply.	Action	Director of HR
	Improving e-rostering Open and transparent e-rostering processes help drive greater employee engagement, satisfaction and wellbeing, and can also help improve retention. Learn from other trusts' good work and find out how implementing effective e-rostering could help the Trust. The mental health and community e-rostering improvement collaborative report This report shares learnings, best practice and successful case studies from 'The mental health and community trust e-rostering collaborative' — where 24 trusts improved their e-rostering	Information	Director of Nursing

	practices to improve patient care and staff satisfaction, and make financial savings. Nursing and midwifery e-rostering: a good practice guide With effective e-rostering, the right staff with the right skills will be in the right place at the right time, so patients receive the care they need, and trusts can better manage their workforce and financial efficiency. This practical guide, for nursing and midwifery across all sectors, contains examples of tools the Trust can use to improve the Trust e-rostering practices		
	NHS England update on adalimumab As part of NHS Englands work to help the NHS switch from prescribing and supplying high-cost branded medicines to safe and equally effective biosimilars, NHS England has created a toolkit to support implementation . The toolkit, which particularly focuses on adalimumab, provides supporting materials and resources for providers and commissioners, linked to a project plan for best value biological implementation.	Information	Medical Director

MEETING OF THE PUBLIC TRUST BOARD – 6th September 2018			
Monthly Nurse Staffing Report			**AGENDA ITEM: 8**
Report Author and Job Title:	Dr Kara Blackwell Deputy Director of Nursing	**Responsible Director:**	Dr Karen Dunderdale Director of Nursing
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	This is a revised Nursing and Midwifery report. This will continue to be refined over the next couple of months to include further data, narrative and actions being taken. It will include further analysis around triggers and triangulated data from the Nurisng and Midwifery dashboard. The average fill rate for registered nurses in July 2018 was 95.8% for day shifts and 96.2% for nights shifts in comparison to June 2018 when it was 97.0% for days and 97.4% on nights. The fill rate for Care Support Workers (CSW) remained the same in July 2018 at 91.9% on day shifts and decreased to 97.5% on night shifts filled as planned in comparison to June 2018 when it was 102% for nights. The lower fill rates on Ward 21 (Paeds) is due to them running a flexible seasonal model of staffing which means the RNs are reduced to 3 overnight during the Summer months. The Lower fill rates on Ward 2 is due to gaps in staffing being unable to be filled by temporary staffing requests. The Divisional Director of Nursing for both Paediatrics and Medicine have confirmed there were no safety concerns regarding the lower fill rates on nights. This report presents CHPPD benchmarked, as this data is new to the Trust Board and to the Trust at ward level, further information needs to be obtained about all outlier areas, due to national definitions of ward areas. Although this gives us information about how our CHPPD is compared to other organisation, this data should be used in conjunction with the comprehensive establishment review process being developed by the Director of Nursing which would be applied and discussed during any establishement review and monthly with the senior nursing team at the Nursing and Midwifery Advisory Forum.		
Recommendation	The Trust Board is requested review and note		
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 and safe scheduling and allocation of nursing staff and the prompt action to resolve shortfalls in staffing whenever possible to mitigate the risk to patient care and safety		
Legal and Equality and Diversity implications	None		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	

	Partners ☒	Value colleagues ☐
	Resources ☒	

MONTHLY NURSE STAFFING REPORT

1. PURPOSE OF REPORT

This is a routine monthly report to the board in accordance with the requirements of the updated National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance (July 2016) and the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014.

The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is receognised that decisions in relation to safe clinical staffing require a triangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing data, acuity patient outcomes and clinical judgement. This report provides evidence that processes are in place to record and manage Nursing and Midwifery staffing levels across both hospital and community settings and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care.

This report continues to be developed to provide more oversight of professional standards, patient safety and standards of care across our clinical areas, in line with the on-going development of the Nursing dashboard.

2. SHIFT FILL RATES

Data in this section of the report relates specifically to shift fill rates. This data is used to populate the monthly Hard Truths return, previously referred to as the Unify return which is now submitted to NHS Digital. This submission is a mandatory requirement for NHS Trusts and information is collected monthly by the Senior Nurse for Workforce.

The fill rate submission currently requires information on in-patient areas not ambulatory care, short stay and ED. The full NHS Digital upload is provided in Appendix 1.

The average fill rate for registered nurses in July 2018 was 95.8% for day shifts and 96.2% for nights shifts in comparison to June 2018 when it was 97.0% for days and 97.4% on nights. Shift fill rates have decreased this month for RNs on days and nights. The fill rate for Care Support Workers (CSW) remained the same in July 2018 at 91.9% on day shifts and decreased to 97.5% on night shifts filled as planned in comparison to June 2018 when it was 102% for nights.

Of the 20 areas reported on during July 2018;

- 9 areas recorded less than 95% shift fill rate on days for RN
- 4 areas fell between 80% and 89% shift fill rate on days for RN
- None of the clinical areas had an RN fill rate below 80% on day shifts
- On nights 4 areas recorded less than 95% shift fill rate on nights for RN
- On nights 2 areas recorded an RN shift fill rate between 80% and 89%; these were ward Ward 21 (Paeds) and Ward 2.

The lower fill rates on Ward 21 (Paeds) is due to them running a flexible seasonal model of staffing which means the RNs are reduced to 3 overnight during the Summer months. Ward 2 was due to gaps in staffing being unable to be filled by temporary staffing requests. The Divisional Director of Nursing for both Paediatrics and Medicine have confirmed there were no safety concerns regarding the lower fill rates on nights in the areas identified above.

Figure 1 below shows the RN fill rate has flucturated on days with the lowest recorded in March 2018.

The fill rate for RNs on days has been above 90% for the last 12 months and above 90% for RN fill rates on nights since January 2018, the fill rate for registered nurses on days declined for the second consecutive month in July 2018 and also declined on nights in July 2018 with fill rates of 95.8% and 96.2% respectively.

Figure 1

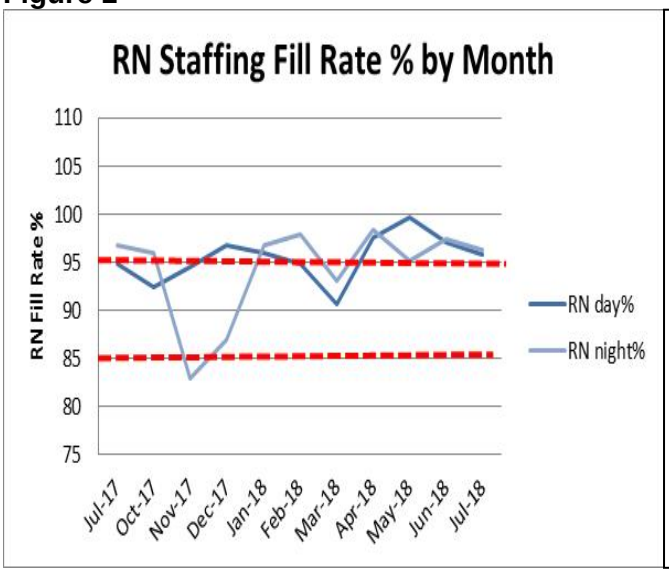


Figure 2

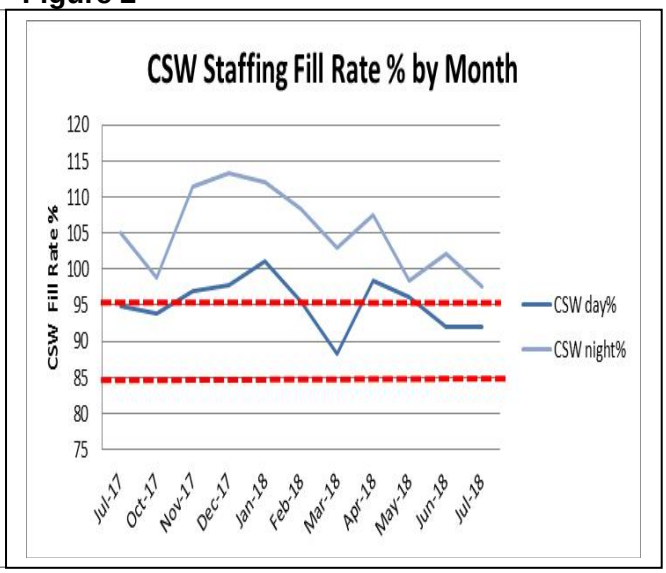
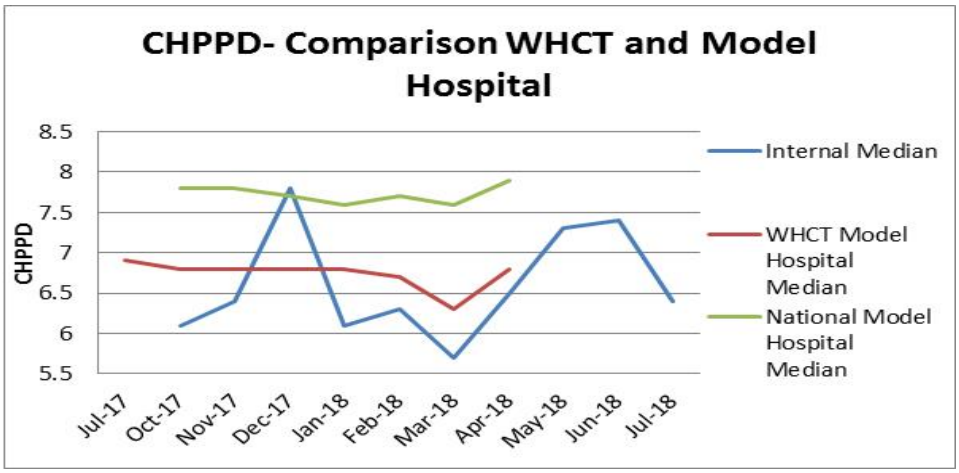


Figure 2 shows that the fill rate for CSWs on nights also declined for the seventh month but remain above 95%, this is often due to the 1:1 specials required for patients with mental health issues whose behaviour can be challenging and require supervision particularly at night when rostered staffing levels are reduced.

3.0 Care Hours per Patient Day (CHPPD)

The Care Hours per Patient Day (CHPDD) is reported monthly and is included in the Trusts monthly NHS Digital return (Appendix 1). CHPPD is the total hours per day of registered nurses (RN) and Care Support Workers (CSW) divided by the number of patients in the ward/department at 23.59 hours each night. Figure 3 provides the score for the CHPPD for WHCT by month and the comparison with the Model Hospital data for CHPPD reported.

Figure 3:



The CHPPD by Division is shown in Table 1.

Table 1

July 2018	Qualified	Unqualified	Total
Medicine	2.7	3.0	5.3
Community (Stroke)	4.6	4.4	8.9
Surgery (& 23)	3.9	3.4	6.4
CYP	7.5	0.0	7.5
Maternity	4.0	2.3	6.3

A comparison of the CHPPD by Division for 2018-2019 YTD are shown in Figure 4. These have remained consistent across Medicine, CTP and Maternity. In Community the CHPPD have increased which reflects the additional beds which have been intermittently used for medical outliers on the Stroke Rehabilitation ward in July 2018.

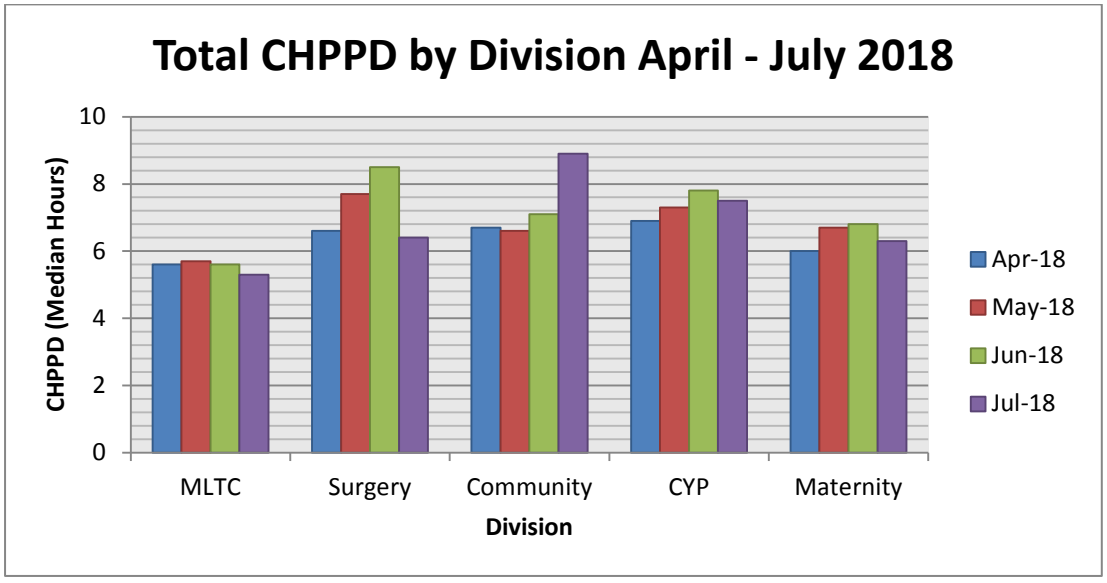


Table 2 includes the CHPPD National Benchmarking data by speciality ward at WHCT (June 2018) which has been mapped against national CHPPD for these specialities. The CHPPD totals are the combined qualified and unqualified CHPPD totals. As this data is new to the Trust Board and to the Trust at ward level, further information needs to be obtained about all outlier areas, due to national definitions of ward areas. Although this gives us information about how our CHPPD is compared to other organisation, this data should be used in conjunction with the comprehensive establishment review process being developed by the Director of Nursing which would be applied and discussed during any establishement review and monthly with the senior nursing team at the Nursing and Midwifery Advisory Forum.

Table 2

WARD	Combined CHPPD (June 2018)	Comparison to National CHPPD	National CHPPD
Ward 1	4.81	↓**2.85**	7.66
Ward 2	5.52	↓**2.14**	7.66
Ward 3 (Swift)	5.27	↓2.39	7.66
Ward 4 (Stroke)	7.05	↓1.15	8.2
AMU	9.9	↑0.03	9.96
Ward 7	7.38	↓0.59	7.97
Ward 15	6.23	0	6.23
Ward 16	5.64	↓0.57	6.21
Ward 17	5.59	↓1.19	6.78

Ward 29	5.82	↓**1.84**	7.66
Ward 9	9.07	↑**1.83**	**7.24**
ASU	5.76	↓**1.72**	**7.48**
20A	6.58	↓**0.66**	**7.24**
20B	7.92	↑**0.44**	**7.48**
Ward 18 (HDU)	17.31		
Ward 19 (CCS)	28.30		
Ward 21 (Paeds)	7.82	↓**4.84**	**12.66**
Ward 23	8.52	↓**0.01**	**8.53**
Ward 24/25	6.75	↓**8.22**	**14.97**
Ward 28	14.61	↓**0.36**	**14.97**

4.0 Safe Staffing, Staff Incidents and Quality and Safety Key Performance Indicators

A review of those wards where the staffing fell below the 90% target for staffing fill rates were reviewed in relation to the quality and safety key performance indicators (KPI). These KPIs are shown below, (the KPIs for all wards are shown in Appendix 1):

Ward	Hospital Acquired Pressure Ulcer	Falls	Serious Incidents	Complaints	FFT Score	Number of Staffing incidents	Any correlation between staffing and KPI dates?
ASU	2	1	0	1	92.75%	2	No
AMU	2	3	2	2	85%	8	Yes
15	2	3	0	1	100%	0	No
20a	0	0	0	0	0%	2	No
16	4	1	0	0	92.59%	0	No
23	0	0	0	0	96.36%	0	No
24/25	0	0	0	0	100%	0	No
2	3	6	0	1	94.4%	1	Yes

The incidence of pressure ulcers and falls can be influenced by the ward speciality and patient demographics e.g. a higher incidence of falls may be expected on an elderly care or rehabilitation clinical area; however, these can also correlate with staffing issues and shortages. 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; pressure ulcers reported in July are currently going through the RCA investigation process and 1 fall on AMU which resulted in the patient sustaining a fractured neck of femur (NOF) is currently being investigated and staff shortages were identified as part of this process.

All the staffing related incidents reported on the Trust Safeguard incident reporting system for July 2018 were reviewed to identify any correlation with patient harms. In total there were 41 staffing related incidents reported which related to low staffing due to gaps on ward rosters which could not be covered by temporary staffing. These are outlined below:

Ward	Number of staffing related incidents	Level of Impact
ASU	2	Low
Ward 1	6	1 incident correlates with a patient fall on the same day
Ward 2	1	1 incident correlates with a patient fall on the same day
Ward 3	4	2 incidents correlate with patient falls on the same day
Ward 4	2	Low
AMU	8	1 incident correlates with a patient fall on the same day
Ward 7	2	Low
Ward 9	4	Low
Ward 17	1	Low
Ward 20a	2	Low

Ward 20b/c	6	Low
Ward 29	2	1 incident correlates to a patient fall on the same day
Ward 10	1	Low

One fall on AMU which resulted in sever harm was also reported as a staffing incident. On review of the reported staffing incidents in July, 5 of the reported staffing incidents correlated with days when a patient had a fall although these patients did not sustain significant harm.

The reporting of nursing red flag events (NICE 2014) as part of the risk assessment used to assess gaps in staffing commenced in mid July 2018. Wards reported 24 red flag events as part of their risk assessment of staffing, these included delays/omissions in medications, delays in personal care, delays in recording vital signs, delays in providing pain relief and shortfall of more than 8 hours or 25% of RN time.

The Director Nursing will be developing a Nursing Metrics Review to increase the oversight and narrative on standards of care. The outcomes of these reviews will inform this board report on an on going basis.

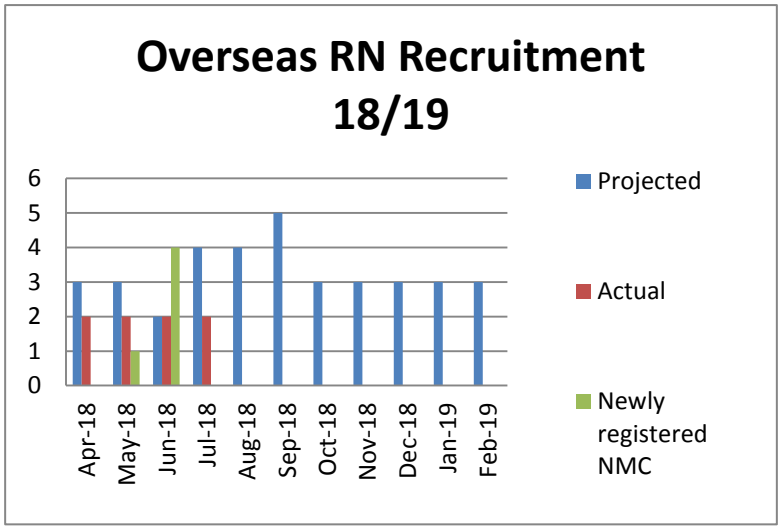
5.0 Update on Vacancies and Recruitment

The current vacancies in July 2018 at present (excluding theatres)

DIVISION	WTE VACANCIES- Registered Nurse
MLTC	50.19
SURGERY	18.91
COMMUNITY	2.0
WCCSS	18 Midwives 5.7 Paeds (including HV, neonates, School Nursing)
Total	94.8

The current initiatives being undertaken in relation to RN recruitment:

- There is a rolling advert for Band 5 RN posts in the Medicine and Surgical Division on NHS jobs
- Tailored recruitment events tailored to specialities e.g. AMU, emergency surgery.
- Regional RN recruitment event taking place in September 2018 co-ordinated by the Professional Development Unit
- Planned integration of newly qualified Nurse Associates into the nursing workforce in Q4 of 2018-2019



The ongoing recruitment of overseas nurses will continue throughout 2018-2019. WHCT has overseas arrivals planned for the remainder of this financial year with an expected conversion to RN registered with the NMC within 6 months. The target for recruitment is 30WTE for this financial year. The Trust is expecting an average of 3-4 planned arrivals per month, and 5 planned arrivals for September. Year to date 7 overseas nurses that have qualified as RN in England and are now working as RNs on the wards.

Student RNs are offered a conditional job offer upon commencement of placements with WHCT during their training. There are a planned 37 newly qualified RNs who have accepted RN posts in the Trust and are expected to start in September 2018 unless they subsequently obtain a role elsewhere. Retention of student nurses on qualifying as RN who have trained at WHCT is about 90%. The corporate nursing team have already commenced planning for the student RN's who will qualify in January 2019 and are working with Divisions to plan allocation of roles. 8 midwives are due to start in September 2018.

6.0 RECOMMENDATIONS

The Trust Board is requested to discuss the information contained in this report including:

- Support the implementation of the Nursing Metrics Review which will continue to develop the nursing dashboard, once these metrics have been added an escalation process will be refined
- The current Trust performance in relation to local and national safe staffing KPIs
- The review of quality KPIs, reported staffing incidents and any correlation to deficits in staffing
- To note the update on vacancies and planned recruitment.

7.0 CONCLUSIONS

The report is presented as part of the on-going work across WMCT focussing on ensuring safe and appropriate staffing and skill mix levels for Nursing, Midwifery and Community Services.

The report continues to require some further formatting and narrative around identified areas of concern and actions being taken and this development will continue over the coming months

Appendix 1: NHS Digital Upload and Ward Quality KPIs July 2018

Dept		Day		Night		Day		Night		CHHPD													
	RN WTE established	Av. fill rate - RNs (%)	Av. fill rate - carestaff (%)	Av. fill rate - RN	Av. fill rate - carestaff (%)	Av. fill rate - substantive RN (%)	Av. fill rate - Substantive carestaff (%)	Av. fill rate - substantive RN (%)	Av. fill rate - substantive carestaff (%)	RN	Care Staff	Overall	Staffing Related Incidents	% safety thermometer harm free care	Falls (excluding no harm)	Pressure Ulcers grade 2	Pressure ulcer grade 3	Unstageable/deep tissue injury	CDIFF	MRSA	NUMBER OF DAYS WHERE RED FLAGS OCCURRED	COMPLAINTS	FFT(%)
Acute Surgical Unit		88.5%	96.3%	96.9%	100.8%	68.59%	82.61%	52.23%	62.42%	3.5	2.9	6.4	2	97.73%	1	2	0	0	0	0	0	1	92.8%
Ward 01		91.9%	91.0%	97.9%	99.2%	87.26%	83.26%	53.97%	64.29%	2.4	3.0	5.4	6	97.06%	6	0	1	1	0	0	3	0	87.5%
Ward 02		99.1%	95.3%	100.4%	83.6%	93.67%	58.89%	61.45%	68.50%	2.7	3.0	5.8	1	100.00%	6	3	0	0	0	0	1	1	94.4%
Ward 03		104.1%	93.5%	100.0%	100.0%	78.14%	67.36%	66.67%	46.22%	2.0	3.3	5.3	4	85.71%	6	0	0	1	0	0	1	0	89.2%
Ward 04		98.3%	104.6%	101.6%	100.0%					4.6	4.4	8.9	2	68.57%	2	0	0	0	0	0	3	0	90.9%
Acute Medical Unit		86.4%	83.8%	98.2%	94.7%	75.81%	75.91%	57.26%	75.94%	3.9	3.6	7.5	8	92.50%	3	0	0	1	1	0	3	2	85.0%
Ward 07		94.6%	95.2%	97.8%	97.8%	82.28%	86.62%	92.59%	81.48	3.4	3.4	6.8	2	100.00%	2	2	0	0	0	0	0	0	94.9%
Ward 09		97.8%	97.3%	99.0%	98.6%	77.27%	63.28%	58.24%	45.06%	2.9	3.6	6.4	4	100.00%	2	0	0	0	0	0	3	0	91.7%
Ward 15		88.5%	92.0%	89.2%	118.8%	76.70%	88.11%	48.19%	88.16%	2.6	2.5	5.1	0	96.43%	3	1	0	0	0	0	4	1	100.0%
Ward 16		95.3%	68.0%	97.2%	96.8%	70.21%	59.80%	65.24%	68.33%	2.9	2.0	4.9	0	100.00%	1	3	0	0	1	0	3	0	92.6%
Ward 17		94.5%	97.9%	96.8%	103.2%	81.06%	91.14%	43.33%	90.63%	3.0	2.2	5.2	1	94.90%	2	0	0	0	0	0	1	0	100.0%
Ward 18 (CCS/HDU)		96.9%	64.7%	94.2%	65.9%	90.61%	100.00%	91.10%	39.15%	16.5	2.3	18.8	0	100.00%	0	0	0	0	0	0	0	0	93.3%
Ward		92.3%	-	93.5%	-	85.62%		89.08%		27.4	0.0	27.4	0	100.00%	0	2	0	0	0	0	0	0	100.0%
Ward 20A		86.6%	100.2%	98.4%	100.0%	90.06%	54.68%	54.10%	77.42%	3.6	2.5	6.1	2	100.00%	0	0	0	0	0	0	1	0	0.0%
Ward 20B/20C		96.5%	98.9%	98.9%	100.0%	79.94%	92.20%	63.04%	82.26%	3.9	3.4	7.2	6	100.00%	1	0	0	0	0	0	0	0	94.5%
Ward 21(Paeds)		98.3%	-	79.0%	-	96.79%		88.78%		7.5	0.0	7.5	0	100.00%	0	0	0	0	0	0	0	0	94.7%
Ward 23		105.8%	66.5%	94.4%	106.0%	100.00%	82.40%	96.58%	87.83%	4.0	2.4	6.4	0	100.00%	0	0	0	0	0	0	0	0	96.4%
Wards 24/25		120.3%	83.3%	100.7%	92.5%	100.00%	41.53%	85.38%	32.54%	4.0	2.3	6.3	0	100.00%	0	0	0	0	0	0	0	0	100.0%
Ward 28		100.0%	100.0%	100.0%	100.0%	99.42%	100.00%	99.36%	100.00%	15.1	1.9	17.0	0	100.00%	0	0	0	0	0	0	0	0	N/A
Ward 29		93.1%	104.5%	98.9%	100.0%	65.86%	78.52%	59.78%	60.87	2.7	2.5	5.2	2	86.67%	10	2	0	0	1	0	1	1	95.2%
TOTAL FILL RATE		95.80%	91.90%	96.20%	97.50%	84.95%	75.12%	72.99%	67.20%														

MEETING OF THE PUBLIC TRUST BOARD – 06 September 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 ☐ (select the relevant action required)		
Executive Summary	This paper aims to update the Quality & Safety Committee / Board on the actions the trust has been taking over the past few 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. 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 • 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: 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		
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 (highlight which Trust Strategic objective this report aims to support)	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. It should be noted that all actions being taken are aimed at becoming 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, formal feedback following the spot inspection of Maternity Services carried out by the CQC, 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

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 individual 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. However, there are still gaps, which will be addressed at the Trustwide outcomes work shop organised for the 04 September 2018.

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 (June '18)	Update (July 18)
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)	95.57%
There were **high levels of nursing staff vacancies** across acute services. This	Trust target is aligned to the National vacancy rate of 10.66%	8.73% (run chart in ap. A)	13.06%

Regulatory Issue	Trust Target	Update (June '18)	Update (July 18)
meant the provider was not providing sufficient numbers of suitably qualified staff to keep patients safe			
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)	98.54% 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)	83.6%
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 the Intercollegiate document (2014).	Achievement of targets for all levels of Children and Adult Safeguarding by end June 2018 Level 1=95% Level 2 & 3=85% PREVENT=85%	Training compliance figures in Appendix A	SG Paeds: L1: 99.26% L2: 84.52% (shd be the same as L3) L3: 92.24% SG Adults: L1: 99.92% L2: 87.04% L3: 89.64%
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	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	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	Medical Documentation Audit scheduled for 24.08.18 & agreed that MD documentation audit to be piloted across the trust commencing 15.08.18

Regulatory Issue	Trust Target	Update (June '18)	Update (July 18)
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	Confirm Trust strategy for EPR by 30th June 2018. 'Mobile' notes implemented across community	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. Compared to last month, the trust remains compliant with 4½ of the 8 regulatory actions. However, there has been an overall improvement from June, with compliance being achieved in safeguarding and mandatory training (full details in Appendix A). Of concern, remains compliance with documentation, and completion of the MCA assessment as part of the DNACPR form. 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 (7/14) – more detail in Appendix A.

Issue	Must	Trust Target	Update June '18	Update July '18
Action plans are monitored and managed for serious incidents	Must	Zero outstanding	See appendix A	See appendix A
Lessons are disseminated effectively to enable staff learning from serious incidents, incidents and complaints.	Must	TBA	See appendix A	See appendix A
Patient medical notes are kept secure at all times	Must	TBA	Policy is being developed for implementation & audit	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)	Figures not available
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	See Appendix A
The service uses an acuity tool to evidence safe staffing (nursing & midwifery)	Must	100%	SNCT & midwife: birth ratio in place	SNCT & midwife: birth ratio in place 1:28
All staff receive an appraisal in line with local policy	Must	90%	83.41%	87.56%
COMMUNITY FOR CHILDREN & YOUNG PEOPLE: Continue to follow standard operating procedures with medicines in special schools	Must	100%	100%	100%
MATERNITY: Risks are explained	Must	TBA	Consent audit	Re-audit being

Issue	Must	Trust Target	Update June '18	Update July '18
when consenting women for procedures			undertaken 2017. Re-audit required	undertaken in August 2018
ED: completes the action plan completed following the CQC inspection carried out in September 2015	Must	TBA	Currently reviewing compliance	2 actions outstanding and being implemented
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	Adult Policy completed. 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		Monthly trajectory to be established
OUTPATIENTS: All staff have the required competencies to effectively care for patients, and evidence of competence is documented.	Must	90%	90%	90%
OUTPATIENTS: All outpatient clinics are suitable for the purpose for which they are being used (This relates specifically to the Fracture Clinic)	Must	TBA		See appendix A for actions taken. Once evidence received can be altered to blue

10. Whilst there is still quite a bit of work to be undertaken in relation to compliance, there has been some improvement from the previous month e.g. staff appraisal compliance has improved and is only 2.5% away from the target and outpatients are taking a number of actions to enhance the Fracture Clinic Environment. A trust-wide workshop has been arranged for 04 September, whereby metrics and trajectories will be identified for the outstanding areas.

11. Currently, the PCIP is generated in Excel and is split between Divisions, making it difficult to gain Trustwide oversight of the document and therefore compliance as a whole. The trust was looking in the short-term to develop a system on Share Point, however this has now changed as the trust has purchased a business intelligence system, Power BI which will enable reports to be developed with 'drill down' facilities, so that details can be observed from ward through to board. This is currently in development.

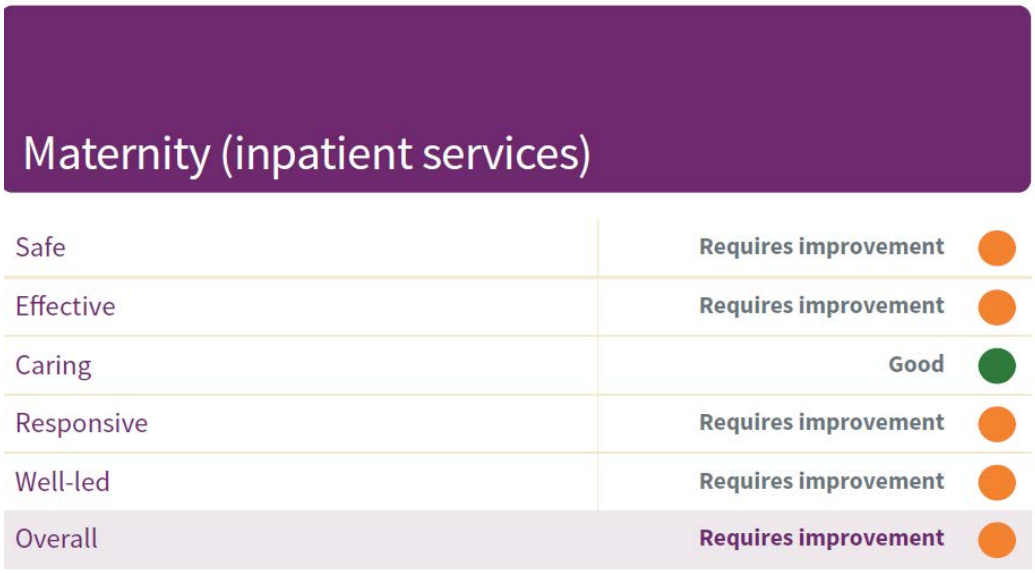
12. In the meantime, the excel spreadsheets have been standardised to ensure they all contain the same headings, and work has commenced on identifying SMART objectives and outcome measures with trust staff to make it easier for them to monitor their improvements.

CQC spot inspection of Maternity Services

13. 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 recognising individual members of staff, no concerns around

clinical practice, but corporate issues such as fire risk assessments which needed to be improved upon.

14. Since then, the CQC have published the final report on their website. This has demonstrated a significant improvement from the previous inspection, with the service moving from Inadequate to Requires Improvement overall. Staff are to be congratulated on all their hard work and the recognition that their service has improved significantly. The ratings received by maternity services are as follows:



15. However, unfortunately, the CQC website is still showing the Inadequate rating, under which the Requires Improvement rating has been added. This has been queried by the Trust as it is confusing for patients and doesn't present an accurate picture of improvements. The trust have been told that additional narrative has been added at the top of the rating table, and there is nothing further that can be done.

16. The report acknowledged that all the concerns raised in the Section 29a Warning Notice relating to Maternity Services (07 September 2017), following the previous inspection have now been satisfied. The trust has requested that the CQC formally acknowledge this in a letter to the Chief Executive, so that this loop can be closed – we await a response.

Fundamental Standards of Care

17. 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

18. 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 Provider Information Request (PIR).

19. 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

20. Following the initial self-assessment, a Quality Assurance session was held between the executive team and the individual care groups to ascertain the evidence and rationale for their self-assessment. This process evaluated very positively by the Care Groups, Divisions and the executive team. As a result, some of the initial self-assessment ratings were altered (both up and down).

21. Below is a comparison between the ratified self-assessment and the previous CQC inspection outcome:

	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

	Ratified Self-Assessment 2018 (August)					
	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	Overall
Urgent & Emergency Services	RI	RI	RI	RI	GOOD	RI
Medical Care	RI	RI	GOOD	RI	RI	RI
Surgery	RI	RI	GOOD	GOOD	GOOD	RI
Critical Care	GOOD	GOOD	GOOD	RI	GOOD	GOOD
Maternity	RI	RI	GOOD	RI	RI	RI
Gynae	RI	GOOD	GOOD	GOOD	RI	RI
Children & Young People	GOOD	GOOD	OUTSTANDING	OUTSTANDING	OUTSTANDING	OUTSTANDING
End of Life	RI	RI	OUTSTANDING	GOOD	GOOD	RI
Outpatients	Good	NA	GOOD	RI	GOOD	GOOD
Diagnostics (not ratified)	RI	RI	GOOD	RI	RI	RI
Community (Adults)	GOOD	GOOD	OUTSTANDING	GOOD	OUTSTANDING	GOOD
Community (Paeds)	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
Community (End of Life) (not ratified)	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
OVERALL (Manor Hospital)	RI	RI	GOOD	RI	RI	RI

22. It is apparent that some core services believe that their services have declined, and they need to take action to rectify this; whilst others have improved since the last CQC inspection, which should be celebrated.

23. 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. This will commence from September 2018 onwards.

b) Monitoring of Fundamental Standards

24. The last report, articulated changes being implemented to standardise audits relating to the fundamental standards of care. It has now been agreed that the new audits will be piloted over the next 2-3 months on 3 ward areas, with the documentation audit being rolled out across the trust – this commenced on the 15 August 2018.

25. Results will be available electronically and should 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. Where appropriate, the results will also be incorporated into the monthly performance reviews (divisional & corporate).

Board self-assessment against the CQC Well-Led Framework

26. Following the self-assessment conducted by the Board against the well-led framework (CQC, 2107), an action plan has been developed which has been presented to September 2018 board for ratification. Implementation of the actions and outcomes will be monitored via Trust Management Board and the Board on a quarterly basis.

Board self-assessment against the Use of Resources Framework

27. The self-assessment being conducted by the executive team against the new Use of Resources Framework (CQC, 2018) is not yet finalised. Once completed, actions will be identified to move the trust forward, which will be incorporated into the well-led action plan outlined above. A board development session has also been arranged to discuss the assessment and actions being taken.

CQC Inspection Preparation

28. The trust continues to meet weekly at the CQC Preparation Steering Group, chaired by the Chief Executive, to address issues relating to compliance against the fundamental standards.

29. Examples of issues which have been highlighted for additional action during the last month include: compliance with DNACPR and completion of MCA assessments; medication safety; outpatient follow ups; the standard of multi-professional documentation and purchase of bedside equipment and establishing a process to keep spare beds / trolleys out of the corridors.

30. Sharing of best practice continues at each meeting, with departments presenting: sharing the learning from incidents (HSJ award) and the work that the Bereavement Midwife has been undertaking. In addition, once a month, the Head of Patient Experience shares a patient experience ‘Sound Bite’ with the group which is then discussed and action identified as appropriate.

31. 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. In addition, from September onwards, monthly Quality Asurance meetings are being held with each of the Care Groups, jointly chaired by the Director of Nursing & the Medical Director to monitor implementation of their PCIPs.

32. The trust is anticipating that there will be a full inspection and plans are in place to prepare the organisation as a whole.

Conclusion

33. 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, in order that the organisation moves from Requires Improvement to Good.

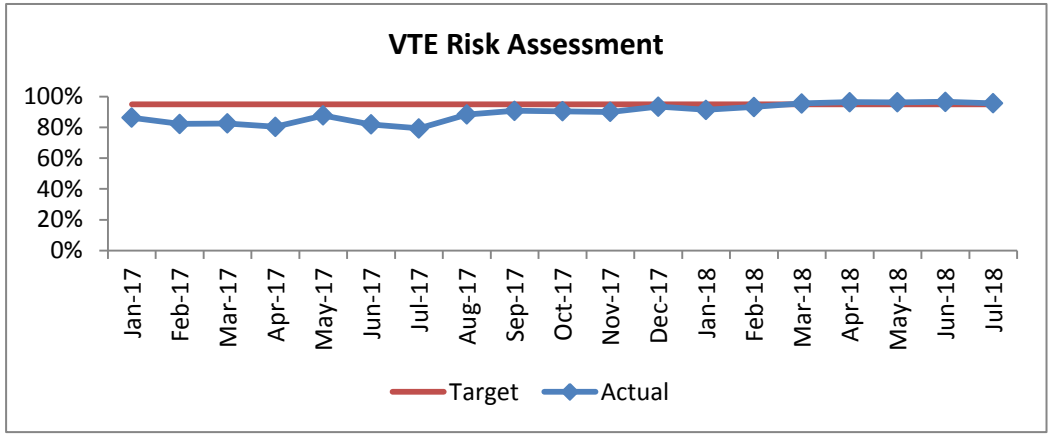
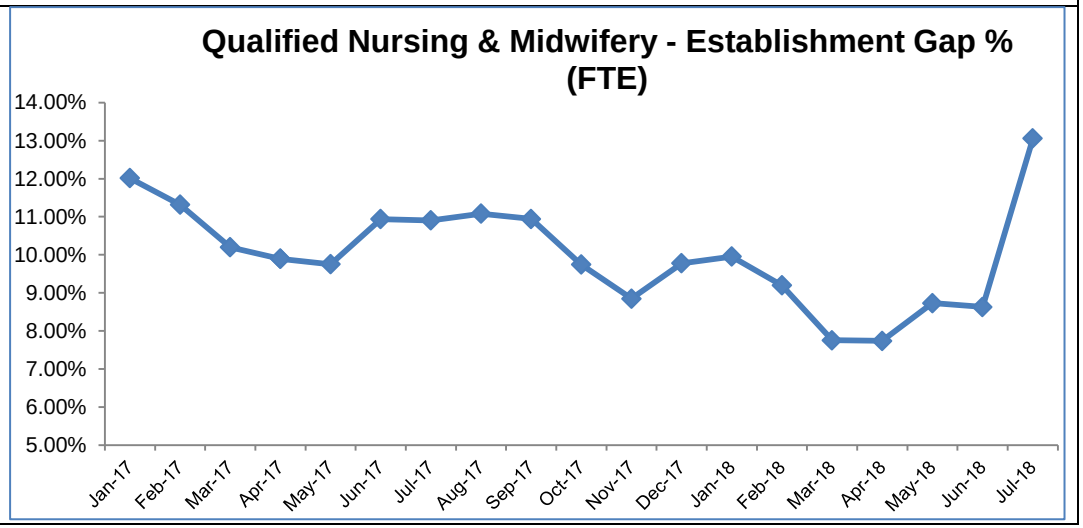
Appendices:

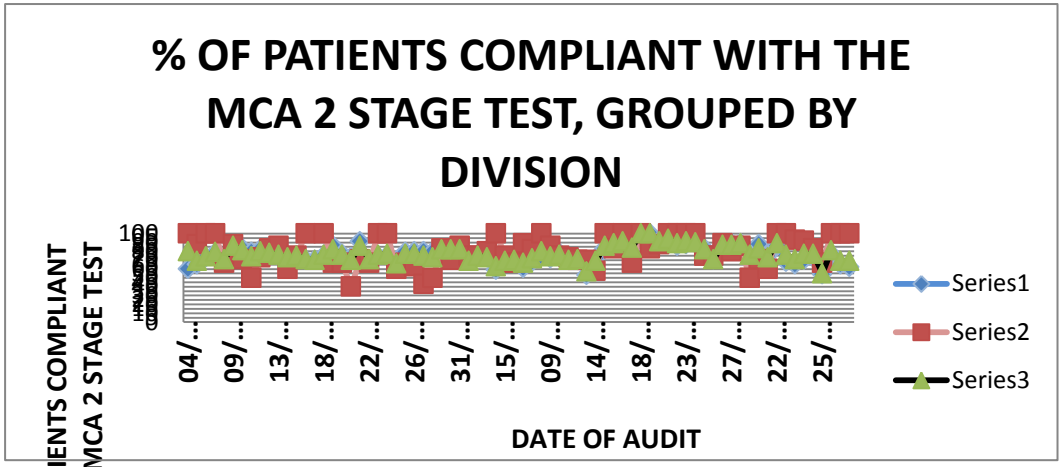
A: Update on Regulatory & Must Do Actions
B: C Section Rates – Maternity Services

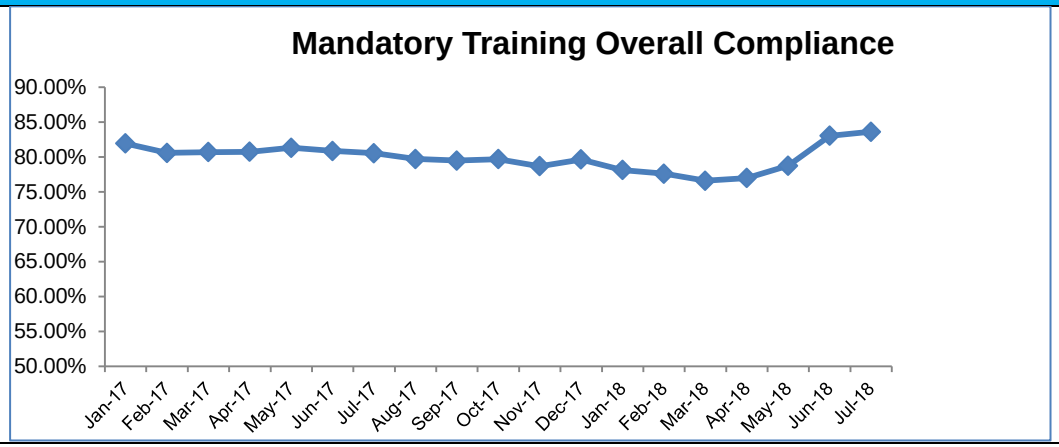
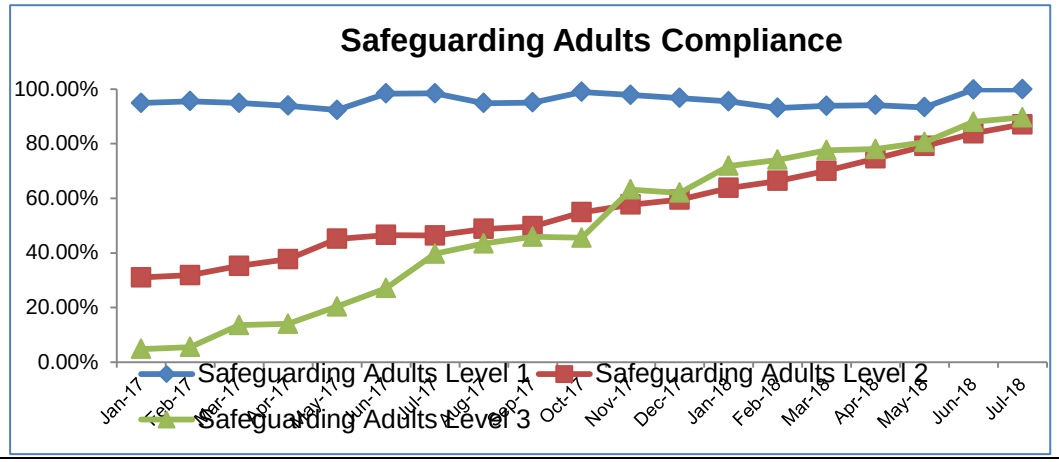
Appendix A

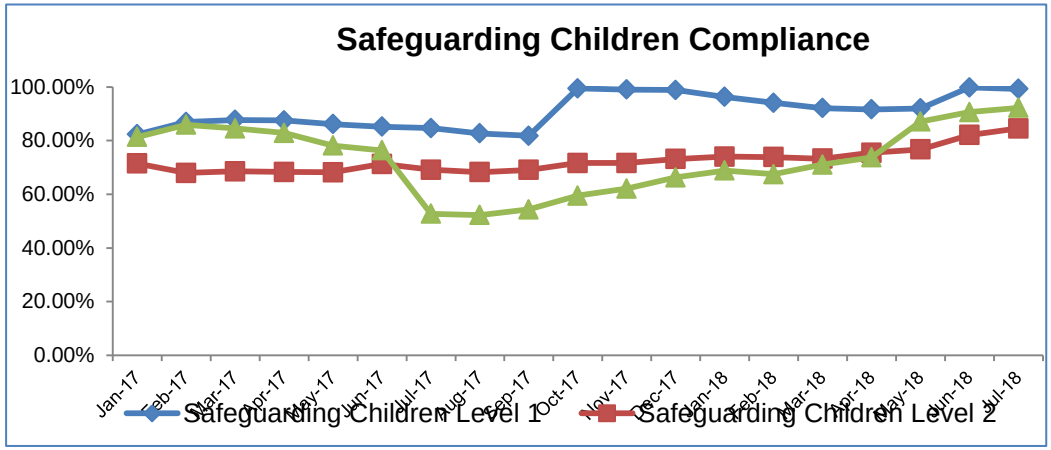
Update on Regulatory & MUST DO Actions (July 2018)

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 = 98.54%** 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.
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. Trust target now 85%	**July achievement; 83.63%**

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart
			
Blind cords were not secured in all of the rooms at the child development center	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: 
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.	Medical Documentation Audit scheduled for 24.08.18 & agreed that MD documentation audit to be piloted across the trust commencing 15.08.18

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart
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

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.

Division	SI's with actions outstanding past completion date (July 2018)	SI's with actions outstanding past completion date (Jun 2018)	SI's with actions outstanding past completion date (May 2018)	SI's with actions outstanding past completion date (Apr 2018)	SI's with actions outstanding past completion date (Mar 2018)	SI's with actions outstanding past completion date (Feb 2018)	SI's with actions outstanding past completion date (Jan 2018)
WCCSS	**9**	8	8	6	7	6	7
Surgery	**1**	1	2	2	1	1	6
MLTC	**0**	0	3	5	3	1	0
Total	**10**	9	13	13	11	8	13

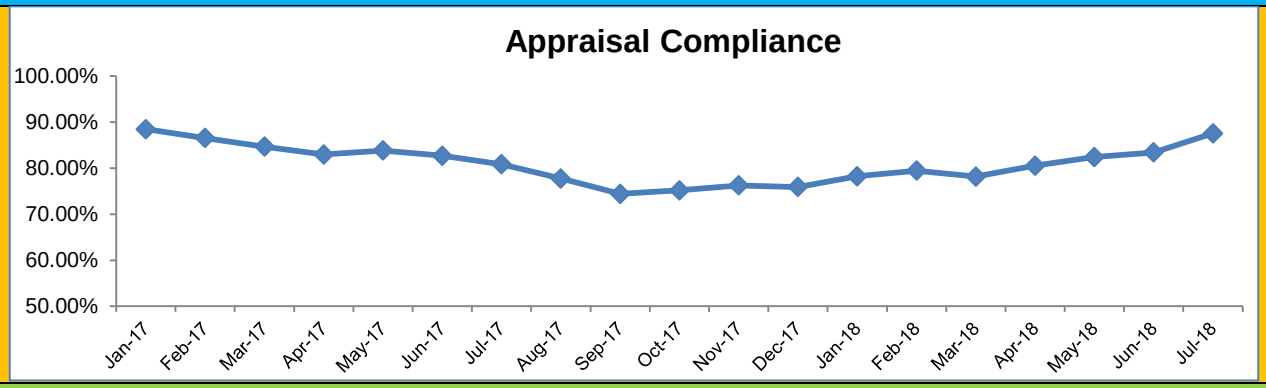
Issue	Must	Trust Target	Update / SPC Chart
Lessons are disseminated effectively to enable staff learning from serious incidents, incidents and complaints.	Must	TBA	Lessons learnt are disseminated via: • Email automatically sent via Safeguard to the reporter when an incident is closed by the responsible manager • Sharing the SI investigation report with the staff involved • Weekly Divisional Safety Huddles • Safety huddles at department level have started • Risk Roadshows • 'Incidents at a glance' one page summaries describing the incident, lessons learned - discussed at Care Groups as part of their quality meeting agenda and in MLTC are added it the ward display boards at the entrance to the ward. • Weekly ward based drop in sessions to share learning from incidents and risks and to answer staff questions • Lessons learned bulletin • Care Groups quality/audit meeting • Specialty Governance meetings – i.e General surgery, TACC. • Workshops covering professional responsibilities and human factors - we share learning relating to specific incidents, complaints, claims, coroners and/ or audits from that department so that staff at the frontline understand the learning. • Social media feedback has started – Twitter / Yammer with development of a blog / vlog planned • Twice yearly Patient Safety Kitchen Table events in line with the national Sign up to Safety agenda. Feedback following an incident is also covered in Clinical Update training 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. • Participants in workshops in ESR
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	Must	TBA	No figures provided this month

<table>
<tr><th>Issue</th><th>Must</th><th>Trust Target</th><th>Update / SPC Chart</th></tr>
<tr><td>syringe driver</td><td></td><td></td><td></td></tr>
<tr><td>Staff follow best practice national guidance (NICE, CAS alerts, Royal College Guidelines, local clinical guidelines etc. etc.</td><td>Must</td><td>TBA</td><td>2 CAS Alerts outstanding:
NATSIPPS (aiming for closure in September 2018)
Luer lock connectors (aiming for closure January 2019)

Clinical Guidelines have recently been reviewed, with the outcome highlighted below:

<table>
<tr><th>Document Type</th><th>Number</th></tr>
<tr><td>Number of documents in total</td><td>743</td></tr>
<tr><td>Number of Guidelines including the separated Neonatal Guideline *</td><td>440</td></tr>
<tr><td>Number of Guidelines excluding the separated Neonatal Guideline *</td><td>298</td></tr>
<tr><td>Number of SOPs</td><td>167</td></tr>
<tr><td>Number of Policies</td><td>25</td></tr>
<tr><td>Number of Forms</td><td>85</td></tr>
<tr><td>Number of Queries</td><td>61</td></tr>
<tr><td>Number of Other documents</td><td>107</td></tr>
</table>

In total, there are 287 guidelines of which 78 are expired and 47 had no information regarding review date – a full action plan has been submitted to CQC preparation group for implementation and review.</td></tr>
<tr><td>The service uses an acuity tool to evidence safe staffing (nursing & midwifery)</td><td>Must</td><td>100%</td><td>SNCT & midwife: birth ratio in place</td></tr>
<tr><td>All staff receive an appraisal in line with local policy</td><td>Must</td><td>90%</td><td>July: 87.56%</td></tr>
</table>

Issue	Must	Trust Target	Update / SPC Chart
			
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)
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	ED have reviewed previous action plan and have just 2 remaining, which are currently being worked on.
SAFEGUARDING: adults and Safeguarding	Must	100%	Revised Adult Policy to be ratified by 31.07.18 Revised Children's Policy – date to be confirmed

Issue	Must	Trust Target	Update / SPC Chart
children policies are up to date and include relevant references to external guidance			
CRITICAL CARE: All staff working within the outreach team are competent to do so	Must	100% by 01.01.2019	Monthly trajectory to be established
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	Issues and actions outlined below: 1. OPD TOT to assess waiting area and corridor area in fracture clinic for accessibility for patients in wheelchairs or those that require the use of a walking aid. SR Allport has completed the audit (see attached) we have also enlisted a seating company to design a bespoke seating solution. 2. Areas to be decluttered Completed and ongoing 3. Risk assessment to be completed and added to risk register Risk added to risk reg and updated. 4. In fracture clinic, we found that three cubicles where patients were treated had a curtain to maintain patient's privacy and dignity. However, consultations with patients could be heard within the department due to the confined spaces within fracture clinic and the lack of a wall between the corridor and treatment area. Implementing "Curtain Conversations" as per hyperlink below https://www.uclh.nhs.uk/News/Pages/Itscurtainconfidential.aspx and have devised the Confidential Conversation Poster attached to use in cubicle area (please see attached.)

Issue	Must	Trust Target	Update / SPC Chart
			5. Within fracture clinic, patients of all ages waited within the same space. We observed adult patients seated next to or near children and young people. The senior management team had not considered the impact of joint adult and child waiting areas on those patients. Construction of a dedicated children's waiting area completed, just awaiting furnishing and decoration.

Appendix B

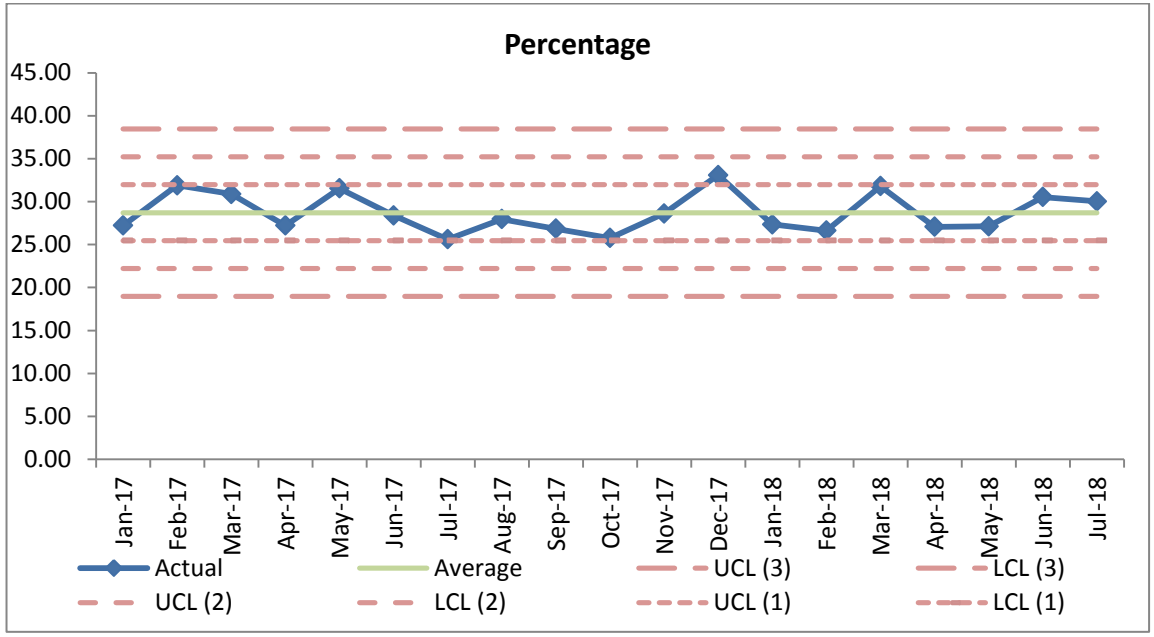
C Section Rates – Maternity Services

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

MEETING OF THE PUBLIC TRUST BOARD – 06 September 2018			
Well-led: Self-assessment & Action Plan			**AGENDA ITEM: 10**
Report Author and Job Title:	Suzie Loader Improvement Consultant	**Responsible Director:**	**Chief Executive Chair**
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐ (select the relevant action required)		
Executive Summary	The trust undertook a self-assessment against the Key Lines of Enquiry (KLOE) for the Well-Led Domain of the CQC standards (2017), in order to identify areas for development. This report outlines the self-assessment methodology undertaken, details the resulting action plan for approval and suggests that progress against the plan should be monitored via the Trust Management Board (TMB) and Trust Board on a quarterly basis.		
Recommendation	Members of the Trust Board are asked to: • Acknowledge that the methodology for the self-assessment undertaken was robust • Ratify the resulting action plan • Approve the governance surrounding implementation of the action plan		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	If the action plan is not implemented at pace and successfully, this will leave the organisation at risk of not improving how the organisation is led, which will ultimately impact on the standard of care delivered for patients.		
Resource implications	Any resource implications will be identified by the individual executive lead for each of the actions identified within the action plan.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper."		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

WELL-LED:SELF-ASSESSMENT & ACTION PLAN

1. PURPOSE OF REPORT

The purpose of the report is to highlight to the board the outcome of the self-assessment undertaken against the Well-Led KLOE (CQC, 2017), the methodology used, the resulting action plan and governance surrounding how that action plan will be monitored going forward.

2. BACKGROUND

The CQC reviewed the standards by which they assess trusts in 2017, introducing two new assessments: 'well-led' and 'use of resources'. It was important for the trust board to understand where the organisation was in relation to these new standards, in order that developmental areas can be identified and actioned.

This report outlines the methodology used to self-assess against the well-led standards (other work is being undertaken to assess against the use of resources domain which will be presented at a different time), and the resulting action plan.

3. METHODOLOGY

The Board carried out the self-assessment in 3 phases to ensure it was robust. These are summarised as:

- Board workshop, led by the Improvement Director (NHSI) and Improvement Consultant. The aim of the workshop was to consider each of the standards within the well-led framework, identify any evidence to support implementation of that standard and then to review the CQC Ratings Characteristics to ascertain what rating to give each of the standards. Attendees were divided into 2 groups: executives & non-executive directors (NEDs) and asked to consider each of the 8 standards. As well as undertaking a self-assessment, they were asked to identify 3 actions which needed to be taken to improve compliance – these actions were then considered by the board as a whole and the top 3 agreed for each of the standards. However, the number of NEDs who attended this session was limited and the self-assessment undertaken by the NEDs and the Executives differed. As a result, it was agreed to hold a second board workshop a month later.
- The process used for the second Board workshop was the same as that used for the first one, with the exception that the 2 groups were a mixture of executives and NEDs and there was a real focus on providing evidence. This session was led by the Improvement Consultant. This time, there was a more proportional attendance by NEDs and Executives; a consensus was agreed in relation to the outcome of that self-assessment and the top actions which needed to be taken to improve compliance.

- Following the board workshops, the executives each met with the Improvement Consultant / interim Corporate Secretary to clarify the evidence available to support that self-assessment – this is currently being collated and held in a central shared drive.

4. OUTCOME

The table below summarises the results of the self-assessment carried out by the trust board during June & July 2018. The full assessment is available on request:

KLOE	Self-Assessment Rating
1. Leadership capacity & capability	**RI**
2. Clear vision & credible strategy	**RI**
3. Culture of high quality, sustainable care	**RI**
4. Clear roles, responsibilities & accountabilities	**RI**
5. Managing risk, issues & performance	**RI**
6. Is appropriate and accurate information being effectively processed, challenged and acted on?	**RI**
7. Are people who use the services, the public, staff & external partners engaged and involved to support high quality sustainable services?	**RI**
8. Are there robust systems and processes for learning, continuous improvement and innovation?	**RI**
Overall Self-Assessment Rating	**Requires Improvement**

Key actions were identified with the aim of moving the overall rating to 'Good' (as determined by the CQC). These actions have been pulled into an action plan (which will include additional actions following the self-assessment against the CQC 'Use of Resources' Framework (2018)), which when finalised will be monitored by the Trust Management Board (TMB) and the Board on a quarterly basis.

The resulting well-led action plan can be found in Appendix A. The board is asked to consider that action plan, challenge its contents and ratify it.

Once ratified, it is suggested that progress of the well-led action plan is monitored quarterly by the Trust Management Board (TMB) and the Trust Board.

5. RECOMMENDATIONS

Members of the Trust Board are asked to:

- Acknowledge that the methodology for the self-assessment undertaken was robust

- Ratify the resulting action plan
- Approve quarterly monitoring of progress made against the action plan at TMB & Trust Board

APPENDICES

Appendix A: Well-Led Action Plan (September 2018)

Well-led Action Plan – September 2018

KLOE	Actions	Desired Outcome	Lead	Deadline date
1. Leadership Capacity & capability	• Develop a Leadership Development Strategy (which includes: talent management & succession planning) o Develop a delivery plan against the strategy & implement utilizing good governance to monitor effectiveness o Evaluate the effectiveness of the strategy in relation to desired outcomes & make changes as necessary	Strategy, delivery plan and evidence of implementation Talent pool of bands 2-6 identified as potential managers Succession plan for doctors	***Director of People & Culture*** Chief Operating Officer	December 2018
	• Develop a Board / Senior Leadership Visibility plan o Evaluate the effectiveness of the plan in relation to desired outcomes and make changes as necessary	Visibility Plan, evaluation & action Staff know who their leaders are, have easy access to them and describe them as approachable (LiA pulse survey / weekly audits)	***Interim Trust Secretary***	Complete July 2018
	• Implement the new Values & Behaviour Framework • Evaluate the effectiveness of the: • Values implementation • The Behaviour Framework • Against the desired outcomes and make changes as necessary	Staff understand the trust values and can demonstrate how they implement them in everyday practice Behaviours improve across the organisation, demonstrated via LiA pulse surveys, retention figures, reduction in grievances and sickness rates.	***Director of People & Culture*** Chief Executive	September 2018 November 2018

KLOE	Actions	Desired Outcome	Lead	Deadline date
		Staff Engagement scores increase to xxx by yyy		
2. Clear Vision & credible strategy	• Develop a Clinical Services Strategy & delivery plan o Complete the sustainability reviews o Evaluate the effectiveness of the strategy in relation to desired outcomes, making necessary changes	Strategy, delivery plan and evidence of implementation ++	***Medical Director*** Director of Strategy & Improvement	March 2019
	• Identify metrics / outcomes to monitor partnership working (Walsall Together) & implement o Monitor effectiveness of metrics against delivery of the plan		***Director of Strategy & Improvement***	October 2018
	• Develop a delivery plan which supports implementation of the trust strategy o Evaluate the effectiveness of plan implementation against the desired outcomes, making necessary changes	One Delivery plan identifying the requirements of the Walsall Together; Winter Plan and Estates Plans& evidence of implementation	***Director of Strategy & Improvement*** Chief Operating Officer	December 2018
3. Culture of high quality, sustainable care	• Review the appraisal system to ensure that the appraisal delivered is of high quality o Evaluate the effectiveness of the new appraisal system, making changes as appropriate	Revised appraisal system Staff report that they find their appraisal useful in LiA pulse survey's / weekly audits	***Director of People & Culture***	December 2018
	• Develop an Equality & Diversity Strategy, linking this to the Staff Engagement strategy, new values & behaviors framework.		***Director of People & Culture***	November 2018

KLOE	Actions	Desired Outcome	Lead	Deadline date
	o Develop a delivery plan against the strategy & implement utilizing good governance to monitor effectiveness o Evaluate the effectiveness of the strategy in relation to desired outcomes, making changes as appropriate			
4. Clear roles, responsibilities & accountability	• Review the Accountability Framework,; including roles, responsibilities & assurance systems and implement effectively o Evaluate the effectiveness of the Accountability & Assurance Framework in relation to desired outcomes, making changes as appropriate	Revised accountability & assurance framework & evidence of implementation via Divisional & Corporate Performance Reviews Improved compliance & performance across the trust Evidence of use of accountability framework in place	***Director of Governance*** Director of Finance Chief Operating Officer	September 2018
	• Review key leadership roles and responsibilities across the organisation, to ensure the organisation has the right structure in place to meet its needs. o Review the capability of staff within the roles to ensure they have the skills and knowledge necessary to carry out their roles effectively o Implement a development programme to address any gaps in knowledge/skills identified	Review of key identified roles & responsibilities Completion of a TNA Implementation of a development programme which meets needs identified within the TNA Improved performance across the trust	***Chief Executive***	December 2018

KLOE	Actions	Desired Outcome	Lead	Deadline date
	• Review trust governance systems & processes, putting a plan in place to improve o Governance Framework o Cycles of Business o Effectiveness Review o Governance Handbook for staff o Evaluate the effectiveness of the revised governance system in relation to desired outcomes, making changes as appropriate.	Streamlined governance systems, which promote escalation of unresolved issues, and a clear line of site from the ward/department to the board Demonstration of compliance against national standards, systems and processes (e.g. NICE guidance, CAS alerts, Learning from Deaths, Duty of Candour etc.) Demonstration of enhanced continuous learning and development	***Director of Governance*** Interim Trust Secretary	August 2018
5. Managing risk, issues & performance	• Develop and implement a Risk Management Strategy o Updated BAF and BAF processes o Update Risk Management Strategy and Policy o Review Safeguard system o Review and implement Risk Management Training o Evaluate the effectiveness of the Risk Management Strategy in relation to desired outcomes, making changes as necessary	Risk Management Strategy Demonstration of a greater understanding of how to manage risk appropriately A dynamic risk register & BAF, which is used appropriately to identify, mitigate and proactively manage risk	***Director of Governance*** Interim Trust Secretary	August 2018

KLOE	Actions	Desired Outcome	Lead	Deadline date
	• Enhance CIP processes across the trust, reviewing effectiveness on a regular basis o Review Business Planning process o Confirm accurate business case process o Undertake a post implementation assessment o Review the Quality Impact Assessment Process (QIA) o Evaluate the effectiveness of the revised business planning processes in relation to desired outcomes, making changes as appropriate	Evidence of a transparent business planning process implemented which aligns to delivery of the strategic objectives Implementation of a robust and dynamic monitoring system to capture the impact of changes on quality (QIAs)	***Director of Strategy & Improvement*** Director of Finance	November 2018
6. Appropriate, accurate information is being effectively processed, challenged and acted upon	• Review and improve the Data Quality Strategy (to include the use of Kite Marks) o Evaluate the effectiveness of the revised Data Quality Strategy against the desired outcomes, making changes as appropriate	Data Quality Strategy, delivery plan and evidence of implementation ++	***Director of Strategy & Improvement***	March 2019
	• Develop / purchase an business intelligence system reporting system (which uses SPC charts to demonstrate variance & statistical relevance in data presentation) and implement across the trust o Review and improve the Integrated Performance Report, ensuring use of benchmarking and Model Hospital data is used o Procure business intelligence system o Deploy system o Where possible, introduce the use of	Ability to quickly interrogate 'real time', accurate data at different levels of the organisation Demonstration that staff understand, use & present data effectively to make informed decisions Evidence of improvement demonstrated through the use of intelligence (metrics / outcomes / triangulation /	***Director of Strategy & Improvement (BI system)*** ***Director of Finance (use of data as intelligence)***	New Board report October 2018 Procure October 2018 Deploy

KLOE	Actions	Desired Outcome	Lead	Deadline date
	‘real-time’ data o Educate staff in the use of SPC charts to ensure data is used as intelligence o Review effectiveness of the integrated performance reporting system against desired outcomes	use of Big data)		November 2018 Education roll out December 2018
	• Develop a strategy & delivery plan which aims to Invest in technology o Initial technology paper to Board o Technology strategy developed		***Director of Strategy & Improvement***	August 2018 October 2018
	• Develop a training needs analysis around the use of data as intelligence o Design an education programme to meet the needs of staff in relation to use of data as intelligence o Evaluate the effectiveness of the education programme on the desired outcomes, making changes as appropriate.	TNA, Education Programme Evidence of informed decision making	***Director of Finance***	Jan – May 2019
7. Are the public, staff & external partners engaged and involved in supporting high quality sustainable services?	• Develop a Patient involvement, Staff & Public Engagement Strategy o Review existing strategies for staff and public engagement o Revise stakeholder strategy o Develop a delivery plan against the strategy & implement utilizing good governance to monitor effectiveness o Evaluate the effectiveness of the strategy in relation to desired outcomes, making changes as appropriate	Strategy, delivery plan and evidence of implementation	***Director of Nursing*** Medical & Director & Director of Strategy & Improvement	January 2019

KLOE	Actions	Desired Outcome	Lead	Deadline date
8. Robust systems and processes for learning, continuous improvement & innovation	• Develop an integrated Quality Improvement Strategy, placing the Quality Improvement Academy at the heart of strategy delivery o Develop a delivery plan against the strategy & implement utilizing good governance to monitor effectiveness o Evaluate the effectiveness of the strategy in relation to desired outcomes, making changes as appropriate	Strategy, delivery plan & evidence of good governance systems to monitor delivery & impact Evidence of alignment of effort across the trust with strategic objectives Evidence of a Learning Organisation (against the CQC criteria for improvement & learning)	***Improvement Consultant*** Medical Director & Director of Nursing	March 2019 December 2018 April 2020
	• Develop systems to identify & reward innovation o Establish Clinical Senate o Develop Quality improvement Strategy o Implement and evaluate the effectiveness against the desired outcomes, making changes as appropriate.		***Director of Strategy & Improvement***	December 2018

Walsall Healthcare NHS
NHS Trust

Integrated Performance Report

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

Caring for Walsall together

Contents

Walsall Healthcare NHS
NHS Trust

Partnerships

Caring for Walsall together

Partnerships – Highlight Page

Executive Lead: Director of Strategy & Improvement, Daren Fradgley / Non-Executive Director Lead: TBC

Key Areas of Success

As this is the first report it is worth highlighting the significant progress that rapid response have made in terms of additional activity over winter which continues through spring and summer. This is against a backdrop of a reduced workforce due to vacancies which is currently being addressed. Despite this the team continues to be influential on avoidable admissions per month. Work is now being undertaken with rapid response and the use of Total Mobile to establish additional activity in the run up to winter that can be shared across the seven locality teams. For example; if seven teams create two additional appointments each day through the efficient use of mobile technology we can provide additional capacity to rapid response virtually rather than increasing the size of the team.

Key Areas of Concern

As this is a new dashboard it will take sometime to establish a baseline across the monitoring areas. However it should be noted from the outset that different localities have different issues that place pressure on the number of admissions coming into hospital. For example the 2 localities with the highest readmissions are North (121) and South 2 (94).

Key Actions Taken

As mentioned above a current review of virtual capacity within rapid response is underway and is expected to be in place before November. In addition the community team in partnership with adult social care are currently redesigning the way the frailty pathway works on both the front door of ED but also referring back into rapid response and the locality teams. Future reports will include monthly frailty numbers.

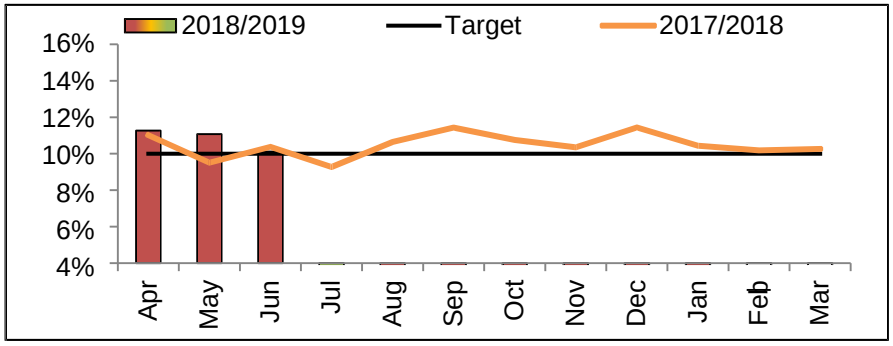
Key Focus for Next Committee

Given the fact that this is a new dashboard for the Performance report additional work is being undertaken to bring meaningful metrics relating to the seven localities to the attention of the board. From next month each locality will identify their overall caseloads and population served so that outliers in terms of admissions, readmissions and significant referrals from specific GP practises an easily identified.

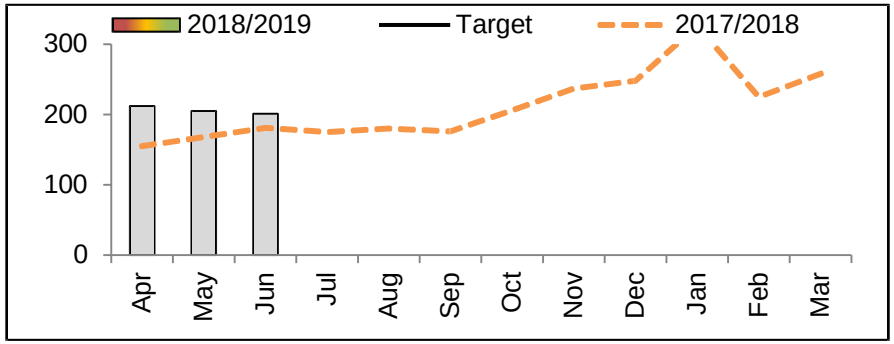
This report will not only show the Trusts activity in partnership with other providers in the borough but will also show where the greatest opportunity for future service and partnership development exist. So for example, looking at referrals by GP's and the type of those referrals will enable the Trust to respond in the appropriate manner with the relevant services.

Partnerships

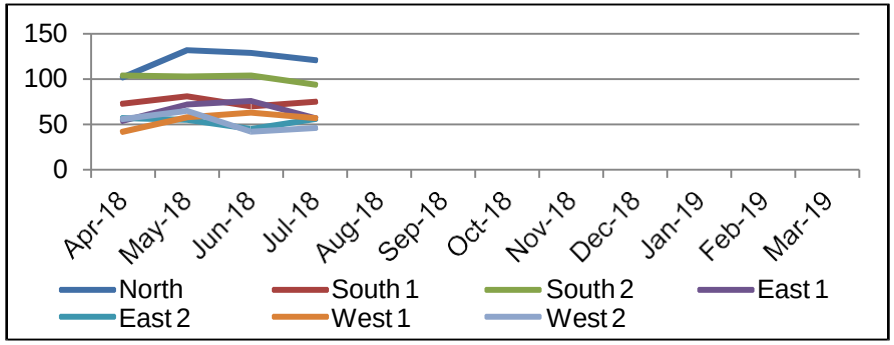
Emergency Readmissions



Rapid Response – Avoidable Admissions



Re-admissions by Locality



Narrative (supplied by Director of Strategy & Improvement)

From the outset of the seven locality teams it was decided that one of the key metrics was the amount of admissions by locality team. To enable this data to be meaningful this was broken down to each of the teams and more importantly to each GP practise. Using this data the leadership of the locality teams can focus their efforts on areas of high admission and often more importantly readmission to hospital within 30 days.

This graph represent the rapid response teams activity that has been recorded as an avoidable admission via the use of a snomed code. I.e. if there was no contact by the rapid response team the patient would have been sent to ED. The rapid response team in essence is the eighth team that covers the entire borough and acts as the urgent team to catch any referrals that have either been missed by the localities or require rapid intervention.

This chart shows the number of emergency readmissions within 30 days of discharge by locality. The highest readmitting locality is the North however there is a small reducing trend emerging.

Walsall Healthcare NHS Trust

PARTNERSHIPS
2018-2019

		Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	18/19YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	10.18%	10.26%	11.27%	11.07%	10.12%		10.81%	10.00%		L
no	Rapid Response Team - Avoidable admissions (one month in arrears)	225	258	212	205	201					
	CARE AT HOME										
%..	ED Reattenders within 7 days	6.18%	6.87%	6.80%	7.68%	7.12%	7.46%	7.28%	7.00%	6.76%	BP
	RESOURCES										
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only			21	26	30	32				
no	Average Number of Medically Fit Patients - Trust			49	42	39	36				
	PARTNERS										
no	Beddays per Locality - new metric under development										
no	Contacts per Locality - new metric under development										
no	Readmissions per Locality - North	111	103	102	132	129	121	484			
no	Readmissions per Locality - South 1	79	65	73	81	70	75	299			
no	Readmissions per Locality - South 2	76	78	104	103	104	94	405			
no	Readmissions per Locality - East 1	67	63	54	72	76	57	259			
no	Readmissions per Locality - East 2	55	63	57	55	45	56	213			
no	Readmissions per Locality - West 1	56	55	42	58	63	57	220			
no	Readmissions per Locality - West 2	42	61	56	65	42	46	209			
no	No. of patients on stroke pathway in partnership with Wolverhampton - new metric under development										

Walsall Healthcare NHS
NHS Trust

Quality and Safety Committee

Caring for Walsall together

Quality and Safety Committee – Highlight Page

Executive Lead: Director of Nursing, Karen Dunderdale / Non-Executive Director Lead and Chair of Q&S Committee: Professor Russell Beale

Key Areas of Success

The Quality & Safety Committee noted a month on month improvement in the percentage of patients who achieve their chosen place of death.
The Friends and Family Test reported an improvement in the % recommended in Maternity Antenatal and Birth.

Key Areas of Concern

The Trust continues to report mixed sex accommodation breaches.
There have been 3 cases of C. Difficile identified in July. The Infection Prevention & Control Committee continues to focus on this.
There continues to be concerns regarding Electronic Discharge Summaries being completed within 48 hours.
There had been an increase in readmission rates

Key Actions Taken

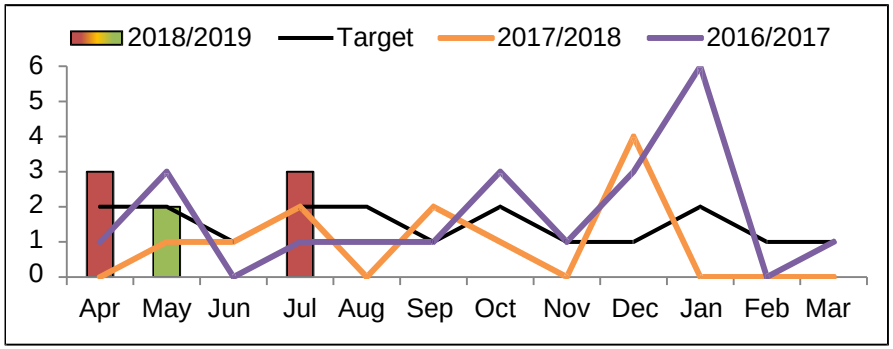
The Director of Nursing has asked for a review of all mixed sex accommodation breaches and the breach process.
The role of the DIPC will move to the Director of Nursing who will undertake a review of adherence to Infection Control policies.
Electronic Discharge Summaries will be a focus for the Quality & Safety Committee next month.
The Medical Director has established a group to review each readmission case with the divisional and care group teams.

Key Focus for Next Committee

Concerns were raised at the Quality & Safety Committee about the lack of information regarding mortality and the committee have specifically asked for a focus on crude mortality in the absence of SHMI and HSMR through the national reporting routes.
Infection Prevention & Control in light of the 3 cases of C. Difficile
The Quality and Safety Committee expressed anxiety that the integrated performance report failed to provide data in relation to falls and pressure ulcers this month.
In relation to serious incident reporting to the Quality & Safety Committee, the committee have asked for explicit information describing the Duty of Candour process associated with each individual incident.

Quality and Safety Committee

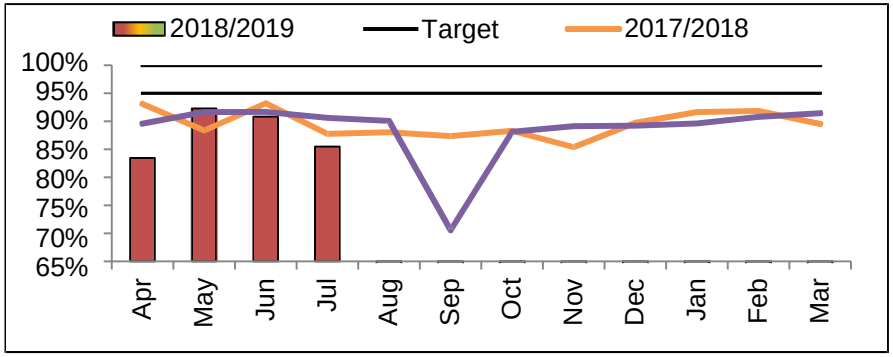
C Difficile



Narrative (supplied by Medical Director)

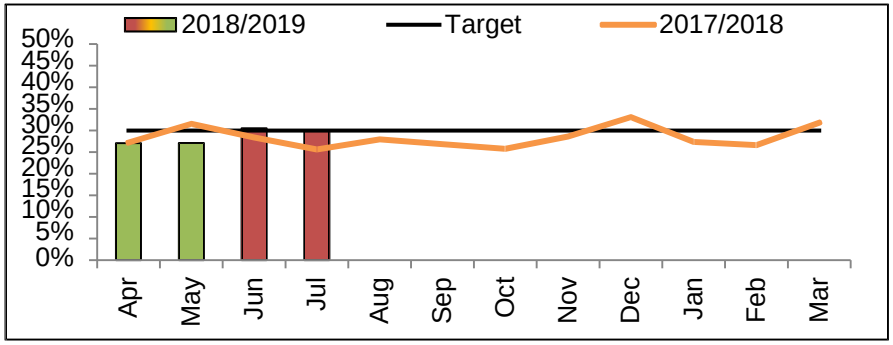
Running very close to trajectory for the year. RCA's carried out on July cases and an action plan put in place to provide learning to teams. The newly appointed microbiologist will be the lead for antimicrobials and a meeting is to be held with Public Health Walsall and the CCG to confirm whether the cases were avoidable.

Electronic Discharge Summaries



EDS has seen poor performance, work has commenced with the performance team to review the reporting function and develop daily reporting and escalation to clinical leads. This will be managed through the accountability framework reporting to Medical Advisory Committee.

C-Section Rates



Narrative (supplied by Director of Nursing)

C – Section rates show monthly variation. The overall rate for 2018/19 remains below target at 28.67%

- Daily C-Section review occurs with the multi-disciplinary team
- Weekly C-Section Review Group
- Monthly audit meeting includes C-section review as appropriate (no less that quarterly). Actions entered on to action log as required. Learning points cascaded.

Walsall Healthcare NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE 2018-2019

	SAFE, HIGH QUALITY CARE	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
no..	HSMR (HED)	106.19	110.50	100.97	85.55				100.00		N
no..	SHMI (HED)								100.00		BP
no	Clostridium Difficile - No. of cases	0	0	3	2	0	3	8	17	11	N
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired Avoidable per 1,000 beddays (one month in arrears)			1.07	0.82	0.67					
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired Avoidable per 10,000 CCG Population (one month in arrears)			0.03	0.07	0.00					
no..	Falls - Rate per 1000 Beddays	5.10	5.64	5.32	5.62	3.57	5.09		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	0	0	3	0	0	2	5	0	8	BP
%..	VTE Risk Assessment	93.18%	95.49%	96.34%	96.28%	96.50%	95.57%	96.17%	95.00%	88.49%	N
%..	Controlled Drug Compliance		71.00%						100.00%		
no..	Midwife to Birth Ratio	1:22.4	1:26.3	1:29.8	1:29.2	1:26.2	1:28.6		1:28	1:26.3	N
%..	C-Section Rates	26.61%	31.80%	27.06%	27.12%	30.53%	30.03%	28.67%	30.00%		
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	10.18%	10.26%	11.27%	11.07%	10.12%		10.81%	10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	91.84%	89.51%	83.45%	92.29%	90.83%	85.48%	87.91%	100.00%	89.33%	N/L
%..	Compliance with MCA 2 Stage Tracking	77.00%	77.00%	55.00%	81.00%	69.00%	69.00%		100.00%		
%..	Friends and Family Test - Inpatient (% Recommended)	97.00%	94.00%	96.00%	95.00%	97.00%	94.00%		96.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	98.80%	96.56%	98.59%	98.29%	98.22%	98.75%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	70.90%	75.97%	76.07%	77.51%	84.47%	89.59%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	93.10%	93.86%	94.43%	93.69%	99.84%	99.92%		95.00%		
%..	Adult Safeguarding Training - Level 2 Compliance	66.37%	70.09%	75.55%	80.32%	83.77%	87.04%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	74.09%	77.64%	78.26%	80.41%	87.98%	89.64%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	94.06%	92.12%	91.67%	92.38%	99.77%	99.26%		95.00%		
%..	Children's Safeguarding Training - Level 2 Compliance	73.84%	73.25%	75.49%	76.93%	88.58%	93.69%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	67.48%	71.07%	74.52%	88.58%	90.62%	92.24%		85.00%		L

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

Caring for Walsall together

Performance, Finance and Investment Committee – Highlight Page

Executive Lead: Director of Finance, Russell Caldicott / Non-Executive Director Lead and Chair of PFIC Committee: John Dunn

Key Areas of Success

- Referral to Treatment achieved trajectory (90%) ahead of plan and highest performance in the past twelve months
- Cancer 62 day national target continues to deliver (85% of patients referral to treatment achieved)
- Diagnostic target attained (99% of patients seen within 6 weeks)
- Integrated Critical Care Unit (ICCU) on trajectory to open November 2018
- Maternity Theatre and Neo-Natal Unit construction commenced and on trajectory
- Emergency Department Business Case approved at Strategic Outline Case (SOC)
- Achieved planned deficit for Quarter 1 and received Provider Sustainability Funds

Key Areas of Concern

- Emergency Department 4 hour wait performance dropped below plan in July 2018
- Temporary workforce costs continue at higher than planned levels
- Cost Improvement Programme (CIP) behind plan and phased heavily into the latter half of the financial year
- Current run rate needs to reduce in order to attain 2018/19 financial plan

Key Actions Taken

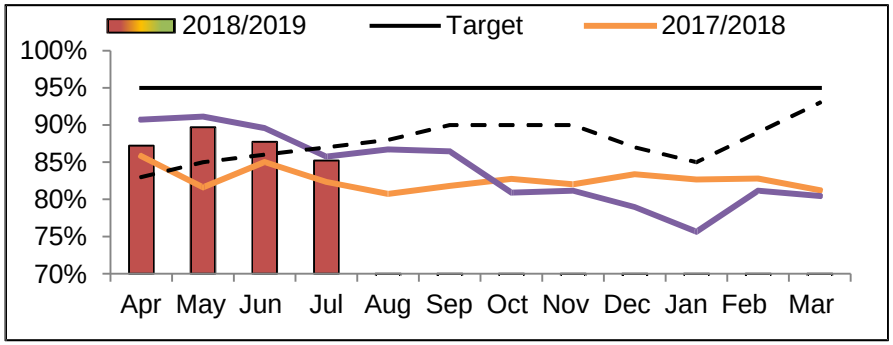
- SAFER deployed within the Trust to support enhanced ED performance
- Financial recovery Plan endorsed through PFIC & Trust Board to mitigate current run rate

Key Focus for Next Committee

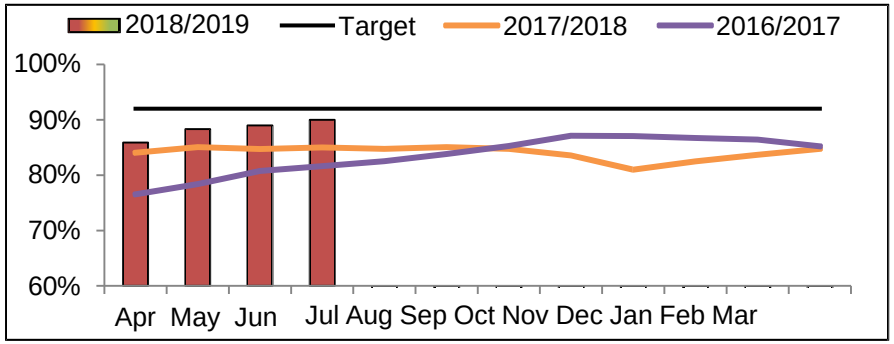
- Continued focus on performance against constitutional standards, focus on ED 4 hour performance
- Delivery of the Financial Recovery Program
  - Temporary workforce cost reductions (Medical and Nursing)
  - Income performance driven by CIP attainment (productivity within Theatres and Outpatients)
- Run rate reductions delivered month on month

Performance, Finance and Investment Committee

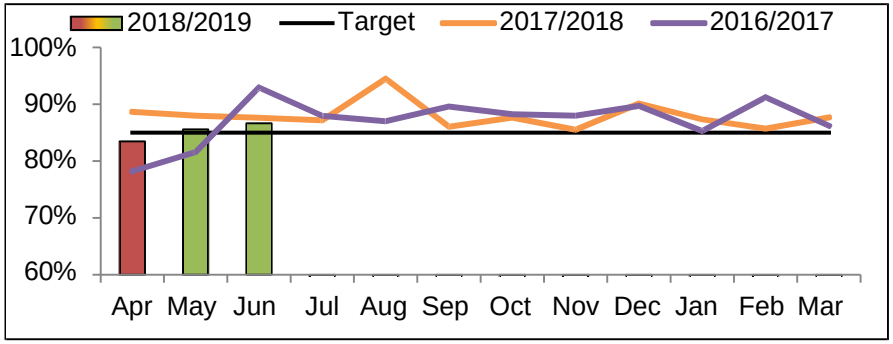
ED - % within 4 hours - Overall (Type 1 and 3)



18 Weeks RTT Incomplete Pathways



Cancer 62 Day RTT



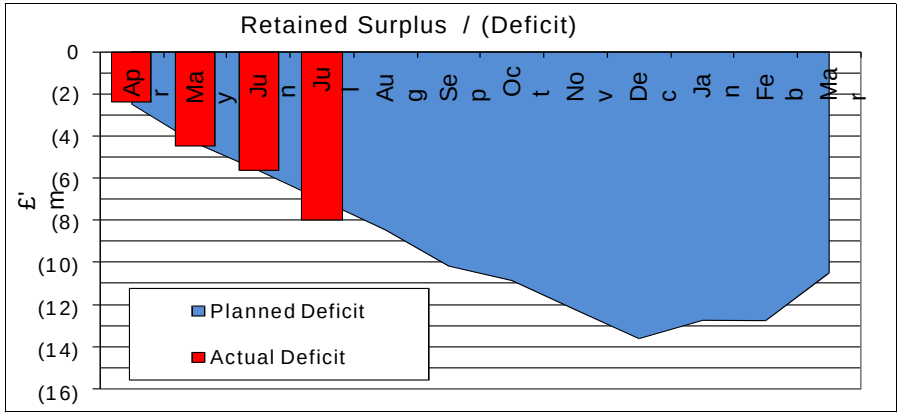
Narrative (supplied by Chief Operating Officer)

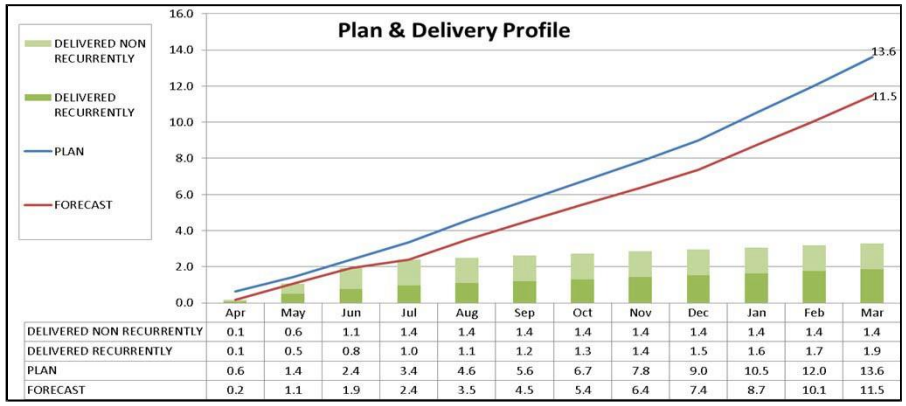
July was a difficult month for Emergency activity in Walsall (as across the NHS) with high attendances above plan for example; over 90 ambulances on 18 days of the month. Admissions remained at the lower 30% and non-admitted attendances increased. The small ED congested and breach rate rose. LOS increased slightly with discharges dropping. This legacy has continued into August. SAFER is now mandated and compliance is being monitored. Individuals/areas that are falling below the standard are being supported following discussions.

RTT continues to improve with validation of waiting lists and improved throughput in outpatients and theatres compared with previous years. September will see full clinic review of all specialties and commencement of centralisation of all specialties to ensure consistency of outpatient services.

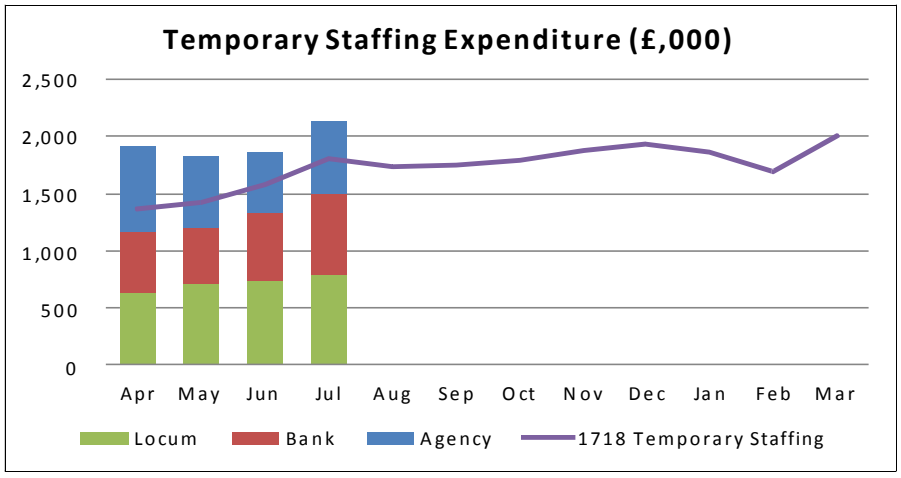
Continued good performance with Tertiary referral patterns to be reviewed in September to mitigate risks inherent in low volumes.

Summary Financial Performance to July 2018 (Month 4)





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.1	0.6	1.1	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4
DELIVERED RECURRENTLY	0.1	0.5	0.8	1.0	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.9
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	2.4	3.5	4.5	5.4	6.4	7.4	8.7	10.1	11.5



Financial Performance

- The total financial position for the Trust at M4 is a deficit of £8m. The YTD planned deficit is £7.1m, resulting in an unfavourable variance of £0.9m.
- The £0.9m adverse variance driven by an operational deficit (£0.4m) and loss of M04 Provider Sustainability funds (PSF) of £0.3m and a further PSF reduction (£0.2m) for non delivery of the A&E national performance target in Q1.
- The contracted income shows an adverse variance to plan of £0.2m, the main area of under-performance occurring in Maternity and Adult/Neonatal Critical Care, (other income reflects the PSF reduction referred to above).
- Expenditure, the main area of overspending is pay (£0.6m) due to temporary staffing costs in Medical and Nursing. Temporary workforce costs in month total £2.1m (highest over the past twelve months) and are placing increasing pressure on delivery of the financial plan.
- CIP targeted in year totals £15.5m and the YTD target is £3.3m, YTD delivery totals £2.4m with £1.4m delivered non-recurrently. The profiling of CIP largely into the later half of the financial year results in the Trust needing to improve the run rate over the remaining months of the financial year.
- Next steps are to ensure delivery of the Financial Recovery Plan (FRP) and profiling the schemes within the CIP modelling, key components being review of Medical & Nursing temporary workforce costs and income productivity, with weekly oversight of FRP delivery.

Cash

- The actual cash holding is £1.1m & the Trust's agreed borrowing for 2018/19 is £10.6m, reflecting the deficit plan. The deficit above plan increases pressure on cash flow and borrowing.

Capital

- The year to date capital expenditure is £3.9m, with the main spends relating to ICCU (£2m), Estates Lifecycle (£0.6m), Maternity (£0.8m) and Community Mobile technology (£0.1m).

Financial Performance - Period ended 31st July 2018

Description	Annual Budget	Budget to Date	Actual to Date	Variance
	£'000	£'000	£'000	£'000
Income				
NHS Activity Revenue	228,361	75,776	75,569	(207)
Non NHS Clinical Revenue (RTA Etc)	550	370	557	186
Education and Training Income	7,096	2,456	2,473	17
Other Operating Income (Incl Non Rec)	15,550	4,266	3,717	(549)
Total Income	**251,557**	**82,868**	**82,315**	**(553)**
Expenditure				
Employee Benefits Expense	(177,291)	(58,104)	(58,714)	(610)
Drug Expense	(9,606)	(6,151)	(6,131)	20
Clinical Supplies	(17,545)	(6,352)	(6,504)	(151)
Non Clinical Supplies	(15,579)	(5,502)	(5,543)	(41)
PFI Operating Expenses	(5,078)	(1,717)	(1,728)	(10)
Other Operating Expense	(22,321)	(6,777)	(6,496)	282
Sub - Total Operating Expenses	**(247,419)**	**(84,604)**	**(85,115)**	**(511)**
Earnings before Interest & Depreciation	**4,133**	**(1,736)**	**(2,799)**	**(1,064)**
Interest expense on Working Capital	51	17	15	(2)
Interest Expense on Loans and leases	(8,259)	(3,135)	(3,224)	(89)
Depreciation and Amortisation	(6,560)	(2,187)	(2,020)	166
PDC Dividend	0	0	0	0
Losses/Gains on Asset Disposals	0	0	0	0
Sub-Total Non Operating Exps	**(14,769)**	**(5,305)**	**(5,229)**	**76**
Total Expenses	**(262,188)**	**(89,908)**	**(90,344)**	**(435)**
RETAINED SURPLUS/(DEFICIT)	**(10,631)**	**(7,040)**	**(8,028)**	**(988)**
Adjustment for Gains on Donated Assets			16	16
Adjusted Financial Performance (Control Total)	**(10,631)**	**(7,040)**	**(8,012)**	**(972)**

Walsall Healthcare NHS
NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-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)	82.81%	81.23%	87.22%	89.70%	87.73%	85.21%	87.48%	95.00%	82.67%	N
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	71.31%	70.36%	80.95%	80.65%	76.24%	71.95%	77.41%	85.00%	65.80%	BP
no	Ambulance Handover - No. of Handovers completed over 60mins	21	9	1	5	0	7	13	0	236	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	96.61%	97.90%	93.45%	93.98%	96.08%	97.49%	95.27%	93.00%	95.45%	N
%..	Cancer - 62 day referral to treatment of all cancers	85.71%	87.69%	83.33%	85.58%	86.67%	85.19%	85.09%	85.00%	88.05%	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	83.69%	84.74%	85.89%	88.33%	89.00%	90.01%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	0	0	0	0	0	0	0	0		N
%..	Diagnostic Waits - % waiting under 6 weeks	99.66%	98.06%	99.05%	99.57%	99.79%	99.75%	99.52%	99.00%	99.06%	N
no	Rapid Response Team - Avoidable admissions (one month in arrears)	225	258	212	205	201					
no	No. of Open Contract Performance Notices	6	7	7	7	8	7		0	7	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	6.18%	6.87%	6.80%	7.68%	7.12%	7.46%	7.28%	7.00%	6.76%	BP
	RESOURCES										
%..	Outpatient DNA Rate (Hospital and Community)	11.27%	10.73%	10.47%	11.03%	10.59%	10.45%	10.64%	8.00%	12.16%	
%..	Theatre Utilisation - Touch Time Utilisation (%)	63.60%	70.73%	80.91%	83.76%	82.63%	84.44%	83.58%	75.00%		
%..	Delayed transfers of care (one month in arrears)	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	88		80		
no..	Average LoS for Medically Fit Patients (from point they become Medically Fit)			8.61	10.57	8	9		5		
£	Surplus or Deficit (year to date) (000's)	-£23,257	-£23,267	-£2,386	-£4,509	-£5,616	-£8,012	-£8,012		-£23,267	L
£	Variance from plan (year to date) (000's)	-£4,238	-£2,511	-£2,483	-£186	-£18	-£553	-£553		-£2,511	L
£	CIP Plan (YTD) (000s)			£806	£1,612	£2,268	£3,182	£3,182			
£	CIP Delivery (YTD) (000s)			£168	£1,080	£1,919	£2,391	£2,391			
£	Temporary Workforce Plan (YTD) (000s)			£1,459	£2,784	£4,246	£5,935	£5,935			
£	Temporary Workforce Delivery (YTD) (000s)			£1,914	£3,743	£5,594	£7,733	£7,733			
£	Capital Spend Plan (YTD) (000s)			£1,040	£2,129	£3,183	£4,105	£4,105			
£	Capital Spend Delivery (YTD) (000s)			£506	£1,077	£2,542	£3,946	£3,946			

Walsall Healthcare NHS
NHS Trust

People and Organisation Development Committee

Caring for Walsall together

People and Organisation Development Committee – Highlight Page

Executive Lead: Interim Director of Organisational Development, Louise Ludgrove / Non-Executive Director Lead and Chair of POD Committee: Philip Gayle

Key Areas of Success

Mandatory training – an increase of 0.57% in July compared to June 2018.
PDRs – an increase of 4.15% in July compared to June 2018.
Appointment of Equality, Diversity & Inclusion Manager – commencing 10th September 2018.
Quality Improvement Academy – positive response to involvement and identification of schemes.

Key Areas of Concern

Staff Engagement – embedding improvements. Building on achievements and on-going action planning.
Flu campaign – additional resource required/capacity within Occupational Health. Comms plan to be developed.

Key Actions Taken

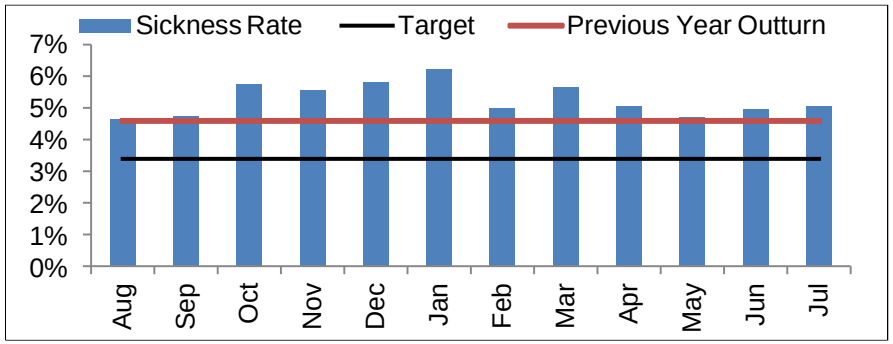
Consider on-going requirements for Staff Engagement Lead.
Mandatory training – breakdown of compliance required for further analysis.
Turnover – review of Exit process and reporting.

Key Focus for Next Committee

SAS Doctors – Review of input of SAS Doctors and equality of opportunity.
National Staff Survey 2018/19 - update
Flu Campaign - update

People and Organisation Development Committee

Sickness Absence

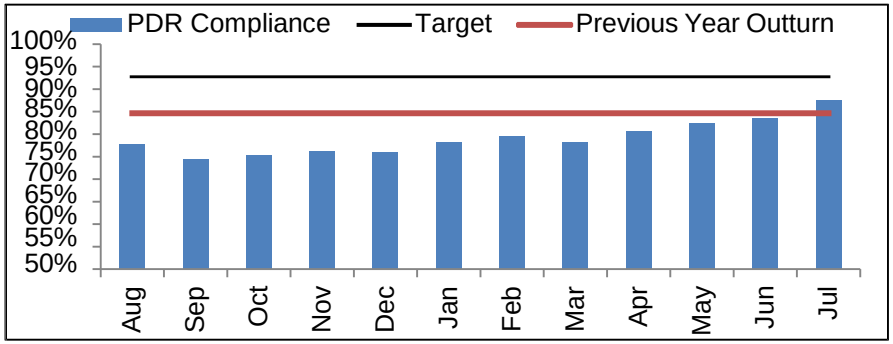


Narrative (supplied by Interim Director of Organisational Development)

Sickness levels declined in June with performance of 5.06% compared to 4.97% in June 2018. This represented a rise of 0.31% compared to same period 2017/18.

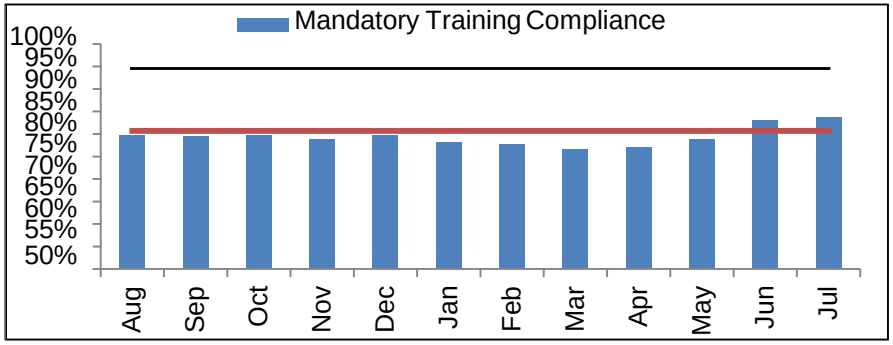
The sickness absence during the past 12 months was 5.29%, 1.90% above the Trust target.

PDR Compliance



The appraisal rate at the end of July 2018 was 87.56%, an increase on June's 83.41%. This represented a rise of 4.15% month on month.

Mandatory Training Compliance



Mandatory training compliance levels in July improved to 83.63% compared to 83.06% reported in June. A rise of 0.57% month on month. This represented a rise of 7.02% since the end of Q4 17/18 and a rise of 3.08% compared to the same period last year.

Walsall Healthcare NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 2018-2019

		Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	18/19YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Mandatory Training Compliance	77.61%	76.61%	76.99%	78.76%	83.06%	83.63%	83.63%	90.00%	76.61%	L
.	Equality, Diversity & Inclusion - new metric under development										
.	Equality, Diversity & Inclusion - new metric under development										
	VALUE COLLEAGUES										
%..	Sickness Absence	5.00%	5.65%	5.06%	4.71%	4.97%	5.06%	4.92%	3.39%	5.30%	L
%..	PDRs	79.47%	78.17%	80.55%	82.42%	83.41%	87.56%	87.56%	90.00%	78.17%	L
.	Staff Referral to Occupational Health - new metric under development										
	RESOURCES										
no	Staff in post (Budgeted Establishment FTE)	4116	4095	4125	4114	4125	4121	4121			L
%..	Turnover	8.89%	9.13%	9.83%	9.92%	10.33%	9.20%	9.20%	10.00%	9.13%	L
.	Time to Recruit - new metric under development										

Glossary

Glossary

A

ACP – Advanced Clinical Practitioners

AEC – Ambulatory Emergency Care

AHP – Allied Health Professional

Always Event® - those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system

AMU – Acute Medical Unit

AP – Annual Plan

B

BCA – Black Country Alliance

BR – Board Report

C

CCG/WCCG – Walsall Clinical Commissioning Group

CGM – Care Group Managers

CHC – Continuing Healthcare

CIP – Cost Improvement Plan

COPD – Chronic Obstructive Pulmonary Disease

CPN – Contract Performance Notice

CQN – Contract Query Notice

CQR – Clinical Quality Review

CQUIN – Commissioning for Quality and Innovation

CSW – Clinical Support Worker

D

D&V – Diarrhoea and Vomiting

DDN – Divisional Director of Nursing

DoC – Duty of Candour

DQ – Data Quality

DQT – Divisional Quality Team

DST – Decision Support Tool

DWMHPT – Dudley and Walsall Mental Health Partnership NHS Trust

E

EACU – Emergency Ambulatory Care Unit

ECIST – Emergency Care Intensive Support Team

ED – Emergency Department

EDS – Electronic Discharge Summaries

EPAU – Early Pregnancy Assessment Unit

ESR – Electronic Staff Record

EWS – Early Warning Score

F

FEP – Frail Elderly Pathway

FES – Frail Elderly Service

G

GAU – Gynaecology Assessment Unit

GP – General Practitioner

H

HALO – Hospital Ambulance Liaison Officer

HAT – Hospital Acquired Thrombosis

HCAI – Healthcare Associated Infection

HDU – High Dependency Unit

HED – Healthcare Evaluation Data

HofE – Heart of England NHS Foundation Trust

HR – Human Resources

HSCIC – Health & Social Care Information Centre

HSMR – Hospital Standardised Mortality Ratio

I

ICS – Intermediate Care Service

ICT – Intermediate Care Team

IP - Inpatient

IST – Intensive Support Team

IT – Information Technology

ITU – Intensive Care Unit

IVM – Interactive Voice Message

K

KPI – Key Performance Indicator

L

L&D – Learning and Development

LAC – Looked After Children

LCA – Local Capping Applies

LeDeR – Learning Disabilities Mortality Review

LiA – Listening into Action

LTS – Long Term Sickness

LoS – Length of Stay

M

MD – Medical Director

MDT – Multi Disciplinary Team

MFS – Morse Fall Scale

MHRA – Medicines and Healthcare products Regulatory Agency

MLTC – Medicine & Long Term Conditions

MRSA - Methicillin-Resistant Staphylococcus Aureus

MSG – Medicines Safety Group

MSO – Medication Safety Officer

Glossary

Mcont
MST – Medicines Safety Thermometer
MUST – Malnutrition Universal Screening Tool
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

Scont
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

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

MEETING OF THE PUBLIC TRUST BOARD – 6th September 2016			
Partnership Update September 2018			**AGENDA ITEM: 13**
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 paper updates Board Members on the key partnership working undertaken this month. This includes the following • Walsall Together Workshops • Partners in Paediatrics		
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 (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

Partnership Report

September 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. WALSALL TOGETHER WORKSHOPS

A series of workshops have been held throughout August to develop the governance arrangements for the Host Provider Model and to commence the design of the clinical operating model for Walsall Together.

It should be noted that this work builds on the current Walsall Together work streams that have made significant progress over the last two years. The Place Based and Intermediate Care Teams are already working to service specific models on a daily basis to deliver care in partnership. The next step of the partnership is to build arrangements out from these areas into a full operating model.

Below is a summary of the workshop progress.

2.1 GOVERNANCE WORKSHOP

The governance workshops have been focused on designing the role of the host provider. A series of questions have been developed that each partner is completing to support the selection criteria and the appointment of the Host.

To strengthen the Trust Board knowledge and oversight and new committee is proposed which is covered in a separate board paper.

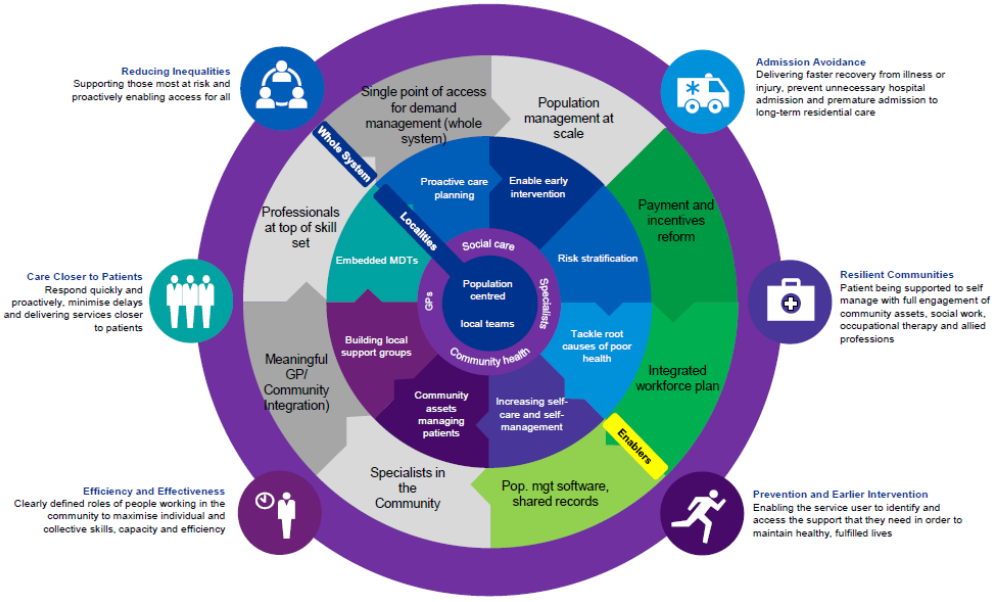
2.2 CLINICAL OPERATING MODEL WORKSHOP

The first formal workshop took place on the 13th August with representation from all of the partners.

A set of design principles have been agreed which will be used to build the clinical Operating Model framework for Walsall. Following the workshop a draft framework has been developed and will be refined throughout future workshops. Please refer to figure 1 below.

The framework will outline the future vision for the provision of health and social care in Walsall.

Figure 1: Draft Design Framework



Work has also commenced on agreeing how the operating model might actually work for a particular target group of patients. Personae's were designed (Figure 2) based on the group discussions and will be used to build the detailed design of the operating model in future workshops. It should be noted that all of the patient names and descriptions are not specific to any person in the Trusts care. They are designed to represent the population that the partnership serves.

Figure 2: Personae's developed for the design of the Operating Model

Sophie Wilkins

26yo with drink and drug dependencies. Mother of Joshua Wilkins..

Sophie is a victim of domestic violence and a frequent visitor of A&E. She is anxious that her son will be taken in to care.

Joshua Wilkins

7yo child at risk of neglect and violence at home.

Joshua is underperforming at school, although is not known to social services.

Karanjit Siddhu

85yo with a history of falls. She has been treated for multiple UTIs.

She has fallen repeatedly at home, but wishes to remain independent. Her family would like to see her better supported.

David Worger

68yo with bowel cancer, in last year of life.

He lives with his wife at home, however would benefit from a wider support network to discuss his wishes.

Cassie Simmons

32yo with a high risk pregnancy due to existing Lupus.

She is anxious about her pregnancy but manages her pre-existing condition well.

Marvin Dooley

52yo with poorly managed Type 2 diabetes and recently diagnosed COPD.

He is distrusting of health professionals and avoids visiting his GP. He works night shits full time and has a poor diet.

Maria McBride

14yo with undiagnosed anxiety and depression.

A frequent self-harmer, her family are concerned this is due to bullying at school.

Muhammad Atif

34yo with learning disabilities, he currently lives at home with his family.

He has little social interaction outside the home and would like to play sports.

John Boswell

41yo healthy traveller not registered with a GP.

He has an active job and believes he is in good shape. He drinks frequently and smokes 20 cigarettes a day.

Clara Hoskins

84yo with dementia, living in a Care Home for 3 months.

Easily confused, which has led to aggression. Her family were unable to care for her and have visited only twice.

2.3 DATA ANALYTICS WORKSHOP

Information leads have been meeting over the last month to build a system wide activity model that can be used to test scenarios run by the operational model. This approach was used in Rotherham. They have used their model to inform them what resources can be directed to the biggest possible areas of gains. It was this data that informed them that a care coordination centre would be the best way to coordinate teams in and out of hours. The partnership is currently exploring options for this approach within the clinical model.

3. PARTNERS IN PAEDIATRICS

Following an Executive review with each care group this month, the below partnership was shared. The Trust is an active participant and uses this partnership to benchmark and improve the service we provide to paediatrics in our care.

Partners in Paediatrics (PiP) is a partnership of organisations and clinicians working to improve the quality and accessibility of services for children and young people.

It is a West Midlands Network that advocate for children and young people's services, with the overall aim of improving the quality of service provision. It has worked strategically with Children's Leads and Commissioners to explore options for service delivery, and to keep the importance of services for children and young people on the agenda.

The current member organisations are:

Birmingham Women's & Children's NHS Foundation Trust
Black Country Partnership NHS Foundation Trust
Dudley Clinical Commissioning Group
Dudley Group NHS Foundation Trust
East Cheshire NHS Trust
George Eliot Hospital NHS Trust
Midlands Partnership NHS Foundation Trust
Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust
South Warwickshire NHS Foundation Trust
The Royal Orthopaedic Hospital NHS Foundation Trust
The Royal Wolverhampton Hospitals NHS Trust
The Shrewsbury & Telford Hospital NHS Trust
University Hospitals Coventry & Warwickshire NHS Trust
University Hospitals of Derby and Burton Hospitals NHS Foundation Trust
University Hospitals of North Midlands NHS Trust
Walsall Healthcare NHS Trust
Worcestershire Acute Hospitals NHS Trust

PiP provides a host of up to date clinical guidelines that are adopted by most Trusts in the region and different working groups within the network meet throughout the year.

Board meetings are held twice a year and there is an annual AGM to be held in October. A senior nurse and a Consultant from the Trust are present at the meetings.

The Matron for Paediatrics and Neonates has been asked to present the Trust's approach to CAMHS as the service has been identified as a leader in this area. A Nurse Leadership group has been established which the Trust attend, the group is currently working on a tool for Safer Paediatric Nursing and reviewing the issues / challenges the use of nursing associates in paediatrics presents.

4. RECOMMENDATIONS

Board members are asked to NOTE the information within this report

MEETING OF THE PUBLIC TRUST BOARD – 6th September 2018			
Risk Appetite Statement			**AGENDA ITEM: 14**
Report Author and Job Title:	Jackie White- Interim Trust Secretary Jenna Davies- Director of Governance	**Responsible Director:**	Jenna Davies- Director of Governance
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The UK Corporate Governance Code states that 'the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. Risk Appetite is defined as 'the amount of risk the organisation is prepared to accept, tolerate, or be exposed to at any point in time.' It allows the board to take considered risks and to seek assurance that risks of any grade in areas of low tolerance are being managed, rather than focussing predominately on high rated risks. As per best practice the Trust should have a Risk Appetite Statement as a separate document; however we do not currently have one. The Board has previously considered and provided feedback on the statements as part of the Board development session. The feedback from this session has been incorporated and the Board is asked to approve the proposed statements.		
Recommendation	Members of the Trust Board are asked to: • Approve the Risk Appetite Statements		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	To ensure the Trust complies with recommended good governance practice.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

1. PURPOSE OF REPORT

The Board recognises the complexity of risk issues in decision-making. There is no absolute formulaic approach to establishing whether the Board considers that an activity is or is not an acceptable risk.

Each case requires the exercise of judgement. However, there are some indicators on the limits that the Board would see as outside of their tolerance and the Risk Appetite Statement can be used to inform decision making in connection with risk.

2. BACKGROUND

The Board held a Board Development session on the 2nd July 2018. At the session members of the Board considered and debated the Trusts risk appetite against each one of its strategic objectives. As a Trust currently in special measures with its regulators, the Board has taken a cautious view of regarding the risks that it is prepared to take in terms of risks to quality, patient safety and financial control, expressing a preference for safe delivery options that have a low degree of risk and which may only have a limited potential for reward.

3. RISK APPETITE

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take on in pursuit of value. Or, in other words, the total impact of risk an organisation is prepared to accept in the pursuit of its strategic objectives.

Risk appetite therefore goes to the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

The amount of risk an organisation is willing to accept can vary from one organisation to another depending upon circumstances unique to each. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

A report produced by KPMG suggests that a well-defined risk appetite should have the following characteristics:

- Reflective of strategy, including organisational objectives, business plans and stakeholder expectations
- Reflective of all key aspects of the business
- Acknowledges a willingness and capacity to take on risk
- Is documented as a formal risk appetite statement
- Considers the skills, resources and technology required to manage and monitor risk exposures in the context of risk appetite
- Is inclusive of a tolerance for loss or negative events that can be reasonably quantified
- Is periodically reviewed and reconsidered with reference to evolving industry and market conditions
- Has been approved by the Board.

The Good Governance Institute (GGI) has produced a briefing paper on risk appetite for NHS organisations with a matrix to support better risk sensitivity in decision taking which has been attached at Appendix A

4. RISK APPETITE STATEMENTS

	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme	The Trust is committed to delivering high quality services provided to patients and we will seek to implement a low appetite for taking risks that will compromise quality, patient safety or affect the experience of our service users
	Improve our financial health through our robust improvement programme	The Trust will adopt a moderate risk taking appetite when taking decisions about financial risk. We will strive to deliver our services within the budgets modelled in our financial plans and will only consider exceeding these constraints if a financial response is required to mitigate risks associated with quality of care or patient safety. All such financial responses will be undertaken ensuring optimal value for money in the utilisation of public funds.
 	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts	The Board's risk appetite for innovation, research and development is broad, depending on the nature of the innovation being proposed. It has a flexible view of innovation that supports quality, patient safety and operational effectiveness. This means that it will support the adoption of innovative solutions that have been tried and tested elsewhere, which challenge current working practices and involve systems/technology developments as enablers of operational delivery. Other innovations will be limited to only essential developments and with decision making held by senior management. The Board is willing to accept risks associated with innovation, research and development to enable the integration of care, development of new models of care and improvements in clinical practice that could support the delivery of Walsall Together
	Develop the culture of the organisation to ensure mature decision making and clinical leadership	The Trust will foster a culture of accountability and decision making through the design of organisational systems, processes and behaviours. The Board will act as a role model of the culture expected through personal behaviours and actions and will nurture the balance between risk taking, risk management and rewards in line with an organisation's risk appetite.

5. RECOMMENDATIONS

The Board is asked to approve the risk appetite statements

Appendix A- The Good Governance Institute risk management matrix

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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MEETING OF THE PUBLIC TRUST BOARD – 6 September 2018			
Board Assurance Framework and Corporate Risk Register			**AGENDA ITEM: 15**
Report Author and Job Title:	Jackie White, Interim Trust Secretary	**Responsible Director:**	Jenna Davies, Director of Governance
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	The new Board Assurance Framework (BAF) has been updated, in line with the 2018/19 annual objectives; there are still some risks requiring assessment and gaps in control and assurance need further clarity with regard to timescales. The greatest corporate risk currently recorded relates to delivery of the sustainable long term financial plans and ability to deliver scale of CIP. The Director of Governance is undertaking a full review of the Trust's risk management processes and systems including a review of the risks contained on all the Trust's risk registers (corporate, divisional, care group and department). These will be aligned to the new (in development) Trust Risk Management Strategy and overseen by the appropriate Board sub committee or executive level group.		
Recommendation	Members of the Trust Board are asked to approve the new BAF and note the Corporate Risk Register and progress.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risk Implications are identified within the document.		
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 ☒		

Board Assurance Framework 2018/19 and Corporate Risk Register

1. PURPOSE OF REPORT

The purpose of the reports is to present the final draft BAF for 2018/91 and provide details of the Corporate Risk register.

2. BACKGROUND

Risk is inherent in all Trust activities. Failure to manage risk could lead to harm to patients, staff or others, loss or damage to the Trust's reputation and assets, financial loss and potential for complaints, litigation and adverse publicity.

Effective risk management across all levels of the Trust is essential for safe and effective service delivery as well as proactive planning for Trust development. This paper details the processes in place to effectively manage risk.

3. DETAILS

Board Assurance Framework (BAF)

The Board of Directors has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate risks which may threaten the achievement of the Trust's objectives. The Board achieves this primarily through the work of its sub committees, through use of Internal Audit and other independent inspection and by systematic collection and scrutiny of performance data to evidence the achievement of the objectives.

The Board Assurance Framework (BAF) is designed to provide the Board with a simple but comprehensive method for the effective and focussed management of Principal Risks to Trust objectives. The Board defines the Principal Risks and ensures that each is assigned to a Lead Director as well as to a Lead Committee:

- The Lead Director is responsible for assessing any Principal Risks assigned to them by the Board and for providing assurance as to the effectiveness of primary risk controls to the Lead Committee
- The role of the Lead Committee is to review the Lead Director's assessment of their Principal Risks, consider the range of assurances received as to the effectiveness of primary risk controls, and to recommend to the Lead Director any changes to the BAF to ensure that it continues to reflect the extent of risk exposure at that time
- The Audit Committee is responsible for reviewing the whole BAF in order to provide assurance to the Board that Principal Risks are appropriately rated and are being effectively managed; and for advising the Board as to the inclusion within the BAF of additional risks that are of strategic significance

A revised BAF for 2018/19 has been developed and is attached as Appendix I. Principal risks that are considered to be of strategic significance to the achievement of each objective are recorded on the BAF for regular review by the lead committee.

Consideration has been taken of the Board Assurance Framework High Level Assessment Internal Audit Assurance Report WHT18-009 and a draft BAF has been shared with the Internal Audit lead. Recommendations have been incorporated into the BAF which is enclosed as Appendix 1.

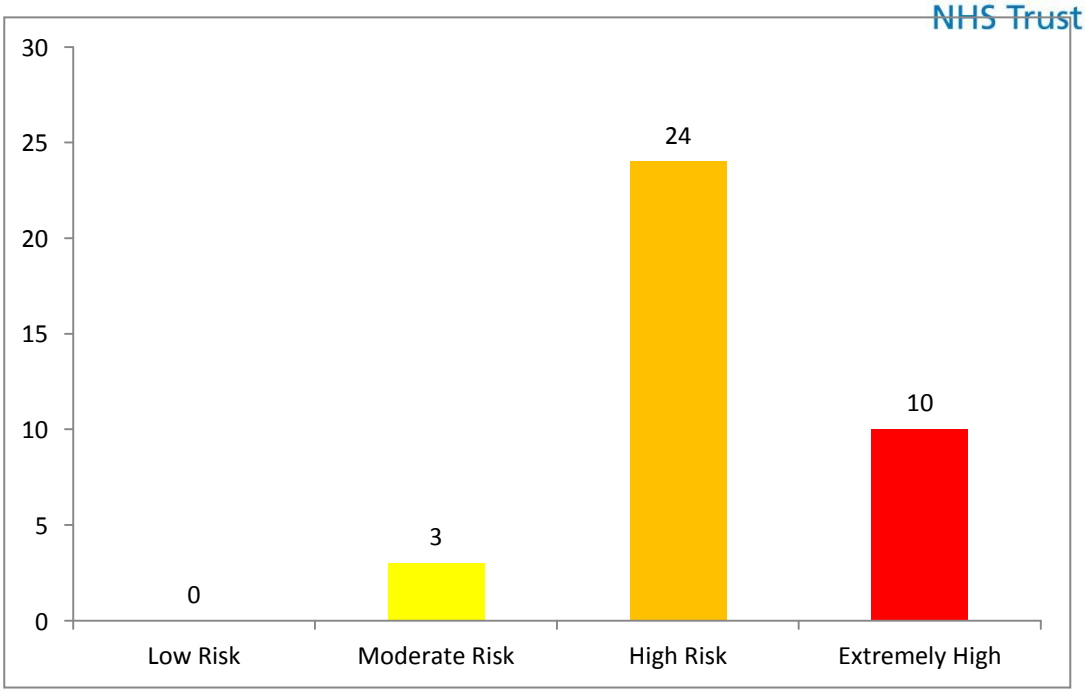
Corporate risk register

A corporate risk is defined as a risk that would have consequences for the objectives of more than one directorate, or for the whole Trust. All corporate risks have a risk rating of 15 and above and are assigned to the lead executive as responsible manager and a senior operational manager as risk lead. From time to time additional risks will be identified that are not captured within the corporate risk framework. These will be classified as 'Emergent risks' and will be individually assessed and managed in accordance with the Trust's Risk Management Strategy.

Wherever possible, corporate risks are also assigned to a lead management committee for regular review and oversight as well as upward reporting to the lead Trust Board sub committee.

The Director of Governance is undertaking a full review of the Trust's risk management processes and systems including a review of the risks contained on all the Trust's risk registers (corporate, divisional, care group and department). These will be aligned to the new (in development) Trust Risk Management Strategy and overseen by the appropriate Board sub committee or executive level group.

At this stage, the Trust's corporate risk profile (showing the number of risks by current risk rating) is as follows:



The areas of greatest risk within the draft Corporate Risk Register at present (rated 20) relates to two risks: Delivery of the sustainable long term financial plans and Ability to deliver scale of CIP.

A copy of the draft Corporate Risk Register is attached as Appendix II.

Reporting and assurance

The Board are required as a minimum to review the BAF on a quarterly basis, at each quarter the Board will received an updated report showing progress against risk mitigation and a brief narrative report on the changes to, and risk flows between, the BAF and corporate risk register.

Each BAF risk will be owned by a Board Committee. The Committee shall be responsible for the scrutiny and assurance of:

- Controls in place
- Assurances in place and whether they give positive or negative assurance
- Gaps in controls or assurance
- Actions to close gaps and mitigate risk

Where a BAF risk has a risk rating of 12 or over the Committee will conduct a 'deep dive' into the BAF risk. As part of the deep dive process Committees will be asked to consider the following questions:

- To what extent are the key controls (i.e. existing controls) effective?
- What are the gaps in the controls, how significant are they in relation to the current
- risk score?

- What internal assurances and independent external assurances are in place? Are they sufficient/adequate and are there any gaps? Are additional assurances required?
- Are there any areas where assurance is duplicated, repeated or excessive when compared with the activity undertaken?
- What actions are in place to further mitigate the risk to the agreed 'tolerated' level? Are they current and active? Are they adequate? Does more need to be done?

The Audit Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The overall BAF is regularly overseen and scrutinised by the Audit Committee prior to submission to Board. Audit Committee may also ask for a 'Deep Dive' if they have not received sufficient assurance from a Committee or when a Committee has asked for Audit to complete a deep dive.

4. RECOMMENDATIONS

The Trust Board are asked to:

- Approve the final BAF for 2018/19
- Note the Corporate Risk Register

APPENDICES

Appendix 1 – Board Assurance Framework

Appendix 2 – Corporate Risk Register

Appendix 1

WALSALL HEALTHCARE NHS TRUST

BOARD ASSURANCE FRAMEWORK 2018/19

VERSION 1.0 TRUST BOARD JULY 2018

Ref	Risk Owner	Board Committee	Annual Objective	Risk description	Initial score			Controls in place	Positive Assurance				Residual risk score			Gaps in control and assurance	Timescales	Progress
				Should be high level potential risks that are unlikely to be fully resolved and require on-going control	Likelihood	Impact	RAG status	Systems and processes (plan/policy/strategy) that are in place and operating that mitigate this risk	Internal and external evidence that this risk is being effectively managed	L1	L2	L3	Likelihood	Impact	RAG status	Additional actions required to mitigate this risk further		
Provide safe high quality care across all our services																		
BAF 001	Director of Nursing / Medical Director	Quality & Safety Committee	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme	The quality and safety of care we provide does not improve	4	5	20	Quality Commitment and Plan	PICP report	X			4	3	12	Implementation of the Safer Bundle	Aug-18	
								Governance Framework	Learning from deaths report	X						Delivery of NHSI Safer Staffing recommendations		
								Workforce Plan	Risk Management Committee reports		X					Development of a plan for medical staffing including robust job planning		
								Recruitment Strategy	Maternity Taskforce Group			X				Development of an engagement strategy		
								PCIP	CQC preparation group		X					Development of an Integrated Improvement Plan		
								Risk Management Strategy	Nursing & Midwifery Advisory Group		X					Implementation of the Behaviour framework		
								Staff Engagement Action Plan	Medical Advisory Group		X							
								CQC Well Led action plan	Quality & Safety Committee reports		X							
								CQC project plan	Listening into action reports	X								
								Quality Account	Quality Account	X								
									Safer Staffing Report	X								
									CQC report			X						
									Internal Audit Reports			X						
									Monthly oversight meetings with CQC			X						
									Regular oversight meetings with NHSI			X						
Value our colleagues so that they recommend us as a place of work																		
BAF 002	Director of People and Culture	People & Organisational Development Committee	Develop the culture of the organisation to ensure mature decision making and clinical leadership	There is a lack of leadership capability and capacity to leader performance improvement and build a high performing organisation	4	4	16	Kings Fund Development Programme for DDs	People & OD Committee reports		X		3	3	9	Implementation of staff engagement action plan		
								Staff Survey Action Plan	Pulse survey report	X								
								Implementation plan for behaviours framework	Staff survey report			X						
								Workforce Strategy	Engagents	X								
									Equality, Diversity and Inclusion Group		X							
									Values Launch	X								
Use resources well to ensure we are sustainable																		
BAF 003	Director of Finance & Performance	Performance, Finance and Investment Committee	Improve our financial health through our robust improvement programme	Failure to achieve financial plans as agreed by NHSI	4	5	20	Financial recovery plan	Regular oversight meetings with NHSI			X	4	3	12	Procurement and implementation of integrated performance reporting system		

Ref	Risk Owner	Board Committee	Annual Objective	Risk description	Initial score			Controls in place	Positive Assurance				Residual risk score			Gaps in control and assurance	Timescales	Progress
				Should be high level potential risks that are unlikely to be fully resolved and require on-going control	Likelihood	Impact	RAG status	Systems and processes (plan/policy/strategy) that are in place and operating that mitigate this risk	Internal and external evidence that this risk is being effectively managed	L1	L2	L3	Likelihood	Impact	RAG status	Additional actions required to mitigate this risk further		
								NHSI Workforce recommendations plan	Performance, Finance and Investment Committee reports		X					Implementation of NHSI workforce recommendations		
								Accountability Framework	NHSI review of temporary workforce			X				Implementation of Financial recovery plan		
								SFI/SO/SOD	CIP	X						Delivery of CIP	On-going	
									PIDs for each CIP	X						Capacity modelling to be undertaken	On-going	
									Financial recovery plan meetings		X							
									Vacancy control panel		X							
									Performance meeting with Divisions and Corporate Directorates	X								
									Performance reports	X								
Work closely with partners in Walsall and the surrounding areas																		
BAF 004	Director of Strategy & Improvement	Trust Board / TBE Integrated Committee	Develop the clinical services strategy focussed on service integration in Walsall and in collaboration with other Trusts	If the Trust does not agree a suitable alliance approach with the Local Health Economy partners it will e able to deliver a sustainable integrated care model	3	4	12	Black Country Provider Partnership Agreement	Partnership report	X			2	3	6	Develop and implement a clinical services strategy	Mar-19	
								Trust Strategy	Sustainability reviews	X						Review and implement appropriate governance arrangements for Walsall Together	Oct-18	
								Commercial strategy	Walsall together reports	X						Undertake and implement the recommendations from the clinical sustainability reviews	Sep-18	
									Walsall Together Partnership Board			X				Implement phase 3 of the sustainability reviews	Mar-19	
																Develop and seek approval for full business case - appointment of host provider	Oct-18	
Care for patients at home whenever we can																		
BAF 005	Director of Strategy & Improvement	Trust Board		Failure to progress the delivery of the Walsall Integrated model for health and social care	3	3	9	Trust Strategy	CQC rating for community services			X	2	3	6	Establishment of host provider and governance arrangements; management structures and pathways		
								Dedicated pathway for frail and elderly patients	WMQR frailty - positive outcome			X				Undertake review of community estate	Dec-17	
									Work plan to commence primary care MDTs	X						Establish single point of access for all partners	Apr-18	
									Sustainability reviews	X								
									Walsall together reports	X								
									Walsall Together Partnership Board			X						

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
209	Ensuring that patient health records are complete and readily available at the start of all clinics	Failure to ensure that health records are complete and readily available at the start of all clinics could impact on the clinicians' ability to determine the correct safe course of treatment for the patient and to fully understand their clinical history.	5 - Controlled - Target Risk Achieved	Corporate	31/10/2016	6	12	27/05/2017	Philip Thomas-Hands	Quality And Safety Committee	Review of risk mitigation plan	27/04/2017	Philip Thomas-Hands
798	Failure to assure the Safeguarding Children agenda	Potential risk of harm to children should the organisation not fulfil its statutory duty in assuring the safeguarding children agenda across Walsall Healthcare NHS Trust due to gaps in the safeguarding team.	4 - AgreedRisk/ Actions In Place	Corporate	31/05/2018	12	6	26/11/2017	Karen Dunderdale	Quality And Safety Committee	Business case for resourcing the extra 2 safeguarding nurses has been developed and awaiting funding approval. Ongoing prioritisation of workload to manage service	25/07/2018	Kara Blackwell

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
274	Lack of resources to meet depreciation needs causes breakdown delays in diagnosis and treatment and insufficient control over equipment being brought onto site.	EBME require sufficient resources to be made available for the purchase of medical equipment. Medical equipment within the Trust is depreciating faster than the current capital programme allocation. There is no programme in place for equipment replacement nor budget ringfenced to support the programme. There is also a need to have effective control over equipment being brought to site.	4 - AgreedRisk/ Actions In Place	Estates And Facilities	31/03/17	12	8	06/04/18	Daren Fradgley	Performance Finance And Invest	Reprioritised capital replacement list and reduction in risk scores	05/06/18	Daren Fradgley

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
220	Failure to assure the Children and Adult Safeguarding Legislative and Regulatory Requirements resulting in potential avoidable harm	Failure to consistently meet the legislative, regulatory and professional requirements associated with children and adults safeguarding could result in adults not being fully assessed so adults may be left at potential risk of harm. CQC inspection September 2015 required immediate improvements to remedy gaps in documented decisions relating to MCA/DNAR and improvements to DoLS assessment process.	4 - AgreedRisk/ Actions In Place	Corporate	31/08/2016	12	6	26/11/2017	Barbara Beal	Quality And Safety Committee	Risk score has been increased to 12 due to gaps in assurance around training numbers. Expected to reduce to 6 in the next quarter.	27/10/2017	Rachel Overfield

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
278	Failure to have in place robust and tested Emergency Preparation, Resilience and Response plans leading to inability to provide contracted services	Following the resignation of the previous Emergency Planning Officer (July 2015) the Trust has had no substantive resource to manage emergency planning. Expert advice has been brought in to provide core support and development pending substantive appointment. Concerns had been historically raised by the West Midlands LHRP which had not been responded to; the Trust is working with the LHRP to mitigate the risks/gaps identified.	4 - AgreedRisk/ Actions In Place	Corporate	31/08/2016	8	10	13/12/2017	Philip Thomas-Hands	Performance Finance And Invest	target score over inflated slightly so reviewed and changed to more realistic score.	13/11/2017	Philip Thomas-Hands
693	Failure to follow up patients post outpatient appointment causes harm to patients.	.	4 - AgreedRisk/ Actions In Place	Corporate	13/03/2017	9	6	20/01/2018	Philip Thomas-Hands	Performance Finance And Invest	Risk Assessor has been amended to reflect new Director of Nursing Barbara Beal.	21/12/2017	Ruth Barnard

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
215	Failure to improve colleague engagement and experience levels above that shown in the 2014 National Staff Survey. Poor staff engagement has a directly negative impact on patient care, recruitment and retention. Measurement of progress against standard will be through Pulse checks, focus group outcomes and Staff Survey.	Failure to improve colleague engagement levels will impact on our ability to consistently deliver safe patient care and a good patient experience and to recruit and retain staff.	4 - AgreedRisk/ Actions In Place	Corporate	30/04/2016	12	8	06/04/2018	Louise Ludgrove	People And Organisational Deve	Risk reviewed and additional controls and evidence added	05/06/2018	Louise Ludgrove
244	Failure to recognise and learn from events that contribute to avoidable deaths and risk an increase in SHMI performance. to above 100	Failure to learn lessons by undertaking reviews of death that occur in the trust presents a risk of poor governance and failure to recognise actions that could be taken to improve clinical outcomes and reduce avoidable deaths. Poor SHMI performance leads to negative publicity and poor reputation and potential litigation.	4 - AgreedRisk/ Actions In Place	Corporate	30/04/2018	8	8	07/03/2018	Amir Khan	Quality And Safety Committee	Mortaity Group working well under leaderhip of new lead. Education and training progressing nicely. Year to date SHMI and HSMR both below 100	24/07/2018	Amir Khan

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
1009	There is a current gap in knowledge for formulation of Medical Staffing rotas as currently populated out of Divisional control. Divisionally rota management is felt best to be placed back to medical staffing so that there are clinicians that can actively action queries rather than a reliance on an individual.	risk of rotas not been adequately staffed skill mix may not be addressed patient safety may be compromised if insufficient staff on rota reputation may be affected loss of staff to other organisations	4 - AgreedRisk/ Actions In Place	Medicine And Long Term Conditi	30/09/2018	9	4	21/02/2018	Amir Khan	Quality And Safety Committee	The risk is now being managed by Jo Adams as a corporate risk	24/07/2018	Najam Rashid
1233	Increase in Nursing Agency spend during Winter to suggested unprecedented levels, whilst keeping our patients safe and staffing levels safe.	Increase in Nursing Agency spend during Winter to suggested unprecedented levels, whilst keeping our patients safe and staffing levels safe to assure the quality and safety of care. Combination of vacancies, sickness, extra capacity, poor compliance with e rostering, understanding and alignment of systems and processes, ownership, accountability and responsibility. Contributing to failure to achieve year end financial position	6 - Rejected Risk	Corporate	31/03/2018	12	12	04/08/2018	Kara Blackwell		Reallocated risk to Kara Blackwell to establish the status of this rejected risk.	23/04/1902	Sharon Thomas

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
1163	Friends and Family Test - if we fail to improve the experience of patients and services users about the care then we will have poor FFT results resulting in reputational damage	Increased risk of poor patient experience resulting in loss of trust and patient/ service user dissatisfaction. Increased risk of informal concerns/ complaints raised by patients/ carers as a result of poor experience and low expectation. Continued poor results has the potential to demotivate staff which has the potential to perpetuate poor behaviours such as communication and attitude. Continued poor results has the potential to make recruitment and retention of staff more difficult. Results from surveys are commonly used by regulators to measure performance; this has the potential to impact negatively on organisational reputation and assurance provision forming poor regulatory opinion. Delayed sharing of intelligence from the provider via an online portal delays local action to remedy issues in a timely manner	4 - AgreedRisk/ Actions In Place	Patient Experience - Corporate	28/09/2018	12	6	14/05/2018	Kara Blackwell	Quality And Safety Committee	Risk accepted onto corporate risk register. Target risk score needs to be reviewed as does the current score as QSC felt the score was too low.	13/02/2018	Kirstie MacMillan

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
211	Failure to deliver timely nursing care due to insufficient nursing levels may lead to harm to patients	Failure to ensure safe nurse staffing levels during periods of excessive demand and pressure as recommended by the safer nursing care tool which could result in poor experience and an increase in avoidable harms	4 - AgreedRisk/ Actions In Place	Corporate	30/06/2018	12	9	23/02/2018	Karen Dunderdale	Trust Board	Risk title and description reviewed	25/718	Kara Blackwell
707	Failure to comply with equality, diversity and inclusion standards for services leads to poor experience for patients causing increased complaints	A gap analysis of the Trust arrangements regarding equality, diversity and inclusion highlighted significant gaps in provision, monitoring and reporting. The risk to the organisation is: - Users of the services will have a poor/inequitable experience - Staff could receive inequitable treatment and opportunity - The Trust fails to meet its statutory obligations under the Race Equality Act and other legislation	4 - AgreedRisk/ Actions In Place	Corporate	30/09/2018	9	4	26/11/2017	Louise Ludgrove	Quality And Safety Committee	Reviewed description and current score to remain the same.	25/07/2018	Louise Ludgrove

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
1321	Inaccuracies within ESR does not allow correct training figures to be supplied to the division which is a risk to reported data that the Division appears incompliant with mandatory training	ESR is not updated timely with training records. ESR has wrong mandatory requirement attached to wrong people.	2 - Escalated Risk (Pending)	Medicine And Long Term Conditi	22/05/18	15	4	04/08/18	Louise Ludgrove		Action assigned to Head of Governance at June 2018 RMC to update risk to reflect potential cross divisional impact. Action redirected to the Corporate Governance Manager who will liaise with ESR lead to ensure the risk is appropriately structured.	05/07/18	Sharon Thomas
1322	No available training within the Trust for medical equipment leading to a potential risk that the Division cannot evidence staff have had or provide relevant equipment training to new staff or those that training has lapsed.	The previous trainer left the trust. No further training has been provided. Therefore staff are out of date with equipment training.	2 - Escalated Risk (Pending)	Medicine And Long Term Conditi	/ /	15	4	/ /	Daren Fradgley			/ /	
210	Robustness of data quality.	If data quality is not robust then information provided to local and national bodies may misinform. This could impact on the view taken of our performance by our regulator leading to potential reputational damage and loss of income.	4 - AgreedRisk/ Actions In Place	Corporate	30/06/2018	12	8	30/07/2016	Daren Fradgley	Performance Finance And Invest	Review of risk mitigation action plan	30/06/2016	Russell Caldicott

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
1105	Management of Child Health Paper and Electronic Records (Careplus)	Careplus has been transferred to another provider as part of new regional contract. The SNS continues to have access to the CarePlus system and some its functionality however the organisation does not own the system. This creates the following difficulties 1.Uploading PID onto an electronic system that does not belong to our organisation. Therefore we do not have control of who else, including staff outside of WHT might have unauthorised access to this information 2.Our organisation receives electronic versions of child health records, for CYP who move into Walsall, from organisations which no longer hold paper records. We have no process in place to manage these records. They are currently stored on the SNS shared drive which breaches IG procedures for secure storage of PID 3.Loss of ability to produce recalls which supports the flagging alert system to identify vulnerable children	4 - AgreedRisk/ Actions In Place	Womens, Childrens And Clinical	31/10/18	15	3	04/05/18	Daren Fradgley		Risk reviewed	04/04/18	Caroline Whyte

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
196	Delivery of the sustainable long term financial plans.	If the Trust fails to deliver its sustainable long term financial plans the Trust will be exposed to regulatory sanction (potential financial special measures) which may impact on the way the Trust is able to respond to patient needs.	4 - AgreedRisk/ Actions In Place	Finance	30/09/18	20	10	19/05/17	Russell Caldicott	Performance Finance And Invest	Risk description updated, controls and actions reviewed.	05/06/18	Russell Caldicott
271	Insufficient capital to meet infrastructure needs leads to inability to completed planned project programme impacting on patient flow and expereience	Risk of failure from key building and engineering infrastructure due to failure to replace or upgrade because of insufficient capital money across the retained estate.	4 - AgreedRisk/ Actions In Place	Estates And Facilities	30/09/2016	12	8	30/07/2016	Daren Fradgley	Performance Finance And Invest	Review of risk mitigation plan	05/06/2018	Daren Fradgley

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
694	Failure to comply with equality, diversity and inclusion standards for the workforce leads to lack of engagement with staff,potential breach of legislation requirements, dissatisfaction and difficulty in recruitment and retention. Poor standards of patient care can also result. .	The Trust needs to be compliant with appropriate equality, diversity and inclusion standards to ensure a positive experience for staff	4 - AgreedRisk/ Actions In Place	Corporate	26/04/2017	12	3	06/04/2018	Louise Ludgrove	People And Organisational Deve	Additional controls and assurances added	05/06/2018	Louise Ludgrove

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
340	PFI Estate -Fire Stopping work not to the statutory standard or to Condition B as part of contract responsibilities which exposes staff and patients to potential risk exposure caused by the spreading of fire, smoke and toxic gases from once compartment to another.	Fire stopping has been completed by Oak leaf. The Trust needs a statement to say where the work has been carried out and to confirm the work is compliant with statutory standards. Failure to undertake the work to the statutory standard exposes staff and patients to an increased risk of harm caused by the spreading of fire, smoke and toxic gases from once compartment to another. Risk of contravening Article 17 of the Regulatory Reform Fire Safety Order 2005.	4 - AgreedRisk/ Actions In Place	Estates And Facilities	/ /	16	5	06/04/18	Daren Fradgley	Performance Finance And Invest	Fire stopping is being reviewed actively by PFI provider and they have provided evidenc of low risk.	05/06/18	Daren Fradgley

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
265	Electrical Power Failure and Generator failure in retained estates links with Lack of IPS and UPS on retained estate in critical areas in West Wing	Generator failure in the retained estate leading to loss of power to essential services leading to serious disruption to clinical services as well as potential fatality - Links with lack of IPS/UPS This could lead to delays and interruption of essential services following a loss of supply. All business continuity plans should identify that critical systems need to be plugged into the essential sockets. Mobile UPS provided to West Wing theatres as back up.	4 - AgreedRisk/ Actions In Place	Estates And Facilities	30/09/2016	9	5	06/04/2018	Daren Fradgley	Performance Finance And Invest	Additional controls and assurances added	05/06/2018	Daren Fradgley

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
665	Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation	Risk of a deliberate/intentional attack/hack on any part of the IT services and systems within the NHS or partner organisations from an external or internal source which could include infecting computers/networks/systems with a lethal virus or malware resulting in disrupting to NHS services and NHS care provision.	4 - AgreedRisk/ Actions In Place	Corporate	/ /	12	4	21/10/2018	Daren Fradgley	Performance Finance And Invest	Windows 10 agreement now in place and engagement with Microsoft to provide support on upgrading from windows 7 to windows 10 Anti malware software renewed for 1 year whilst a review of products is performed. Business case for storage/compute to be completed during summer, this will enable the upgrade from 2008 to commence Replacement of Perimeter security devices (Firewalls) business case has begun	23/07/2018	Mark Taylor
1005	Hard FM Estates Baseline review - Premises Assurance Model Jan-May 17	The management of HARD FM services at Walsall Healthcare Trust on PFI /Retained and Community Estate have gaps in assurance that would deem as moderate improvement required. Backlog maintenance of retained estates valued around £8.6m	4 - AgreedRisk/ Actions In Place	Estates And Facilities	31/03/19	16	4	06/04/18	Daren Fradgley	Performance Finance And Invest	Review underway through the SWBH SLA and mitigation being taken where required.	05/06/18	Daren Fradgley

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
1155	Fire Stopping to the Retained Estate	Fire Stopping to the retained estate requires the integrity of the fire compartments to be identified, remediated and certificated to provide a Condition B element as per Estates Risk Adjusted Backlog . The actions identify key areas for remedial work or survey .	4 - AgreedRisk/ Actions In Place	Estates And Facilities	/ /	8	5	21/05/2018	Daren Fradgley	Performance Finance And Invest	review updated	05/06/2018	Steve Lawley
208	Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks	Delays in assessment/treatment in ED due to lack of flow out of the department to appropriate destination will result in failure to achieve 4 hour standard as per National Performance Target and poor emergency patient experience.	4 - AgreedRisk/ Actions In Place	Medicine And Long Term Conditi	31/03/2017	12	9	13/12/2017	Philip Thomas-Hands	Performance Finance And Invest	Additional controls and assurances added	05/06/2018	Philip Thomas-Hands

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
25	Failure to achieve National Referral to Treatment Standard means patients waiting beyond acceptable waiting times causing harm to patients and complaints and fines from commissioning bodies.	Failure to improve access to services will result in lengthy waiting times for patients which could result in clinical harm from delayed diagnosis and treatment. - 92% Incomplete An increase in referral rates will negatively impact on the ability of the Trust to meet targets.	4 - AgreedRisk/ Actions In Place	Corporate	/ /	15	15	13/12/17	Philip Thomas-Hands	Performance Finance And Invest	New trajectory sent to EAPG in October working with Divisioanl teams to achieve 92% by q1 2018/19. Improved perofamcne achieved in Oral Surgery, Pain and Cardiology others have struggled in face of demand and shortage of expertise. Trajectory and spend plans being reviewed to agree Trust priority. Forecats for Q3 is 15 continued,	13/11/17	Philip Thomas-Hands

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
1137	Non-compliance of Security of Network & Information Systems Regulations (NIS) and potential fines for non-compliance of up to 4% of annual turnover. These regulations apply to the healthcare sector as an operator of essential services (OES). The law came into effect 10th May 2018. The organisation does not have a sufficiently robust governance & security structure to ensure compliance at present.	The NIS regulations states that operators of essential services must: 1.take appropriate and proportionate technical and organisational measures to manage the risks posed to the security of network and information systems which they use in their operations. Those measures should ensure a level of security of network and information systems appropriate to the risk posed; 2.take appropriate measures to prevent and minimise the impact of incidents affecting the security of the network and information systems used for the provision of such essential services, with a view to ensuring the continuity of those services"; and 3.inform, without undue delay, the competent authority (NHS Digital) or the CSIRT of incidents having a significant impact on the continuity of the essential services they provide". The regulation lists the following high-level	1 - New Risk - (Pending/Draft)	Corporate	31/12/2018	6	8	21/10/2018	Daren Fradgley		Work continues with suppliers on there ability to support the NIS requirements	23/07/2018	Mark Taylor

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
776	Ability to deliver scale of CIP	The service improvement and cost efficiency programme does not deliver the financial impact planned resulting in non-delivery of financial plan. The Trust's long-term financial plans assume that a significant saving will be required each year during the period.	4 - AgreedRisk/ Actions In Place	Corporate	31/08/18	20	15	10/01/18	Russell Caldicott	Performance Finance And Invest	Risk remains high as forward indicators (KPIs) with regard to productivity gains targeted to deliver within the last quarter of the financial year indicate opportunity but not delivery.	05/06/18	Russell Caldicott

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
218	Demand exceeds physical estate capacity and capacity within delivery suite, NNU, obstetric theatre and postnatal wards.	Demand exceeds physical estate capacity and capacity within delivery suite, NNU, obstetric theatre and postnatal wards. High activity within Maternity Services, resulting in capacity shortages leading to increased risk of delayed patient care and lack of facilities/equipment for patients due to increase demands on the service and poor patient experience. Inadequate staffing for current demand Physical estates capacity inadequate for demand Impact on other services including Neonatal unit as a result of demand within Maternity Services. Use of room 11 as a secondary theatre in order to meet demand however, acknowledges risk of noncompliance to current standards for an Obstetric theatre.	4 - AgreedRisk/ Actions In Place	Womens, Childrens And Clinical	/ /	15	8	30/07/16	Daren Fradgley	Performance Finance And Invest	Review of risk mitigation plan	05/06/18	Daren Fradgley

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
663	Delivering a 7 day service as per the four critical standards in the NHSE guidance	The inability to deliver standard 2, acute admissions to be reviewed by a consultant within 14 hours of admission and standard 8, all acute admissions have on going review and are seen during a consultant delivered ward round once ever 24 hours. The inability to deliver these standards presents risks relating to increased LOS, mortality, poor clinical outcomes and an impact of the 4 hour wait. The Trust is to comply to all standards by March 2020	4 - AgreedRisk/ Actions In Place	Corporate	31/03/2019	9	6	07/03/2018	Amir Khan	Quality And Safety Committee	Reviewed - risk still stays the same. We have identified the gaps, now the ongoing work to plug gap which will involve more detailed job planning may require further investment.	25/07/2018	Amir Khan

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
466	Non-compliance with Trust Medicines Policy and UK law in relation to the supply, storage and recording of controlled drugs.	Pharmacy conducts regular 3 monthly audits of controlled drugs in ward areas. The current annual report shows that there are some criteria for which there are high levels of non-compliance. The CD audit is in line with current practice and is fully described within the Medicines Policy. The Director of Pharmacy is the Controlled Drug Accountable Office for the Trust and has reviewed the audit results.	4 - AgreedRisk/ Actions In Place	Corporate	/ /	12	6	10/03/2018	Amir Khan	Quality And Safety Committee	Based upon the attached CD audit results for 2017 it can be seen that there has been a marginal overall improvement in CD audit compliance (75% in Jan 2017, 78% in Nov/Dec 2017). There are however, some improvements in specific criteria - eg criteria 1, 13, and 26 - all of which were previously RED. There is however, a significant reduction in compliance with criterion 24 - the requirement for two nurses to sign entries in the CD register. Therefore, the current risk has been downgraded to 12 and will be further reviewed after the next CD audit results.	24/07/2018	
212	Inability to recruit to consultant and middle grade posts due to national shortages in the division of Medicine and long Term Conditions	Reliance on locum and agency doctors which does not allow for continuity of care / practice, and at times where shifts cannot be filled completed gaps in rotas leads to risks in quality and safety of patient care	4 - AgreedRisk/ Actions In Place	Medicine And Long Term Conditi	31/05/18	9	9	07/03/18	Amir Khan	People And Organisational Deve	vacancy in respitory medicine,mitigation in place.	24/718	Amir Khan

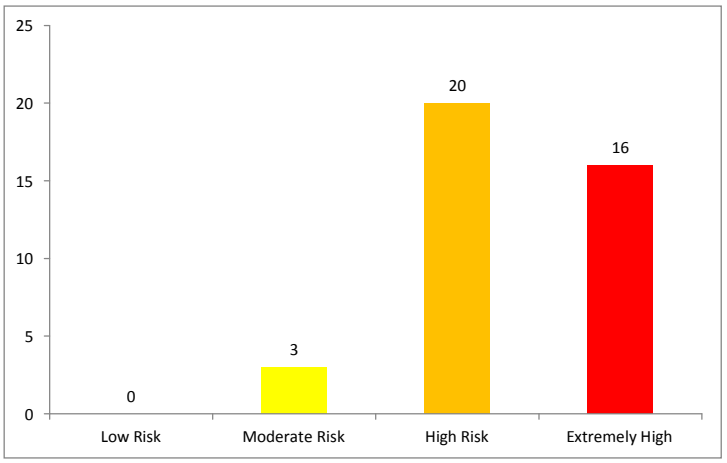
ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
201	Failure to recognise and respond to the deteriorating patient and those with early signs of sepsis leads to increased incidents of harm to patients including death.	Serious Incidents (SIs) reported across the Trust during 2015/16 show 6% relate to ineffective recognition and response to the deteriorating patient. The outcome for these patients is often poor - in 8 out 10 of these patients the reported outcome was death. There was no clear theme identified from RCA trend analysis. 2016/17 Serious Incident trend analysis demonstrates lack of escalation from NEWS 5+, delay in response times from clinicians. The recent (July 2016) WMQRS review of 'Identification and Management of Patients with Sepsis' showed a number of items requiring improvement to evidence optimal clinical care and compliance with the newly published NICE guidance NG51. CQUIN audit update December 2016: 59% in month for compliance with recording of observations (target 60%), 65% in month for compliance with evidence of clinician	4 - AgreedRisk/ Actions In Place	Corporate	30/06/18	12	10	10/09/17	Amir Khan	Quality And Safety Committee	Risk reviewed	24/07/18	Amir Khan

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
193	Consultant Radiologist Capacity - The capacity of the radiologist workforce is not sufficient to accommodate the demand placed on imaging services which continues to increase. Performance is not meeting the required standard and establishment is below expected average. Recent benchmarking has indicated that WHT is in the upper quartile for examinations performed per WTE consultant radiologist and has the highest backlog of reporting. As a result of reduced establishment there is a risk of delayed turnaround of reports and limited support to MDT's resulting in delayed diagnosis and potential for reduced prognosis across all care pathways with associated trust and national targets breeched as a result.	Delayed report turnaround time due to a service with significantly reduced effectiveness, leading to delay in patient diagnosis and/or treatment delivery on a daily basis. This may result in a poor or altered patient prognsis leading to patient dissatisfaction and formal complaints. Reduced effectivness of the diagnostic aspect of the of the patient pathway will lead to reduced effectiveness of the whole trust to meet national standards e.g. cancer, 18 week and AE. This would lead to low performance ratings with improvement notices and possible national media coverage. Length of stay will also be increased. Complaints from consultants and clinical teams due to reports being unavailable and potential for wasted outpatient appointments as a result. This may result in low staff morale and breeches of 18 week targets Low staff morale affecting all members of the imaging team, associated with not being able to	4 - AgreedRisk/ Actions In Place	Womens, Childrens And Clinical	29/06/18	9	6	12/06/18	Amir Khan		Business case approved	24/07/18	Amir Khan

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
1101	Regulatory Intervention in Maternity Services based on recent CQC assessment - section 29a	Following the recent CQC inspection a section 29a warning notice was issued identifying 4 areas of concern which required significant improvement. - CTG recording, review and documentation - Safeguarding training - HDU competence - ensuring women are cared for by midwives with relevant HDU competencies - Staffing on delivery suite and the maternity wards There is a risk to the reputation of the organisation as a result of these ongoing concerns.	5 - Controlled - Target Risk Achieved	Womens, Childrens And Clinical	/ /	4	4	10/08/2019	Kara Blackwell	Quality And Safety Committee	Continue to monitor against targets, Paper presented to Oversight committee 20/07/18 - attached. Parameters being met consistently. Unannounced inspection in June - awaiting final report.	10/08/2018	Nicola Wenlock

ID	Title	Description	Status	Division	Target Date	Current Risk	Target Risk	Next Review Date	Owner	Monitoring Group	Last review Details	Date of Last Review	Last Review By
41	Concerns with management of children and young people who have mental health problems, behavioural difficulties and delays accessing in-patient tier 4 provision.	The CAMHS service is provided by Dudley and Walsall Mental Health Trust. The service operate from 08.00 - 20.00 meaning outside of these hours there is no access for a specialist mental health opinion for this group of patients. Tier 4 in-patient mental health beds for children and young people are commissioned and procured by NHS England. There is a national shortage which leads to delays in access and high risk children and young people being cared for on a general ward. A number of young people require high risk social care placements and these placements are not available nationally. This means that CYP have extended periods of time on a children's ward whilst appropriate placements are procured. There is risk of harm to the patient, staff, other patients / relatives on the ward and trust property.	4 - AgreedRisk/ Actions In Place	Womens, Childrens And Clinical	02/11/18	15	12	20/09/18	Karen Dunderdale		This is ongoing and is monitored within the Division / escalated accordingly. Nation problem with local challenges in Social care and Mental Health provision.	21/08/18	Charlotte Yale

1	0
2	0
3	0
4	1
5	0
6	2
8	3
9	6
10	0
12	11
14	0
15	9
16	6
18	0
20	1
25	0



Low Risk	0
Moderate Ris‹	3
High Risk	20
Extremely High	16

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD			
Update against Trust Objectives for – Q1 2018			**AGENDA ITEM: 16**
Report Author and Job Title:	**Roseanne Crossey, Head of Business Development and Planning**	**Responsible Director:**	Daren Fradgley, Director of Strategy and Improvement
Action Required	Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	This report shows progress as at Quarter 1 against the Trust objectives agreed for 2018/19. The Trust operated inline or above planned trajectories, and hit its planned financial target, though planned savings were slightly off track. A finance recovery plan is in place. Trust values were launched and well received at the Leadership conference. Q1 Pulse Surveys achieved 52% response. Work on establishing joint health and social care teams are slightly behind track. Phase 2 sustainability reviews are on track.		
Recommendation	Members of the Board are asked to: to note the content of the updates, and be assured of progress against the objectives is being made within an acceptable framework.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 1: That the quality & safety of care we provide across the Trust does not improve in line with Quality Commitment. BAF 5: That our emergency care pathway does not improve resulting in continued delays for patients & poor flow through the hospital. BAF 7: That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff. BAF 8: that we are not successful in our work to establish a clinically-led engaged and empowered culture. BAF 10: That we cannot deliver our planned programme of hospital estate improvement including ITU, Neonatal Unit, 2nd Maternity Theatre & a plan for Emergency Department BAF 12: That the overall strategy does not deliver required changes resulting in services that are not affordable to the Local Health Economy. BAF 13: That the Service Improvement and Cost Improvement Programme does not deliver the financial impact planned resulting in non-delivery of financial plan. BAF 15: If the Trust does not agree a suitable alliance approach with Local Health Economy partners it will be unable to deliver a sustainable integrated care model. 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 ☒	

Update of Progress Against Trust's Objectives for 2018/19 at Q1

1. PURPOSE OF REPORT

The purpose of the reports is to assure the Board of the progress made against the Trust's annual objectives as at Quarter 1, 2018.

2. BACKGROUND

As part of the annual planning process the Board agreed four priorities for the period 2018/19 as follows:

Each objective has sub-objectives with outcomes allocated to executive leads.

Elements of this Report have been previously submitted and approved by the relevant sub-committees of the Board, i.e. People & OD; PFIC and Quality and Safety Committee.

3. DETAILS

Below is a summary of achievement against plan for each of the objectives as at Quarter 1:

3.1 Objective 1:

Objective 2018/19		Lead	Measures for 2018/19	Q1 Plan	Q1 Actual
1. Continue our improvement journey on patient safety culture and clinical quality through a comprehensive improvement programme which focuses on outcomes	**1.1**	**MD& DN**	**Deliver the Integrated Improvement Plan which includes delivery of our Quality Commitment**	Plan to be developed and approved.	The Integrated Improvement Plan is being developed by the Improvement Consultant this has not yet been developed and at present the focus has been on delivering the CQC PCIP
	1.2	**COO& MD**	**Improve quality and patient experience for our elective care pathways – ensuring a continuing reduction of patients waiting over 18 weeks**	85.5%	89%
	1.3	**COO& MD**	**Improved quality and patient experience in our emergency care pathways – ensuring 90% seen within 4 hours in ED by September 2018.**	86.0%	87.73%
	1.4	**Lead Execs**	**Ensure each of our Improvement Work streams deliver tangible improvement for patients and staff:**		
			➢ **Outpatients – Improve clinic utilisation rates**	94 %	94.41%
			➢ **Theatres –Improve theatre utilisation rates**	85 %	85.12%
			➢ **Patient Flow – Reduce overall bed occupancy**	85 %	88.35%
	1.5	**DSI**	**Invest in IT and new technologies to enable technology supported change to include:**		
			➢ **Bed Management System**	Design	BM System Designed on time
			➢ **Electronic records**	Business Case	ER Business case drafted
			➢ **E-prescribing rollout**	Business Case	E-prescribing on hold.
	1.6	**DSI**	**Wider Development Control Plan for next stage of hospital (modular block upgrade, office accommodation, on-site MLU) and community estate approved by the Board by June 2018.**	Commission	This work has been commissioned and will commence in Q2
	1.7	**DFP & DSI**	**Finalise the approval for a new Emergency Department and have a clear plan for its delivery**	FBC Approval	SOC approved by NHSI as has the capital allocation from the STP

In Quarter 1 there was a focus on evolving the CQC Patient Care Improvement Plan, which has delayed the development of the integrated improvement plan.

Operationally, despite challenging weather in Q1 the Trust has been operating inline or above planned trajectories as shown. The ED operated at 87.73% for four hour waits against a trajectory of 86%. We have also seen improvements in outpatient and theatre utilisation. The planned rollout of e-prescribing has been put on hold.

The Trust is working with NHS Digital to progress e-prescribing.

3.2 Objective 2:

Objective 2018/19				Q1 Plan	Q1 Actual
	2.1	DHR &OD	**Improved colleague satisfaction measured through the 2018 and 2019:**		
			Ø **National staff survey**		
			Ø **Pulse Checks**	50%	52%
			Ø **Staff Friends and Family**	20%	19%
	2.2	DHR &OD	**Embed new Trust Values with an associated behavioural framework and approach to feedback to drive improvement which reflects the Trust's approach to a clinically led model.**	Launch	Values were developed from staff input and officially launched at the Leadership Conference in July.
	2.3	DHR &OD & COO	**Deliver standards for appraisal by September 2018.**	90%	82%
	2.4	DHR &OD & COO	**Continued reductions in sickness absence.**	5%	5%
	2.5	DSI	**Empower staff to make appropriate service decisions supported by accurate demand and capacity modelling**	Overview	Overview incorporated in to Phase 2 sustainability reviews. Demand and capacity modelling has been completed for all operational services. The Trust now has 9 qualified demand and capacity "train the trainers".

In Quarter 1, the majority of plans relating to this objective were achieved, though we are slightly behind in Staff Friends and Family surveys and work on appraisals. There is a focus on these two areas for Quarter 2.

The launch of the new Values in July was well received, and staff continue to engage in the development of the Behaviour Framework.

The Trust now has 9 qualified demand and capacity "train the trainers". Demand and capacity is one of the key domains included in Phase 2 of the sustainability reviews.

The responses to the Q1 Pulse Surveys were at 52%, which is a great achievement.

3.3 Objective 3:

Objective 2018/19		Lead	Measures for 2018/19	Q1 Plan	Q1 Actual
3.Deliver the next stage of our journey of financial improvement, driven by improvements to services process and productivity through our improvement programme	**3.1**	**DFP**	**Annual deficit in line with plan - £10.6M in 2018/19**	(£5.6m)	(£5.6m)
	3.2	**DFP**	**Deliver savings program of £15.5m in 2018/19.**	£2.4m	£1.9m
	3.3	**MD& DN**	**Plan agreed for reducing agency spend and delivered as planned to ensure we reduce agency below our £7.6m**	Provide Actuals	£1.9m
	3.4	**DFP & DSI**	**Identify and build a program of work around outlying metrics in Model Hospital**	Provide Narrative update	Use of model hospital being assessed as part of Phase 2 sustainability reviews.

Quarter 1 finished on plan though there was some slippage on income schemes relating to performance which affected the outturn against the savings plan. The plan anticipates £1.1m of non-recurrent delivery. Increased births delivered at the Trust will off-set £0.35m of the non-recurrent delivery this year. A Financial Recovery Plan has been activated.

3.4 Objective 4:

4. Develop and deliver our clinical services strategy through the implementation of integrated local care (Walsall Together) and increased acute hospital collaboration to ensure service resilience and sustainability	**4.1**	**DSI**	**Development of integrated Health and Care approach through a programme of work outlined in the case for change.**	Establish Team	Slightly behind plan at Q1. Work still being completed to establish the team
	4.2	**COO**	**Complete the deployment of an Integrated Intermediate Care Service. Reduce medically fit for discharge patients in hospital beds**	80	90
	4.3	**DFP& MD**	**Deliver a Black Country Pathology Service in line with our agreed plan.**	Narrative update	On plan.
	4.4	**MD & DSI**	**Work across the STP and with the Black Country Provider Partnership to develop a shared strategy for the future services**	Phase 2 of sustainability reviews	Phase 2 of sustainability reviews has been completed. Service route maps to be identified in Phase 3. Started a bespoke partnership group with RWT ref services with which we could potentially work together.
	4.5	**DSI**	**Continue our work to undertake a strategic review of each service to assess their potential for sustainability - Clear view by Q 2 2018/19.**	Phase 2	Phase 2 of sustainability reviews of services self-assessed as Amber or Red completed, continue to go through assurance and Paper to go to Private Board September.

The work relating to the development of an integrated health and care approach fell slightly behind in Q1 with work still being completed to establish the joint team. We expect to recover this in Q2.

Work on the transition of the Black Country Pathology Services is going well and was on plan at the end of the quarter.

The Board will receive a separate paper in Private Board relating to strategic reviews of services. At the end of Q1 plans were in place to complete the reviews on time.

4. RECOMMENDATION

Members of the Board are asked to note the content of the Report, and to assure themselves that they are satisfied with the progress being made against plan is within acceptable boundaries.

Roseanne Crossey
Head of Business Development and Planning

MEETING OF THE PUBLIC TRUST BOARD – 06 September 2018			
Strategy Committee Terms of Reference			**AGENDA ITEM: 17**
Report Author and Job Title:	Daren Fradgley – Director of Strategy and improvement Jenna Davies- Director of Governance	**Responsible Director:**	Daren Fradgley – Director of Strategy and improvement
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	To present the draft terms of reference for the Strategy Committee for comment and approval. A strategic group made up of Executive and Non-Executive members of the Board meets on a regular basis; given the importance of strategic programmes and the pace at which strategic changes are progressing there is a requirement for a strategy sub-committee of the Trust Board.		
Recommendation	Members of the Trust Board are asked to approve the Committee Terms of Reference		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This Committee will act as an assurance Committee linked to the BAF risks relating to providing care closer to home and partnerships		
Resource implications	Any resource implications will be identified by the individual executive lead for each of the actions identified within the action plan.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

STRATEGY COMMITTEE

TERMS OF REFERENCE: Version 0.1

RATIFIED BY THE TRUST BOARD ON:

NEXT REVIEW DUE:

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Strategy Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. PURPOSE

2.1 To support the Trust Board by monitoring the delivery of the Trust's portfolio of strategic change programmes relating to the achievement of the Trust's strategic objectives relating to integration and partnership working

2.2 To drive the strategic change programmes forward and provide oversight of the effectiveness of changes that are implemented to ensure that the outcomes and benefits of these are realised, sustained and embedded within the organisation.

2.1 The Committee is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or independent advice and to see the attendance of outsiders with relevant experience and expertise if it considers necessary.

3. MEMBERSHIP

3.1 The Membership of the Committee shall consist of;

- A Non-Executive Director (chair) to be appointed by the Chairman
- Two Non-Executive Directors
- Director of Strategy & Improvement
- Chief Operating Officer
- Director of Governance
- Medical Director

4. ATTENDEES

4.1 Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

4.2. It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year.

5. QUORUM

5.1 A quorum shall be 2 Non-Executive Directors and two Executive Director.

6. FREQUENCY OF MEETINGS

6.1 The Committee will meet 6 times a year additional meetings may be arranged as required.

7. CHANGES TO TERMS OF REFERENCE

8.1 Changes to the terms of reference including changes to the Chair or membership of the Committee are a matter reserved to the Trust Board.

8. **ADMINISTRATIVE ARRANGEMENTS**

8.1 The Chair of the Committee will agree the agenda for each meeting with the Director of Strategy and Improvement. The Committee shall be supported administratively by the Executive PA who's duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the committee on pertinent issues / areas
- Enabling the development and training of Committee members

All papers presented to the Committee should be prefaced by a summary of key issues and clear recommendations setting out what is required of the Committee.

9. ANNUAL CYCLE OF BUSINESS

10.1 The Committee will develop an annual cycle of business for approval by the Trust Board meeting at its first meeting of the financial year. The Committee work plans informs the standing agenda items as described within the terms of reference, to ensure that all regulatory and legislative items are adequately reviewed and acted upon.

10. REPORTING TO THE TRUST BOARD

10.1 The Chair of the Strategy Committee will provide a highlight report monthly to the Trust Board outlining key actions taken with regard to the issues, key risks identified and key levels of assurance given.

11. STATUS OF THE MEETING

12.1 All Committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Committee.

12. MONITORING

13.1 The Committee will provide the Trust Board with an Annual Report setting out the issues that have been considered by the Committee and details of assurance provided

14. DUTIES

14.1 To lead the development and updating of the Trust's five year strategy, prior to submission to the Board of Directors

14.2 To seek assurance on the robustness of the Trust's processes to support mid to long term strategic planning

14.3 To engage and influence commissioners and partners in the wider system to address the care needs of people of Walsall

14.4 To provide assurance that needs of the community and patients are best serviced by the proposed partnering arrangements

14.5 To review the legal, financial and risk implications of proposed partnering arrangements and propose to the Board of Directors an appropriate vehicle for each partnering arrangement

14.6 To identify key metrics against which to measure the success external partnerships, to review performance against these metrics and ensure appropriate action is taken in response

14.7 To establish meaningful patient and public engagement in planning for the future.

14.8 To have a strategic clinical input as required into the system wide transformation process.

14.9 To build plans for the safe delivery of internal Trust services for future organisational configuration, whatever that form may be

14.10 To be responsible for establishing the selection criteria, selecting, approving and setting the terms of reference for any independent consultants who advise the Committee

MEETING OF THE PUBLIC TRUST BOARD – 06 September 2018			
To provide the Board with an overview of the Core Standards submission of compliance in Emergency Preparedness, Resilience and Response reported to NHS England and to gain the Boards approval for the submission			**AGENDA ITEM: 18**
Report Author and Job Title:	Ian Billington, Head of Emergency Planning, Resilience and Response	**Responsible Director:**	Philip Thomas-Hands Chief Operating Officer
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	This report contains; • Description of Emergency Preparedness, Resilience and Response Core Standards self-assessment process and timelines • Last year (2017 submission), the Trust was substantially compliant • This year's position is Partially Compliant • Remedial actions incorporated alongside specific standards, with timetable		
Recommendation	Members of the Trust Board are asked to: Approve the submission of the 2018 EPRR Core Standards return. Receive an update report on the actions identified being completed to ensure compliance with the Core Standards and provide assurance to the Trust Board that the Trust is meeting its requirements as outlined in the CCA 2004.		
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 ☒		

Emergency Preparedness, Resilience and Response (EPRR) Core Standards
Self-Assessment Submission 2018

1. PURPOSE OF REPORT

The purpose of the report is to gain approval of the EPRR Core Standards 2018.Each year NHS England is committed to operating an assurance process across the country, this is known as the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR). NHS England EPRR teams and Local Health Resiliency Partnerships (LHPR) are asked to conduct the assurance process during 2018/19 as outlined below:

August

- Submit self-assessment against core standards by midday on the 31st August to NHS England and lead CCG

September

- Local health Resilience Partnership (LHRP) to receive an overview of results and an initial draft of the LHRP co-chairs statement of assurance.
- Clinical Commissioning Groups (CCGs) during September, will lead the local evaluation of Trust submissions and provide an evaluation to LHRPs.

October

- LHRP co-chairs to meet with CCG leads, NHS England and NHS Improvement to discuss results. Depending on the findings, organisations may be required to submit further evidence for evaluation during October.
- 31st October: Deadline for LHRP co-chair statements of assurance and submission of evidence to regional offices of NHS England.

November

- LHRPs to receive a copy of minutes of the public Board meeting (providers) / Governing Bodies receiving the EPRR Core Standards self-assessment report.

2. BACKGROUND

It is a mandatory requirement for all organisations who receive NHS funding to carry out a self-assessment against the NHS England Core Standards for EPRR. Further, all organisations participating in the 2018 assurance process will ensure their Boards are sighted on the level of compliance achieved, the results of the self-assessment and the action/work plan for the forthcoming period.

The 2018 Core Standards compliance levels have been simplified from the previous year. The Trust achieved substantial compliance year and this year is in a good position to make further progress in the areas were full compliance has not been achieved; these areas are identifiable through completion of the Core Standards 2018.

3. DETAILS

2018 Submission

- Results of the self-assessment against the NHS England Core Standards for EPRR
- A resulting action/work plan stemming from the self-assessment

Organisations must state overall whether they believe they are fully compliant, partially compliant or non-compliant with the NHS England Core Standards for EPRR. The definitions of which are included below:

Compliance level	Evaluation and testing Conclusion
Full Compliance	Fully Compliant with Core Standards
Partial Compliance	Not compliant with Core Standard. The organisations EPPR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months
Not Compliant	Not compliant with Core Standards. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months

* Should an Organisation be non-compliant the LHRP will regularly monitor progress throughout the year until it is has attained an agreed level of compliance.

The results of the self-assessment and peer review have led to a conclusion that the Trust has achieved Partial Compliance against the Core Standards. The tabular breakdown on the Trust performance is included below:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	13	1	0
Command and Control	2	2	0	0
Training and exercising	3	4	0	0
Response	7	4	2	1
Warning and Informing	3	2	1	0
Cooperation	4	7	0	0
Business Continuity	9	7	1	1
CBRN	14	8	5	1
Total	64	55	11	3

This is because of the number of standards where a plan is in place but work is not complete and does not, at this stage, meet the Fully Compliant requirements. The Local Health Resilience Forums will agree a final rating in due course as outlined above.

In those to the areas where full compliance was not achieved there has been progress made this year. Some of the progress was delayed while a Head of EPRR was recruited to the vacancy. The Trust is now well positioned to progress with the areas of evacuation and exercises. One of the key differences with last year is the additional prominence given to Business Continuity which the organisation aims to acknowledge by developing a new distinct Business Continuity policy by 2019.

4. RECOMMENDATIONS

The provider peer review process has recognise the Trust's position in relation to Emergency Preparedness, Resilience and Response Core Standards, however there is still work to complete, not least of all a full scale live Multi Agency Exercise, until this is completed the Trust will not achieve Full Compliance.

An action plan is in place to improve the rating to Fully Compliant. The Action Plan as pulled direct from the Core Standards submission is included within this report. This Action Plan will be monitored via the monthly EPRR meeting which is chaired by the AEO.

There is further work to do, actions are detailed and progress will be monitored as we continue to work with the West Midlands EPRR network towards Full Compliance.

The Board is asked to support the submission of the 2018 Core Standards return.

The Board is asked to receive an update report on the actions identified being completed to ensure compliance with the Core Standards and provide assurance to the Trust Board that the Trust is meeting its requirements as outlined in the CCA 2004.

APPENDICES

Appendix A – Action Plan generated through completion of the EPRR Core Standards 2018

Appendix A – Action Plan generated through completion of the EPRR Core Standards 2018

Overall assessment:	Partially Compliant						
Ref	Domain	Standard	Self-Assessment	Action to be taken	Lead	Timescale	Comments
20	Duty to maintain plans	Shelter and evacuation	Partially compliant	Write up full a Shelter and Evacuation Policy for consultation and agreement. Draft document is in place but need to ensure that the document involves full participation from the clinical side to ensure the document is based on the most appropriate clinical decision making.	Head of EPRR	Nov-18	The Trust has in place references toward evacuation and shelter within the Fire Strategy. The Trust wants to further develop their approach and response to incidents that require evacuation and shelter. A draft Trust wide document is currently in draft. Critical Care are currently writing a new Evacuation Plan which will be relevant to the new ED. This process will be tested with the Fire Brigade before the new Critical Care Unit goes fully operational.
32	Response	Management of business continuity incidents	Partially compliant	Consideration given to developing a separate Business Continuity Policy profile	Head of EPRR	Oct-18	The trust currently has a joint Emergency Preparedness and Business Continuity Policy. The principles of Business Continuity have a significant role within the Major Incident Plan. The trust is seeking to further build on the progress made in relation to Business Continuity with the implementation of the Tactical Commander Handbook. This handbook will also support the Ward based perspectives on Business Continuity. The Trust

							led by the EPRR Steering Group is giving consideration to developing a distinct policy for Business Continuity.
33	Response	Loggist	Partially compliant	Implement training with the assistance of another Trust. Ensure the Trust is sustainable going forward by ensuring the Head of EPRR can deliver the training sessions	Head of EPRR	Dec-18	The Trust recognises that there is an opportunity for improvement in relation to increasing the loggist coverage that the organisation can offer. The Trust is considering starting a robust training programme for Loggists which would begin in autumn 2018.
35	Response	Access to 'Clinical Guidance for Major Incidents'	Non compliant	This document was released in around 2005 and predominantly in hard copy. Electronic versions have been requested for Public Health England	Head of EPRR	Sep-18	
39	Warning and informing	Media strategy	Partially compliant	The current Communications Strategy is under review. During the design phase	Head of Communication	Dec-18	

				consideration will be given to the requirements outlined within the EPRR Core Standards			
48	Business Continuity	BCMS scope and objectives	Partially compliant	Consultation and design of the Business Continuity approach to ensure that it distinct but still supportive of Emergency preparedness	Head of EPRR	Dec-18	The Emergency Preparedness and Business Continuity Policy outlines the scope and objectives around Business Continuity focussing on the definition and responsibilities that support it.
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	Non compliant	Email sent to finance for clarity of the position relating to this criteria 07/08 - follow up meeting with Procurement week beginning the 13/08	Head of EPRR	Sep-18	
58	CBRN	HAZMAT / CBRN risk assessments	Partially compliant	Arrange WMAS CBRN Inspection	Head of EPRR	Dec-18	CBRN Plan agreed as fit for purpose by HART team lead. All public facing reception staff and volunteers have received or are about to receive IOR training. CBRN Self Assessment submitted to WMAS, awaiting confirmation of date of inspection.
61	CBRN	PRPS availability	Partially compliant	Await outcome of the conversations, hopefully enabling the Trust to become fully operational in relation to the required amount of suits	Head of EPRR	Dec-18	Verification of exact position in relation to the PRPS Suits. Conversations are ongoing with the suppliers led by NHS England.

62	CBRN	Equipment checks	Partially compliant	Reporting compliance against the criteria to the EPRR Steering Group - focus on RAMGENE Testing	CBRN Lead Nurse	Dec-18	The Trust via the CBRN Lead Nurse, who is based in ED and will carry out all of the required training and equipment checks and report back to the EPRR Group in Autumn 2018
63	CBRN	Equipment PPM	Partially compliant	Await confirmation of the RAMGENE status? UHB to confirm status after service	CBRN Lead Nurse	Dec-18	The Trust has in place a full and comprehensive inventory of the suits and awaiting confirmation of the Ramgene
66	CBRN	Training programme	Partially compliant		CBRN Lead Nurse	Sep-18	Handouts and guidance available. The Trust aims to establish a comprehensive programme of face to face training
67	CBRN	HAZMAT / CBRN trained trainers	Non compliant	Records are well maintained by the CBRN Lead but the Trust needs to review both its sustainability and resilience in this area by increasing the number of trained staff to deliver training	CBRN Lead Nurse	Sep-18	

MEETING OF THE PUBLIC TRUST BOARD – 6th September 2018			
Quality & Safety Committee Highlight Report			**AGENDA ITEM: 19**
Report Author and Job Title:	Dr Karen Dunderdale, Director of Nursing	**Responsible Director:**	Vicky Harris, 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 30th August 2018 together with the confirmed minutes of the meeting held on 26th July 2018 (appendix 1). Key items discussed at the meeting were: • CQC Preparedness and feedback received from the Enable East Peer Review (included on the Trust Board agenda) • Outcome of the CQC re-inspection to Maternity services • The requirement to agree an integrated approach for monitoring the impact of CQUIN schemes on quality and patient experience • Progress with the development of the monthly Nurse Staffing Report • Process for reporting Enhanced Quality Impact Assessments to the committee • A comprehensive presentation was provided by the Division of Women's & Children's Services The meeting was quorate and chaired by Vicky Harris, Non-Executive Director in the absence of the Chair, Professor Beale. Ms Oum, Chair and John Dunn, Non-Executive Director also attended the meeting.		
Recommendation	Members of 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	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	Compliance with Trust Standing Orders		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Quality & Safety Committee Highlight Report

1. PURPOSE OF REPORT

The purpose of the report is to provide a highlight of the key items discussed at the most recent Quality & Safety Committee meeting held on the 30th August 2018 together with the confirmed minutes of the meeting held on 26th July 2018 (appendix 1).

2. BACKGROUND

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.

3. DETAILS

The Quality & Safety Committee resolved that the following items would be referred to the Trust Board at its meeting on 6th September 2018:

CQC Preparedness and feedback received from the Enable East Peer Review

The committee received a report on CQC preparedness which has also been included on the Trust Board agenda. A discussion took place regarding the feedback received from the Enable East team who had undertaken a peer review during week commencing 20th August 2018. The committee were also informed that the final CQC report from the recent re-inspection to Maternity services had been published and the overall rating had improved from Inadequate to Requires Improvement.

CQUIN Schemes

An update on the position with CQUIN schemes was provided and committee members queried how progress against the schemes would be overseen by the committee. It was agreed that an integrated approach should be taken for monitoring the impact of CQUIN schemes on quality and patient experience. Committee members requested a regular report with updates from the executive leads on progress with each scheme and actions that were being taken to ensure delivery.

Monthly Nurse Staffing Report

The Director of Nursing presented a revised version of the Nurse Staffing report and explained that this would continue to be refined over the next couple of months to

include further data, narrative and actions being taken. A comprehensive establishment review was being undertaken with all wards during September and it was anticipated that staffing reports would be co-authored by the Director of Nursing and Director of Finance once this had been undertaken.

The Director of Nursing has secured the support of a senior nurse to support the Nursing Workforce workstream she has set up. The Director of Nursing has negotiated the secondment of Angie Davies from her acute provider for 6 months. John Dunn will also provide NED confirm and challenge support to the workstream.

Quality Impact Assessment Process

The committee discussed the process for reporting Enhanced Quality Impact Assessments associated with Financial Recovery Plan and it was agreed that a written report would be provided at the next meeting in relation to the major CIP schemes that had been agreed and the process for reporting monthly on schemes being developed moving forward. The committee also requested that the work of the Programme Management Office be strengthened to monitor progress with schemes from a quality perspective as well as financially.

Presentation from the Division of Women's & Children's Services

Members of the Women's & Children's division attended the meeting to provide a presentation on their quality improvement journey including outcomes from the CQC inspection, updates on the divisional PCIP, summary of divisional and corporate risks and staff survey results.

Members recognised the strengthened leadership within the divisional and care group triumvirate.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note and discuss the information contained in this report.

APPENDICES

Appendix 1 – Minutes of the Quality & Safety Committee meeting held on 26th July 2018.

Appendix 1

MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON THURSDAY 26TH JULY 2018 AT 9.00 A.M MEETING SUITE A, 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
	Mrs V Harris	Non-Executive Director
	Mr A Khan	Medical Director
	Mr P Thomas-Hands	Chief Operating Officer
In Attendance:	Ms D Oum	Trust Chair
	Mrs L Pascall	Associate Director of Nursing (Up to item 69/18 only)
	Mr N Rashid	Divisional Director, MLTC (Item 77/18 only)
	Mrs W Lear	Divisional Director of Nursing, MLTC (Item 77/18 only)
	Miss S Garner	Executive Assistant (minutes)
Apologies:	Mr R Beeken	Chief Executive
	Mr P Gayle	Non-Executive Director

63/18 Welcome and Introductions

Professor Beale welcomed everyone to the meeting.

64/18 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

65/18 Declarations of Interest

There were no declarations of interest.

66/18 Minutes of the Meeting Held on Thursday 28th June 2018

Resolution
The minutes of the meeting held on 28th June 2018 were agreed as a true and accurate record.

67/18 Action Sheet and Matters Arising

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

68/18 Role of the Trainee Nursing Associate

Mrs Pascall attended the meeting to provide a presentation on the role of the Trainee Nursing Associate (TNA) and the following points were highlighted:

- The Trust had been the Trailblazer for the pilot for the TNA role which commenced in January 2017 and had since presented at four national conferences to share the journey. The purpose of the pilot was to incorporate new roles into the workforce to support the current gap of Registered Nurses.
- The 19 TNAs who had commenced on the programme would qualify as Nursing Associates (NA) and register with the NMC in January 2019.
- The programme had now been agreed as an apprenticeship programme and the cohort had commenced in March 2018.
- There was a need to acknowledge and celebrate the completion of the first programme as the TNA's would be the first across the country alongside the other pilot sites.
- The structure of the current nursing workforce was explained including where the TNA role would sit within that.

There was a further discussion about how the newly qualified NA's would be integrated into the workforce and Ms Blackwell advised that they would not be recognised as a trained member of staff nationally, however, the Trust had undertaken a risk assessment and had confirmed that the NA would supplement a Registered Nurse under supervision. It was agreed that there would need to be some clear communication across the Trust to ensure that the current workforce were aware of the position of the NA role. Mrs Pascall confirmed that the skills annex for the role had been developed alongside some of the current Registered Nursing teams.

Ms Oum confirmed that some of the TNA's had raised concerns that staff in some areas would not allow them to undertake specific tasks and that they were risk averse to the role. Mrs Pascall identified that work was ongoing with the current teams to resolve this and help them understand how the TNA role could support the ward.

Mr Khan asked for an update on the work to incorporate new roles into theatres. Mrs Pascall confirmed that an apprenticeship group had been

agreed through Staffordshire University and a skills assessment was being undertaken. It was hoped that this programme would commence in March 2019.

Professor Beale acknowledged that further communication work was required in relation to the role and that the job description was being adapted for the Trust. It was agreed that a further update on the communication plan for Registered Nurses and placement of TNA's would be provided to the committee in September **LP Sep 18**

Resolution
The Committee received and noted the presentation on the Role of the Trainee Nursing Associate.

69/18 Performance & Quality Report

Mr Khan presented the performance & quality report and the following points were noted:

- There had been no C. Diff cases reported in June 2018
- The HSMR had reduced
- There was a reduction in the number of falls
- Re-admission rates remained higher than trajectory

Ms Oum raised concerns in relation to safeguarding training compliance. Ms Blackwell confirmed that there had been significant improvements over the last few months and the target for level 1 and 3 Adult and Children Safeguarding and Level 2 Adult Safeguarding had been achieved at the end of June 2018. Further work was being done to achieve the 85% target for Level 2 Children's training and the team were visiting the wards to encourage staff to complete the training. This was also being picked up at the monthly divisional performance review meetings to help drive the accountability. Ms Davies also highlighted that work was required to strengthen the Trust's HR policies to ensure staff were held responsible for not completing training and ensuring this was reflected during the revalidation process.

Mrs Baines queried what actions were being taken to address the poor performance in relation to readmission rates and EDS. Mr Khan recognised that there was further action that could be taken in relation to readmission rates and confirmed that each care group would be reviewing their readmissions as part of an audit and actions to improve would be agreed. He agreed to provide a report on this in the next 2 months. It was noted that the main area of concern for completion of EDS was out of hours due to the lack of medical staff. This had been covered by an additional junior doctor previously; however, this had been ceased due to financial constraints. Members agreed that it would be useful to see performance using an SPC approach so that a decline **AK Sep 18**

in performance could be recognised. It was confirmed that the Trust were working with NHS Improvement and the Performance team to present data differently moving forward.

Ms Oum highlighted that the C-section rate had increased this month, however, it was confirmed that this was within the normal variation. Concerns were also raised regarding the lack of responses to the FFT in maternity. Ms Blackwell confirmed that the SMS service had been stopped therefore responses had reduced. The department would be using iPads in future to ask patients to complete the survey before discharge.

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

70/18 Progress Update on the Emergency Care Improvement Programme

Mr Thomas-Hands provided an update on the Emergency Improvement Programme and the Winter Plan and it was noted that the implementation of Red to Green and Safer would commence on 1st August in line with Royal College guidance. The recent workshop on the frailty assessment pathways was outlined and the teams had been asked to implement this in the next 2 weeks. There was a discussion about the pressures which meant that closure of beds was difficult as part of the Financial Recovery Plan. Ms Davies highlighted that there would be a Quality Impact Assessment (QIA) completed as part of the Financial Recovery Plan and some schemes would require an enhanced QIA. It was acknowledged that the process for reviewing QIA's would need to be strengthened and members confirmed that these had not been reviewed previously by the committee.

It was agreed that the process for reviewing QIA's would be presented to the next committee meeting along with the schemes within the Financial Recovery Plan that required an enhanced QiA to ensure the balance between quality impacts and financial impacts were correct. **JD Aug 18**

Mr Thomas-Hands apologised that a report had not been shared for this item and agreed to circulate the summary that had been provided to the A&E Delivery Board. **PTH**

Resolution
The Committee received the update on the Emergency Care Improvement Programme.

71/18 Update on the Patient Care Improvement Programme and Regulatory Breaches

Ms Blackwell presented the report on the Patient Care Improvement Programme and the following points were noted:

- There were risks around consistently achieving the safeguarding training, VTE assessments and the issues around documentation
- An outcomes workshop was planned on 4th September 2018
- The multi-professional quality audits were 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
- Check and challenge sessions were being scheduled with the Care Groups in relation to the self-assessments they had undertaken as part of the CQC prep work

Mrs Baines queried how the self-assessment process had been monitored to ensure that the assessment had been reflective of the services. Ms Blackwell confirmed that the executive team had attended a session led by the Improvement Consultant with the divisions and care groups to complete their self-assessment. It was acknowledged that some areas had been over critical when completing this and further work was being done to support the teams to recognise good practice and areas for improvements. There was some communication work being done to empower staff to talk about the positive practice in place in their areas and the Learning from Excellence approach was being taken.

Resolution

The Update on the Patient Care Improvement Programme and Regulatory Breaches was received and noted by the Committee.

72/18 Equipment Replacement Programme

Mr Khan presented the equipment replacement programme which had been achieved within the current financial constraints. The following points were noted:

- The programme had prioritised some equipment that must be replaced due to changes in guidance
- Due to the financial implications, there was a proposal for leasing some equipment requiring replacement in radiology
- The list had been agreed with the Divisions and Care Group teams
- The programme had taken into consideration services that may be provided through partnership working

Mrs Baines highlighted that the report had been difficult to understand, particularly as she was a new member to the committee and had not

been involved in previous discussions.

It was noted that with the exception of the lease for radiology equipment, the list presented would be covered by the current budget for equipment replacement, therefore formal approval would not be required. Mr Khan confirmed that following the transfer of Pathology services to the Black Country Pathology Service, the equipment would continue to be managed by the Trust until the next financial year.

Resolution
The Committee received and noted the report on the Equipment Replacement Programme.

73/18 WMQRS Radiology Action Plan

The Committee received the WMQRS Radiology Action Plan and the main areas for noting were:

- The review had identified a gap in medical staffing in radiology. A business case had been presented to the Performance, Finance & Investment Committee to increase the radiology workforce. This had been approved as a priority for 2018/19.
- Actions had been agreed to address the infection control issues highlighted during the review.

Resolution
The WMQRS Radiology Action Plan was received and noted by the Committee.

74/18 Risk Management Committee Information & Escalation Report

Ms Blackwell presented the Risk Management Committee Information and Escalation report and the following points were highlighted:

- 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 was a discussion about the proposal to have a Patient Safety Committee reporting into the Quality & Safety Committee. Ms Davies highlighted that the Risk Management Committee currently oversees risk management, incident reporting and serious incidents and a review of this had been requested by the Chief Executive. This had identified that there was a need for a Patient Safety Committee to ensure incidents were being reviewed robustly and actions were agreed and monitored. The proposal would be discussed further with the Chair and Chief Executive. Mrs Harris highlighted that the committee should also focus on patient experience and link with the Patient Experience Committee.

It was recognised that there were some outstanding actions from previous serious incidents that had been open for some time. It was noted that the process for closing down investigations was not robust and would need strengthening. There was also some work to be done to improve the quality of actions agreed as part of the RCA process. It was agreed that more focus would be put on closing down actions as soon as possible.

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

75/18 Monthly Nursing & Midwifery Quality & Staffing Report

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

- Fill rates remained above the 90% target and were 96.72% in June 2018
- Care Hours per Patient Day had improved slightly to 7.4 but remained below the national median
- The daily acuity tool was now in use alongside the risk assessment
- 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

Mrs Harris asked how staff had responded to the use of the acuity tool. Ms Blackwell confirmed that the staff were familiar with the acuity tool and this was now being completed as part of their morning handover. An electronic solution had been provided to make it as easy as possible.

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

76/18 Mortality Report

Mr Khan presented the Mortality Report and the following points were noted:

- HSMR for the year remained high, although positioned well regionally. Areas highlighted included fluid electrolyte balance.
- Mortality reviews were not being achieved in all specialities and it was noted that a report was being developed in relation to the recruitment of a medical examiner as per national guidance. The

possibility of partnership working in relation to this would be explored.

Resolution
The Committee received and noted the Mortality report

77/18 Presentation from the Division of Medicine & Long Term Conditions

The Chair welcomed the Medicine & Long Term Conditions Divisional team to the meeting and a presentation was provided. The following points were noted:

- An update on the self-assessment for the CQC was provided and actions being taken in relation to outstanding PCIP items. Improvements had been sustained in the medicine care group which had been seen as a result of the deanery review.
- There had been improvements in relation to observations recorded on Vital Pac which were now above 90%
- The risk register items were shared and there was a discussion about the risk in relation to inaccurate clinical coding in ED due to the IT infrastructure – this was being mitigated by staff scanning the documentation and there was a plan included in the EPR work to resolve the IT issues.
- There was work ongoing to build on the improvements within the division since the CQC inspection including end PJ paralysis, open visiting, activity sessions on MFFD/Elderly care ward, embedding the new Trust values
- The recent video produced as part of the Enhanced Care Collaborative work with NHS Improvement and awarded best video was shared. The 4 week improvement programme led on the modular block had resulted in a significant reduction in complaints and no sitters had been required during this time. Further work would be done with the Mental Health team to roll this out across other wards.
- Areas of ongoing concern included staff recruitment, pressure ulcers on heels and the Emergency Department environment

Professor Beale highlighted that staff attitude and communication were often mentioned in the FFT results and complaints and asked how the communication clinics would help to improve this. Mrs Lear confirmed that the clinic would offer a specific time for relatives to see the nursing or medical staff to ask any questions. Open visiting would also support with this as clinicians would be accessible. There was a more detailed discussion about open visiting and it was agreed that the views of the staff on the ward would be taken into consideration when agreeing ward open times and before piloting open visiting. It was agreed that there would need to be a balance and privacy and dignity would need to be

taken into consideration. Mrs Lear confirmed that staff engagement sessions were also taking place with the matrons and junior doctors to share complaints and FFT responses and actions were agreed as part of those.

Mr Rashid talked about some of the work the division were doing to reduce admissions including implementation of Safer and Red to Green and partnership working to reduce the number of A&E attendances. There was also work to be done to ensure the staff in the Emergency Department had alternative services that patients could be directed to.

Mr Khan asked how the issues with medical recruitment in the division were being addressed. It was noted that this was being reviewed specifically for individual services to identify what could be done differently e.g. changing skill mix, utilising specialist nurses, changing job plans to attract staff, partnership working.

Ms Davies commended the division on the ownership she had seen throughout all levels of staff and the governance arrangements that were in place.

Ms Oum asked about the understanding of the "Walsall Together" partnership for staff in the Division. Although the pathways were being agreed, it was noted that engagement with the clinical teams needed strengthening so they were able to understand their part in this.

Committee members thanked the division for their presentation and asked that feedback be shared with the teams.

Resolution
The Divisional presentation was received and noted by the Committee.

78/18 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 2nd August 2018:

- The process for Quality Impact Assessments needed to be reviewed for consideration at the next Quality Committee
- The discussion in relation to maximising the opportunity for clinical engagement of staff in relation to the Walsall Together Programme
- The positive highlights from the Medicine divisional presentation

79/18 Any Other Business

There was no other business.

90/18 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.

91/18 Date & Time of Next Meeting

Thursday 30th August 2018, 9:00am
Room 10, MLCC