

**MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN
PUBLIC ON THURSDAY 4 OCTOBER 2018 AT 10.00 A.M.
IN THE LECTURE SUITE, MLCC, MANOR HOSPITAL, WALSALL**

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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 6 September 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	Chief Executive	ENC 7	11.15
10. Safe Nurse Staffing Levels	Information	Director of Nursing	ENC 8	11.25
11. Establishment Review Medicine	Information	Director of Nursing	ENC 9	11.35
12. Establishment Review Surgery & Medicine	Information	Director of Nursing	ENC 10	11.45
BREAK – TEA/COFFEE PROVIDED				
RESOURCES				
13. Integrated Performance Report	Discussion	Chief Operating Officer	ENC 11	12.05
PARTNERS				
14. Partnership update	Information	Director of	ENC 12	12.20

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
			Strategy & Improvement		
GOVERNANCE AND COMPLIANCE					
15.	Standing Financial Instructions, Standing Orders, Scheme of Delegation	Approval	Director of Governance	ENC 13	12.30
16.	Board Committee review of terms of reference	Approval	Director of Governance	ENC 14	12.40
17.	Brexit Assurance	Information	Director of Strategy & Improvement	ENC 15	12.50
18.	STP - ICS roadmap and STP governance	Information	Chief Executive	ENC 16	13.00
19.	Quality and Safety Committee Highlight Report and Minutes	Information	Committee Chair	ENC 17	13.10
20.	Performance, Finance & Investment Committee Highlight Report & Minutes	Information	Committee Chair	ENC 18	13.15
21.	Audit Committee Highlight Report & Minutes	Information	Committee Chair	ENC 19	13.20
22.	QUESTIONS FROM THE PUBLIC				
23.	DATE OF NEXT MEETING Public meeting on Thursday 1 November 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 – 4 OCTOBER 2018			
Declarations of Interest			AGENDA ITEM: 3
Report Author and Job Title:	Jackie White Interim Trust Secretary	Responsible Director:	Danielle Oum
Action Required	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input type="checkbox"/> Assure <input checked="" type="checkbox"/>		
Executive Summary	<p>The report presents a Register of Directors' interests to reflect the interests of the Trust Board members.</p> <p>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.</p>		
Recommendation	<p>Members of the Trust Board are asked to:</p> <p>Note the report</p>		
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 <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		



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.
Miss Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy Ltd Chattered Institute of Personnel (CIPD)

Report Author: Jackie White, Interim Trust Secretary

Date of report: 18 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 6TH SEPTEMBER 2018 AT 10:00 a.m. IN THE LECTURE SUITE, MANOR
LEARNING & CONFERENCE CENTRE, MANOR HOSPITAL, WALSALL**

Present:

Ms D Oum	Chair of the Board of Directors
Mr J Dunn	Non-Executive Director
Mr S Heer	Non-Executive Director
Mrs V Harris	Non-Executive Director
Professor R Beale	Non-Executive Director
Mr P Gayle	Non-Executive Director
Mr R Beeken	Chief Executive
Mr A Khan	Medical Director
Dr K Dunderdale	Director of Nursing
Mr P Thomas-Hands	Chief Operating Officer
Mr R Caldicott	Director of Finance

In Attendance:

Mrs A Baines	Associate Non-Executive Director
Mr D Fradgley	Director of Strategy & Improvement
Ms J Davies	Director of Governance
Mrs J White	Interim Trust Secretary
Miss J Wells	Senior Executive PA (Minutes)

Members of the Public 0
Members of Staff 4
Members of the Press / Media 0
Observers 2

110/18 Patient Story

Mrs Gregory attended the meeting along with her daughter and granddaughter to share the story of her late mother Mrs Pritchard's care. Mrs Gregory listed some examples of the care received;

- Mrs Pritchard's clothing was lost and not located during a ward move.
- She was discharged home but readmitted by ambulance the following day which resulted in 15 hours spent in A&E.
- The family did not feel like they were getting answers to their questions from staff.
- A conversation took place with a doctor on Thursday, giving the impression that Mrs Pritchard was recovering well, though she quickly deteriorated and passed away on Monday.
- Mrs Gregory requested that she spend the night with her mother on Sunday as she knew she was unwell. Though she was able to stay, her brother was not as it was a female only ward.

- Mrs Pritchard had an issue with swallowing tablets, therefore Mrs Gregory asked whether the medication was available in a liquid form. The response from nursing staff was unhelpful and unsatisfactory.
- Mrs Gregory carried out much of her mother's care by herself with family members, such as turning her, encouraging her to eat and giving her medication.
- Doctor's bedside manner and compassion was appalling when delivering the news that Mrs Pritchard was end of life.
- The Doctor advised the family that Mrs Pritchard would be moved to a private room for end of life care, however the Nurses advised there would be a wait. Mrs Gregory closed the curtains whilst in the shared bay in order to retain privacy, however nursing staff asked them not to do this.
- Mrs Gregory had promised her mother that she would move and care for her at her own home for her end of life care. The family were advised that the Palliative Care Team would liaise with them. The family never met with the team due to being outside of the catchment area.
- Mrs Gregory's daughter attended the hospital on the Monday to visit Mrs Pritchard and knew straight away that she was not well at all, though nurses stated that she was ok. Mrs Gregory was called by her daughter to attend the hospital and arrived 20 minutes before her mother passed away.
- Prior to Mrs Pritchard's death, a Nurse had entered the room to advise that there were too many people round the bed, until she realised how sick Mrs Pritchard was.
- Mrs Pritchard's notes had been lost and to date had not been located.
- The family felt that there was not enough staff on duty during weekends which they felt impacted upon patient care.

Mrs Gregory advised that she could not understand what had happened between the Doctor advising her that her mother was recovering then days later was told that Mrs Pritchard was end of life. Meetings had been held with PALS and the notes were requested but had been lost. Mrs Gregory explained that she blamed herself for accepting what the nursing team and doctors had told her and she needed to know what went wrong.

Mrs Gregory added that her mother had been admitted to the hospital a number of times and could not fault the care however on this occasion it failed her mother.

Ms Oum offered her condolences and apologised for the distress caused which fell short of what was expected by the Trust. Ms Oum appreciated the family attending to share their experience which was important for members to hear in order to take forward lessons learned.

Dr Dunderdale thanked the family for sharing their story, which was difficult to hear. It appeared that staff tried to do the right thing but failed in their execution. Dr Dunderdale advised that Mrs Gregory's brother should have been allowed to stay with his mother overnight during end of life care and would take the matter forward with teams.

Dr Dunderdale expressed concern that nursing staff did not display compassion and kindness, nor looking at Mrs Pritchard as an individual and apologised for the unacceptable issues encountered.

Dr Dunderdale added that it was her fifth week in post as the Director of Nursing and had identified that there were development needs within nurse staffing and working towards the Trust values. The family were asked whether they would like to work with Dr Dunderdale to help to develop a nursing strategy, their support would be welcomed.

Mrs Gregory gave praise to Matron Emma Harper who was really thoughtful and compassionate. Emma had been recently appointed but Mrs Gregory trusted that she would make improvements. Mrs Gregory added that she hoped that the notes would be located in order for her to obtain closure.

Mr Khan apologised for the failings in care and acknowledged the importance of getting end of life care right. Mr Khan also recognised the need to sit and explain things properly to patient's relatives, stating that he would work with the teams to reiterate this message.

Mr Khan advised that efforts had been made to locate the notes and this would be followed up.

Ms Oum recognised a theme in elements of the story, advising that a previous patient's relative had been assisting with the development of nursing team training around end of life experiences.

Mr Fradgley reinforced the need for updated record management by investing in new technology in order to track files properly or moving to electronic records. Work in that area was underway and would be a significant step forward.

111/18 Apologies for Absence

Apologies were noted from Mrs P Furnival, Associate Non-Executive Director and Mr A Yates, Associate Non-Executive Director.

It was noted that there was no Human Resources representative. Catherine Griffiths, Director of People and Culture commences post on 10th September.

Ms Oum announced that it was Mr Khan's last Trust Board meeting as the Medical Director, thanking him for his work done within the role.

112/18 Declarations of Interest

Dr Dunderdale's had been received and would be included at the next meeting.

113/18 Minutes of the Board Meeting Held in Public on 2nd August 2018

The Board approved the minutes of the meeting held on the 2nd August 2018 as an accurate record.

114/18 Matters Arising and Action Sheet

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

101/18 – Freedom to Speak up Guardians Report – A meeting has been arranged for 24th September 2018.

Resolution

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

115/18 Chair's Report

Ms Oum presented the report which was taken as read.

Resolution

The Board received and noted the Chair's report.

116/18 Chief Executive's Report

Mr Beeken presented the report and highlighted the following key points;

- Item 3.1 detailed the mock inspection undertaken by Enable East which was critical in order to review processes. Feedback had now been received and overall compassionate care centred around individuals was observed, though issues had been identified. Work had started on changing the approach to capacity management and patient flow with a revised plan. Actions with regard to environment, particularly to the Emergency Department were being made.
- The delivery of fundamentals of care would only be complete when individuals paid focus on their own professionalism.
- The Walsall Together full business case was likely to be considered at Trust Board in December.

Ms Oum commended Mr Beeken and Dr Dunderdale with the transparency of outlining key objectives within the report.

Mr Fradgley advised that in relation to the Walsall Together work, KPMG were doing a specific piece of work with all boards individually during development sessions.

Mrs Baines asked whether any feedback from the summer roadshows and Mr Beeken replied that the key objective was to have an in depth conversation with all staff groups in regard to how they could contribute to the delivery of the four priorities. There had been an impressive spread of staff attendance and results would be cross referenced with the pulse check survey. Initial feedback received related largely to the day to day frustrations of administrative processes and narrowing the gap between senior management and front line staff, linking to the visibility of senior managers.

Professor Beale referring to the Enable East feedback stated that the review was disappointing. Care was not consistent, reiterating that the Trust was a people organisation. There was also a failing to communicate person to person, with both families and patients. This strategy was down to staff to deliver. More effort and action needed to be injected. Mr Beeken agreed that more time should be focused on these issues.

Mr Gayle referenced safeguarding and that there still appeared to be inconsistencies of staff understanding. He also commented on the way in which the Trust prepared for inspections and reviews and felt that this did not offer an opportunity to embed change and queried how that could be changed.

Ms Oum responded that all were in agreement of the changes that needed to be made and to focus on the people and work done in the values launch and behaviours framework which was key to sustainability.

Mr Thomas-Hands advised that there were staff that had gone above and beyond expectation, giving examples of porting staff and a consultant who had demonstrated their commitment.

Resolution

The Board received and noted the content of the report.

117/18 Monthly Nursing and Midwifery Safer Staffing Report

Dr Dunderdale presented the revised report, advising that it would continue to be refined to include narrative, actions and further analysis of triangulated data from the dashboards.

The report had been reviewed at the Quality and Safety committee where positive feedback had been received.

In addition, further resource had been identified for 6 months to assist with the nursing workforce agenda. Dr Dunderdale advised that she had agreed with Mr Dunn that he would provide confirm and challenge to that work stream. Establishment reviews were underway and would be reported to the board 6 monthly.

Ms Oum observed that resources were required from all teams and queried whether any assistance was required. Dr Dunderdale replied that it was imperative that there was absolute engagement at ward level which wasn't currently being seen. Current resources had to support staff. Governance needed to be supported and processes would be reported back through the Quality and Safety Committee.

Mr Heer welcomed the renewed report and requested that key points be outlined for board members.

Mr Caldicott advised that he and Dr Dunderdale were working on a baseline and realigning performance metrics with reporting models.

Resolution

The Board received and noted the content of the report.

118/18 CQC Preparedness Update

Mr Beeken presented the update that included current performance against regulatory notices, outcome of the recent unannounced inspection into maternity services and preparation for the new elements of CQC including Well Led and Use of Resources.

The following key points were highlighted;

- The Trust needed to consistently improve the percentage of staff trained and audit of practice.
- Pleasing results had been seen within maternity which was no longer rated inadequate, though there was disappointment that the CQC would not adjust their public facing website to reflect the outcome. This would be communicated to the public.

Ms Oum was disappointed to hear that the technical aspects of the CQC website did not reflect the changes. It was important to commend the maternity team for their hard work, particularly; Nicola Wenlock, James Davies and Fateh Ghazal. Sue Holden, Improvement Director also worked closely with and supported the team.

Ms Oum added that DOLs was a priority and expressed concern that progress was not fast enough.

Ms Oum asked for an update in relation to the audit of the completion of patient records.

Mr Khan replied that the audit was complete and a report would be presented at the next Medical Records Committee.

Suzie Loader, Improvement Consultant was invited to join the Board discussion and advised that steps had been taken to include multidisciplinary teams in decisions and education. Workshops were being undertaken on CQC outcomes which

reviewed the impact that actions had on change and outcomes. Weekly CQC preparation meetings were taking place.

Ms Loader added that there was also a monthly Quality Assurance Outcomes meeting held with Dr Dunderdale to review patient care improvement plans, ensuring that the actions were delivering the outcomes. Focus was on combining education with a stronger approach to accountability.

Mrs Baines queried what the Board could do to help and support. Ms Loader replied that divisions had been asked to present what actions they were taking to improve fundamental patient care and to report any issues.

Resolution

The Board received and noted the content of the report.

119/18 Well Led Action Plan

Mr Beeken advised that the Well Led standard was a new part of how an organisation was assessed.

The board was required to agree the methodology used for the self-assessment and to ratify the action plan.

The following key points were highlighted:

- Early phases of the new values and behaviours framework had been successful so far.
- The West Midlands Leadership Academy would be utilised to undertake a diagnostic of the personal development of senior leaders.
- Ms Davies was leading the governance review. Feedback would be provided at the Trust Board meeting in October.
- Financial and service planning could be improved upon – the Performance, Finance and Investment Committee would oversee the planning process for 19/20 to scrutinise and ensure robustness.

Mr Dunn stated that the action plan was comprehensive and hugely ambitious, particularly in relation to timescales, the amount of work required and the implementation. Mr Dunn queried whether the Trust had the resource and capacity to complete the work within the timeframe.

Mr Beeken agreed that the plan was ambitious, but recognised that the Trust was starting from a low point. Mr Beeken believed that the Trust had the capacity to delivery but not the capability at the moment. Current processes and systems were inadequate.

Ms Loader recognised that there were a number of gaps in the self-assessment. Involvement and delivery dates had been sought from all Executives.

Mr Heer advised that he would like to see a more aggressive timetable and added that the challenge would be with embedding within the Trust.

Ms Oum asked board members if they accepted the assessment with the pace that could be achieved without any slippage.

The Well Led Action Plan was approved.

Resolution

The Board:

- **Received and noted the content of the report.**
- **Approved the Well Led Action Plan**

120/18 Pulse Check

Mr Beeken gave a verbal update and advised members that the survey was far more user friendly and more popular than the national staff survey. The following key points were highlighted;

- A good response rate had been received with 51.4% of staff having completed it which equated to over 2000 members of staff and thanked colleagues for taking part.
- An overview of the results had been shared in the Trust Daily Dose communication and analysis sent to the Teams of Three and Care Groups. Detail had also been shared at the summer road shows and in a communications plan with key themes included in the staff engagement action plan.
- Particular focus was paid on the departments that started low and had shown improvement, such as Orthopaedics and Audiology.
- 3 questions scored low compared to others:
 - Day to day issues and frustrations in relation to systems and processes.
 - Quality of environment and speed of resolve.
 - Communication between senior management and front line staff.
- It was noted that the outcomes were similar issues nationally. Consideration should be given to:
 - A specific Executive visibility plan. Increasing the drop in session approach and increased unannounced visits to departments.
 - Clinical staff did not routinely read the Daily Dose communication.
 - Staff wanted to see accountability. Poor performers were not being tackled.
 - Bridging the gap between board members and front line staff by increased visibility at Trust events and good practice and performance against Trust values.
 - Change of the Trust Ball to an annual staff awards evening.

Mr Gayle suggested the use of an app for staff to download in order to receive key messages. Mr Gayle added that Ms Oum had encouraged visibility of board members and queried whether

weekend visits to ward and departments could be an approach. Mr Beeken agreed the approach if it were realistic and better suited for board members.

Mr Fradgley advised that an app was being designed. Digital media boards within wards could also be utilised.

Resolution

The Board received and noted the content of the report.

121/18 Integrated Performance Report

Mr Caldicott presented a refreshed, condensed version of the report which included trajectories. Integration and trends would be added to provide further clarity.

Partnerships

Mr Fradgley advised that this was the first time partnerships had been included in the performance report and that a number of indicators had been pulled through from other areas. However future reports would include monthly frailty numbers and Social Care contacts and referrals to mental health.

Ms Oum thanked Mr Fradgley for the revised report, reminding members that the locality teams had been operating in their current configuration for a year. She added that being able to track the impact through partners was helpful.

Professor Beale observed that the format was clearer and referred members to the Rapid Response non-success rate. Mr Fradgley replied that Rapid Response stopped 92% responses consistently and that the percentage of patients seen within 2 hours, was currently reported at 80-85%.

Mr Dunn asked for additional metrics to be included in this section relating to the volume of activity, response times and impact from a quality and cost perspective.

Mr Fradgley confirmed that quality measures could be included and reiterated that a large part of the hospital was the community and was glad to be sharing their progress.

Mrs Harris queried the tracking of mental health and Mr Fradgley replied that 15 areas were tracking long term conditions but none included mental health, though mental health teams had been committed throughout the journey. There was a robust model in place however and work was underway within the partnership to improve.

Mrs Baines asked whether it was possible to obtain data from partners that impacted upon the Trust, such as the social care impact for knowledge purposes and Mr Fradgley replied that he would liaise with the project group.

DF

Quality and Safety Committee

Dr Dunderdale stated that the committee had noted a month on month improvement in the percentage of patients who achieved their chosen place of death.

The Trust however continued to report mixed sex accommodation breaches, an increase in admission rates and concerns regarding the electronic discharge summaries.

The report outlined the C Difficile figures, electronic discharge summaries and C-section rates.

Mr Heer asked how the Trust learned from incidents and reviewed trends, stressing the importance of having sight of incidents on a timely basis and obtaining assurance of actions being taken.

Dr Dunderdale advised that this was considered by the Care Group and Divisional Quality Boards along with the Quality & Safety Committee, however an exception report could be provided for the board, plotting trends and utilising data through SPC charting.

Performance, Finance & Investment Committee

Mr Thomas-Hands provided an update of Operations, highlighting the following key points:

- The Trust had appointed a substantial Respiratory Physician.
- Mental Health ED attendance had recently risen.
- There were high attendance numbers and a rise in length of stay.
- The whole escalation process was being reviewed involving multidisciplinary teams.
- A&E Acute teams were utilising AMU to stop patients waiting in ED unnecessarily.
- Winter preparation was well underway and focus was on improving upon elderly hospital admissions. A presentation would be given at Trust Management Board the following week.
- RTT continued to improve.
- Cancer performance had been consistently good with the exception of April.
- Links with community were much stronger than previously.

Mr Dunn advised that focus remained on ED 4 hour performance, temporary workforce costs and the current run rate.

Mr Beeken observed that there was a delay in discharge of medically fit patients, adding that there had to be a 25% reduction of stranded patients by winter.

Mr Thomas-Hands replied that the numbers were being monitored and further analysis and detail would be included in the Performance, Finance and Investment Committee report.

Mr Caldicott highlighted the following key points in relation to finance;

- The Trust deficit was currently £8m. There was an unfavourable variance of £0.9m.

- The Trust had adopted a financial recovery plan.
- Temporary workforce remained a concern with significant costs above historic trends reaching a total of £2.1m. Two deep dives were taking place during the month in an effort to understand why the figures were not decreasing.
- There was a risk to run rate and improvements needed to be made.

Mr Khan referenced the temporary staffing costs, advising that there were a number of vacancies within the Trust which should have assisted in offsetting the costs.

Professor Beale expressed concern that he felt not enough action was being taken to tackle the deficit.

Mr Beeken replied that there was an issue with productivity but was resisting taking dramatic action on expenditure which was unplanned that would impact upon safety. Dr Dunderdale was reviewing the nursing establishment baseline and there were more vacancies than the previous year.

Mr Khan stated that the model hospital data did not highlight that the Trust was an outlier compared to its peers.

Ms Oum asked for benchmarking and the model hospital to feature as a topic at a Board Development session.

**Board
Development**

People and Organisation Development Committee

Mr Beeken advised that there had been an improvement in the completion of mandatory training and PDRs.

Sickness performance figures were high in comparison to other Trusts. Trust policies were in order however there was no assurance that the policies were being applied. Human Resources needed to support to line managers to ensure they were getting the right level of advice and support.

Resolution

The Board received and noted the content of the report.

122/18 Partnership update

Mr Fradgley presented the update to be taken as read, but updated that Walsall together workshops were progressing at pace.

Ms Oum asked for understanding of the link back to the sustainability of services for children in Walsall.

Resolution

The Board received and noted the content of the report.

123/18 Risk Appetite

Ms Davies advised members that feedback from the Board Development workshop on risk had been incorporated into the new statements on Risk Appetite.

Mr Beeken stated that the statements needed to be further refined before the Board could approve them and that the Executive Lead in conjunction with the appropriate Committee review the statements.

JW/JD

The Board received and noted the content of the report.

124/18 Board Assurance Framework and Corporate Risk Register

Ms Davies presented the draft Board Assurance Framework which had been developed. It was noted that lead Committee will review the principal risks identified and consider the range of assurances received as to the effectiveness of 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 will review 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

Ms Davies also advised members that she was undertaking a review of the risk management processes from the top to bottom of the organisation

Ms Oum was pleased with the structured process and the whole approach to identifying and managing risk. The board had to be assured of the risks and how they were being managed. Ms Oum asked for consideration at committees prior to the December Trust Board.

Mr Heer observed that the BAF risks identified were rather generic. Risks seen during the meeting today related to people, finance, attitude, staff engagement and sustainability of services. Risks did not appear to be tracked on an objective basis.

Mr Beeken advised that the Trust needed to manage risk through the risk register and regular review of mitigation of scores, ensuring the framework was mandated. Regular discussions need to take place regarding whether risks were mitigated.

Ms Oum asked each committee to review their section of the BAF during October. The Audit Committee would then complete a review in November prior to December Trust Board.

Resolution

The Board:

- **Received and noted the content of the report.**
- **Agreed each committee would review their risks during October prior to Board review in December.**

125/18 Annual objectives update

Mr Fradgley presented the update which had been reviewed by the Executive Team and at Committee meetings.

There had been greater alignment with the Integrated Performance Report which was being monitored monthly, though the paper reviewed by board members would be presented quarterly.

It was recognised that quality and safety scope and measures needed to be revised.

Mr Heer did not think the report was necessary in addition to the performance report.

Mr Beeken responded that board members often requested assurance that the annual plan was being delivered.

Mr Dunn advised that he would like to review the report quarterly as a commitment had been made to the plan.

Ms Oum endorsed a quarterly review in order to understand how monthly performance aggregates to what the Trust had said it would deliver.

Resolution

The Board:

- **Received and noted the content of the report.**
- **Agreed a quarterly review at Trust Board.**

126/18 Strategy Committee Terms Of Reference

Ms Oum advised that further work needed to be undertaken with input from board members. The paper would come back to Trust Board at a later date for review.

Resolution

The Board noted the paper would be reviewed at a later date.

127/18 Emergency Preparedness, Resilience and Response

Mr Thomas-Hands reported that following a self-assessment and peer review, the Trust was partially compliant.

An action plan was generated with a view to reach full compliance by the end of September 2018.

Resolution

The Board received and noted the content of the report.

128/18 Quality and Safety Committee Highlight Report and Minutes

Mrs Harris advised that she chaired the meeting held in August. A number of points had already been discussed but highlighted the remaining key points;

- Discussion had taken place in relation to assurance of the quality aspects of decisions made.
- The committee noted the improvement maternity colleagues had made to the service.

- Team members from Women's and Children's provided a presentation where the levels of improvement made were applauded.

Ms Oum advised that the committee would review the process and QIs with regard to the quality impact assessment. Ms Oum added that Mr Dunn had been invited to the committee to review the enhanced QIAs associated with the financial recovery plan therefore they must be available at the next meeting.

Q&S

Resolution

The Board received and noted the content of the report.

129/18 Performance, Finance & Investment Committee Highlight Report & Minutes

Mr Dunn provided a verbal update as the meeting was not quorate nor could the previous minutes be approved. The members present reviewed the performance and finance situation with key action points.

Mr Dunn reiterated the importance of quoracy as approvals could not be made without sufficient members present. The terms of reference would be reviewed in order to agree emergency action.

PFIC

Resolution

The Board received the verbal update.

130/18 People & Organisational Development Committee Highlight Report & Minutes

Mr Gayle provided a verbal update, advising that no report was available due to the timing of the departure of the Interim Human Resources Director. The following key points were highlighted;

- Workforce KPIs were discussed. There were concerns that Junior Doctors were not included within that data therefore it was important to monitor compliance on a regular basis.
- Clarification on the figures around bank staff and reporting had been requested.
- A breakdown of compliance of mandatory training had been requested to understand any trends that needed to be addressed.
- Agency spend and retention was discussed and were to consider retention initiatives in order to retain good staff.
- No representative attended the meeting to report on the Consultant Vacancy Update paper submitted.
- The committee had asked for a review of the Consultant vacancy review process. To minimise delays, the committee requested the consideration of other lay members, to make the process more meaningful and focused on values.
- Charter for SAS doctors was discussed. Opportunities to be discussed with Mr Khan.

- Quality Academy work was reported to the committee. Members were extremely impressed with the progress made to date.
- Concern was raised in relation to the number of Executive attendee's attendance. Nominated deputies were to attend.

Mr Beeken agreed that the Trust had poor retention. Lack of professional development was a factor. Catherine Griffiths would commence work on a workforce strategy once in post. Mr Beeken added that the recruitment process redesign needed to include the new values and reminded Executives of the importance of attendance at the committee.

Resolution

The Board received and noted the content of the report.

131/18 Questions from the Public

Mr Cliff Lemord, Unison Representative reminded members that a number of staff who Unison represented were off sick with long term conditions and to be mindful of the individual person behind the sickness figure.

Mr Lemord referenced finance and the need to get back in balance but being mindful about possible cuts being made.

Mr Beeken replied that long term sickness causes were always clearly documented. Focus of sickness was largely based on short term sickness patterns which blighted departments already in difficulty.



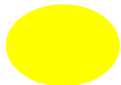
132/18 Date of Next Meeting

The next meeting of the Trust Board held in public would be on Thursday 4th October 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.


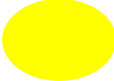


PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
035/18 Performance & Quality Report	Ms Blackwell to liaise with Mrs Furnival regarding the offer of assistance in relation to multi-agency training.	Acting Director or Nursing	02/08/2018	Update Ms Blackwell and Mrs Furnival have a meeting in place to agree this action	
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 took place on the 24 th September. A number of actions were agreed and will be taken forward by the Director of People and Culture	
121/18 Integrated Performance Report	Mr Fradgley to liaise with the project group in regard to obtaining data from partners that impacted upon the Trust, such as the social care impact for knowledge purposes.	Director or Strategy & Improvement	01/11/2018		
122/18 Partnership Update	Ms Oum asked for understanding of the link back to the sustainability of services for children in Walsall.	Director or Strategy & Improvement	01/11/2018		
123/18 Risk Appetite	Statements needed to be further refined by Executive Leads prior to Board approval	Trust Secretary/ Director of Governance		The Risk Appetite statement are currently under review by each of the Board Sub committees and will be presented to the Board in November 2018.	

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
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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 – 4 th October 2018		
Chair's Report	AGENDA ITEM: 6	
Report Author and Job Title:	Danielle Oum, Chair Responsible Director: Danielle Oum, Chair	
Action Required	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>	
Executive Summary	<p>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.</p> <p>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.</p> <p>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.</p>	
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 <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>
	Partners <input checked="" type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>
	Resources <input checked="" type="checkbox"/>	

Chair's Update



PRIORITY OBJECTIVES FOR 2018/19**1. Continue our journey on patient safety and clinical quality through a comprehensive improvement programme**

I had the pleasure of opening the new MRI Scanner and attended the official opening of the Walsall Child Development Centre's Sensory Room.

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

A refreshed advert for a Clinical Non-Executive Director has been published.

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

A Board to Board meeting was held with colleagues from the CCG to discuss Walsall Together, safety and quality, Urgent Care Centre and acute hospital sustainability.

Meetings attended / services visited

Library & Knowledge Services

Equality Diversity and Inclusion Manager

One to one meetings with Executive Directors

Objective setting and appraisals with Non-Executive Directors

Beyond the Conversation – Equality & Diversity in the NHS

Regional Talent Board

RECOMMENDATIONS

The Board are asked to note the report

Danielle Oum

October 2018

MEETING OF THE PUBLIC TRUST BOARD – 4 th October 2018			
Chief Executive's report			AGENDA ITEM: 7
Report Author and Job Title:	Richard Beeken, Chief Executive Jackie White, Interim Trust Secretary	Responsible Director:	Chief Executive
Action Required	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/> (select the relevant action required)		
Executive Summary	<p>The report provides a brief summary of the key events and issues I have been involved in within the last month, set against our four key priorities for the year.</p> <p>Appendix 1 sets out the guidance, expectations and reports published by regulators and other arms length bodies, during the past month.</p>		
Recommendation	<p>Members of the Trust Board are asked to:</p> <ul style="list-style-type: none"> • Note the content of the report • Discuss any prospective implications for the Trust arising from its content 		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no immediate or direct risk implications associated with this report.		
Resource implications	There are short term resource implications associated with resolving over the medium to long term, the financial run rate issues associated with temporary medical staffing.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		



1. PURPOSE OF REPORT

The purpose of the report is to inform the Board of the key issues and events which I have been involved in over the past month, set against the four key priorities of the Trust for this financial year. Appendix 1 also sets out all the guidance, expectations and reports received from arms length bodies during the month of September, to which we must respond. The lead executive director is named for each.

2. DETAILS

2.1 Quality improvement

I noted the content of the CQC report into the emergency department of our neighbouring Trust, The Dudley Group FT, with some concern. At my request, our CQC preparation steering group received a thorough presentation from our Clinical Director of Emergency Medicine, which provided assurance to us against many of the issues raised by the CQC. The Quality Committee can expect further assurance in due course, when the results of the WMQRS review into the care of the deteriorating patient in our ED, is received. That review took place on 25th and 26th September.

Our internal clinical senate, a regular forum made up of clinical directors, matrons and professional leads, met this month to discuss the implications for them of the Walsall Together programme. The members also helpfully agreed to review, critique and where necessary, amend, the Trust's winter plan, at an extraordinary meeting to be convened in October.

Since being placed in special measures in 2015, we have received the input of the intensive support programme for maternity services, driven by NHS Improvement. This week, their midwifery lead informed the Director of Nursing and myself, that we were being withdrawn from that programme by virtue of the progress made by the service on all of the original safety and quality concerns highlighted by the CQC in 2015.

On 26th September, I attended the NHSI Learning from Improvement event for special measures Trusts, held in London. I was pleased to have attended the event with our Director of Nursing and our incoming Medical Director, Dr Matthew Lewis. Key learning from the event was that all of the Trusts who have made the successful transition from inadequate to good and beyond, focused on cultural change, a reduction in the transactional approach to performance management and the introduction of meaningful clinical leadership.

2.2 Financial health

The September Performance and Finance Executive meeting highlighted our deep concern that the financial recovery plan was not taking hold, most notably in the arena of temporary nursing and temporary medical staffing expenditure.

Whilst I am confident that the Director of Nursing and Finance Director have a robust set of actions which will bring nursing expenditure in to line, I do not share that confidence on the issue of medical workforce. A detailed assessment of capacity available and capacity required, not just at consultant level, is needed and we await NHS Improvement's approval of our business case for the external support we deem necessary to introduce a similarly robust approach here, as we are starting see in the management of the nursing establishment requirements.

2.3 Culture and clinical leadership

This month I have had productive meetings with both the OD team assisting our maternity service to develop its multi-professional working culture, as well as with Mr Manjit Obhari. Mr Obhari was the Medical Director tasked with cultural turnaround at Mid Staffordshire FT, following the Robert Francis Report. He has also been the Chief Executive at one of the most challenged Trusts in the country. I am pleased that we will be securing his services to assist our new Medical Director in developing medical engagement, at our Trust.

This month, I opened the West Midlands Leadership Academy programme on triumvirate leadership team development, in Birmingham. Three of our multi-professional leadership teams are on the programme, along with teams from other acute, specialist and mental health Trusts in the region. I have agreed to remain as executive sponsor for the programme.

This month, I attended an enjoyable meeting of the Walsall NHS retirement fellowship, celebrating 70 years of the NHS. Our Consultant Paediatrician, Professor Ghatrad, opened the event with an enjoyable and thought provoking summary of his 40 years in the NHS.

2.4 Clinical Strategy and collaboration

This month, we held a productive and constructive 'Board to Board' meeting with our colleagues from Walsall CCG. A well managed event, it avoided the pitfalls of detailed performance management but instead focused strategically, on our shared objectives around the development of integrated care in Walsall and the Walsall Together programme.

I attended the Health Overview and Scrutiny Committee of the council in September, to outline the excellent progress our teams have made with regard to outpatient efficiency and waiting time reduction. I also shared the methodology but not the interim results of, our acute service sustainability review process.

On 8th September, I presented an award at the Dudley and Walsall Mental Health Trust staff awards evening, held at Dudley Zoo and Castle. The planning for our own staff awards evening, to be held on 16th November, is progressing well. The nominations have been made against 12 different categories. Board colleagues are encouraged to attend this important event, which this year, will be entirely devoted to celebrating individual staff and team achievement, using our new Trust values as criteria of success.

3. RECOMMENDATIONS

The Trust Board are asked to note the content of this report and discuss any prospective implications for the Trust arising from its content.

APPENDICES

New national guidance, reports and consultations (Appendix 1)

NEW NATIONAL GUIDANCE, REPORTS AND CONSULTATIONS

The following guidance and policy actions, which have been received from the wider regulatory and policy system during September, 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
	<p>Regulatory approach to subsidiary companies NHSI will be consulting on a new regulatory approach to establishing subsidiary companies this in October and following the consultation will issue new guidance.</p>	Action	CEO
	<p><i>Leadership for improvement — board development programme</i> This free of charge programme will help NHS provider boards develop the knowledge and skills you need to lead and embed quality improvement at an organisational level. It will be delivered between January 2019 and March 2020.</p>	Information	Director of People & Culture / Director of Strategy & Improvement
	<p><i>Help prevent Never Events</i> NHSI have published two new patient safety resources to help understand the challenges faced and actions being taken by organisations to improve the safety of invasive procedures with the potential for Never Events to occur. The first identifies key contributory factors and actions taken from a sample of investigations into surgical Never Events that occurred in 2016/17. The second is a summary of responses from providers to a questionnaire to assess the current level of implementation of the National Surgical Standards for Invasive Procedures (NatSSIPs).</p>	Information	Director of Nursing & Director of Governance
	<p><i>Obtaining funds through section 106 and community infrastructure levy</i> You can secure revenue and capital to support services and sites when these are directly impacted by a local development such as housing growth. While section 106 and</p>	Information	Director of Finance & Performance

	<p>community infrastructure levy (CIL) funds have been available for some time, many trusts are not optimising their chances of accessing them by working closely with their local planning authority (LPA) and council members.</p> <p>NHSI's guide explains what s106 and CIL are and what you need to do to engage with your LPA, as well giving contact points for advice.</p>		
	<p>NHS volunteer services: submit your expression of interest</p> <p>The Chair of NHS England, Sir Malcolm Grant, has called for health organisations to renew their commitment to volunteering and announced additional funding for the NHS volunteering organisation HelpForce to increase the number of effective volunteer roles in the NHS.</p> <p>If your trust has an existing volunteer service, or if you have an idea for a new volunteer service, please <u>submit an expression of interest</u>. 10 selected trusts will each receive a £75,000 grant for up to 18 months to develop these ideas with support from HelpForce.</p>	Action	Director of People & Culture
	<p><i>Performance of the NHS provider sector for quarter 1 2018/19</i></p> <p>NHSI have published their quarterly analysis of performance data. The start of the financial year saw frontline staff cope with record A&E attendances, high bed occupancy levels and improved discharge rates.</p> <p>The sector ended the quarter £814 million in deficit, which is £22 million better than planned at the beginning of the year but £78 million worse than the same quarter last year.</p> <p>This is the first year the 'underlying deficit' of the provider sector is included in the report, reported as £4.3 billion. It's also the first time the report contains mental health data and shows that mental health trusts have exceeded the standard for early intervention in psychosis.</p>	Information	Director of Finance & Performance
	<p><i>Learning from last winter to plan for 2018/19</i></p> <p>NHS I have reviewed NHS performance during the 2017/18 winter period to help better understand the issues and pressure the service dealt with on a daily basis, and to identify measures the NHS should take to manage increased demand this winter period.</p>	Information	COO

	<p>Apply for funding to develop local non-executive community networks NHSI have partnered with NHS Clinical Commissioners (NHSCCs) and NHS England to support the development of local networks of lay members and trust non-executive directors.</p>	Action	Director of Governance / Chair
	<p>How clinicians are using patient-level costing information to improve patient care Clinicians have a very important role to play in patient-level costing (PLICS). NHSI have been working with clinicians and costing teams across the country to understand how clinical and costing teams can work together more effectively. In our new series of videos, clinicians share their experience of costing – how they got involved, why it remains important to improve the quality of the data, and how they have used costing information to make decisions about patient care.</p>	Information	Director of Nursing / Medical Director
	<p>National workforce recruitment campaign: marketing toolkit for trusts As part of the national recruitment campaign '<u>We Are The NHS</u>', NHS England has produced a campaign toolkit for trusts to use in their local recruitment marketing activities. This toolkit includes still images, logos and poster templates, along with social media templates.</p>	Information	Director of Strategy & Improvement
	<p>Talk Health and Care digital platform: share your views Secretary of State Matt Hancock has this week launched a new DHSC digital platform called <u>Talk Health and Care</u>, which can be used by staff to quickly and easily to post ideas, questions and challenges for government. The Secretary of State has named workforce as one of his early priorities and wants to make sure that the expertise and views of those who work in the NHS and adult social care are heard. NHSI welcome this move, as listening to staff and showing that NHSI value them, is a vital enabler as NHSI consider the long-term NHS workforce plans.</p>	Information	Director of Strategy & Improvement
	<p>Launch of the Mental Health at Work gateway <u>Mental Health at Work</u>, developed by mental health charity Mind with the backing of The</p>	Information	Director of People & Culture

	<p>Royal Foundation, has been launched. This new online gateway brings together resources, training and information to help any organisation, including NHS trusts, support the mental health needs of their workforce.</p> <p>Mental health is one of the pillars of the <u>NHS Health and Wellbeing Framework</u>, launched in May by NHS England, NHS Improvement and NHS Employers.</p>		
	<p>Patient and public involvement in revalidation</p> <p>The Academy of Medical Royal Colleges is undertaking a UK-wide survey to update their <u>December 2017 report on patient and public involvement in revalidation</u> — recognising the important contribution it can make to revalidation processes and to encourage organisations to increase the opportunities for lay involvement at national, regional and local level.</p>	Information	Medical Director
	<p><i>Contribute your ideas, experiences and insights to the long-term plan for the NHS</i></p> <p>the NHS is working on a plan setting out its ambitions for improvement over the next decade, and plans to meet them over the five years of the new funding settlement.</p> <p>This month, NHSI are looking to help stimulate ideas and understand views across three key themes – life stage, clinical priorities and enablers of improvement. Each covers several different areas which NHSI believe have the greatest potential to deliver improvements to the way the NHS provides care.</p> <p>Through a <u>new discussion guide and online form</u> NHSI provide an overview of some of the key challenges and a series of questions to answer. Please submit your response by 30 September.</p>	Information	Director of Strategy & Improvement
	<p><i>Model Hospital trust ambassadors programme relaunch</i></p> <p>This week NHSI relaunched the Model Hospital trust ambassadors programme. You can benefit from previews and learning opportunities, help shape and influence the Model Hospital, and be a champion within your trust.</p> <p>To sign up to the programme please email nhsi.modelhospital@nhs.net.</p>	Information	Director of Finance & Performance

	<p>Words Save Lives campaign This Organ Donation Week, (3-9 September) NHS Blood and Transplant is asking people to talk about organ donation with their families. You can help support Organ Donation Week in the following ways:</p> <ul style="list-style-type: none"> • use the campaign press release • share content online from @NHSOrganDonor • display campaign materials in your trust • support Organ Donation Week events in your trust or organise your own • share your donation decision with your loved ones and ask them if they want to be a donor <p>A range of Words Save Lives campaign materials are <u>available to download</u>— you will find a range of videos, digital assets and social media posts.</p>	Information	Director of Strategy & Improvement
	<p>New impact report on falls and fragility fractures <u>The report</u> explores how NICE guidance has been implemented by the healthcare system and what progress has been made to improve outcomes for those at risk of falls and fragility fractures. This is the fourth in a series of impact reports which review how NICE recommendations have been used in priority areas of the health and care system. These impact reports are based on data from national audits, reports, survey and indicator frameworks that show the uptake of the guidance and quality statement measures. Professor Gillian Leng, NICE’s Deputy Chief Executive and Director of Health and Social Care recently <u>shared her thoughts</u> about the report.</p>	Information	Director of Nursing
	<p>Call to participate in a Delphi study on asepsis and aseptic technique The RCN is undertaking a programme of work on asepsis and aseptic technique because of the recent <u>Glove Awareness Week</u> pilot. A Delphi study will start this month to support a better understanding of current challenges in practice and the RCN are inviting directors and deputy directors of nursing to participate and share with their nursing teams.</p>	Information	Director of Nursing

	<p><i>Complaints handling — a reminder</i></p> <p>NHSI recently had several MPs express concern about patient complaints that only seemed to be taken seriously when a local MP became involved.</p> <p>NHSI want to remind all trusts that you should approach your complaints handling the same, no matter who raises the concern, in line with the <u>Local Authority Social Services and National Health Service Complaints (England) Regulations 2009</u>.</p>	Information	CEO

TRUST BOARD – 4 th OCTOBER 2018			
Monthly Nurse Staffing Report- August 2018 data			AGENDA ITEM: 8
Report Author and Job Title:	Kara Blackwell Deputy Director of Nursing	Responsible Director:	Dr Karen Dunderdale Director of Nursing
Action Required	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input type="checkbox"/> Assure <input type="checkbox"/>		
Executive Summary	<p>This report outlines the monthly nurse staffing for August 2018. The report continues to be refined to include further data, narrative, actions being taken, analysis around triggers related to staffing and triangulated data from the Nursing and Midwifery dashboard as this develops further.</p> <p>The average fill rate for registered nurses in August 2018 was 95.1% for day shifts and 94.6% for nights shifts in comparison to July 2018 when it was 95.8% for days and 96.2% on nights; the shift fill rates decreased in August for RNs on both days and nights. The fill rate for Care Support Workers (CSW) increased in August 2018 to 92.4% on day shifts and increased slightly on nights to 97.7% filled in comparison to July 2018 when it was 91.9% on day shifts and 97.5% on night shifts.</p> <p>The continued lower fill rates in August 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 RN fill rate on Ward 18 (HDU) and 19 (ITU) was due to sickness and no temporary staffing cover was required on nights due to ability to plan staffing against activity which maintained nationally recommended staffing levels. The RN shortage on nights on AMU was due to gaps in staffing that could not be filled by temporary staffing requests.</p> <p>This report presents CHPPD at ward level for August 2018 which is benchmarked with the latest Model Hospital data (last published for June 2018). This shows that our CHPPD in most ward areas are lower than those the Trust has been benchmarked against. Although this gives us information about how our CHPPD compare to other organisation, this data needs to be considered in conjunction with the comprehensive establishment review process currently being undertaken by the Director of Nursing. Going forward this will also be discussed at the monthly Nursing and Midwifery Advisory Forum.</p> <p>A total of 56 red flag events were reported by the wards in August 2018 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. This figure is higher than last month but is the first complete month of data collection.</p>		
Recommendation	The Trust Board is requested review and note		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	<p>BAF Objective No 5: Establish a substantive workforce that reduces our expenditure on agency staff.</p> <p>Corporate Risk No 11: Failure to assure safe nurse staffing levels.</p>		



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 <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>
	Resources <input checked="" type="checkbox"/>	

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 recognised 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 August 2018 was 95.1% for day shifts and 94.6% for nights shifts in comparison to July 2018 when it was 95.8% for days and 96.2% on nights; the shift fill rates decreased in August for RNs on both days and nights. The fill rate for Care Support Workers (CSW) increased in August 2018 to 92.4% on day shifts and increased slightly on nights to 97.7% filled in comparison to July 2018 when it was 91.9% on day shifts and 97.5% on night shifts.

Of the 20 areas reported on during August 2018:

- 2 areas recorded less than 90% shift fill rate on days for RN; Ward 16 and AMU
- None of the clinical areas had an RN fill rate below 80% on day shifts
- On nights 4 areas recorded less than 90% shift fill rate for RN; these were ward Ward 21 (Paeds), HDU/ITU and AMU.
- None of the clinical areas had an RN fill rate below 80% on night shifts

In line with the previous month, the lower fill rates on Ward 21 (Paeds) are 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 RN fill rate on Ward 18 (HDU) and 19 (ITU) was due to sickness and no temporary staffing cover was required due to the ability to plan staffing against activity whilst still maintaining nationally recommended levels of staffing for this area. The RN shortage on AMU was due to gaps in staffing which could not be filled by temporary staffing requests, during the day support was provided by the supervisory ward sister working clinically and at night the co-ordinator also took a cohort of patients to ensure safe care was maintained. The Divisional Directors of Nursing who are accountable for safe staffing in these areas have confirmed that there were no safety concerns regarding the low fill rate in the areas identified above.

The lower CSW fill rate on Ward 23 was due to sickness and no temporary staffing cover was required due to ability to move RNs between ward and day case activity to compensate.

Figure 1 below shows the RN fill rate has fluctuated on days with the lowest recorded in March 2018. For nights, the lowest RN fill was in November 2017.

The fill rate for RNs on days has been consistently above 90% for the last 12 months and this was maintained in August 2018. For nights there has been a consistent >90% fill rate on nights since January 2018. The fill rate for RNs on days declined for the third consecutive month in August 2018 and also declined on nights in August 2018 with fill rates of 95.1% and 94.6% respectively.

Figure 1

Figure 2

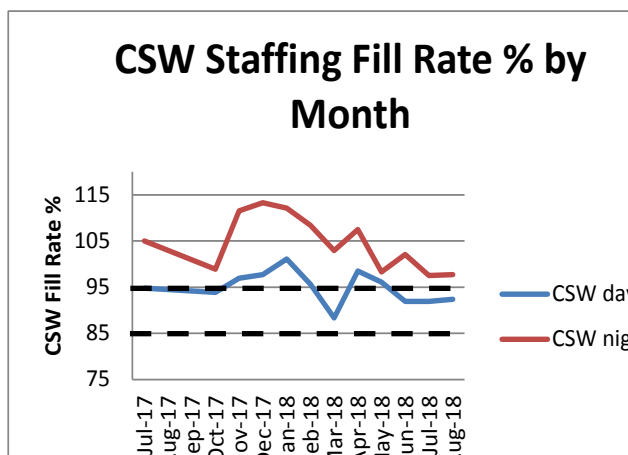
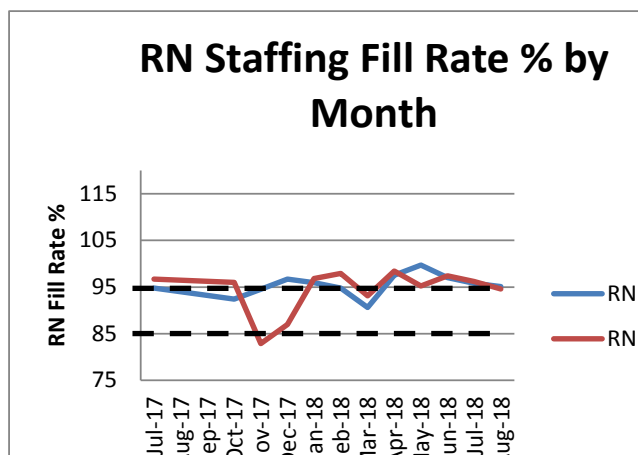
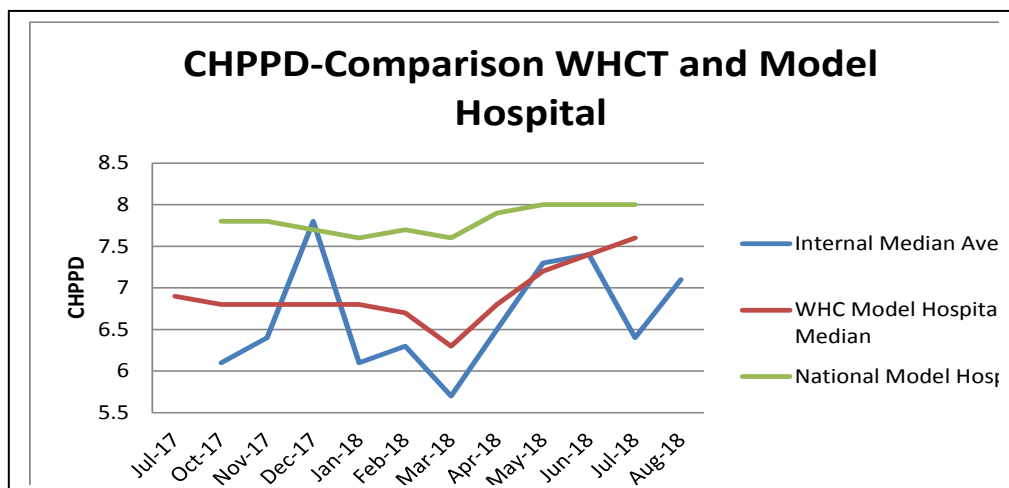


Figure 2 shows that the fill rate for CSWs on both days and nights has improved slightly but day shift fill remains below 95%. Some CSW shifts continue to be used to provide 1:1 specials for patients with mental health issues whose behaviour can be challenging and requires supervision particularly at night when rostered staffing levels are reduced.

3.0 Care Hours per Patient Day (CHPPD)

The Care Hours per Patient Day (CHPPD) 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. The Trust internal median improved to 7.1 CHPPD in August 2018, Model Hospital data for August 2018 was not available at time of writing report.

Figure 3:



The Median CHPPD by Division is shown in Table 1.

Table 1

August 2018	RN July 2018	RN August 2018	CSW July 2018	CSW August 2018	Total July 2018	Total August 2018
Medicine	2.7	2.9↑	3.0	2.8↓	5.3	5.5↑
Community (Stroke)	4.6	2.9↓	4.4	3.0↓	8.9	5.9↓
Surgery & Ward 23 (excluding SAU/HDU/ITU)	3.9	4.0↑	3.4	3.2↓	6.4	7.3↑
Children's/Paeds (excluding PAU)	7.5	10.95↑	0	0.85↑	7.5	11.8↑
Maternity	4.0	4.6↑	2.3	2.4↑	6.3	7.0↑

A comparison of the CHPPD by Division for 2018-2019 YTD are shown in Figure 4. These have remained consistent across Medicine and Maternity. In August 2018, within CYP Division, the fill rate on NNU was 100% throughout which contributes to the elevated CHPPD.

Figure 4

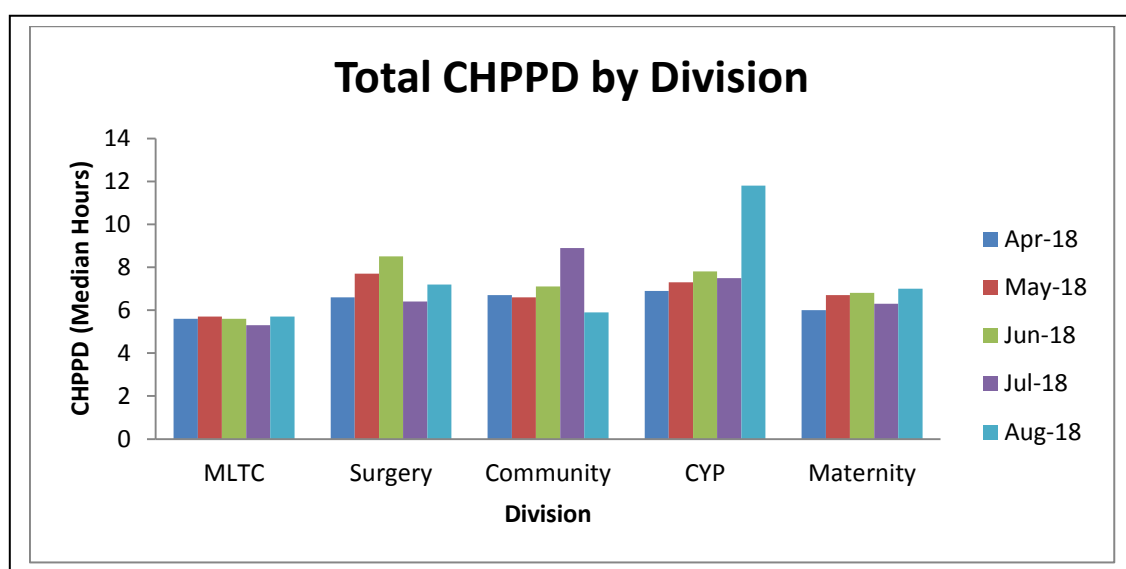


Table 2 includes the CHPPD data by ward at WHCT (August 2018) which has been mapped against national CHPPD for these specialities (taken from latest Model Hospital Data June 2018). The CHPPD totals are the combined qualified and unqualified CHPPD totals. Although this gives us information about how our CHPPD compare to other organisation benchmarked in the Model Hospital (July 2018), this data needs to be considered in conjunction with the comprehensive establishment review process currently being undertaken by the Director of Nursing. The CHPPD across all the clinical areas will be discussed with the senior nursing team at the monthly Nursing and Midwifery Advisory Forum.

Table 2

WARD	Total CHPPD (August 2018, internal data)	Comparison to National CHPPD	National CHPPD (Model Hospital published June 2018)
Ward 1	5.5	2.16↓	7.66
Ward 2	4.9	2.76↓	7.66
Ward 3	4.6	3.06↓	7.66
Ward 4	5.9	2.3↓	8.2
AMU	8	1.96↓	9.96
Ward 7	7	0.97↓	7.97
Ward 15	5.6	0.63↓	6.23
Ward 16	5.4	0.81↓	6.21
Ward 17	5.3	1.48↓	6.78
Ward 29	5.9	1.76↓	7.66
Ward 9	6.4	0.84↓	7.24
ASU	7.1	0.38↓	7.48
20A	7.3	0.06↑	7.24
20B	7.6	0.12↓	7.48
Ward 18 (HDU)	21.6		
Ward 19 (CCS)	28.5		
Ward 21 (Paeds)	9.5	3.16↓	12.66
Ward 23	7.8	0.73↓	8.53
Ward 24/25	7	7.97↓	14.97
Ward 28	14.1	0.87↓	14.97

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

Table 3 shows a review of those wards where the staffing fell below the 90% target for staffing fill rates. These have been 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):

Table 3

Ward	Hospital Acquired Pressure Ulcer	Falls	Serious Incidents	Complaints	FFT Score	Number of Staffing incidents	Any correlation between staffing and KPI dates?
AMU	1	1	2	3	80%	9	No
15	0	1	1	0	92.86%	1	No
16	1	0	1	0	90.32%	6	No
18	0	0	0	0	100%	0	No
19	0	0	0	0	100%	0	No
20b	0	0	0	0	100%	0	No
21	0	0	0	0	92.65%	0	No
23	0	0	0	0	99.15%	0	No
24/25	0	0	0	0	91.67%	0	No

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 August are currently going through the RCA investigation process.

All the staffing related incidents reported on the Trust Safeguard incident reporting system for August 2018 were reviewed to identify any correlation with patient harms. In total there were 50 ward 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 in Table 4 below:

Table 4

Ward	Number of staffing related incidents	Level of Impact	Any correlation to other reported incidents?
Ward 1	2	Low	No correlation
Ward 2	12	Low	5 falls incidents correlate with a low staffing report on the same days (3 separate dates).
Ward 4	10	Low	1 fall incident correlates with a low staffing report on the same day
AMU	9	Low	No correlation
Ward 7	1	Low	No correlation
SAU	2	Low	No correlation
Ward 9	2	Low	No correlation
Ward 15	1	Low	No correlation
Ward 16	6	Low	No correlation
Ward 18	1	Low	No correlation
Ward 19	1	Low	No correlation
Ward 20a	1	Low	No correlation
Ward 20b	1	Low	No correlation
Ward 23	1	Low	No correlation

On review of the reported staffing incidents in August 18, 4 of the reported staffing incidents correlated with days when a patient had a fall although these patients did not sustain significant harm. Low harm falls are reviewed in local RCAs held at ward level and overseen by Matrons. On reviewing the incidents there is no reference to staffing having contributed to the falls in the summary of the incident report following the local RCA.

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 56 red flag events in August 2018 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. This figure is higher than last month but is the first complete month of data collection.

A Nursing Metrics Review is currently being developed by the Director of Nursing to increase the oversight and narrative on standards of care. The outcomes of these reviews will inform this board report moving forward.

5.0 Update on Vacancies and Recruitment

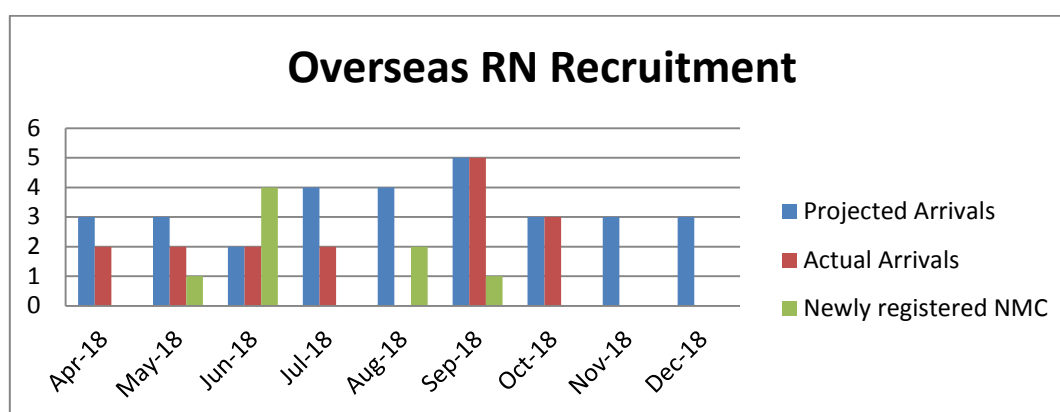
The vacancies in August 2018 have not changed from those reported in July 2018 although there are a planned 37 newly qualified RNs who have accepted RN posts in the Trust who are expected to start in September 2018. A total of 8 midwives are due to start in September 2018. The current vacancies and are outlined below (excluding theatres)

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

Recruitment initiatives continue to be undertaken with the following taking place in September 2018.

- There is a rolling advert for Band 5 RN posts in the Medicine and Surgical Division on NHS jobs
- Emergency Surgery recruitment day on 22nd September 2018
- A regional RN recruitment event took place on 18th September 2018 co-ordinated by the Professional Development Unit

Overseas recruitment continues. The target for recruitment is 30WTE for this financial year. Year to date 8 overseas nurses that have qualified as RNs in England and are now working as RNs on the wards.



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
- Note the current Trust performance in relation to local and national safe staffing KPIs
- Discuss the review of quality KPIs, reported staffing incidents and any correlation to deficits in staffing

7.0 CONCLUSIONS

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

The report needs to be considered alongside the nursing establishment review which has been undertaken by the Director of Nursing and will be presented to the Trust Board in October 2018.

Appendix – Fill rates Nursing, Midwifery and Care staff

Appendix – Fill rates Nursing, Midwifery and Care staff																							
Aug-18																							
Dept		Day				Night				CHHPD													
	RN/NMTE Vacancy rate %	Avg. fill rate - RN (%)	Avg. fill rate - care staff (%)	Avg. fill rate - RN (%)	Avg. fill rate - care staff (%)	Avg. fill rate - substantive RN (%)	Avg. fill rate - Substantive care staff (%)	Avg. fill rate - substantive RN (%)	Avg. fill rate - substantive care staff (%)	RN	Care Staff	Overall	Staffing Related Incidents	% safety thermometer harm free care	Falls (excluding no harm)	Pressure Ulcers grade 2	Pressure ulcer grade 3	Urinary/catheter/line/needle injury	CDIFF	MBSA	NUMBER OF DAYS WHERE RED FLAGS OCCURRED	COMPLAINTS	FFT (%)
Acute Surgical Unit	30.61%	90.6%	97.1%	95.5%	93.4%	70.88%	87.07%	46.61%	62.95%	3.7	3.4	7.1	0	94.74%	0	0	0	0	0	0	2	0	94.9%
Paediatric Assessment Unit	-3.50%	100.0%	93.2%	96.8%	95.7%	100.00%	79.63%	100.00%	75.28%	46.8	67.3	114.1	0	N/A	0	0	0	0	0	0	0	0	N/A
Ward 01	22.52%	100.2%	91.9%	95.7%	104.4%	79.78%	64.94%	60.67%	46.51%	2.3	3.1	5.5	2	79.41%	4	0	0	1	0	0	5	1	76.5%
Ward 02	-2.83%	92.7%	90.9%	96.1%	104.3%	86.30%	65.04%	60.44%	47.42%	2.3	2.6	4.9	12	76.47%	8	0	0	2	0	0	6	0	90.2%
Ward 03	18.66%	104.5%	102.0%	101.6%	105.7%	97.45%	62.81%	80.95%	78.33%	1.8	2.8	4.6	0	97.06%	2	0	0	0	0	0	4	3	88.7%
Ward 04	20.84%	98.0%	108.7%	100.0%	101.4%	74.67%	75.36%	67.74%	78.08%	2.9	3.0	5.9	10	75.00%	3	1	0	0	0	0	4	0	93.8%
Acute Medical Unit	15.88%	90.5%	86.5%	88.5%	92.8%	79.57%	75.02%	54.68%	71.45%	3.9	4.1	8.0	9	96.77%	1	1	0	0	0	0	10	3	80.0%
Ward 07	12.92%	92.8%	90.8%	96.8%	95.9%	89.88%	85.75%	88.89%	91.03%	3.5	3.4	7.0	1	100.00%	3	0	0	0	0	0	5	3	93.9%
Surgical Assessment Unit	22.34%	103.2%	124.0%	-	-	100.00%	100.00%			66.9	40.2	107.1	2	N/A	0	0	0	0	0	0	0	0	92.3%
Ward 09	15.05%	91.6%	90.7%	101.1%	99.4%	67.61%	79.19%	49.46%	43.51%	2.9	3.5	6.4	2	100.00%	1	0	0	1	0	0	2	0	94.4%
Ward 15	31.39%	94.6%	91.6%	95.7%	87.2%	80.17%	79.29%	33.71%	74.39%	2.7	2.8	5.6	1	100.00%	1	0	0	0	0	0	3	0	92.9%
Ward 16	25.16%	87.4%	82.5%	96.8%	111.3%	65.63%	75.43%	56.67%	65.22%	2.9	2.5	5.4	6	96.00%	0	1	0	0	1	0	5	0	90.3%
Ward 17	15.25%	90.3%	99.4%	97.5%	98.4%	81.24%	84.32%	56.02%	88.52%	3.0	2.3	5.3	0	96.00%	2	1	0	1	1	0	2	0	98.3%
Ward 18		91.8%	82.4%	81.3%	64.5%	90.82%	100.00%	97.62%	70.00%	18.5	3.1	21.6	1	100.00%	0	0	0	0	0	0	0	0	100.0%
Ward 19	3.43%	86.6%	-	82.5%	-	93.48%		94.46%		28.5	0.0	28.5	1	100.00%	0	0	0	0	0	0	0	0	100.0%
Ward 20A	1.02%	91.3%	98.5%	100.0%	100.0%	87.92%	66.19%	64.52%	41.94%	4.5	2.8	7.3	1	100.00%	0	0	0	0	0	0	1	0	100.0%
Ward 20B/20C	15.47%	93.9%	89.3%	101.1%	100.0%	78.86%	78.59%	58.38%	85.48%	4.2	3.4	7.6	1	80.95%	0	0	0	0	0	0	1	0	100.0%
Ward 21		96.8%	-	85.5%	-	94.17%		89.62%		9.5	0.0	9.5	0	100.00%	0	0	0	0	0	0	0	0	92.7%
Ward 23	4.99%	108.2%	78.2%	100.0%	96.8%	100.00%	79.37%	98.39%	90.00%	4.8	2.9	7.8	1	88.24%	0	0	0	0	0	0	0	0	99.2%
Wards 24/25	12.38%	122.1%	81.3%	107.8%	82.2%	98.84%	51.38%	94.70%	35.32%	4.6	2.4	7.0	0	100.00%	0	0	0	0	0	0	0	0	91.7%
Ward 28	13.27%	100.0%	100.0%	100.0%	100.0%	98.78%	88.89%	96.73%	100.00%	12.4	1.7	14.1	0	100.00%	0	0	0	0	0	0	0	0	N/A
Ward 29	23.72%	90.5%	96.3%	97.8%	125.8%	73.10%	72.38%	39.56%	58.41%	3.1	2.8	5.9	0	96.30%	7	1	0	0	0	0	6	1	93.8%
TOTAL FILL RATE		95.10%	92.40%	94.60%	97.70%	84.90%	75.29%	71.14%	65.48%														

Fill Rate	
> 90%	Green
> 80% < 90%	Yellow
Below < 80%	Red
> 115%	Blue

Safety Thermometer key	
Over	> 94%
Over	< 94%
Under	< 85%

FFT	
Over	> 96%
Below	< 96%

MEETING OF THE QUALITY & SAFETY COMMITTEE – 27 September 2018			
PUBLIC TRUST BOARD – 04 October 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 <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input type="checkbox"/> Assure <input type="checkbox"/> (select the relevant action required)		
Executive Summary	<p>This paper aims to update the Quality & Safety Committee / Board on the actions the trust has been taking over the past few months to improve the quality of care to patients, whilst simultaneously preparing the organization for the next CQC inspection.</p> <p>The paper outlines on-going concerns regarding PCIP compliance with:</p> <ul style="list-style-type: none"> • The standards of multi-professional documentation • Completion of the mental capacity section of the Do Not Resuscitate form <p>Appraisal rates for the first time have met trust targets.</p> <p>Feedback following the external peer review conducted by Enable East identified a number of areas of concern which need to be addressed urgently. These include;</p> <ul style="list-style-type: none"> • Lack of adherence to fundamental standards of care • Documentation & storage of medical records • Patient flow (not meeting 4hr standard), bed capacity issues & site / bed management meeting. • Difficulties in some areas reaching agreed staffing levels (Recruitment, retention & sickness rates) • Concern regarding content of safeguarding training – as a result an external review is being conducted at the beginning of October 2018 • Lack of mental capacity & / or DOLs assessment of some patients (DNACPR & consent for example) • Medication (documentation, administration, storage) • Poor environment (clutter, storage, estates issues (timely repairs), signage, monitoring of smoking policy etc.) <p>However, there were also areas of good practice noted, including:</p> <ul style="list-style-type: none"> • Strong visible leadership in some areas • Motivated staff (including ‘unsung hero’s) • Team culture of continuous improvement: hunger for development • Compliant with mandatory training & appraisals • ‘Learning from Excellence’ was a good system <p>Finally, the report identifies on-going work relating to ‘well-led’, ‘use of resources’ and CQC inspection preparation.</p>		

Recommendation	<p>Members of the Trust Board are asked to:</p> <ul style="list-style-type: none"> ○ 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 <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>
	Partners <input type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>
	Resources <input checked="" type="checkbox"/>	

CQC Preparedness Update

Purpose

1. This report aims to update the Quality & Safety Committee and Trust Board on work being undertaken to improve the quality and safety of care delivered to patients, whilst simultaneously preparing 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, feedback following the external peer review conducted by Enable East, followed by how the organisation is preparing the trust for the next CQC inspection.

Recommendations

3. The trust board are asked to:
 - o 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 were still gaps, which have been addressed at a trustwide outcomes work shop. The new outcomes agreed by trust staff (and ratified by the CQC Preparation Steering Group committee) are highlighted in yellow in appendices A & B.
7. Appendix A summarises compliance against the Regulatory & Must Do actions, which all now have outcomes associated with them. Areas of on-going concern relate to:
 - a. Completion of the MCA section of the DNARCPR form (68%, 1% drop from the previous month)
 - b. Standards of multi-professional documentation (Compliance approx. 30% September 18). Agreed 90% compliance against professional standards by end of December 2018. Each individual Division have discussed issues relating to fundamental standards of care and have identified a plan to achieve compliance against the plan within agreed timeframes.

8. Compared to last month, the trust remains compliant with 5 ½ of the 8 regulatory actions. However, there has been an overall improvement from July, with compliance being achieved for the first time in appraisals and 'risks are explained when consenting women for procedures' (full details in Appendix A). Of concern, remains compliance with documentation, and completion of the MCA assessment as part of the DNACPR form. The Divisional teams of three were asked to explain what plans they had put in place within their areas to address these fundamental standards of care – we expect to see improvements next month.
9. The same process has been adopted to demonstrate compliance against the Must Do's. Following the Trust-wide Outcomes Workshop, the trust now has outcomes associated with all the Must Do's which are highlighted in yellow in appendices A & B. 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, with staff appraisal rates now compliant and outpatients improving the Fracture Clinic environment.
10. 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 with work due to be completed by the end of September.
11. 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.

External Peer Review (Enable East)

12. The trust invited a 'not-for-profit' organisation, Enable East to conduct an external peer review against the CQC KLOE. The review was conducted over 4 days, with verbal feedback provided to members of the Trust Management Board on the 5th day. A full report will follow.
13. From a ratings perspective, the outcome of the review can be found in the 'Core Service Self-Assessment against the KLOE' section below.
14. Following the results of the review, it is clear that a number of urgent actions need to be taken to improve the quality of care / service provided in relation to:
 - a. Documentation & storage of medical records
 - b. Patient flow (not meeting 4hr standard), bed capacity issues & site / bed management meetings

- c. Difficulties in some areas reaching agreed staffing levels (Recruitment, retention & sickness rates)
- d. Concern regarding content of safeguarding training – as a result an external review is being conducted at the beginning of October 2018
- e. Lack of mental capacity & / or DOLs assessment of some patients (DNACPR & consent for example)
- f. Medication (documentation, administration, storage)
- g. Poor environment (clutter, storage, estates issues (timely repairs), signage, monitoring of smoking policy etc.)
- h. Infection control
- i. PAT testing of equipment
- j. Evidence of audit, but not always evidence of change as a result
- k. Profile of the Freedom to Speak Up Guardians
- l. Perception that staff have regarding Finance
- m. Need to be 'Brilliant at the Basics'

15. However, there were also areas of good practice noted:

- a. Strong visible leadership in some areas
- b. Motivated staff (including 'unsung hero's')
- c. Team culture of continuous improvement: hunger for development
- d. Compliant with mandatory training & appraisals
- e. 'Learning from Excellence' was a good system
- f. Innovating new approaches following patient feedback
- g. HSJ award around learning from incidents
- h. Community services

16. Divisions & Care Groups have been asked to consider the feedback given and with their staff, identify actions to enhance the quality and safety of care delivered. Additional actions identified will be added to the PCIP. Those areas which received positive feedback were to celebrate this with their staff.

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. Previous reports have outlined results of Care Group self-assessments against the KLOE. This has been taken one step further following the results of the external peer review conducted by Enable East. Below is a comparison between the ratified self-assessment and the outcome from the external review:

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

19. It is apparent that:

- a. Urgent & Emergency Services overestimated themselves on ‘Responsive’ and ‘Well-led’, whilst the remainder of the self-assessment was accurate. It is suggested the main reason for this is the *trust’s* continued failure to achieve the 4 hour target.
- b. The Medical Division overestimated themselves on ‘Safe’, ‘Caring’ & ‘Well-Led’. As a result they have put plans in place to ensure that their division focus’ on delivering fundamental standards of care.
- c. Surgery overestimated ‘Responsive’ & ‘Well-Led’ and have put plans in place to improve performance.
- d. Critical Care overestimated ‘Safe’, ‘Effective’ & ‘Well-Led’
- e. On a positive note, Gynae, Outpatients & Diagnostics had underestimated themselves, receiving ‘good’s’ across the board.

b) Monitoring of Fundamental Standards

20. 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 peer reviews will be piloted over the next 2-3 months on 3 ward areas, with the documentation peer review being rolled out across the trust – this commenced on the 15 August 2018 and is continually being evaluated.

21. Results are not yet available as a new reporting system (Power BI) is being developed into which the results will be placed. Once finished (end of September), the wards / departments, Care Groups & Divisions will be fed their results as soon as the audits are completed. It is then expected that these will be discussed at their regular governance meetings so that actions can be taken to improve and achievements celebrated. Where appropriate, the results will be incorporated into the monthly performance reviews (divisional & corporate).

Board self-assessment against the CQC Well-Led Framework

22. The September board ratified the well-led action plan which was developed following self-assessment against the well-led framework. 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

23. 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

24. 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.

25. Examples of issues which have been highlighted for additional action during the last month include:

- a. Improve the quality of multi-professional documentation – Divisional Teams of 3 were asked to identify how they were going to ensure there would be enhanced compliance with delivery of fundamental standards of care. Outcome metrics have been jointly agreed (see appendix A), so that staff know what is expected of them.
- b. Out of date policies and clinical guidelines – a task & finish group has been set up to progress this;
- c. Governance approval for small works (<£5K) has been revised with the aim of speeding up the approval process;
- d. ESR training data – accuracy of data is much improved, but there is still room for further improvement;
- e. Summarised position re compliance against the regulatory & must do actions;
- f. Medication safety – emphasis has been placed on addressing fundamental aspects of care .

26. Sharing of best practice continues at each meeting, with departments presenting practice which could be adopted in some or all other departments across the organisation. 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.

27. Staff engagement sessions have begun, with 2 workshops being run for managers responsible for arranging the individual ward/department engagement sessions. The aim of the individual sessions is to help prepare staff for the forthcoming inspection and include: what the CQC found; what the team have done to improve; what the team are proud of; top 3 risks & mitigations; a CQC quiz (designed by the individual teams) and a number of supporting pieces of information. The sessions are supported by a member of the executive team, deputy executive or member of the Quality Academy. In addition, from September onwards, monthly Quality Assurance meetings are being held with each of the Care Groups, jointly chaired by the Director of Nursing & the Medical

Director (supported by the Improvement Consultant) to monitor implementation of Care Group PCIPs and evidence of achievement.

28. Board development continues, with a number of sessions delivered over the past few weeks. These will continue for the foreseeable future.

Conclusion

29. It is clear that improvements have been made in some areas, but the external peer review identified a number of areas where urgent action is required in order to improve the quality and safety of care for patients. The Divisions & corporate departments are responsible for taking this forward within their Care Groups.

30. Work is on-going to enhance the quality of leadership within the organisation through the use of the well-led framework with staff preparation for the forthcoming inspection continuing. The aim for the actions outlined in this paper are designed to become sustained and embedded in every day practice, to ensure that the organisation moves from 'Requires Improvement' to 'Good'.

Appendices:

A: Progress Summary re Regulatory & Must Do Actions

A: Detailed update on Regulatory & Must Do Actions

B: C Section Rates – Maternity Services

Summary update regarding progress against Regulatory Actions:

Regulatory Issue	Trust Target	Update (June '18)	Update (July 18)	Update (Aug. 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%	95.08%
There were high levels of nursing staff vacancies across acute services. This meant the provider was not providing sufficient numbers of suitably qualified staff to keep patients safe	Trust target is aligned to the National vacancy rate of 10.66%	8.73% (run chart in ap. A)	13.06%	8.78%
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)	98.4% trailing compliance 68% (August 2018)
The critical care environment had only one isolation room. This provision was not meeting the needs of patients so was not	Revised SOP February 2018 New build October 2018.	SOP has been revised and audits undertaken to measure compliance.		

Regulatory Issue	Trust Target	Update (June '18)	Update (July 18)	Update (Aug. 18)
sufficient to maintain safe management of infectious patients.		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 30 th June 2018.	78.76% (Run chart ap. A)	83.6%	85.46%
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	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:	SG Paeds: L1: 98.67% L2: 85.37% (shd be the same as L3) L3: 92.08% SG Adults:

Regulatory Issue	Trust Target	Update (June '18)	Update (July 18)	Update (Aug. 18)
Intercollegiate document (2014).			L1: 99.92% L2: 87.04% L3: 89.64%	L1: 99.83% L2: 89.53% L3: 87.89% MCA: 98.49%
Staff were not consistently completing patient records . There were trust documentation that was not completed. Staff were not always on signing entries. There were a number of entries where there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times.	Secure accurate, complete contemporaneous records by 4 th March 2018. 90% compliance against professional standards by December 2018 Develop a work stream plan to address the physical condition of the paper records by 31 st March 2018	A new multiprofessional audit is in development (completion 31.07.18) which will be piloted alongside the other fundamental standards peer review audits commencing 15.08.18	Medical Documentation Audit scheduled for 24.08.18 & agreed that MD documentation audit to be piloted across the trust commencing 15.08.18	Audit conducted and results indicated approx. 30% compliance . Each Division have individually agreed a plan to improve compliance by December 2018
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 30 th June 2018. 'Mobile' notes implemented across community	Total Mobile note system implemented	Total Mobile note system implemented	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

Summary update regarding progress against Must Do Actions:

Issue	Must	Trust Target	Update June '18	Update July '18	Update Aug '18
Action plans are monitored and managed for serious incidents	Must	Zero outstanding by January 2019	See appendix A	See appendix A	See appendix A
Lessons are disseminated effectively to enable staff learning from serious incidents, incidents and complaints.	Must	100% of staff interviewed can share one example of a lesson learnt and action taken	See appendix A	See appendix A	See appendix A
Patient medical notes are kept secure at all times	Must	90% compliance against the trust policy by January 2019	Policy is being developed for implementation & audit	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	100% of relevant staff have undergone syringe driver equipment training 100% of relevant staff have undergone	80% compliance (Alaris PCAM)	Figures not available	Population which requires training currently unknown, but numbers of staff trained known. Meeting to

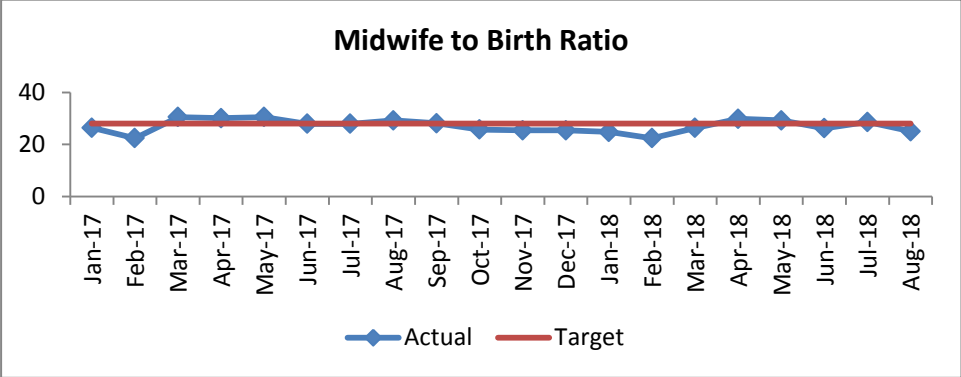
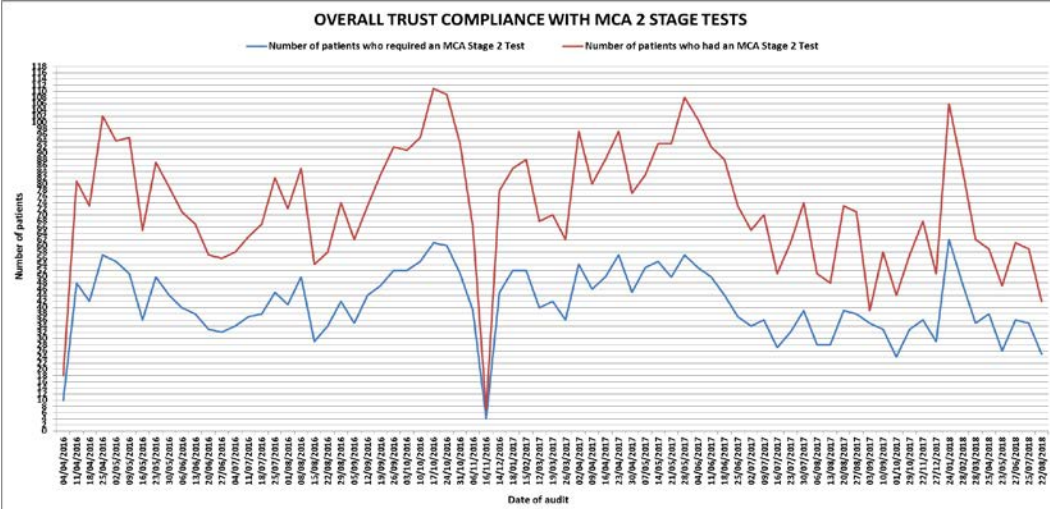
Issue	Must	Trust Target	Update June '18	Update July '18	Update Aug '18
		syringe driver competency training			agree way forward established
Staff follow best practice national guidance (NICE, CAS alerts, Royal College Guidance, local clinical guidelines etc.)	Must	Zero CAS alerts outstanding 100% Technology Appraisals, assessment & implementation within 90 days Zero Clinical Guidelines out of date by xxxx	2 CAS Alerts outstanding: Review of clinical guidelines	See Appendix A	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	SNCT & midwife: birth ratio in place 1:25
All staff receive an appraisal in line with local policy	Must	90%	83.41%	87.56%	90.04%
COMMUNITY FOR CHILDREN & YOUNG PEOPLE: Continue to follow standard operating procedures with medicines in special schools	Must	100%	100%	100%	100%
MATERNITY: Risks are explained when consenting women for procedures	Must	100%	Consent audit undertaken in 2017. Re-audit required	Re-audit being undertaken in August 2018	Achieved, CQC inspection report August 2018

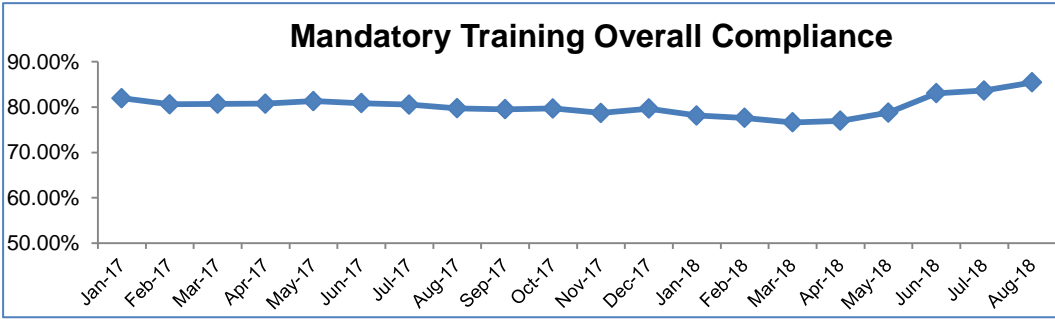
Issue	Must	Trust Target	Update June '18	Update July '18	Update Aug '18
ED: completes the action plan completed following the CQC inspection carried out in September 2015	Must	100%	Currently reviewing compliance	2 actions outstanding and being implemented	2 actions outstanding and being implemented
SAFEGUARDING: 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	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	August – 50% Trajectories Sept – 60% Oct – 80% Nov – 100%
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	100%		See appendix A for actions taken. Once evidence received can be altered to blue	See appendix A for actions taken. Once evidence received can be altered to blue

Update on Regulatory & MUST DO Actions (August 2018)

REGULATORY ACTION UPDATE:

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (August 2018)																																																															
<p>Thromboembolism assessments were not carried out for all patients at risk.</p>	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p>	<p>95% are assessed on admission March 2018.</p>	<div style="text-align: center;"> <p>VTE Risk Assessment</p> <table border="1" style="display: none;"> <caption>VTE Risk Assessment Data</caption> <thead> <tr> <th>Month</th> <th>Actual (%)</th> <th>Target (%)</th> </tr> </thead> <tbody> <tr><td>Jan-17</td><td>85</td><td>95</td></tr> <tr><td>Feb-17</td><td>82</td><td>95</td></tr> <tr><td>Mar-17</td><td>82</td><td>95</td></tr> <tr><td>Apr-17</td><td>80</td><td>95</td></tr> <tr><td>May-17</td><td>85</td><td>95</td></tr> <tr><td>Jun-17</td><td>82</td><td>95</td></tr> <tr><td>Jul-17</td><td>80</td><td>95</td></tr> <tr><td>Aug-17</td><td>85</td><td>95</td></tr> <tr><td>Sep-17</td><td>88</td><td>95</td></tr> <tr><td>Oct-17</td><td>88</td><td>95</td></tr> <tr><td>Nov-17</td><td>88</td><td>95</td></tr> <tr><td>Dec-17</td><td>90</td><td>95</td></tr> <tr><td>Jan-18</td><td>88</td><td>95</td></tr> <tr><td>Feb-18</td><td>90</td><td>95</td></tr> <tr><td>Mar-18</td><td>92</td><td>95</td></tr> <tr><td>Apr-18</td><td>92</td><td>95</td></tr> <tr><td>May-18</td><td>92</td><td>95</td></tr> <tr><td>Jun-18</td><td>92</td><td>95</td></tr> <tr><td>Jul-18</td><td>92</td><td>95</td></tr> <tr><td>Aug-18</td><td>92</td><td>95</td></tr> </tbody> </table> </div>	Month	Actual (%)	Target (%)	Jan-17	85	95	Feb-17	82	95	Mar-17	82	95	Apr-17	80	95	May-17	85	95	Jun-17	82	95	Jul-17	80	95	Aug-17	85	95	Sep-17	88	95	Oct-17	88	95	Nov-17	88	95	Dec-17	90	95	Jan-18	88	95	Feb-18	90	95	Mar-18	92	95	Apr-18	92	95	May-18	92	95	Jun-18	92	95	Jul-18	92	95	Aug-18	92	95
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<p>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</p>	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p>	<p>Trust target is aligned to the National vacancy rate of 10.66%</p>	<div style="text-align: center;"> <p>Nurse Staffing – 8.78%</p> <p>Qualified Nursing & Midwifery - Establishment Gap % (FTE)</p> <table border="1" style="display: none;"> <caption>Qualified Nursing & Midwifery - Establishment Gap % (FTE) Data</caption> <thead> <tr> <th>Month</th> <th>Actual (%)</th> <th>Target (%)</th> </tr> </thead> <tbody> <tr><td>Jan-17</td><td>12.00</td><td>8.78</td></tr> <tr><td>Feb-17</td><td>10.50</td><td>8.78</td></tr> <tr><td>Mar-17</td><td>10.00</td><td>8.78</td></tr> <tr><td>Apr-17</td><td>10.00</td><td>8.78</td></tr> <tr><td>May-17</td><td>9.75</td><td>8.78</td></tr> <tr><td>Jun-17</td><td>11.00</td><td>8.78</td></tr> <tr><td>Jul-17</td><td>10.00</td><td>8.78</td></tr> <tr><td>Aug-17</td><td>10.25</td><td>8.78</td></tr> <tr><td>Sep-17</td><td>10.00</td><td>8.78</td></tr> <tr><td>Oct-17</td><td>9.75</td><td>8.78</td></tr> <tr><td>Nov-17</td><td>9.00</td><td>8.78</td></tr> <tr><td>Dec-17</td><td>9.75</td><td>8.78</td></tr> <tr><td>Jan-18</td><td>10.00</td><td>8.78</td></tr> <tr><td>Feb-18</td><td>9.25</td><td>8.78</td></tr> <tr><td>Mar-18</td><td>7.75</td><td>8.78</td></tr> <tr><td>Apr-18</td><td>7.75</td><td>8.78</td></tr> <tr><td>May-18</td><td>8.75</td><td>8.78</td></tr> <tr><td>Jun-18</td><td>8.75</td><td>8.78</td></tr> <tr><td>Jul-18</td><td>13.00</td><td>8.78</td></tr> <tr><td>Aug-18</td><td>9.00</td><td>8.78</td></tr> </tbody> </table> </div>	Month	Actual (%)	Target (%)	Jan-17	12.00	8.78	Feb-17	10.50	8.78	Mar-17	10.00	8.78	Apr-17	10.00	8.78	May-17	9.75	8.78	Jun-17	11.00	8.78	Jul-17	10.00	8.78	Aug-17	10.25	8.78	Sep-17	10.00	8.78	Oct-17	9.75	8.78	Nov-17	9.00	8.78	Dec-17	9.75	8.78	Jan-18	10.00	8.78	Feb-18	9.25	8.78	Mar-18	7.75	8.78	Apr-18	7.75	8.78	May-18	8.75	8.78	Jun-18	8.75	8.78	Jul-18	13.00	8.78	Aug-18	9.00	8.78
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Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (August 2018)
			<p>Midwifery Staffing 1:25 (August 2018):</p> 
<p>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).</p>	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p>	<p>90% compliance with MCA training By March 2018</p> <p>Compliance with MCA when completing DNA CPR decisions by March 2018.</p>	<p>MCA Training compliance = 98.49%</p> <p>Compliance with completion of part 2 of the DNACPR form in relation to MCA = 68%</p> 

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (August 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.	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 30 th June 2018.	<p>August achievement; 85.46%</p>  <table border="1"> <caption>Mandatory Training Overall Compliance</caption> <thead> <tr> <th>Month</th> <th>Compliance (%)</th> </tr> </thead> <tbody> <tr><td>Jan-17</td><td>82.00</td></tr> <tr><td>Feb-17</td><td>80.00</td></tr> <tr><td>Mar-17</td><td>81.00</td></tr> <tr><td>Apr-17</td><td>81.00</td></tr> <tr><td>May-17</td><td>82.00</td></tr> <tr><td>Jun-17</td><td>81.00</td></tr> <tr><td>Jul-17</td><td>81.00</td></tr> <tr><td>Aug-17</td><td>80.00</td></tr> <tr><td>Sep-17</td><td>80.00</td></tr> <tr><td>Oct-17</td><td>80.00</td></tr> <tr><td>Nov-17</td><td>79.00</td></tr> <tr><td>Dec-17</td><td>80.00</td></tr> <tr><td>Jan-18</td><td>79.00</td></tr> <tr><td>Feb-18</td><td>78.00</td></tr> <tr><td>Mar-18</td><td>77.00</td></tr> <tr><td>Apr-18</td><td>78.00</td></tr> <tr><td>May-18</td><td>79.00</td></tr> <tr><td>Jun-18</td><td>83.00</td></tr> <tr><td>Jul-18</td><td>84.00</td></tr> <tr><td>Aug-18</td><td>85.46</td></tr> </tbody> </table>	Month	Compliance (%)	Jan-17	82.00	Feb-17	80.00	Mar-17	81.00	Apr-17	81.00	May-17	82.00	Jun-17	81.00	Jul-17	81.00	Aug-17	80.00	Sep-17	80.00	Oct-17	80.00	Nov-17	79.00	Dec-17	80.00	Jan-18	79.00	Feb-18	78.00	Mar-18	77.00	Apr-18	78.00	May-18	79.00	Jun-18	83.00	Jul-18	84.00	Aug-18	85.46
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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	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:																																										

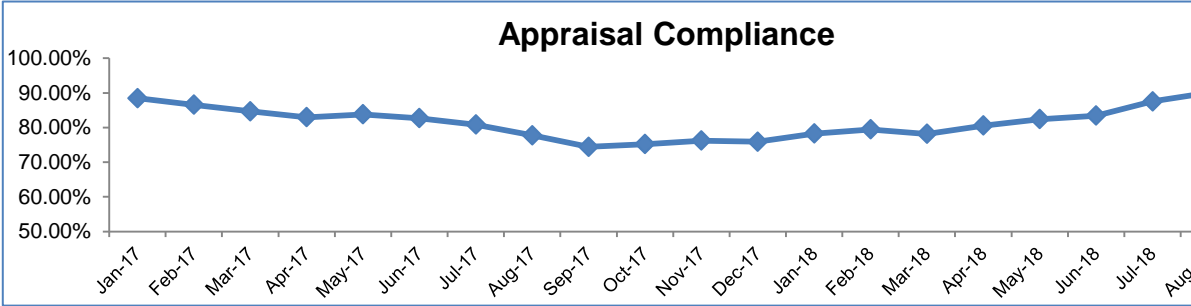
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<p>Staff were not consistently completing patient records. There were trust documentation that was not completed. Staff were not always signing entries. There were a number of entries where there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times.</p> <p>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</p>	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p>	<p>Secure accurate, complete contemporaneous records by 4th March 2018.</p> <p>Target revised to 90% compliance by end of December 2018 (quality of records) & 90% compliance by January 2019 (security of records).</p> <p>Develop a work stream plan to address the physical condition of the paper records by 31st March 2018</p> <p>Confirm Trust strategy for EPR by 30th June 2018.</p>	<p>Nursing Documentation Audit pilot conducted 05.09.18. Provisional results indicate approximately 30% compliance against professional standards.</p> <p>Each Divisional team of three presented their plans to the CQC Preparation Steering Group meeting outlining how they were going to enhance standards of fundamental care across their divisions by December 2018. A sharp focus is being placed on this currently.</p> <p>In addition, the agenda's for the Care Group & Divisional Quality & Safety meetings are being reviewed to ensure that they are standardised and cover essential elements.</p> <p>Each Ward/Department has had a lead consultant identified to help enhance multi-professional team working. The Lead Consultants met with the Senior Ward Sisters, the Medical Director, Deputy Director of Nursing and Improvement Consultant to talk through these new roles and how they wanted to implement them. They will continue to meet on a quarterly basis from now on to monitor progress and share best practice.</p> <p>Total Mobile note system implemented</p>

MUST DO ACTION UPDATE:

Issue	Must	Trust Target & RAG status	Update / SPC Chart																																																					
Action plans are monitored and managed for serious incidents	Must	Zero outstanding by January 2019	<p>The number of outstanding SI actions are reported to the Risk Management Committee and Quality & Safety Committee in the SI report which shows:</p> <ul style="list-style-type: none"> 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. <p>This now shows individual overdue actions.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th rowspan="2">Division</th> <th colspan="8">SI's with actions outstanding past completion date</th> </tr> <tr> <th style="background-color: #ffff00;">Aug 2018</th> <th>July 2018</th> <th>Jun 2018</th> <th>May 2018</th> <th>Apr 2018</th> <th>Mar 2018</th> <th>Feb 2018</th> <th>Jan 2018</th> </tr> </thead> <tbody> <tr> <td>WCCSS</td> <td style="background-color: #ffff00;">5 (6 open actions)</td> <td>9</td> <td>8</td> <td>8</td> <td>6</td> <td>7</td> <td>6</td> <td>7</td> </tr> <tr> <td>Surgery</td> <td style="background-color: #ffff00;">1 (5 open actions)</td> <td>1</td> <td>1</td> <td>2</td> <td>2</td> <td>1</td> <td>1</td> <td>6</td> </tr> <tr> <td>MLTC</td> <td style="background-color: #ffff00;">0</td> <td>0</td> <td>0</td> <td>3</td> <td>5</td> <td>3</td> <td>1</td> <td>0</td> </tr> <tr> <td>Total</td> <td style="background-color: #ffff00;">6</td> <td>10</td> <td>9</td> <td>13</td> <td>13</td> <td>11</td> <td>8</td> <td>13</td> </tr> </tbody> </table>	Division	SI's with actions outstanding past completion date								Aug 2018	July 2018	Jun 2018	May 2018	Apr 2018	Mar 2018	Feb 2018	Jan 2018	WCCSS	5 (6 open actions)	9	8	8	6	7	6	7	Surgery	1 (5 open actions)	1	1	2	2	1	1	6	MLTC	0	0	0	3	5	3	1	0	Total	6	10	9	13	13	11	8	13
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Lessons are disseminated effectively to enable staff learning from serious incidents, incidents and complaints.	Must	100% of staff interviewed can share one example of a lesson learnt and action taken	<p>Lessons learnt are disseminated via:</p> <ul style="list-style-type: none"> 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 to 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 																																																					

Issue	Must	Trust Target & RAG status	Update / SPC Chart
			<ul style="list-style-type: none"> • Speciality 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. <p>Feedback following an incident is also covered in Clinical Update training</p> <p>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.</p> <p>Measures:</p> <ul style="list-style-type: none"> • The number of staff contacted through the Risk Roadshows • Attendance at Care Group governance meetings each month. • Participants in workshops in ESR • Peer review questionnaire for staff to capture the number of staff interviewed who can share an example of a lesson learnt and action taken
Patient medical notes are kept secure at all times	Must	90% compliance by Jan 19	<ul style="list-style-type: none"> • Policy being reviewed (September 2018) • Checklist being developed for ward / departments to use to check compliance • Peer reviews on-going, with results to be monitored by care group / divisional governance meetings and CQC preparation steering group
All staff are trained and competent when administering medications via syringe driver (McKinley T34)	Must	100% of relevant staff undergone syringe driver equipment training 100% of relevant staff have undergone competency training	The population requiring training in the use of syringe drivers is currently unknown. However, the numbers of staff trained in the use of syringe drivers is known. A meeting is being held to define the relevant population in September.
Staff follow best practice national guidance (NICE, CAS alerts, Royal College Guidelines, local clinical guidelines)	Must	Zero CAS alerts outstanding 100% Technology Appraisals, assessment & implementation within 90 days	<p style="text-align: center;">2 CAS Alerts outstanding: NATSIPPS (aiming for closure in September 2018) Luer lock connectors (aiming for closure January 2019)</p> <p style="text-align: center;">NICE Compliance – Technology Appraisals</p> <ul style="list-style-type: none"> ▪ 2017-18 – 07% of TAs were received and reviewed in year ▪ 2018 April – August– 57% of TAs were received and reviewed in year

Issue	Must	Trust Target & RAG status	Update / SPC Chart												
etc. etc.		Zero Clinical Guidelines out of date by xxxx	<p>Clinical Guidelines have recently been reviewed, with the current position below:</p> <table border="1" data-bbox="1102 331 2027 475"> <thead> <tr> <th>Type</th> <th>Number of documents</th> <th>In date</th> <th>Due</th> <th>Expired</th> <th>No information</th> </tr> </thead> <tbody> <tr> <td>Guideline</td> <td>287</td> <td>114</td> <td>34</td> <td>78</td> <td>61</td> </tr> </tbody> </table> <p>There are an additional 75 documents (guidelines, forms, flowcharts) on the A&E team page which are being assessed during September. 3 revised guidelines and 1 new guideline published to date in September:</p> <ul style="list-style-type: none"> • GBS guideline (Gynaecology), • Management of ectopic pregnancy (Gynaecology), • Nausea and vomiting guideline (Gynaecology). • New: Endometrial hyperplasia guideline (Gynaecology) <p>All 33 of the Critical Care Guidelines were out of date. 3 have been re-designated as policies and the Care Group are actively revising them during September.</p>	Type	Number of documents	In date	Due	Expired	No information	Guideline	287	114	34	78	61
Type	Number of documents	In date	Due	Expired	No information										
Guideline	287	114	34	78	61										
The service uses an acuity tool to evidence safe staffing (nursing & midwifery)	Must	100%	SNCT & midwife: birth ratio in place (1:25 for August 18)												
All staff receive an appraisal in line with local policy	Must	90%	<p>August: 90.04%</p> 												

Issue	Must	Trust Target & RAG status	Update / SPC Chart
COMMUNITY FOR CHILDREN & YOUNG PEOPLE: Continue to follow standard operating procedures with medicines in special schools	Must	100%	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	CQC re-inspected maternity services & have agreed that this risk has now been mitigated	Consent audit undertaken 2017. Re-audit to be undertaken August 2018 CQC Inspection report (August 2018) indicated that the trust was now compliant with this issue.
ED: completes the action plan completed following the CQC inspection carried out in September 2015	Must	100% of actions completed within specified timeframes with desired outcomes achieved	ED have reviewed previous action plan and have just 2 remaining, which are currently being worked on. The 4 outstanding areas were: <ul style="list-style-type: none"> • improving staff appraisal rates; • ensuring staff could be identified easily by patients and visitors; • management of equipment • stock in the resuscitation area.
SAFEGUARDING: adults and Safeguarding children policies are up to date and include relevant references to external guidance	Must	100%	Revised Adult Policy to be ratified by 31.07.18 (August update: policy to be ratified by Nursing & Midwifery Advisory Forum on the 20 September 2018) Revised Children's Policy – date not yet confirmed
CRITICAL CARE: All staff working within the outreach	Must	100% by 01.01.2019	Monthly trajectory as follows: September 60%, October 80% and November 100%. August performance = 50%

Issue	Must	Trust Target & RAG status	Update / SPC Chart
team are competent to do so			
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	100% of actions completed within the specified timeframes with desired outcomes achieved	<p>Issues and actions outlined below:</p> <ol style="list-style-type: none"> 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 OPD have also enlisted a seating company to design a bespoke seating solution. Areas to be decluttered Completed and ongoing Risk assessment is now completed and has been added to the risk register. 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. 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.

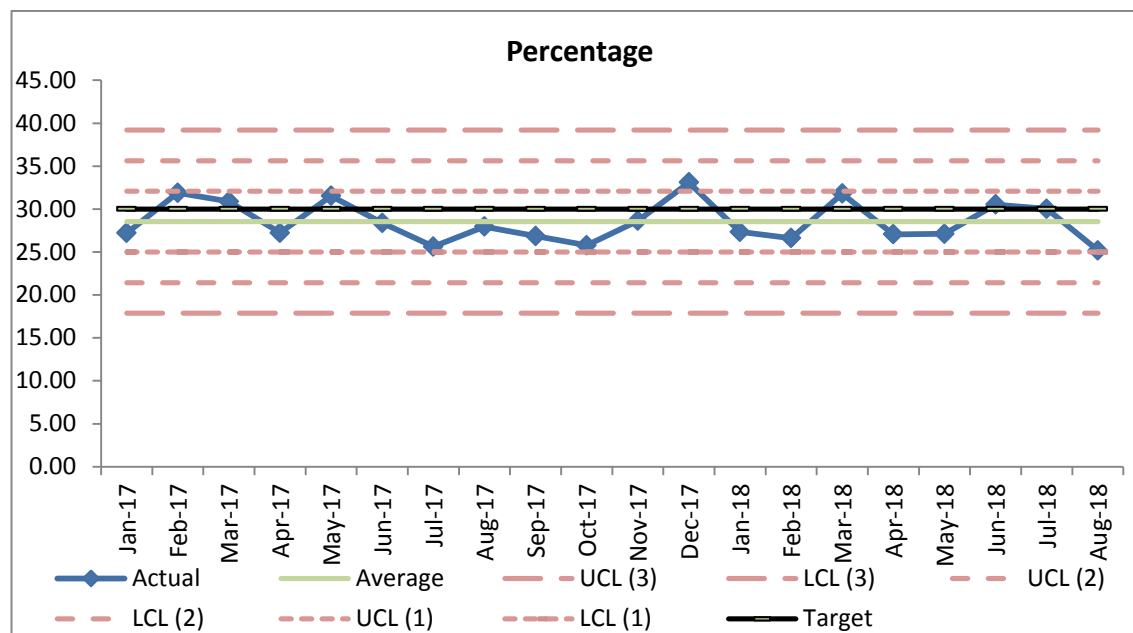
C Section Rates – Maternity Services

Introduction

The maternity unit has introduced the use 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

TRUST BOARD – 4 th OCTOBER 2018			
Safe Nurse Staffing Levels			AGENDA ITEM: 10
Report Author and Job Title:	Dr Karen Dunderdale Director of Nursing	Responsible Director:	Dr Karen Dunderdale Director of Nursing
Action Required	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input type="checkbox"/> Assure <input type="checkbox"/>		
Executive Summary	This report provides assurance to the Board that there are clear principles and processes of nurse staffing on our wards/departments, along with evidence and examples of how we will monitor safe levels.		
Recommendation	The Trust Board is asked to agree the way forward and support the Director of Nursing in implementing the principles described and note any further actions required.		
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 <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		

1.0 Background

Patients and their families' experience of care should be one of safety, dignity and comfort, delivered by staff that have the right skills and qualities to care. There have been numerous reports published that are critical of NHS hospital care. These reports raise issues about people's human rights, dignified care and hospital experience that are highly relevant to nursing practice. In the published Francis Inquiry 2013, it was remarkable how little attention was paid to the potential impact of proposed savings on quality and safety and that lip service was given to these issues. There was an unacceptable delay in addressing the concerns of shortage of skilled nursing staff. As a result of poor leadership and staffing policies, a completely inadequate standard of nursing was offered on some wards in Stafford.

The needs of many patients in hospital today present a significant care challenge due to frailty, complexity and co-morbidities, including significant conditions such as dementia. In order to deliver safe nursing care to patients demand both skill and time.

There are a number of factors that underpin safe, compassionate and dignified care in hospital:

- Sufficient numbers and skill mix of nursing staff on duty at the times when they are needed
- Strong leadership at ward level
- Empowerment of ward managers for ensuring safe staffing and effective support for recruitment
- Proper workforce development, skills and training
- Appropriate resourcing and environment to provide care
- Development of appropriate metrics and measures of patient experience and outcome of compassionate care giving

There is no universal or simple solution to staffing issues. Ultimately local decisions must be made as to what is needed for good, safe care.

This paper will propose to Trust Board members, principles for a co-ordinated and transparent process based on the Royal College of Nursing evidence and NHS Improvement guidance for safe staffing levels. This is so an accurate picture can be obtained and any variance between wards/departments can be clearly identified and addressed.

The principles articulated in this paper also apply to Midwifery, paediatrics and Community. However, midwifery, paediatrics and community safe staff levels will be subject of a separate paper.

If a review identifies that the staffing levels or skill mix on a ward/department fall below the recommendations, a decision is made by the operational team as to whether the staffing levels are unsafe and may result in compromised care and whether immediate action needs to be taken to ensure that the problem is appropriately addressed.

Simply calling for more staff does not guarantee safe care will be achieved. As many factors as possible should be taken into account and there should not be reliance on numbers alone. Efficient ward management, patient flow, appropriate skill mix, a safe and therapeutic physical environment and a positive person centred culture are all part of the discussion.

2.0 Principles of safe staffing levels

There are clear templates which give objectivity to these principles.

1. Workforce planning adequately reviewed for the ward/department

Regardless of the tools that are used to undertake a review of nurse staffing levels the following should be considered:

- Staff should be involved in the principles and outcomes of the review
- A triangulated review should take place using Professional judgement, acuity and dependence tools along with benchmarking data
- Adequate uplift for training, leave and absence must be calculated (25%)
- Quality indicators set within the clinical assurance and nursing Dashboard should be used to evaluate the sufficiency of staffing reviews
- Nurse establishment reviews must be undertaken every 2 years or sooner if the service needs change

2. Ward/department managers should be empowered to make decisions on staffing for their areas

Ward/department managers must be trained to use their professional judgement to ensure safe and realistic day to day workload planning. Professional judgement should take account the following factors:

- The environment of care especially when caring for people with dementia and people at risk of falls
- Additional needs for one to one nursing
- Time required to support relatives
- Time and skills required to manage complex discharges
- Time needed to communicate with patients who may have sensory or cognitive impairments
- Skills and competencies of the staff available in caring for patients with complex needs and co-morbidities
- Time required to deliver care in a compassionate way
- Time required to supervise and support healthcare assistants and other support roles

3. Staffing numbers and skill mix

There is no universal minimum staffing level. However, there is evidence to suggest that there is a threshold of staffing numbers below which care becomes compromised. The RCN make clear recommendations for skill mix and overall staffing numbers. The number of beds typically occupied at any one time should be determined. The e-rostering rotas should be reviewed to identify a daytime shift and what was worked not what the establishment should be.

Skill mix

- For basic care there should be at least 1 registered nurse for 8 patients, this is a nationally recognised figure. For ideal care the skill mix should also aim to meet the RCN recommendations of a ratio of registered nurse to unregistered nurses of 65:35 or above.

Overall staffing numbers

- For basic safe care the overall staffing levels should not drop below 1 nurse to 3.3 to 3.8 patients (depending on acuity). Therefore on a typical 28 bedded ward, 8 staff are required on duty with no less than 4 of these being registered nurses. This excludes any additional support for one to one care. The RCN also recommend that the ward manager should be excluded from this calculation. However there is recognition that in order to achieve this wards need to be fully staffed to establishments without any vacancies.

Additional nursing support

- Ward/department managers should have access to additional nursing resource during periods of high patient acuity, dependency and risk. The development of a response team and use of the internal nursing bank should be surplus to the ward/department establishment. Agency nurses should be used as a last resort.

4. Ward/Department managers and leaders should have sufficient time to lead and support their team

Meeting the recommended nurse establishment levels or deploying additional staff will not provide safe care unless the leadership and organisation of the workforce is right.

- There must be a nurse in charge of every shift
- Ward/department managers should be supervisory to maintain and improve the quality and consistency of health care experienced by patients.

5. Appropriate training and knowledge and skills to care are available to all nurses at both pre and post registration levels and to health care assistants

All registered nurses have a professional responsibility to keep themselves up to date; it is essential that they have access to appropriate training and development.

3.0 Processes for undertaking ward/department nurse establishment reviews

E-rostering is key to ensuring that the agreed establishments are worked and management decisions are effective in ensuring efficient rotas and safe staffing levels on each shift.

Adequate establishments are a beginning. Having safe staffing levels on a daily basis relies on many factors to ensure staff are deployed in an effective way. This all depends on effective management and leadership. A review of the role of the ward manager will be part of a piece of work to commence this year to ensure clinical leadership at the bedside and therefore support the implementation of the Director of Nursing strategy which will also be developed over the next two months and will shared with the Trust Board.

The Director of Nursing, the Director of Operations and the Director of Finance will sign off the nursing establishments and financial plans prior to submitting these to the Trust Board for approval at the two yearly (or sooner if required) review.

Establishments will then form the e-rostering template for the ward.

4.0 Control process for changes to e-rostering template

On a monthly basis the Divisional Directors of Nursing and Director of Operations along with the Director of Nursing will review each ward/department area by exception to identify the budgeted position, worked position, number of nurses, ratio of nurses and occupancy rate; RAG rated to determine trends.

The Director of Nursing will review the overall Divisions monthly position with the Divisional Directors of Nursing to determine the impact of acuity and dependency of patients, vacancy position and quality of nursing care reflected in the clinical quality and nursing dashboard; all of which will be reflected locally in a ward quality risk profile.

Any wards/departments who are deemed to require changes to their establishments will be required to follow the above full establishment review process and principles.

5.0 Monthly reporting arrangements

Divisional Operations Managers and Divisional Directors of Nursing have monthly predictive oversight of their areas to determine if corrective action for rosters is required. Divisional Directors of Nursing will work with their operational matrons to obtain roster intelligence by exception.

They should also be able to review rosters that have been worked to determine the weaknesses and take corrective action.

On a daily basis we are developing the ability of the Operations Centres to have oversight of individual ward/department rotas. They will review absences data, rota changes, staff movement including deployment of the resource team once developed, bank and agency fill rates and support the operational matrons in making any changes.

Control processes need to be robust to ensure any changes to individual ward/department rotas meet the required KPIs and any concerns are escalated.

6.0 Safe Nurse Staff Levels Assurance

Template plans on the e-rostering system will have safe nursing staff levels for each area, based upon plans authorised by the Director of Nursing and the Director of Operations. There will be a rolling review process, as well as a change control process for all changes to staff rostering plan templates within e-rostering.

There will be roster reporting and oversight identification for instances where roster deployment falls below or is projected to fall below safe levels, to allow for corrective management action.

7.0 Budget Setting and Financial Planning

The e-rostering plan templates will be used to set budgets. Budgets will therefore remain directly driven by roster plans – and budget changes will only be actioned where rosters or underlying assumptions around the roster operation are altered.

This will support robust planning, since both establishment and budgets will reflect detailed plans, rather than a rollover of outturn spend.

8.0 Workforce Planning

Roster plans can be directly turned into establishment requirements using a newly developed modelling template. The roster plans can therefore be used to set far more effective workforce plans for the organisation by area and staff type. This will in turn support improved recruitment timetables, reduce vacancies, reduce pressure on bank resources, and improve operational effectiveness.

9.0 Current Intelligence regarding Nursing & Midwifery staffing

The information in this report will be provided in the following categories:

- Workforce numbers
- Financial implications and consequences
- Quality of care delivery
- Innovative solutions to respond to increases in occupancy levels/peaks and toughs in demand

9.1 Workforce numbers

The number of WTE and associated spend is illustrated below as at Month 05 (August 2018) for the Directorate of Operations:

	Period: Month 05 (August 2018)		
	WTE Contracted	WTE Worked	Monthly Spend (£000s)
OPERATIONS CENTRAL	128.6	129.5	273.9
SURGERY & CRITICAL CARE	513.4	519.0	1,505.1
MEDICINE	380.7	404.5	1,143.7
WOMEN AND CHILDRENS SERVICES	430.4	427.2	1,363.4
THERAPY AND COMMUNITY SERVICES	202.1	199.9	594.5
Operations Total	2,012.8	2,051.5	6,060.7

	WTE Contracted	WTE Worked	Monthly Spend (£000s)
Band 8	19.4	18.6	92.6
Band 7	193.0	196.1	839.2
Band 6	334.7	331.6	1,223.7
Band 5	808.7	818.9	2,470.0
Subtotal - Registered	1,355.8	1,365.3	4,625.6
Band 4	19.6	19.7	42.1
Band 3	181.5	180.4	401.5
Band 2	410.4	439.4	849.6
Band 1	45.5	46.8	66.8
Subtotal - HCA/Others	657.0	686.3	1,360.1
Agency Nursing	0.0	0.0	75.1
Operations Total	2,012.8	2,051.5	6,060.7

9.2 Quality of care delivery

The quality of care will be monitored monthly through the Nursing Care Dashboard and the Nursing Quality metrics review meeting. This will inform the integrated performance report. The Board has oversight of quality through the Quality & Safety committee. The Nursing Midwifery Advisory Forum will be responsible for reviewing the quality for each ward and ensuring action is taken when needed. Overview of performance will be monitored at monthly Operations Directorate performance meeting and corrective action taken.

10.0 Actions:

10.1 Response team

Flexibility of staffing is vital. We recognise that some areas struggle to maintain their establishments on occasions due to staff turn-over and vacancies. Coupled with increased patient activity there has been an increased bank and agency usage. The development of a response team within each Division would give flexibility to deploy staff to wards at times of need the benefits of which have been to ensure continuity of care and patient safety. The response teams would also provide succession planning and a trained workforce familiar with the Trust's objectives and policies.

10.2 Bank/rostering

The new Nursing workforce work-stream developments are due to support this agenda in a variety of different ways:

- 1) A reinvigorated E Rostering project will be working to ensure that workforce shift plans are correctly embedded into rostering systems, that roster management is effective, that monitoring data is available on performance against KPIs and our current rostering software meets our needs going forward.
- 2) Recruitment processes will need to be streamlined to support batch recruitment of nurses – removing current recruitment delays, and removing burdens from line managers and operational support staff.
- 3) Bank nursing systems will be modernisation, and bank recruitment and quality verification processes will be improved, to increase the available bank resource.
- 4) Training processes will be redesigned to ensure that mandatory training is built in to rostering processes rather than being left to individuals and their line managers.
- 5) Workforce planning processes will set forward plans for nursing numbers and we will recruit prospectively, rather than in reaction to staff shortfalls that could have been easily predicted.

The projects support an increase in supply of nursing staff, and also improved management of nurse rostering and deployment. They will work effectively if corporate and Operations Directorate support is given to these developments.

10.3 Review of the role of the Ward Manager

It is clear from evidence that leadership is vital to ensure high quality, compassionate patient care. There is extensive research evidence that links the impact of the ward manager role to standards of patient care. The pressure placed on ward managers from looking after and nursing a group of allocated patients on every working shift, in addition to their ward leader responsibilities has made it impossible for them to appropriately lead, manage, *supervise* and develop clinical practice as well as being responsible for all activities and the ward environment.

The literature suggests there are three key components of the ward manager role:

- Clinical nursing expert
- Manager and leader of the ward staff team and the ward environment
- Educator (of nursing and nurses, other health care professionals, patients and carers).

The role of the ward manager is vital to ensuring a patient-centred culture. A small working group of senior nurses led by the Director of Nursing will be convened to review the role to develop.

In order to assess the effectiveness of the clinical leadership and nursing care of a ward, a leadership and compassionate care assessment and accreditation is being developed to identify strong leadership and recognise and reward this as well as supporting all ward leaders to achieve the same high standard.

11.0 Recommendations for staffing levels and skill mix

The Trust Board is asked to agree the way forward and support the Director of Nursing in implementing the principles described and note any further actions required.

The Board will receive an update in 6 months

Performance Report

**September 2018
(August 2018 Results)**

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

Caring for Walsall together



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Partnerships

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Partnerships – Highlight Page

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

Key Areas of Success

Rapid response continues to provide strong performance this month in comparison to previous months. However there are 2 vacancies within the team that will provide additional pressure if not filled before winter. The plan therefore is to get these posts filled quickly and increase the additional capacity with the virtual links to the localities teams through the use of mobile technology to provide the additional flex required.

In addition to this, the commencement of the pilot single referral form is about to commence at the time of writing. It is hoped that the introduction of this form will bring community and social care teams closer together. The next steps of the MDT development will further compliment this work. Finally for this month, the production of a locality based dashboard of key metrics is being tested to ensure that the teams have key data.

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. A complete plan for rapid response capacity and flex has been produced and is being worked through.

Key Focus for Next Committee

The dashboard now shows the contacts per locality that has been validated. From next month there will also be bed days and a calculation against the population size to reference against.

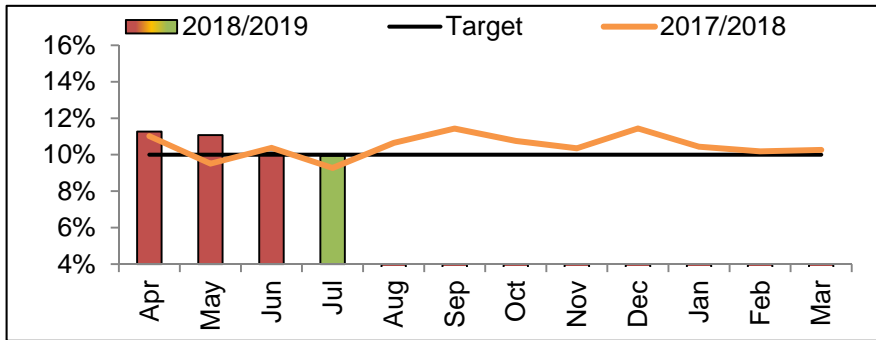
Work is underway to deploy a series of BI dashboards in the community over the next quarter and conversations will be had to understand what data is required next.

Following last months board, the discussions to commence collecting and showing partners data relevant to the place based care operation are underway but as of yet no publication date has been agreed.

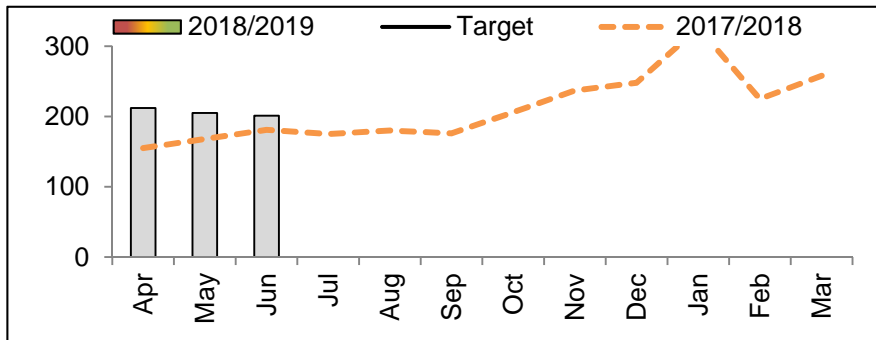


Partnerships

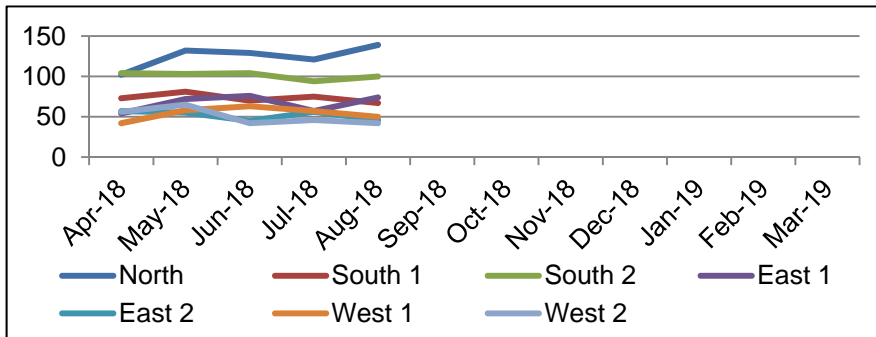
Emergency Readmissions



Rapid Response – Avoidable Admissions



Re-admissions by Locality



Narrative (supplied by Director of Strategy & Improvement) to be updated for Trust Board

As shown by the graph there is a steady improvement month on month, with July at 9.94% achieving the 10% target, a similar pattern to last year. During Q1 the place based teams were enhanced with the addition of continence specialist. The COPD team are due to join during Q2.

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 service is being aligned with the Integrated Care Service and the reporting of data will be reviewed with the new management structure. The team does have two vacancies at the minute but there is a plan to recruit in time for the additional winter demand.

This chart shows the number of emergency readmissions within 30 days of discharge by locality. The highest readmitting locality continues to be the North. Further analysis is to be undertaken in the North to understand if the variance is a significant change or normal fluctuation. We are also working on this as a % of the population size that the teams serve. Once this is complete the teams will be bench marked against each other

PARTNERSHIPS
2018-2019

		Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	18/19 YTD 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)	10.26%	11.27%	11.07%	10.12%	9.94%		10.58%	10.00%		L
no	Rapid Response Team - Avoidable admissions (one month in arrears)	258	212	205	201						BP
CARE AT HOME											
%..	ED Reattenders within 7 days	6.87%	6.80%	7.68%	7.12%	7.46%	7.58%	7.33%	7.00%	6.76%	BP
RESOURCES											
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only		21	26	30	32	31				L
no	Average Number of Medically Fit Patients - Trust		49	42	39	36	42				L
PARTNERS											
no	Occupied Beddays per Locality - Total	12068	11771	10931	10770	10040	10542	54054			L
no	Contacts per Locality - Total		18066	19325	18527	19796	19807	95521			L
no	Contacts per Locality - North		3168	3268	3117	3476	3302	16331			L
no	Contacts per Locality - South 1		2261	2140	2216	2220	2203	11040			L
no	Contacts per Locality - South 2		2929	3144	3010	3173	3218	15474			L
no	Contacts per Locality - East 1		2057	2120	2146	2262	2319	10904			L
no	Contacts per Locality - East 2		2910	3405	3374	3699	3875	17263			L
no	Contacts per Locality - West 1		2230	2422	2242	2350	2345	11589			L
no	Contacts per Locality - West 2		2511	2826	2422	2616	2545	12920			L
no	Emergency Readmissions per Locality - Total	488	488	566	529	506	518	2607			L
no	No. of patients on stroke pathway in partnership with Wolverhampton - new metric under development										L

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

In month improvement in Family & Friends test for ED (% recommend)

Key Areas of Concern

Falls rate per 1000 bed days has deteriorated causing concern.

Percentage of complaints responded too in the agreed timescale has deteriorated in month

Key Actions Taken

The Q&S committee expressed a need to see mortality as a key indicator in the dashboard for next month

The Q&S committee expressed a need to see information presented as trend analysis and SPC charts

Key Focus for Next Committee

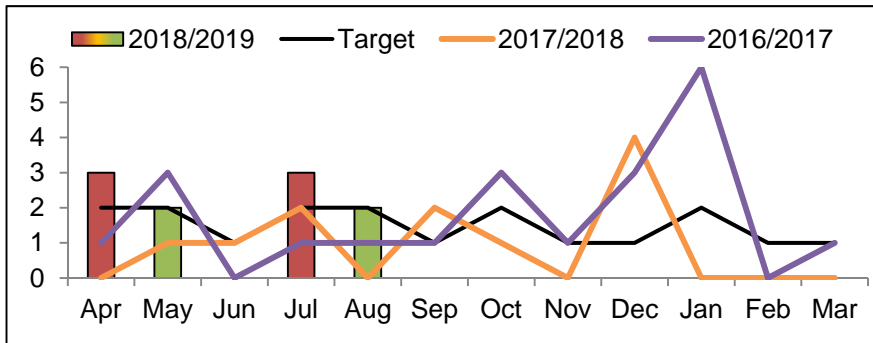
The Q&S Committee will receive a deep dive in relation to Falls at its next committee

The Q&S committee will receive a deep dive in relation to complaints at its next committee



Quality and Safety Committee

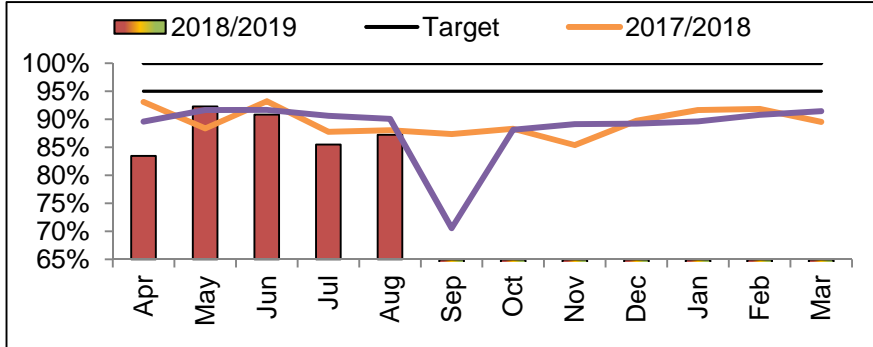
C Difficile



Narrative (supplied by Medical Director)

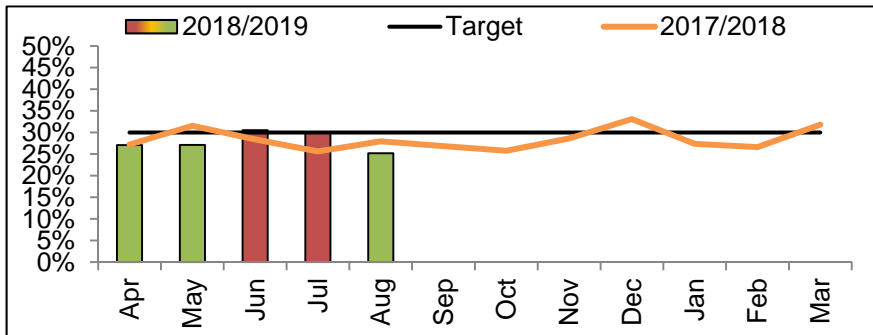
Running very close to trajectory for the year. RCA's carried out on July cases and an action plan put in place to provide learning to teams. The newly appointed microbiologist and lead for antimicrobial management is undertaking a review of the antibiotic formulary together with providing teaching to all Care Groups. The antibiotic usage audit will be shared with all Care Groups for them to develop an action plan.

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. A QIA event to be held to provide multi-disciplinary training which would involve the GP's to improve overall communication between primary and secondary care. A trajectory for EDS to be developed

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 25.17%

- 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.

QUALITY AND SAFETY
COMMITTEE
2018-2019

SAFE, HIGH QUALITY CARE	
no..	HSMR (HED)
no..	SHMI (HED)
no	Clostridium Difficile - No. of cases
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired Avoidable per 1,000 beddays (one month in arrears)
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired Avoidable per 10,000 CCG Population (one month in arrears)
no..	Falls - Rate per 1000 Beddays
no	Falls - No. of falls resulting in severe injury or death
%..	VTE Risk Assessment
%..	Controlled Drug Compliance
no..	Midwife to Birth Ratio
%..	C-Section Rates
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)
%..	Electronic Discharges Summaries (EDS) completed within 48 hours
%..	Compliance with MCA 2 Stage Tracking
%..	Friends and Family Test - Inpatient (% Recommended)
%..	PREVENT Training - Level 1 & 2 Compliance
%..	PREVENT Training - Level 3 Compliance
%..	Adult Safeguarding Training - Level 1 Compliance
%..	Adult Safeguarding Training - Level 2 Compliance
%..	Adult Safeguarding Training - Level 3 Compliance
%..	Children's Safeguarding Training - Level 1 Compliance
%..	Children's Safeguarding Training - Level 2 Compliance
%..	Children's Safeguarding Training - Level 3 Compliance

Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
110.50	103.54	88.00	106.65		
109.80					
0	3	2	0	3	2
	1.07	0.82	0.67	0.75	
	0.03	0.07	0.00	0.03	
5.64	5.32	5.62	3.57	5.09	6.94
0	3	0	0	2	1
95.49%	96.34%	96.28%	96.50%	95.57%	95.08%
71.00%					
1:26.3	1:29.8	1:29.2	1:26.2	1:28.6	1:25.0
31.80%	27.06%	27.12%	30.53%	30.03%	25.17%
10.26%	11.27%	11.07%	10.12%	9.94%	
89.51%	83.45%	92.29%	90.83%	85.48%	87.24%
77.00%	55.00%	81.00%	69.00%	69.00%	68.00%
94.00%	96.00%	95.00%	97.00%	94.00%	95.00%
96.56%	98.59%	98.29%	98.22%	98.75%	98.29%
75.97%	76.07%	77.51%	84.47%	89.59%	90.42%
93.86%	94.43%	93.69%	99.84%	99.92%	99.83%
70.09%	75.55%	80.32%	83.77%	87.04%	89.53%
77.64%	78.26%	80.41%	87.98%	89.64%	87.89%
92.12%	91.67%	92.38%	99.77%	99.26%	98.67%
73.25%	75.49%	76.93%	88.58%	93.69%	85.37%
71.07%	74.52%	88.58%	90.62%	92.24%	92.08%

18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	100.00		N
	100.00		BP
10	17	11	N
			L
			L
	6.63		BP
6	0	8	BP
95.94%	95.00%	88.49%	N
	100.00%		BP
	1:28	1:26.3	N
28.00%	30.00%		BP
10.58%	10.00%		L
87.77%	100.00%	89.33%	N/L
	100.00%		BP
	96.00%		N
	85.00%		L
	85.00%		L
	95.00%		L
	85.00%		L
	95.00%		L
	85.00%		L
	85.00%		L

Performance, Finance and Investment Committee

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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 at 89% consistently ahead of plan and 2nd highest performance in the past twelve months
- 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)

Key Areas of Concern

- Emergency Department 4 hour wait performance dropped below plan in August 2018
- Temporary workforce costs continue at higher than planned levels
- Cost Improvement Programme (CIP) behind plan and phased 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

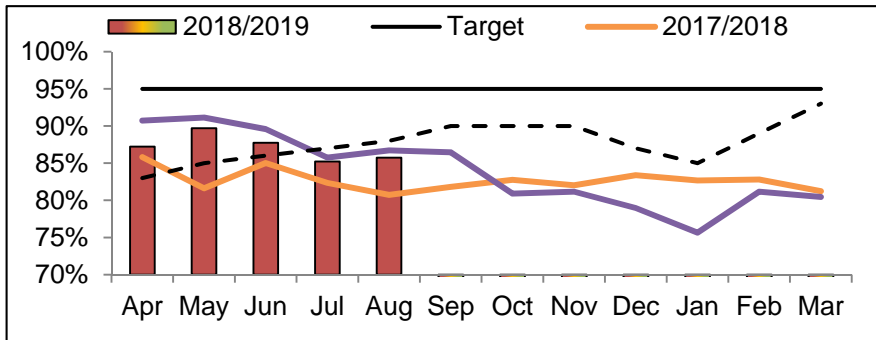
- SAFER deployed within the Trust to support enhanced ED performance, FES re-organised service to start 18th September to reduce elderly admissions, Winter plan workshops to re-align services where appropriate and review escalation systems.
- Financial recovery Plan endorsed through PFIC & Trust Board to mitigate current run rate

Key Focus for Next Committee

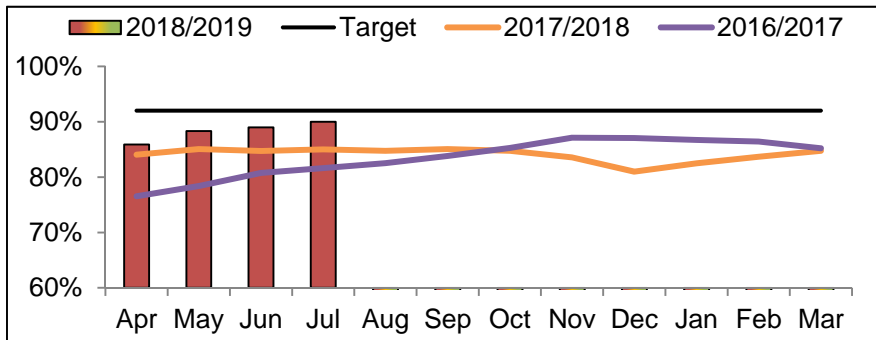
- Continued focus on performance against constitutional standards, focus on ED 4 hour performance
- Delivery of the Financial Recovery Program
 - Temporary workforce cost reductions (Medical and Nursing)
 - Income performance driven by CIP attainment (productivity within Theatres and Outpatients)
- Run rate reductions delivered month on month in accordance with the Financial Recovery programme
- Forward trajectories contained within the Financial Recovery Plan monitored through;
 - Weekly Performance meetings
 - Performance & Finance Executive
 - Performance, Finance & Information Committee (PFIC)

Performance, Finance and Investment Committee

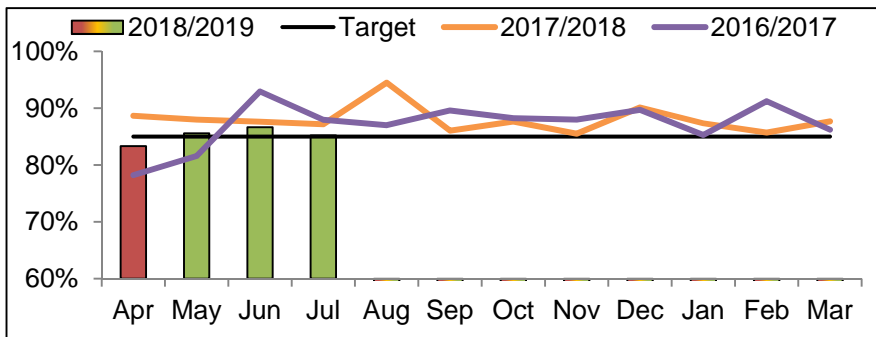
ED - % within 4 hours
- Overall (Type 1 and 3)



18 Weeks RTT
Incomplete Pathways



Cancer 62 Day RTT



Narrative (supplied by Chief Operating Officer)

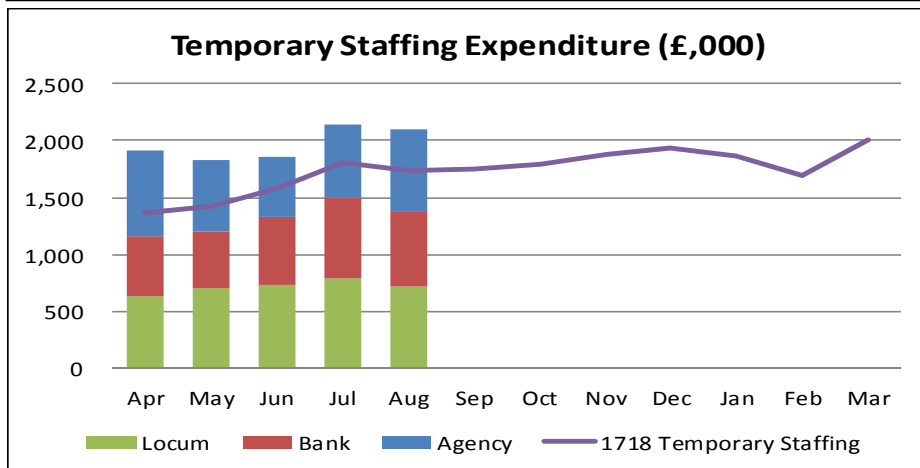
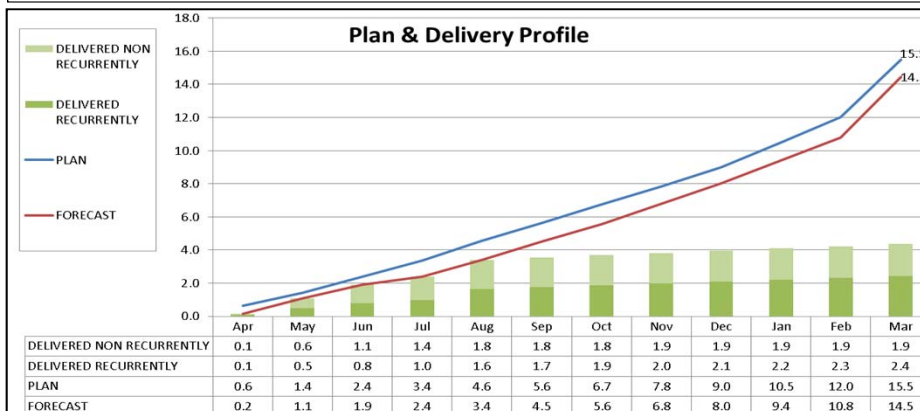
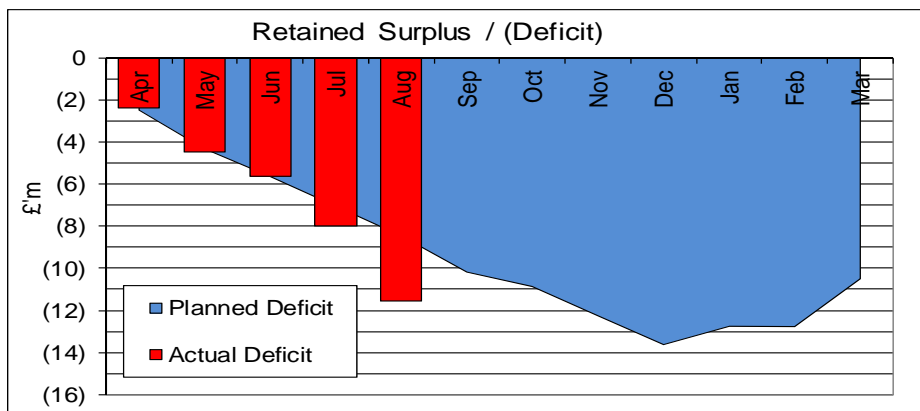
Not as demanding as July, August was a difficult month for Emergency activity in Walsall with high attendances above plan for example; over 90 ambulances on 11 days of the month. The July legacy of slightly increased LOS was compounded with care blockages leading to delays in MFFD discharges. Admissions also increased to 33%. These factors are indicative of high levels of annual leave across the health and social care economy from NHS senior decision makers to care workers. Patient flow was slower than required despite the highest % of patient discharges before 1800 and the highest % arriving at the Lounge before midday causing delays in ED. SAFER is now mandated and compliance is being monitored. Individuals/areas that are falling below the standard are being supported following discussions. September sees the return of all teams and the start of new FES.

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.

62 day cancer performance for August still being validated following return from leave and sickness of key personnel. Management structure is being reviewed to ensure consistency in future.

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

Financial Performance to August 2018 (Month 5)



Financial Performance

- The total financial position for the Trust at M5 is a deficit of £11.5m, resulting in a £3m variance to plan.
- The position provides for £1m of lost PSF (which is recovered in part if the Trust attains plan at the end of quarter 2). The deficit YTD now exceeds the annual plan.
- The contracted income shows an unfavourable 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).
- Expenditure is overspent YTD. The main area of overspending is pay (£1.5m) due to temporary staffing costs in Medical and Nursing. The overspending on non-pay largely relates to non delivery of CIP.

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding is £1.9m.
- The Trust's agreed borrowing for 2018/19 is £10.6m, reflecting the deficit plan. The majority of this borrowing is for the first half of the year reflecting that increased CIP efficiencies planned for the latter half of the year.
- The deficit higher than plan places increased pressure on cash flow and borrowing.

Capital

- The year to date capital expenditure is £5.5m, with the main spends relating to ICCU (£2.6m), Estates Lifecycle (£0.8m), Maternity (£1.3m) and Community Mobile technology (£0.1m).

Financial Performance - Period ended 31st August 2018				
Description	Annual Budget	Budget to Date	Actual to Date	Variance
	£'000	£'000	£'000	£'000
Income				
NHS Activity Revenue	229,041	94,742	94,509	(232)
Non NHS Clinical Revenue (RTA Etc)	550	455	489	33
Education and Training Income	7,101	3,118	3,073	(45)
Other Operating Income (Incl Non Rec)	15,668	6,241	5,474	(767)
Total Income	252,360	104,557	103,545	(1,011)
Expenditure				
Employee Benefits Expense	(176,847)	(73,393)	(74,966)	(1,573)
Drug Expense	(10,800)	(7,779)	(7,736)	43
Clinical Supplies	(17,771)	(8,028)	(8,314)	(286)
Non Clinical Supplies	(15,945)	(6,940)	(6,972)	(32)
PFI Operating Expenses	(5,076)	(2,136)	(2,186)	(50)
Other Operating Expense	(21,633)	(8,102)	(8,285)	(183)
Sub - Total Operating Expenses	(248,072)	(106,378)	(108,459)	(2,081)
Earnings before Interest & Depreciation	4,288	(1,821)	(4,914)	(3,092)
Interest expense on Working Capital	51	21	17	(5)
Interest Expense on Loans and leases	(8,409)	(3,925)	(4,117)	(192)
Depreciation and Amortisation	(6,560)	(2,733)	(2,517)	217
PDC Dividend	0	0	0	0
Losses/Gains on Asset Disposals	0	0	0	0
Sub-Total Non Operating Exps	(14,919)	(6,638)	(6,618)	20
Total Expenses	(262,991)	(113,015)	(115,076)	(2,061)
RETAINED SURPLUS/(DEFICIT)	(10,631)	(8,459)	(11,531)	(3,072)
Adjustment for Gains on Donated Assets			35	35
Adjusted Financial Performance (Control Total)	(10,631)	(8,459)	(11,496)	(3,038)

Use of Resources Ratings

Finance and use of resources rating	03AUDITPY	03PLANYTD	03ACTYTD	03PLANCY	03FOTCY
	<i>i</i>				
	Audited PY	Plan	Actual	Plan	Forecast
	31/03/2018	31/08/2018	31/08/2018	31/03/2019	31/03/2019
	Year ending	YTD	YTD	Year ending	Year ending
Number	Number	Number	Number	Number	
Capital service cover rating	4	4	4	4	4
Liquidity rating	4	4	4	4	4
I&E margin rating	4	4	4	4	4
I&E margin: distance from financial plan	3		4		2
Agency rating	2	1	2	1	1

Statement of Cash Flows		£'000	Statement of Financial Position			
			as at 31/03/18		as at 31/08/18	Movement
			£000	£000	£000	
Cash Flows from Operating Activities						
Adjusted Operating Surplus/(Deficit)		(7,431)				
Depreciation and Amortisation		2,517				
Donated Assets Received credited to revenue but non-cash		(58)				
(Increase)/Decrease in Trade and Other Receivables		(965)				
Increase/(Decrease) in Trade and Other Payables		2,045				
Increase/(Decrease) in Stock		8				
Interest Paid		(4,117)				
Net Cash Inflow/(Outflow) from Operating Activities		(8,001)				
Cash Flows from Investing Activities						
Interest received		19				
(Payments) for Property, Plant and Equipment		(5,091)				
Net Cash Inflow/(Outflow) from Investing Activities		(5,072)				
Net Cash Inflow/(Outflow) before Financing						
		(13,073)				
Cash Flows from Financing Activities						
		12,742				
Net Increase/(Decrease) in Cash		(331)				
Cash at the Beginning of the Year 2017/18						
		2,277				
Cash at the End of the Month						
		1,946				
			Non-Current Assets			
			Total Non-Current Assets			
			140,656	144,265	3,609	
			Current Assets			
			Receivables & pre-payments less than one Year			
			17,214	17,594	380	
			Cash (Citi and Other)			
			2,277	1,946	(331)	
			Inventories			
			2,277	2,269	(8)	
			Total Current Assets			
			21,768	21,809	41	
			Current Liabilities			
			NHS & Trade Payables less than one year			
			(30,702)	(33,143)	(2,441)	
			Borrowings less than one year			
			(60,740)	(72,605)	(11,865)	
			Provisions less than one year			
			(432)	(432)	-	
			Total Current Liabilities			
			(91,874)	(106,180)	(14,306)	
			Net Current Assets less Liabilities			
			(70,106)	(84,371)	(14,265)	
			Non-current liabilities			
			Borrowings greater than one year			
			(127,859)	(126,318)	1,541	
			Total Assets less Total Liabilities			
			(57,309)	(66,424)	(9,115)	
			FINANCED BY TAXPAYERS' EQUITY composition :			
			PDC			
			58,318	60,734	2,416	
			Revaluation			
			16,023	16,023	-	
			Income and Expenditure			
			(131,650)	(131,650)	-	
			In Year Income & Expenditure			
			-	(11,531)	(11,531)	
			Total TAXPAYERS' EQUITY			
			(57,309)	(66,424)	(9,115)	

**PERFORMANCE, FINANCE
AND INVESTMENT COMMITTEE
2018-2019**

SAFE, HIGH QUALITY CARE	
%..	Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED
no	Ambulance Handover - No. of Handovers completed over 60mins
%..	Cancer - 2 week GP referral to 1st outpatient appointment
%..	Cancer - 62 day referral to treatment of all cancers
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete
%..	Diagnostic Waits - % waiting under 6 weeks
no	Rapid Response Team - Avoidable admissions (one month in arrears)
no	No. of Open Contract Performance Notices
CARE AT HOME	
%..	ED Reattenders within 7 days
RESOURCES	
%..	Outpatient DNA Rate (Hospital and Community)
%..	Theatre Utilisation - Touch Time Utilisation (%)
%..	Delayed transfers of care (one month in arrears)
no	Average Number of Medically Fit Patients
no..	Average LoS for Medically Fit Patients (from point they become Medically Fit)
£	Surplus or Deficit (year to date) (000's)
£	Variance from plan (year to date) (000's)
£	CIP Plan (YTD) (000s)
£	CIP Delivery (YTD) (000s)
£	Temporary Workforce Plan (YTD) (000s)
£	Temporary Workforce Delivery (YTD) (000s)
£	Capital Spend Plan (YTD) (000s)
£	Capital Spend Delivery (YTD) (000s)

Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
81.23%	87.22%	89.70%	87.73%	85.21%	85.74%
70.36%	80.95%	80.65%	76.24%	71.95%	71.68%
9	1	5	0	7	4
97.90%	93.45%	93.98%	96.08%	97.64%	95.04%
87.69%	83.33%	85.58%	86.67%	85.23%	79.03%
84.74%	85.89%	88.33%	89.00%	90.01%	89.51%
0	0	0	0	0	0
98.06%	99.05%	99.57%	99.79%	99.75%	99.61%
258	212	205	201		
7	7	7	8	7	7
6.87%	6.80%	7.68%	7.12%	7.46%	7.58%
10.73%	10.47%	11.03%	10.59%	10.45%	10.59%
70.73%	80.91%	83.76%	82.63%	84.44%	81.50%
3.63%	2.97%	4.74%	3.74%	3.65%	
	98	87	85	88	92
	8.61	10.57	8	9	8
£-23,267	£-2,386	£-4,509	£-5,616	£-8,012	£-11,496
£-2,511	£-2,483	£-186	£-18	£-553	£-3,038
	£806	£1,612	£2,268	£3,182	£4,554
	£168	£1,080	£1,919	£2,391	£3,405
	£1,459	£2,784	£4,246	£5,935	£7,502
	£1,914	£3,743	£5,594	£7,733	£9,836
	£1,040	£2,129	£3,183	£4,105	£5,027
	£506	£1,077	£2,542	£3,946	£5,487

18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
87.16%	95.00%	82.67%	N
76.28%	85.00%	65.80%	BP
17	0	236	N
95.23%	93.00%	95.45%	N
84.28%	85.00%	88.05%	N
	92.00%		N
0	0		N
99.54%	99.00%	99.06%	N
			BP
	0	7	L
7.33%	7.00%	6.76%	BP
10.63%	8.00%	12.16%	L
83.58%	75.00%		L
3.76%	2.50%	2.56%	L
	80		L
	5		L
£-11,496		£-23,267	L
£-3,038		£-2,511	L
£4,554			L
£3,405			L
£7,502			L
£9,836			L
£5,027			L
£5,487			L

People and Organisation Development Committee

Caring for Walsall together



People and Organisation Development Committee – Highlight Page

Executive Lead: Director of People and Culture, Catherine Griffiths / Non-Executive Director Lead and Chair of POD Committee: Philip Gayle

Key Areas of Success

Mandatory training – sustained and improving compliance with a positive trend over three months (increase in compliance during August 1.83%).

PDRs – compliance level is green at 90.04% following a 2.48% increase in compliance in August.

Appointment of Equality, Diversity & Inclusion Manager who has started in the role.

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.

Retention - Review of exit data and turnover hot spots.

Attendance – Staff health and wellbeing sickness levels increasing trend.

Key Actions Taken

On-going requirements for Staff Engagement Lead, proposal in place and view on long term approach being developed.

Mandatory training – further analysis on compliance rates has started.

Turnover – review of Exit process and reporting.

Annual Work-plan for POD Committee established.

Board assurance framework review initiated on current workforce risks.

Flu campaign - Communication and engagement plan being developed and weekly multi-disciplinary task group to be established - partnership approach with Staff Side agreed at JNCC.

Key Focus for Next Committee

SAS Doctors – Review of input of SAS Doctors and equality of opportunity.

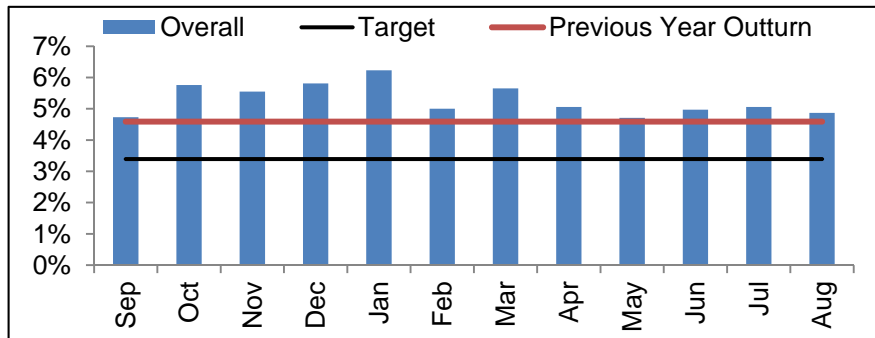
National Staff Survey 2018/19 – update on implementation.

Flu Campaign – update on risks and issues.

Review of Annual Work-plan .

People and Organisation Development Committee

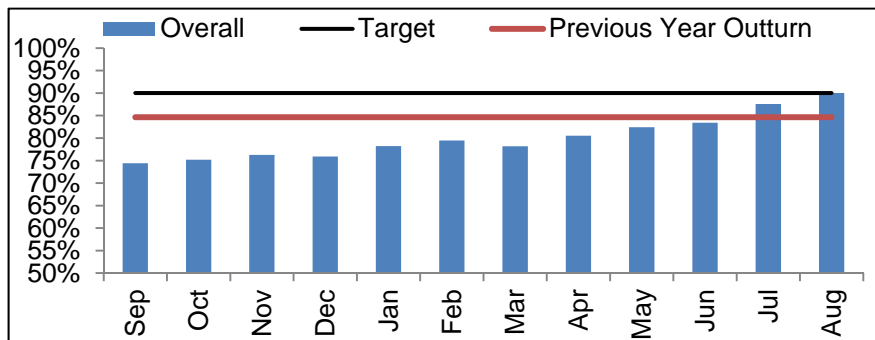
Sickness Absence



Narrative (supplied by Director of People and Culture)

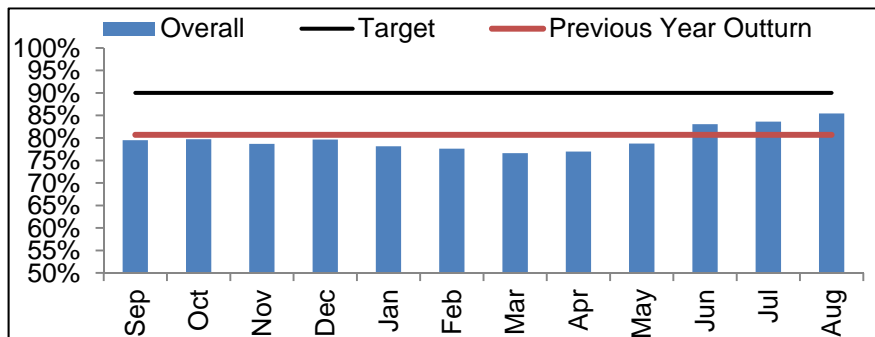
Sickness levels remain above Trust target and above previous year outturn month on month. Discussions have started in order to review the approach to wellbeing and attendance management with the aim of improving attendance rates.

PDR Compliance



There is sustained improvement in PDR appraisal completion rates over the six month period from February 2018 and compliance reached target in August at 90.04%, this indicator is now rated green.

Mandatory Training Compliance



Mandatory training compliance levels continue to improve, in August compliance was 85.46% compared to 83.63% reported in July, a rise of 1.83% month on month. Compliance is however below trust target, so analysis continues in order to support targeted improvement action.

**PEOPLE AND ORGANISATIONAL
DEVELOPMENT COMMITTEE
2018-2019**

SAFE, HIGH QUALITY CARE	
%..	Mandatory Training Compliance
.	Equality, Diversity & Inclusion - new metric under development
.	Equality, Diversity & Inclusion - new metric under development
VALUE COLLEAGUES	
%..	Sickness Absence
%..	PDRs
.	Staff Referral to Occupational Health - new metric under development
RESOURCES	
no	Staff in post (Budgeted Establishment FTE)
%..	Turnover
.	Time to Recruit - new metric under development

Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
76.61%	76.99%	78.76%	83.06%	83.63%	85.46%
5.65%	5.06%	4.71%	4.97%	5.06%	4.87%
78.17%	80.55%	82.42%	83.41%	87.56%	90.04%
4095	4125	4114	4125	4121	4123
9.13%	9.83%	9.92%	10.33%	9.20%	10.42%

18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
85.46%	90.00%	76.61%	L
4.91%	3.39%	5.30%	L
90.04%	90.00%	78.17%	L
4123			L
10.42%	10.00%	9.13%	L

Glossary

Caring for Walsall together



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

M cont

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

S cont

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

N – National / L – Local / BP – Best Practice

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 – 4 th October 2016			
Partnership Update October 2018			AGENDA ITEM: 14
Report Author and Job Title:	Daren Fradgley Director of Strategy and Improvement	Responsible Director:	Daren Fradgley Director of Strategy and Improvement
Action Required	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input type="checkbox"/> Assure <input type="checkbox"/>		
Executive Summary	This paper updates Board Members on the key partnership working undertaken this month. This includes the following <ul style="list-style-type: none"> • Primary care MDT's • Shared care records • Estates workshop • Single referral pilot 		
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 <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		

Partnership Report

October 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. PRIMARY CARE MDT'S

The locality teams are continuing to build positive relationships with Primary Care to enable the MDT meetings to take place. You will see from the grid at appendix 1 of this report that an additional four practices are about to come online within the next month, which collectively will cover an additional 20,000 population of Walsall. The collective population now covered is 55,000 through 16 practices.

This program is not without its challenges, with two practices taking the decision to pause their MDT's due an inability to provide representation to undertake full MDTs. This has now been resolved and it is hoped that these MDT's will recommence in the near future.

In addition to this work, a secondary piece of work is being progressed to see if a locality-based MDT could be adopted to support the integrated teams to offer the best wrap around care possible for the populations that they serve.

2.1 SINGLE REFERRAL PROCESS

The locality team leaders have been meeting for the last couple of months and are now in a position to pilot a single referral form with a small number of GP practices. This process, will mean that the referral will be based on the needs of the patient and the team will work together to respond to those needs. Initially the pilot will focus in a single locality relating to Trust and Social Care referrals, but it is hoped in the near future that this will be extended to include mental health and the voluntary sector.

2.2 EXTENSION OF SERVICES SUPPORTING LOCALITY TEAMS

As the work continues to explore how the localities will risk stratify their case loads and support the population needs, the services outlined below, are now beginning to attend the team meetings. It should be noted that some of these services were planned from

the outset however, some others like drug and alcohol support have been added as a direct result of gaps identified within the case management.

- Heart Failure
- Diabetes
- Lymphoedema
- Walsall House Group
- Welfare Officers
- Voluntary Sector
- Drug & Alcohol support

A continual review is taking place to address what teams attend what meetings to make sure that complex cases can be addressed.

3. SHARED CARE RECORD

Work is continuing to deploy a shared care end of life record between all Walsall Together Partners in the next 12 months. This work is being coordinated by the CCG and follows the principles that have already been successfully deployed in Wolverhampton. A project board has been established and is currently focused on the pilot area and wider deployment plan. Once the timelines are known, a update will be included in a future update.

Further to the work above, the Trust have been in conversation with The Royal Wolverhampton NHS Trust to understand how we can establish a shared care record between our organisations. This will work on the principles that are being established for the end of life record but will focus on populations that we jointly manage on the west side of the borough. This element of the Walsall population often access emergency and urgent care from New Cross but planned and community care through the Trust. It is hoped that the Trust will be in a position to bid for some national funding to establish this work in the early part of 2019/20, the detailed planning has commenced.

4. ESTATES FORUM AND WORKSHOP

Recently the Trust has participated in a Walsall Together Estate workshop to understand the collective challenges across all of the providers and commissioners. This workshop highlighted a number of concerns, both in the present and that may emerge in the future. The main ones of note for the Trust are a lack of collocated capacity for locality teams in the East & South of the Borough and the shortage of office space. Additional issues such as shared coordination space and locations to establish a care coordination centre were discussed and will be considered.

It is planned that the output of this discussion will result in a shared ambition to obtain some national funding to move the partnership forward with some of the estates challenges. Whilst the hospital estate was also discussed in this workshop it is likely to be out of scope for the national funding and therefore will be covered at a later date.

5. RECOMMENDATION

Board members are asked to NOTE the information within this report

Daren Fradgley
Director of Strategy & Improvement
23rd September 2018

MDT Summary - Last Updated 5th Sept 18				
Key		Covered by GP Led MDT's		
Blue	MDT Running - Fully			
Green	MDT's Running			
Amber	MDT's Planned			
Red	MDT's To be agreed			
Pilot - Phase One				
Locality	Practice Name	Time & Date	Status	Comments
West 1	Bentley Med Centre	Monthly Every 3 rd Mon at 13:00hrs	Running	Running well, MDT's have been well attended.since Aug 17
	Berkley Practice			
	Stroud Practice			
West 2	Lockfield Surgery	Monthly Every 2nd Tuesday at 11:30hrs	Running	Running well, MDT's have been well attended.
East 2	Northgate Practice	Bi-Monthly Every 3 rd Tues at 12:30hrs	Paused	Running well, MDT's have been well attended. (historically) Monthly meetings now set for 3rd Tue Bi-monthly Attendance issues in last 2 months have reduced confidence and a pause requested
East 2	Portland Practice	Bi-Monthly Every 3 rd Tues at 13:30hrs	Paused	Running well, MDT's have been well attended. (historically) Monthly meetings now set for 3rd Tue Bi-monthly Attendance issues in last 2 months have reduced confidence and a pause requested
west 2	Moxley Practice	Monthly Every 3 rd Wed at 11:30hrs	Running	Another very good MDT. GP is going to talk to two other practices and see if they want to join his MDT. Monthly meetings to be set for 3rd Wed every month
North	Pinfold St Mary's Surgery	Monthly Last Thurs of every month, attached to monthly MDT meeting so date of meeting wont always be rolling date 1.30pm-2pm	Running	MDT meeting on the 17th May was well attended..
North	Pinfold Bloxwich Practice	Bi-Monthly Next meeting confirmed 22nd Aug @ 12:15hrs	Running	2nd meeting went well, 3rd meeting planned for August, GP looking to see if practice can attach MDT to existing PBT and St Mary's MDT,
South 2	Brace Street Dr Mahbub	Monthly Every 1st Tues at 13:00hrs	Running	First meeting was well attended, Dr Mahbub stated that he thinks the MDT is really useful.
East 1	Parkside Practice	Bi-Monthly Every 4th Wed (bi-monthly) at 13:00hrs	Running	First MDT took place on the 25th July, very well attended.
West 1	Darlaston HC Modality Group-	Monthly Every 3rd Tues at 13:00hrs	Running	First MDT went ahead Sept 18th, only 3 patients were discussed as the others on the list were GSF patients, the practice will be replacing these patients with more MDT appropriate patients.
South 2	Brace Street	Monthly Every 2nd Mon at 13:00hrs	Planned	Practice have confirmed first meeting is to take place Mon 8th Oct at 1pm.
South 1	Pleck HC	Awaiting date and time for first meeting	Planned	Meeting went ahead on the 8th May with practice manager, practice will be contacting MDT Co-ordinator with a suitable rolling date and time, and have confirmed they will be taking part.
East 2	Collingwood Practice	Awaiting date and time for first meeting	Planned	Meeting went ahead on the 21st May with practice manager and GP, practice will be contacting MDT Co-ordinator with a suitable rolling date and time, and have confirmed they will be taking part.
South 2	Brace Street	Awaiting date and time for first meeting	Planned	Practice very interested and will be confirming a rolling date shortly

MEETING OF THE PUBLIC TRUST BOARD – 4 OCTOBER 2018			
Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions			AGENDA ITEM: 15
Report Author and Job Title:	Jackie White Interim Trust Secretary	Responsible Director:	Jenna Davies Director of Governance
Action Required	Approve <input checked="" type="checkbox"/> Discuss <input type="checkbox"/> Inform <input type="checkbox"/> Assure <input type="checkbox"/>		
Executive Summary	<p>The Board has an ongoing responsibility to ensure that it monitors the adequacy and effectiveness of financial governance arrangements. The Board's Standing Financial Instructions (SFIs) and Scheme of Delegation were last reviewed, updated and approved by the Board in February 2016.</p> <p>A full review of governance arrangements is being undertaken to ensure that the SFIs and Scheme of Delegation reflect current organisational responsibilities and current guidance and legislation this will be presented to the Board in December 2018 following consultation and review by the Audit Committee.</p> <p>However a review of delegated limits has taken place. A new section has been added to the SFIs bringing together all delegated limits to clarify who can make a decision and to what level to enable key decisions to be made in a timelier manner.</p> <p>The delegated limits table document is attached.</p>		
Recommendation	Members of the Trust Board are asked to approve the revised delegated limits.		
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 <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		



Current Limits (February 2016)

The Trust's business case procedure is to be followed by managers when proposing service changes. The approval limits are set out below:

AUTHORITY TO APPROVE

Executive Team and then TMB then Performance, Finance & Investment Committee and then Trust Board (as appropriate)

Divisional Directors

SCHEME SIZE

Recurring or non-recurring revenue schemes above £25,000
All capital schemes for capital programme consideration

Recurring or non-recurring revenue schemes below £25,000 (excluding schemes impacting on PFI)

Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with (e.g. an appropriate budget exists), formal authorisation and awarding of a contract may be decided by the following staff to the life value of the contract as follows:

Authorisation of Expenditure

Designated budget holders (or nominated officer)
Divisional Directors or Equivalent (or nominated officer)
Chief Executive and Director of Finance (or nominated Director)
Trust Board

up to £9,999
from £10,000 to £24,999
from £25,000 to £249,999
over £250,000



Authorisation of Expenditure (Charitable funds)

Restricted to the relevant Fund manager for the designated fund balance, with the approval of the Divisional Director

up to £4,999

from £5,000 to £99,999

Chief Executive, Director of Finance and the Charitable Funds Panel (Urgent decisions in relation to expenditure outside of the Charitable Funds Committee meetings must have the approval of the Chair of the Charitable Funds Committee, the Director of Finance and Performance and the Chief Executive. The urgent decision must be reported to the next meeting of the Charitable Funds Committee meeting for formal ratification)

£100,000 and over

Corporate Trustee

SCHEDULES TO STANDING FINANCIAL INSTRUCTIONS (Limits now annual and not every two years)

SFI	Description	Summary of Internal Delegation				Trust Board
		Divisonal Director	All Directors	Chief Executive/ Director of Finance	Performance, Finance and Investment Committee	
1.losses and Special payments						
	Write off NHS Debtors	Nil	Nil	Up to £99,000	Between £100,000 and £149,000	Over £150,000
	Cash Losses (Theft, Fraud, salary Overpayments, Loss of Cash) and abandoned claims	Nil	Up to £20,000	Up to £99,000	Between £100,000 and £149,000	Over £150,000
	Fruitless Payments (including abandoned Capital schemes)	Nil	Up to £99,000	Between £100,000 and £249,000	Between £249,000 and £499,000	£500,000 and over
	Loss or Damage to Buildings, Property, Equipment and stock including linen	Nil	Up to £50,000	Up to £99,000	Between £100,000 amd £199,000	£200,000 and over
	Compensation Payments under legal obligation	Nil	Up to £50,000	Up to £99,000	Between £100,000 amd £199,000	£200,000 and over
	Extra Contractual Payments to Contractors	Nil	Up to £25,00	Up to £50,000	Nil	Nil

	Ex gratia payments for clinical negligence and personal injuries involving negligence (i.e. negotiated or agreed settlements following legal advice)	Nil	Nil	Up to £99,000	Nil	Over £100,00
	Ex gratia payments to patients and staff for loss of personal effects; clinical negligence	Nil	Up to £10,000	Up to £50,00	Nil	Nil
	personal injuries and most other ex gratia payments	Nil	Up to £10,000	Up to £50,00	Nil	Nil
2.HOSPITALITY/GIFTS						
	Personal gifts or hospitality	Director of Governance over £50				
	Petty Cash	Up to £50	Over £50			
3.Trust wide expenditure limits						
	Competitive Tenders	£24,999	£100,000	Up to £250,000	Between £250,000 and £750,000 (plus additional 10% contingency)	Over £750,000
	Non Competitive Tenders	£25,000	£50,000			
	Business Cases (funds not available in current budget)	Nil	Nil	Up to £250,000	Between £250,000 and £750,000 (plus additional 10% contingency)	Over £750,000

	Business cases (within existing resource)	£24,999	£100,000	Up to £250,000	Between £250,000 and £750,000 (plus additional 10% contingency)	Over £750,000
	The Annual capital plan		£500,000			
	Requisition of non-pay expenditure	£24,999	Up to £250,000	Up to £499,000	Between £500,000 and £999,999	Over £1,000,000
	Signing contracts and contract variations for the provision of goods and services	£24,999	Up to £250,000	Up to £499,000	Between £500,000 and £999,999	Over £1,000,000
4. Charitable Funds						
		up to £4,999	CEO/DOF Up to £50,000	Charitable funds panel Up to £99,000	Trustee Over £100,000	

Summary of Procurement Thresholds

Values	Goods and Services	Works*
£0 to £1,000	1 quote (verbal or written)	1 quote (verbal or written)
£1,001 to £5,000	1 written quote	1 written quote
£5,001 to £50,000	3 written quotes	3 written quotes
£50,001 to £106,046	Local tender process	Local tender process
£106,047 to £4,347,999	OJEU Tender	Local tender process
£4,348,000 and above	OJEU Tender	OJEU Tender

*Works relate to Estates and Facilities back log maintenance and/or construction spend

Summary of the Approval Required for Severance Payments

Payment Type	Value	Staff Group	Approval required
Compulsory redundancy / early retirement (contractual)	£ - Any amount	CEO and Directors	- Remuneration Committee, and - NHS Improvement
	> £100,000.00	Other staff	- Remuneration Committee, and - NHS Improvement (process to be agreed by Audit Committee see paragraph 4.8.2)
	< £100,000.00	Other staff	Remuneration Committee (process to be agreed by Audit Committee see paragraph 4.8.2)
Voluntary redundancy / early retirement (contractual)	£ - Any amount	CEO and Directors	- Remuneration Committee, and - NHS Improvement
	> £100,000.00	Other staff	- Remuneration Committee, and - NHS Improvement (process to be agreed by Audit Committee see paragraph 4.8.2)
	< £100,000.00	Other staff	Remuneration Committee
Other contractual severance	£ - Any amount	CEO and Directors	- Remuneration Committee, and - NHS Improvement Remuneration Committee.
	> £100,000.00	Other staff	- Remuneration Committee, and - NHS Improvement (process to be agreed by Audit Committee see paragraph 4.8.2)
	< £100,000.00	Other staff	Remuneration Committee
Non-contractual severance	£ - Any amount	CEO and Directors	- Remuneration Committee, and - NHS Improvement
	> £100,000.00	Other staff	- Remuneration Committee, and - NHS Improvement (process to be agreed by Audit Committee see paragraph 4.8.2)
	< £100,000.00	Other staff	Remuneration Committee

All Financial limits must fall within the available budget. Powers not detailed above are retained by the Board.
The Financial Limits represent the maximum limit. Lower limits may be set for individual budget holders depending on the scale of budgets managed.

Caring for Walsall together



MEETING OF THE PUBLIC TRUST BOARD – 4 October 2018			
Annual review and approval of Tier 1 Committee terms of reference			AGENDA ITEM: 16
Report Author and Job Title:	Jackie White, Interim Trust Secretary	Responsible Director:	Jenna Davies, Director of Governance
Action Required	Approve <input checked="" type="checkbox"/> Discuss <input type="checkbox"/> Inform <input type="checkbox"/> Assure <input type="checkbox"/> (select the relevant action required)		
Executive Summary	Each of the Board Tier 1 Committees have undertaken a review of their Terms of Reference in line with the Scheme of Reservation and Delegation.		
Recommendation	Members of the Trust Board are asked to: <ul style="list-style-type: none"> • Note the information included in this report • Approve the 2018/19 Tier 1 Committee Terms of Reference 		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Yes this report ensures that the corporate governance framework of the Trust is robust.		
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 <input type="checkbox"/>	Care at home <input checked="" type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		



Annual review and approval of Tier 1 Committee terms of reference

1. PURPOSE OF REPORT

The purpose of the report is to allow the Board an opportunity to review and approve the Tier 1 Committee terms of reference.

2. BACKGROUND

The foundations of good governance advise that the starting point when considering committees needs to be that no committee of the board has the right to exist. Committees should exist only because (and for as long as) the Board has identified a need for them and has therefore delegated certain tasks or duties to them.

It is vital that as well as overseeing the work of its committees, the Board also reviews the need for each committee to continue. Each committee's terms of reference and membership should therefore be reviewed annually and considered against the annual report of that committee.

3. DETAILS

Tier 1 Committee Terms of Reference 2018/19

The Scheme of Reservation and Delegation requests the Trust Board Tier 1 Committees to review their Terms of Reference on an annual basis and for the Trust Board to receive them for approval. These are attached at Appendix 1.

- Audit Committee
- Quality, Patient Experience & Safety Committee
- Nomination & Remuneration Committee
- Charitable Funds Committee
- Performance, Finance & Investment Committee
- People & OD Committee

4. RECOMMENDATIONS

It is recommended that the Board:

- Note the information included in this report
- Approves the 2018/18 Tier 1 Committee Terms of Reference

APPENDICES

- Audit Committee Terms of Reference
- Quality, Patient Experience & Safety Committee Terms of Reference
- Nomination & Remuneration Committee - Terms of Reference
- Charitable Funds Committee - Terms of Reference
- Performance, Finance & Investment Committee - Terms of Reference
- People & OD Committee - Terms of Reference

AUDIT COMMITTEE

TERMS OF REFERENCE: Version 4.0

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 Audit 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 The purpose of the Audit Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports achievement of the organisation's objectives.

2.2 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 Committee shall consist of the Chair of the People Organisational Committee, Chair of the Quality, Patient Experience and Safety Committee and Chair of the Performance, Finance & Investment Committee plus one other NED of whom has recent, relevant financial experience.

4. ATTENDEES

4.1 The Director of Finance and Performance, Trust Secretary, and other members of the Finance Directorate Team shall normally attend meetings.

4.2 Representatives of the external auditor and internal audit will attend. The Committee will meet in private with the internal and external audit representatives at least once a year.

4.3 Only members of the audit committee have the right to attend meetings, but the Chief Executive shall generally be invited to attend routine meetings of the audit committee.

4.4 The Chair may be invited to attend meetings of the audit committee as required.

4.3 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.

5. ATTENDANCE

5.1 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.

6. QUORUM

6.1 The Committee has no decision making authority unless there are 2 Non-Executive Directors and 2 Executive Directors present, the Chair or Deputy Chair must always be present.

7. FREQUENCY OF MEETINGS

7.1 The Committee will meet five times a year additional meetings may be arranged as required. Meetings will be expected to last no more than 2 ½ hours routinely.

8. 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.

9. ADMINISTRATIVE ARRANGEMENTS

9.1 The Chair of the Committee will agree the agenda for each meeting with the Trust Secretary and the Director of Finance & Performance. The Committee shall be supported administratively by the Trust Secretary and 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.

10. ANNUAL CYCLE OF BUSINESS

- 10.1 The Committee will develop an annual cycle of business for approval by the Committee 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.

11. REPORTING TO THE TRUST BOARD

- 11.1 The Chair of the Audit Committee will highlight any key actions taken with regard to the issues, key risks identified and key levels of assurance given to the Trust Board.

12. 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 and lead Executive.

13. 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. This will include reporting at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk and governance systems are integrated and embedded in the organisation, the appropriateness of evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the quality accounts.

14. DUTIES

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications;

- the policies and procedures for all work related to counter fraud and security as required by NHS Protect.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards 2013* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit, including the formation of an Audit Appointment Panel as set out in the Local Audit and Accountability Act 2014
- discussion and agreement with the external auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan and ensuring coordination, as appropriate, with other external auditors in the local health economy
- discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

- reviewing all external audit reports, including the report to those charged with governance
- Agreement of the annual audit letter before submission to the Board
- Any work undertaken outside the annual audit plan, together with the appropriateness of management responses

Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Litigation Authority etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality and Safety Committee and the Performance, Finance and Investment Committee.

Clinical Audit Function

In reviewing the work of the Quality & Safety Committee around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function and issues around clinical risk management. This will include requesting specific reports from clinical audit as may be appropriate to the overall arrangements.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Whistleblowing

The Committee shall satisfy itself that the organisation has an adequate policy for whistle blowing and shall review the outcomes where the policy is applied and cases where the policy is not complied with.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit).

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- Letters of representation
- Qualitative aspects of financial reporting

Version Control:

Version 4.0

Reviewed by Audit Committee

Adopted by Trust Board on

Next review due

QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE

TERMS OF REFERENCE: Version 3.0

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 Quality & Safety 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 The purpose of this Committee is to provide assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board.

3. MEMBERSHIP

3.1 The Committee will comprise:

- Three Non-Executive Directors
- Director of Nursing
- Chief Operating Officer
- Executive Medical Director
- Director of Governance

4. ATTENDEES

4.1 The Committee Chair may extend invitations to attend committee meetings to any individual considered appropriate to progress the work plan of the Committee.

4.2 The Divisional Teams of Three will attend as agenda items dictate or where a pre-existing or externally

5. ATTENDANCE

- 5.1 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. A named deputy must be identified for core members of the Committee and must attend when a member is unable to be present. A named deputy will count towards quorum and members or their named deputy should ensure 100% attendance.

6. QUORUM

- 6.1 The Committee has no decision making authority unless there are 2 Non-Executive Directors and 2 Executive Directors present, one of which must be the Director of Nursing or Executive Medical Director, the Chair or Deputy Chair must always be present.

7. FREQUENCY OF MEETINGS

- 7.1 The Committee will meet formally on monthly basis. Meetings will be expected to last no more than 2 ½ hours routinely. Cancellation of meetings will be at the discretion of the Chair and extraordinary meetings of the Committee may be called by any member of the Committee, with the consent of the Chair.

8. 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.

9. ESTABLISHMENT OF SUB GROUPS

- 9.1 The Committee may establish sub groups and / or sub committees made up wholly or partly of members of the Committee to support its work. The terms of reference of such sub group and sub committee will be approved by the Committee and reviewed at least annually. The Committee may delegate work to the sub group and or sub committee in accordance with the agreed terms of reference. The Chair of each sub group and or sub committee will be expected to provide a Chairs report to the Committee and review its effectiveness on an annual basis.

10. ADMINISTRATIVE ARRANGEMENTS

- 10.1 The Chair of the Committee will agree the agenda for each meeting with the Trust Secretary and the lead Director. The Committee shall be supported administratively by the Trust Secretary and 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.

11. ANNUAL CYCLE OF BUSINESS

- 11.1 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.

12. REPORTING TO THE TRUST BOARD

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

13. STATUS OF THE MEETING

- 13.1 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 and Executive Lead.

14. MONITORING

- 14.1 The annual report on assurance will provide a statement that enables the committee to monitor the effectiveness of the Committee. This will include levels of attendance, delivery against the forward looking work programme and the management of identified risk.

15. DUTIES

To develop an Annual Work Plan in the agreed Trust format, denoting the objectives of the Committee for approval by the Trust Board ensuring these are aligned with the Trust's vision, strategy and values and the relevant risks contained in the Board Assurance Framework.

To identify any risks and issues that may prevent the achievement of the Work Plan and ensure that they are assessed placed on the Trust's Risk Register and the action plan is monitored and mitigating actions are undertaken to ensure progress is made.

To consider the actual and potential financial consequences of the Committee's decisions; making referrals to the Performance Finance and Investment Committee as necessary.

To ensure and assure the Medical Revalidation and Appraisal System.

The Committee will assure itself that adequate and appropriate integrated governance structures, processes and controls (including Risk Frameworks at all levels) are in place across the Trust. The Trust Governance Framework allows for the establishment of Divisional governance arrangements within a strong accountability framework. The Committee will approve the governance arrangements proposed by the divisions and will have oversight of the establishment and function of any sub-committees established within those arrangements.

The Committee will receive reports from the Divisional quality governance meetings at which the patient safety and quality issues and risk management processes in the Divisions are debated and monitored collectively.

To ensure that robust regular establishment reviews are undertaken for all staff groups.

The Committee will receive professional staffing reviews relating to clinical; nursing; and midwifery functions (and associated professions) and review the impact of staffing on patient care.

A mortality update highlight report will be received by the committee and be a standing agenda item for the Medical Director.

The Committee will provide the Board with the assurance that the divisional meetings are functioning appropriately in terms of governance and risk management and contribute positively to ensuring the delivery of safe, personal and effective care.

It will satisfy itself that at every level of the Trust staff identify, prioritise and manage risk arising from corporate and clinical issues on a continuing basis.

It has responsibility for scrutinising the Trust's (Corporate) Risk Assurance Framework on regular basis at each meeting and satisfying itself that the identified risks are being managed appropriately within the divisions and departments and at executive level.

It is responsible for ensuring that those risks escalated to the Board Assurance Framework (BAF) are appropriate and proportionate, seeking further assurance from the executive team and escalating to the Board, concerns relating to unresolved risks that may require executive action or pose significant threats to the operation, resources or reputation of the Trust.

The Committee will scrutinise the effective and efficient use of resources through evidence based clinical practice and assure itself that there is an appropriate process in place to monitor and promote compliance across the Trust with all standards and guidelines issued by the regulators, NHS Improvement, Care Quality Commission, NHS England, the NHS Resolution, the Royal Colleges and other professional and national bodies.

It will promote a culture of open and honest reporting of any situation that may threaten the quality of patient care and oversee the process within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, complaints and litigation.

The Committee will satisfy itself that examples of good practice are disseminated within the Trust, ensuring that the investigation of incidents has been adequately scrutinised and that there is evidence that learning is identified and disseminated across the Trust.

The Committee will satisfy itself that those elements of business relating to Patient Safety and Governance that are contained in the Terms of Reference of other Committees are carried out effectively for example ensuring that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit; that guidelines and standards are introduced consistently across the trust and poor practice is challenged.

The Committee will satisfy itself that Safeguarding Children and Vulnerable Adults is at the heart of everything we do, ensuring that the Trust meets all of its obligations in respect of safeguarding at all times. This includes satisfying itself that all staff have training to the standard and frequency required. It will also satisfy itself that the Trust captures the learning from nationally published reports and that the learning is embedded in the practices, policies and procedures of the Trust.

It will also satisfy itself that the appropriate actions in respect of Patient Safety and Governance have been taken following recommendations by any relevant external body. This includes monitoring the Trust's compliance with the Care Quality Commission registration requirements and any reports resulting from visits.

The Committee will receive periodic detailed reports on the activity of the PALs service; Patient Experience Surveys and Stories; Complaints; Serious Incidents; Ombudsman findings; Litigation; and seek assurance on the lessons learned and implemented.

The Committee will seek assurances that as well as delivering safe, personal and effective care to patients, the health and welfare of staff and others for whom the Trust owes a duty of care is protected.

The Committee will also consider matters referred to it by other committees and groups across the Trust provided they are within the Committee's remit.

To oversee the development and implementation of the Trust's Quality Strategy and the agreement of annual quality objectives and the link to strategic objectives.

To consider the monthly Quality & Safety Reporting as part of the Integrated Performance report and Annual Quality Account prior to submission to the Trust Board and publication of the Annual Quality Account.

To ensure that actions arising from the external assurance on the Annual Quality Account are implemented.

To agree key quality and safety performance indicators and utilise these as appropriate to assess Trust performance and delivery of services against the Trust's vision and values to improve quality.

To make recommendations for action to Divisions and the Trust Board for developing or improving standards, systems and processes for improving quality and safety.

To monitor the implementation of National Safety Alerts. To receive the following monthly and quarterly reports:

- Matrons Cleanliness report
- Quarterly Patient Safety Alerts Performance Report
- Quality: Patient Experience

To oversee the development and implementation of the Trust's strategy and approach to collecting and using information to improve the experience of patients.

To receive quarterly reports from the Patient Experience Group.

To facilitate shared learning across the organisation in respect of required improvements to the quality of the patient experience.

To ensure there is a strong focus on responding to findings as well as gathering information.

To consider the findings from the national patients surveys and monitor the development and implementation of appropriate action plans.

To consider themes/trends and learning from complaints, Serious Incidents, claims and concerns and consider how this information might be used as part of the wider Trust approach to improving the patient experience. To consider the findings from Ombudsman's reports and monitor the development and implementation of appropriate action plans.

To consider the outcome from PLACE inspections and monitor the development and implementation of appropriate action plans.

To ensure that the Trust has in place appropriate patient information.

To receive the following quarterly/ad-hoc reports:

- Quarterly Ward Assurance Reports
- Quarterly Director Visit Reports
- Reports from Healthwatch 'Enter & View' Visits
- Quality: Clinical Effectiveness

To monitor the Trust's performance in respect of the achievement of quality contract targets e.g. CQUINs/Quality KPIs and advise on remedial actions where shortfalls are identified.

To use information from the CQC and NHS England Quality & Risk Profile (QRP) and other sources of information to identify and address issues (e.g. Mortality, NICE) which may impact on the Trust's ability to deliver a safe and effective quality service to patients.

To consider the outcomes of relevant local and national audits, reports (e.g. dementia, appraisals) and other sources of evaluation (e.g. Patient Reported Outcome Measures (PROMS)) and recommend appropriate action to further improve quality and/or monitor the development and implementation of appropriate action plans.

To agree the Annual Clinical Audit Programme. To agree the Annual Clinical Audit Report prior to submission to the Trust Board and Audit, Risk Management Group for information.

To receive quarterly and annual reports on the implementation within NLAG of NICE guidance.

To receive the following monthly and quarterly reports:

- Integrated Performance Report: Quality & Safety Section
- Quarterly clinical audit activity report
- Quarterly NICE performance report

To undertake an annual review of the committee terms of reference and effectiveness.

Version Control:

Version 3.0

Reviewed by Quality & Safety Committee

Adopted by Trust Board on

Next review due

NOMINATIONS AND REMUNERATION COMMITTEE

TERMS OF REFERENCE: Version

RATIFIED BY TRUST BOARD ON:

APPROVED BY COMMITTEE 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 Nominations and Remuneration 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 The purpose of the Committee is to determine, on behalf of the Trust board, the remuneration and terms of service for the Chief Executive and other Executive Directors (voting and non-voting members of the Trust Board).

3. MEMBERSHIP

3.1 Membership shall be all Non-Executive Directors of the Trust Board.

4. ATTENDEES

4.1 Associate Non-Executive Directors are in attendance at the meeting.

4.2 The Chief Executive, Director of OD & HR and Director of Governance will attend the Committee at the invitation of the Chairman but will not be involved in decision making regarding their own (in the case of the Chief Executive) remuneration.

5. ATTENDANCE

5.1 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.

6. QUORUM

6.1 The Committee has no decision making authority unless 60% of the members are present.

7. FREQUENCY OF MEETINGS

- 7.1 The Committee will meet as required throughout the year, but at least twice to review performance of the Chief Executive and Executive Directors (voting and non-voting members of the Trust Board).
- 7.2 Meetings will be expected to last no more than 2 ½ hours routinely.

8. 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.

9. ESTABLISHMENT OF SUB GROUPS

- 9.1 The Committee may establish sub groups and / or sub committees made up wholly or partly of members of the Committee to support its work. The terms of reference of such sub group and sub committee will be approved by the Committee and reviewed at least annually. The Committee may delegate work to the sub group and or sub committee in accordance with the agreed terms of reference.

10. ADMINISTRATIVE ARRANGEMENTS

- 10.1 The Chair of the Committee will agree the agenda for each meeting with the Trust Secretary. The Committee shall be supported administratively by the Trust Secretary and 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
- 10.2 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.

11. ANNUAL CYCLE OF BUSINESS

- 11.1 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.

12. REPORTING TO THE TRUST BOARD

- 12.1 The Chair of the 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.

13. STATUS OF THE MEETING

- 13.1 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.

14. MONITORING

- 14.1 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.

15. DUTIES

- 15.1 To determine pay and reward strategy for Chief Executive and other Executive Directors (voting and non-voting members of the Trust Board) including bonus payments and eligibility criteria
- 15.2 To determine the remuneration and terms / conditions of service for the Chief Executive and other Executive Directors (voting and non-voting members of the Trust Board)
- 15.3 To ensure fair reward for individual contribution to the organisation and having proper regard to the organisation's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate
- 15.4 To receive a report from the Trust Chair on the annual performance of the Chief Executive and to give comment before the Chief Executive's annual appraisal is completed
- 15.5 To receive a report from the Chief Executive on the annual performance of the Executive Directors (voting and non-voting members of the Trust Board) and to give comment before their annual appraisals are completed
- 15.6 To consider any remuneration issues of significance to the Trust that do not comply with Trust or national pay / terms and conditions
- 15.7 To receive and consider any matters relating to the test for Fit and Proper Person (FPPT) for Trust Directors and employees within the scope of the test, where a decision of the Committee is required.

CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE: Version 6

APPROVED BY THE CORPORATE TRUSTEE ON:

NEXT REVIEW DUE:

1. CONSTITUTION

1.1 The Walsall Healthcare NHS Trust General Charitable Fund is registered with the Charity Commission, Registered Charity Number 1057416. In line with this registration the Board of Directors collectively are the Corporate Trustee.

2. PURPOSE

2.1 The Board of Directors as Corporate Trustee, approved the establishment of the Charitable Funds Committee for the purpose of:

2.1.1 Ensuring the stewardship and effective management of funds which have been donated, bequeathed and given to the Walsall healthcare NHS Trust General Charitable Fund for charitable purposes.

2.1.2 Determining an investment strategy and arrangements for the investment of funds which are not immediately required for use.

2.1.3 Co-ordinating the provision of assurance to the Board of Directors, acting as trustee of the funds, that the funds are accounted for, deployed and invested in line with legal and statutory requirements.

2.1.4 Considering and approving the annual accounts for charitable funds for submission to the Board of Directors, acting as trustee for the funds.

2.1.5 The Board of Directors, acting as trustee, must approve any changes to these terms of reference.

3. MEMBERSHIP

3.1 The Committee will include the following members who will be voting members:

- A non-executive Director (Chair)
- One other Non-executive Director
- The Director of Finance and Performance
- The Director of Nursing
- The Director of Governance/Trust Secretary

3.2 The Chair of the Committee is the Non-executive Director appointed by the Board of Directors. The Deputy Chair of the Committee will be a second Non-executive Director appointed by the Charitable Funds Committee.

4. ATTENDEES

- 4.1 The Committee may invite individuals to attend from time to time on a regular or ad hoc basis for specific items on the agenda. A named deputy will count towards quorum and members or their named deputy should ensure 100% attendance.

5. ATTENDANCE

- 5.1 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.

6. QUORUM

- 6.1 The Committee has no decision making authority unless three members are present, which must include the Non-executive Director Chair, the Director of Finance and Performance or their deputy and one other member.

7. FREQUENCY OF MEETINGS

- 7.1 Meetings will normally take place on a quarterly basis to ensure that the full scope of the Committee's annual work plan is delivered.
- 7.2 In addition, a funding request review meeting will be held in each month between the quarterly meetings. The purpose of the funding request review meeting is to ensure that requests are considered in a timely manner and that the charity's income does not unduly accumulate. The meeting may be held by teleconference with a quorum of three members as per 6.1 above. The decisions will be formally recorded and reported to the next quarterly meeting of the Committee for ratification.
- 7.3 The Chair may convene additional meetings of the committee to consider business that requires urgent attention.

8. 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.

9. ADMINISTRATIVE ARRANGEMENTS

- 9.1 The Chair of the Committee will agree the agenda for each meeting with the Trust Secretary and the Director of Finance & Performance. The Committee shall be supported administratively by the Trust Secretary and the Executive PA whos 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

9.2 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.

10. 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.

11. REPORTING TO THE TRUST BOARD

11.1 The Chair of the Committee will highlight key actions taken with regard to the issues, key risks identified and key levels of assurance given to the Trust Board.

12. DUTIES

The Committee will:

Assurance

- 12.1 Manage the affairs of the charitable fund within the terms of its declaration of trust and appropriate legislation and ensure statutory compliance with the Charity Commission regulations.
- 12.2 Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law.
- 12.3 Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and trust guidance regarding the ethical use of funds and the acceptance of donations.
- 12.4 Receive a quarterly report on expenditure below £5,000 authorised by Fund Managers and Divisional Directors.
- 12.5 Consider and authorise expenditure with a value of £5,000 up to £99,999 ensuring that it is accompanied by endorsement from the Director of Finance and Performance and the Chief Executive.
- 12.6 Ensure that any urgent decisions in relation to expenditure outside of the Charitable Funds Committee meetings are approved by the Chair of the

Committee, the Director of Finance and Performance and the Chief Executive. The urgent decision must be reported to the next meeting of the Committee for formal ratification.

- 12.7 Consider expenditure with a value of £100,000 and above for recommendation to the Corporate Trustee for approval. Ensure that recommendations for expenditure include endorsement from the Director of Finance and Performance and the Chief Executive.
- 12.8 Receive and approve periodic income and expenditure statements.
- 12.9 Receive and approve annual accounts and consider the annual report from the auditors, before submission to the Board of Directors, acting as corporate trustee.

Investments

- 12.10 Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations.
- 12.11 Appoint and review external investment advisors and operational fund managers.
- 12.12 Review the performance of investments on a regular basis with the external investment advisors to ensure the optimum return from surplus funds.

Fundraising

- 12.13 Ensure a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation.
- 12.14 Ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law.
- 12.15 Ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments.
- 12.16 Ensure a cohesive policy around external media and communication.
- 12.17 Ensure effective communication regarding 'whistle blowing' relating to fundraising, donations or subsequent use of funds.
- 12.18 Receive regular updates from the Fundraising Committee.

PERFORMANCE FINANCE AND INVESTMENT COMMITTEE

TERMS OF REFERENCE: Version 3.0

RATIFIED BY TRUST BOARD ON:

APPROVED BY COMMITTEE 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 Performance, Finance and Investment (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 The purpose of the Committee is to provide assurance to the Trust Board on the management of key Trust resources and performance issues.

- Putting the interests of patients at the heart of what the organisation does.
- Financial/Annual planning and monitoring.
- Cost transformation programmes.
- Activity and productivity including operational efficiency and effectiveness.
- Delivery of the Five Year Forward View, NHS Constitution Standards and local contractual obligations.
- Workforce cost.
- Information Management & Technology: seeking assurances about the underlying data to ensure that it is robust, reliable and accurate.
- Public Finance Initiative performance.
- Challenging relevant managers when controls are not working or data is unreliable.
- Review, approve and evaluate business case investments and requests for capital expenditure within the powers delegated by the Trust Board.

3. MEMBERSHIP

3.1 Membership shall be appointed by the Board and comprise of:

3 Non-Executive Directors (one of whom is the Chair of the Committee)
Director of Finance & Performance
Executive Medical Director
Chief Operating Officer
Director of Strategy & Improvement

Director of Governance

4. ATTENDEES

- 4.1 The Committee may invite individuals to attend from time to time on a regular or ad hoc basis for specific items on the agenda.

5. ATTENDANCE

- 5.1 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. A named deputy will count towards quorum and members or their named deputy should ensure 100% attendance.

6. QUORUM

- 6.1 The Committee has no decision making authority unless there are 2 Non-Executive Directors and 2 Executive Directors present, the Chair or Deputy Chair must always be present..

7. FREQUENCY OF MEETINGS

- 7.1 The Committee will meet monthly. Meetings will be expected to last no more than 2 ½ hours routinely.

8. 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.

9. ESTABLISHMENT OF SUB GROUPS

- 9.1 The Committee may establish sub groups and / or sub committees made up wholly or partly of members of the Committee to support its work. The terms of reference of such sub group and sub committee will be approved by the Committee and reviewed at least annually. The Committee may delegate work to the sub group and or sub committee in accordance with the agreed terms of reference. The Chair of each sub group and or sub committee will be expected to provide a Chairs report to the Quality & Safety Committee.

10. ADMINISTRATIVE ARRANGEMENTS

- 10.1 The Chair of the Committee will agree the agenda for each meeting with the Trust Secretary and the Director of Finance & Performance. The Committee shall be supported administratively by the Trust Secretary and the Executive PA whos 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

10.2 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.

11. ANNUAL CYCLE OF BUSINESS

11.1 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.

12. REPORTING TO THE TRUST BOARD

12.1 The Chair of the 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.

13. 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 Setting key performance, financial, activity and workforce plans over the short, medium and long term. This will include annual targets (including revenue and capital budgets) for approval by the Trust Board on an annual basis prior to the start of each financial year. These plans should be set according to an agreed timetable and ensure that they support the achievement of performance targets.

14.2 Reviewing the development of future strategies and business plans.

14.3 Monitoring in-year performance against the Five Year Forward View, financial, activity and workforce targets agreed by the Trust Board, NHS Constitution Standards and local contractual obligations, discussing and agreeing corrective action where necessary. This will include cost improvement and other productivity improvement programmes.

14.4 Monitoring the financial and performance implications of externally driven new legislation, performance targets and guidance impacting the Trust.

14.5 To consider the Trust's medium and long term financial strategy, in relation to both revenue and capital.

- 14.6 To consider the target level of Cost Improvement Programme (CIP) and actions to ensure that CIP targets are achieved without compromising on quality and to ensure that proposed financial initiatives are rated according to their potential impact on quality.
- 14.7 To agree budget setting principles on an annual basis.
- 14.8 To receive and consider as appropriate, reports on Trust commercial activities.
- 14.9 Business Case Investments and Evaluation - ensuring that these support the delivery of the Trust's corporate objectives and strategic direction.
- 14.10 To review and approve or make a recommendation to the Board on recurring or non-recurring revenue schemes that will result in costs that over twenty four months in line with the Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation.
- 14.11 To review and approve or make a recommendation to the Board on all schemes for capital programmes in line with the Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation.
- 14.12 To receive and scrutinise post implementation reviews on business case and capital investment schemes, escalating areas of concern to the Director of Finance and Performance for further action to be taken.
- 14.13 To receive and consider major Trust Investment Plans and maintain an oversight of the Trust's investments, ensuring compliance with the Trust's Strategic Direction and Annual Plan.
- 14.14 To approve any innovative, commercial or investment activity e.g. proposed joint ventures.
- 14.15 To approve and keep under review, on behalf of the Trust Board, the Trust's Procurement Strategy and related policy.
- 14.16 To consider and approve any significant variations to the Trust's existing procurement methodology in accordance with the Standing Orders.
- 14.17 To consider key issues pertinent to the use of the Trust Estate.
- 14.18 Monitor and provide assurance to the Board on both Board Assurance Framework and corporate risks allocated to the Committee.

PEOPLE AND OD COMMITTEE

TERMS OF REFERENCE: Version 3.0

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 People and OD 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 The purpose of the Committee is to provide assurance to the Trust Board on

- The organisational development and workforce strategy, structures, systems and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care
- Processes are in place to support optimum employee performance to enable the delivery of strategy and business plans in line with the trust's values
- The Trust is meeting its legal and regulatory duties in relation to its employees
- Where there are human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives, that these are being managed

3. MEMBERSHIP

4.1 Membership shall be appointed by the Board and comprise of:

- One Non-executive Director (Chair)
- Two other Non-executive Director (one to be Vice Chair)
- Director of People & Culture
- Director of Nursing
- Director of Strategy & Improvement
- Director of Governance

4. ATTENDEES

4.1 The Director of Postgraduate Medical Education and Deputy Director of HR will be in attendance.

4.2 Other Strategic and Operational Leads will be required to attend, which may include; Divisional Director of Operations, Divisional Directors of Nursing, Heads of HR Advisory, Resourcing, Equalities and Workforce, as appropriate

4.3 The Committee Chair may extend invitations to attend committee meetings to any individual considered appropriate to progress the work plan of the Committee.

5. ATTENDANCE

5.1 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. A named deputy will count towards quorum and members or their named deputy should ensure 100% attendance.

6. QUORUM

6.1 The Committee has no decision making authority unless there are 2 Non-Executive Directors and 2 Executive Directors present, the Chair or Deputy Chair must always be present.

7. FREQUENCY OF MEETINGS

7.1 The Committee will meet on a monthly basis. Meetings will be expected to last no more than 2 ½ hours routinely. Cancellation of meetings will be at the discretion of the Chair and extraordinary meetings of the Committee may be called by any member of the Committee, with the consent of the Chair.

8. 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.

9. ESTABLISHMENT OF SUB GROUPS

9.1 The Committee may establish sub groups and / or sub committees made up wholly or partly of members of the Committee to support its work. The terms of reference of such sub group and sub committee will be approved by the Committee and reviewed at least annually. The Committee may delegate work to the sub group and or sub committee in accordance with the agreed terms of reference. The Chair of each sub group and or sub committee will be expected to provide a Chairs report to the Committee.

10. ADMINISTRATIVE ARRANGEMENTS

10.1 The Chair of the Committee will agree the agenda for each meeting with the Trust Secretary and lead Director. The Committee shall be supported administratively by the Trust Secretary and Executive PA whose 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

10.2 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.

11. ANNUAL CYCLE OF BUSINESS

11.1 The Committee will develop an annual cycle of business for approval by the Committee 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.

12. REPORTING TO THE TRUST BOARD

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

13. STATUS OF THE MEETING

13.1 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 and Executive Lead.

14. MONITORING

14.1 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.

15. DUTIES

15.1 Oversee the initial development and subsequent delivery of the Trust's People and OD Strategies and plans ensuring that they are consistent with the Board's overall strategic direction and with any requirements/guidance set externally. Consider organisational development implications and advise on the development of plans required to deliver the change in culture, leadership, service improvement and processes required by the Trust.

15.2 Receive assurance that the Trust has in place structures, systems and processes for effective people management including strong leadership and transparent lines of accountability.

- 15.3 Receive assurance that the Trust has in place at all levels (Corporate, Divisional and Care Group) the right 'people' systems and processes to deliver, from a patients perspective, safe high quality care.
- 15.4 Receive assurance that people are appropriately selected, trained supported and responsive to the needs of the service, ensuring that professional standards and registration/revalidation requirements are maintained.
- 15.5 Receive assurance that the Trust's people policies and procedures are in accordance with legislation, NHS guidelines and requirements and are operating within the Trust's overall assurance framework.
- 15.6 Receive and consider National Staff Survey results and PULSE survey results for the Trust and advice on improvement actions. Oversee the implementation and effectiveness of improvement plans on colleague experience and engagement. Where necessary bring recommendations to the attention of the Board on key people and OD issues affecting those working within the Trust.
- 15.7 Receive, challenge and approve Trust workforce plans annually. This includes a specific responsibility to seek assurance regarding 'fitness for purpose' for the workforce and its future sustainability.
- 15.8 Receive assurance on the organisational resourcing and vacancy position including information on exit interviews, turnover, reason for leaving etc.
- 15.9 Receive reports and action plans on the requirements of new and emerging guidance from regulators and external agencies that relate to workforce.
- 15.10 Receive assurance that recommendations from audits relation to workforce and development are being progressed and any risks associated with these are being managed.
- 15.11 The Committee will receive annual reports on progress of delivery of the Trust Equality objectives and an annual assessment of overall performance in relation to Equality outcomes. The Committee will also advise the Trust Board on setting of Trust Equality objectives a report demonstrating compliance with the Public Sector Equality Duty.
- 15.12 Receive assurance of workforce related policies on behalf of the Trust Board (**as required**) include Freedom to Speak Up quarterly reporting and trend data, Guardian of Safeworking reporting and trend data.
- 15.13 Develop and oversee the implementation of an annual work programme for the Committee.
- 15.14 Receive assurance regarding the Trusts compliance with equal pay legislation, principally through an annual Equality Pay Audit.
- 15.15 Receive assurance and oversight of the employee relations position between the Trust and its recognised unions and joint working across the partnership over the year.

- 15.16 The Committee will have oversight of agency usage and plans in place to minimise this.
- 15.17 Effective identification and mitigation of Human Resources risks within the supporting infrastructure of the Board Assurance Framework (BAF) and Risk Register
- 15.18 The Trust is monitoring staff engagement and experience, and delivering its plans to achieve a highly motivated and engaged workforce to enhance the quality of patient care
- 15.19 Review progress of leadership, talent management and succession planning processes.
- 15.20 Arrangements are in place for the effective training and education of the workforce in all professions and disciplines. Review progress on plans and actions to improve mandatory training compliance / performance (exception only)
- 15.21 The Trust is delivering its ambition and legal obligations in relation to the Equality, Diversity and Inclusion opportunity of the workforce
- 15.22 Processes & resources are in place, to ensure the development of healthy teams and indicators of poor organisation health are acted upon, as well as support the wider Trust H&WB agenda.
- 15.23 National reports and best practice relating to Human Resource Management and OD is shared, reviewed for relevant findings and actions and the necessary actions implemented.
- 15.24 Receive assurance on the HR aspects of any external/internal compliance reviews that have raised concerns at Board and/or Executive Team.
- 15.25 By exception, consider whistleblowing and receive assurance on how workforce concerns raised are being dealt with.
- 15.26 To review and monitor effectiveness of workforce data and metrics including E roster, rota and other productivity data.
- 15.27 Review progress on the implementation of medical job planning, rotas and e rostering
- 15.28 Review the appraisal system to ensure that the appraisal delivered is of high quality, undertaking an evaluation of the effectiveness of the system.
- 15.29 Receive assurance on the implementation of the Values and Behaviour Framework, ensure an evaluation of the effectiveness of implementation has been undertaken

MEETING OF THE PUBLIC TRUST BOARD –			
The potential impact of “Brexit” on the NHS			AGENDA ITEM: 17
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 <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/> (select the relevant action required)		
Executive Summary	There remains a lack of clarity over the terms of the UK’s March 2019 departure from the European Union. This paper reviews the potential impact that Brexit may have on the NHS, and therefore Walsall Healthcare NHS Trust. It considers issues of the government’s contingency for a No Deal”; and other areas of impact including staffing, healthcare for British citizens abroad, regulation and cross-border co-operation		
Recommendation	Members of the Trust Board are asked to: note the contents of this Paper; take direction from NHSI and other National Bodies, and keep the position under regular review. It is further recommended that the Trust does not commit to any complex plans given the fluidity of Brexit.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	As no deal has yet been confirmed, the full extent of any risks are unknown		
Resource implications	As no deal has yet been confirmed the resource implications are unknown.		
Legal and Equality and Diversity implications	As no deal has yet been confirmed the legal or equality & diversity implications are unknown		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		



The Potential Impact of Brexit on the NHS

1. PURPOSE OF REPORT

The purpose of the reports is to inform the Board of the potential impact of the UK's departure from the European Union (EU), and those of a "no deal" scenario.

2. BACKGROUND

In 2016 the UK voted to leave the European Union (EU). Since the vote to leave, the government has been negotiating the terms of departure for an exit in March 2019. As controversy continues over the UK's departure, with no definite resolution in sight, this Paper explores the implications for the NHS and for Walsall Healthcare NHS Trust.

3. DETAILS

3.1: No Deal Brexit Contingency Plan

In August 2018, the Secretary of State for Health and Social Care, Matt Hancock, wrote to health and care providers about the government's preparations for a potential no-deal "Brexit".

3.2: Key points¹

- Providers should not stockpile medicines, central stocks will be arranged by the pharmaceutical industry and government
- Patients should not store additional medicines at home.
- Separate contingency plans are being developed for medical devices, and stock holding at a national level will be increased. The UK will recognise medical devices approved for the EU market and CE-marked (marked to indicate they conform with health, safety, and environmental protection standards). Should this change in the future, adequate time will need to be provided for businesses to implement any changed new requirements. Formal UK presence at EU committees in respect of devices will cease.
- EU legislation would no longer apply (though in practice the EU Withdrawal Act means that wherever possible, EU legislation will become UK legislation, which can then be amended at a later date).

¹ <http://nhsproviders.org/media/518289/nhs-providers-briefing-uk-governments-preparations-for-a-no-deal-scenario.pdf>

4: Issues

There are a number of other issues for NHS organisations as outlined below:

4.1: Staffing

European Economic Area workers account for 9.1% of doctors, 5.5% of nurses and midwives ²and 15% of dentists, according to the Department of Health and Social Care.

It is widely acknowledged that the NHS and Social Care are currently struggling to recruit and retain permanent staff. The NHS Workforce Strategy has been delayed until November 2018.

4.1.1: Working time directive - The European Working Time Directive was introduced to support the health and safety of workers by limiting the maximum amount of time that employees in any sector can work to 48 hours each week, as well as setting minimum requirements for rest periods and annual leave.

The directive allows doctors to opt out of the 48-hour limit (the UK is one of the few countries to make use of the opt-out). If the government decides to repeal or amend the working time regulations (the UK law enacting the EU directive), this would have implications for NHS employment contracts and require significant changes to the Agenda for Change pay framework.

Until the UK formally leaves the EU, the policy on freedom of movement remains unchanged; The Home Office has recently launched a toolkit to assist employers in reassuring and supporting EU citizens already resident in the UK and their dependents to apply for settled status. The Trust is advised to distribute this to its staff.

4.2: Accessing treatment here and abroad

EU citizens are entitled to hold a European Health Insurance Card (EHIC), which gives access to medically necessary, state-provided health care during a temporary stay in another EEA country. The costs of treatment under these schemes can be subsequently reclaimed from the visitor's country of residence via reciprocal health care agreements.

There are around 1.2 million British migrants living in other EU countries, compared with around 3 million EU migrants living in the UK (Hawkins 2016). There are concerns that UK pensioners currently living elsewhere in the EU may return to the UK for treatments, and so increasing pressures on health and social care services. It is hoped, however, that reciprocal agreements can be achieved, (such as those that already exist with some non-EU countries) or alternatively seek to continue existing arrangements.

² <https://www.theguardian.com/society/2018/aug/21/nhs-fears-over-no-deal-brex-it-highlight-risk-to-patients-labour-says>

4.3: Regulation

The UK is party to generic regulation across the EU. However this may change following Brexit.

4.3.1: Medicines Approval

The UK will no longer be eligible to participate in EU organisations such as the European Medicines Agency (EMA), so will seek to create or adapt UK systems. For example the Medicines and Healthcare products Regulatory Agency (MHRA) will support medicines approval. This may increase the regulatory burden with information having to be submitted both to the EU and the UK. There is an acknowledgment that new regulatory bodies would need to be established and operational by 29 March 2019, for example for paediatric medicines.

4.3.2: Clinical Trials

The 2004 regulations for clinical trials will remain in force, although they will be modified using powers under the EU (Withdrawal) Act to make sure they still work in the UK after exit. The new EU clinical trials regulation (CTR) 536/2014 will not be in force in the EU at the time of exit and so will not be incorporated into UK law. However, the UK will align where possible with the CTR without delay when it does come into force in the EU, subject to parliamentary approvals.

4.3.3: Batch Testing

If the UK leaves the EU with no deal, the UK will accept batch testing of human medicines carried out in countries on an MHRA list, though it will require a UK, EU or EEA-based qualified person (QP) to certify batch testing. These arrangements will continue until the government considers any further change is necessary.

4.3.4: Organ Transplants

Safety and quality standards for organ transplantation, and tissues and cells for human use would continue to apply as they do now. However, the UK would become a 'third country' – meaning it would not be a member of the EU, with the term derived from the sense of the country not being party to an agreement between two other countries.

UK licensed establishments working in this area, such as hospitals, stem cell laboratories, tissue banks and fertility clinics would continue to work to the same quality and safety standards as they did before exit, but some would need new written agreements with relevant EU establishments. UK licensed establishments that import or export tissues or cells from EEA establishments would need to make written agreements with those EEA establishments to continue importing or exporting these products post-exit. Organisations that currently exchange organs can make written arrangements to ensure organs can still move between the UK and EU countries.

NHS Blood and Transplant is the organisation responsible for organ donation and transplantation in the UK. It is currently working with the UK regulator for organs, the Human Tissue Authority, to ensure that appropriate written agreements are in place with EU organisations to allow organ exchange to continue post-exit.

4.3.5: Procurement and competition law

Although a combination of the Competition Act Procurement, Patient Choice and Competition regulations continue to prohibit anti-competitive behaviour by NHS providers and commissioners, withdrawal from the EU would allow policy-makers to modify these arrangements. However, this will depend on the agreement the UK reaches with the EU on their future trading relationship. Overall, it seems unlikely that leaving the EU will have a significant impact on NHS procurement and competition regulation.

4.3.6: Cross-border cooperation

The EU operates systems for the surveillance and early warning of communicable diseases, managed by the European Centre for Disease Prevention and Control. These facilitate the rapid sharing of information and technical expertise in response to potential pandemics, communicable diseases and other cross-border health threats. Recent examples of such collaboration include the H1N1 pandemic and efforts to tackle anti-microbial resistance

Collaboration across the EU has also enabled the UK to further its scientific research agenda, through access to both European research talent and important sources of funding. There are also other formal and informal networks across Europe where the low numbers affected make it beneficial to work across the EU – this arrangement may be affected if the free movement of researchers across Europe is stifled.

5: Business Continuity

The letter outlining the government's preparations for a 'no deal' scenario also covered Business Continuity Plans for the health and care system. It clarifies that work in this area should be seen in the context of that already being done to update existing business continuity plans in line with the NHS England EPRR Core Standards and the NHS England EPRR Annual Assurance process. A separate report has been prepared for Trust Board by the Head of Emergency Planning, Resilience and Response. It outlines the requirement that the EPRR assurance report is taken to public board meetings, with oversight by the accountable officer. It also recommends that colleagues be ready to refresh plans as new information becomes available.

6: RECOMMENDATIONS³

Such a high profile departure from the EU is unprecedented in its history and is influenced by political as well as social and economic issues that need to be addressed across the 27 countries that make up the institution. The negotiations are proving to be unpredictable and while organisations like NHS Providers, and other advocates can make suggestions, in truth, the variables at the minute remain too wide

It is recommended that the Board takes direction from NHSI and other National Bodies, and keeps the position under regular review. It is further recommended that the trust does not commit to any complex plans at this point given the fluidity of Brexit.

³ Dayan, M (2017) "Preparing for the unpredictable", Nuffield Trust comment. <https://www.nuffieldtrust.org.uk/news-item/preparing-for-the-unpredictabl>

MEETING OF THE PUBLIC TRUST BOARD – 4th October 2018			
Black Country STP – Integrated Care System Roadmap and associated STP Governance			AGENDA ITEM: 18
Report Author and Job Title:	Richard Beeken, Chief Executive	Responsible Director:	Richard Beeken, Chief Executive
Action Required	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>		
Executive Summary	<p>The Black Country Sustainability & Transformation Partnership (STP) is a collective of statutory NHS and local authority organisations. Prompted by NHS England and their national programme of accreditation, we have begun our journey to becoming an “Integrated Care System” (ICS). An effective ICS meets certain criteria for success, largely driven by economies of scale in relation to the integration of health and social care and the “left shift” in population health management and chronic disease management, to reduce the resource burden on secondary care in the longer term.</p> <p>The STP has made it very clear to NHS England that “place based” care integration is at the heart of our roadmap on ICS, given the distinct identity of each of our four boroughs. West Birmingham has been identified as a notional fifth “place”.</p> <p>The key enablers we have identified which have particular resonance for Walsall are workforce strategy (our biggest collective risk); IT (shared care record development) and business intelligence (population health management).</p> <p>Key objectives with particular relevance to our work on Walsall Together are the shared outcomes framework (will denote success/failure in capitated contract value delivery) and increasing the percentage share of resource invested in primary and community care. The latter cannot be achieved in the current contractual paradigm. Capitated contract values for acute and community care will be required to make this a reality.</p> <p>A PMO is being formed, which has to be jointly funded by all organisations. NHSE and NHSI are expecting huge management cost savings from their regional integration and we have been told we should not expect any resource for our PMO from this.</p> <p>Finally, the paper concludes with the agreed governance model for the STP.</p>		



Recommendation	<p>Members of the Trust Board are asked to:</p> <ul style="list-style-type: none"> • Note the content of the report • Discuss its implications for Walsall Healthcare NHS Trust in the context of the Walsall Together programme 	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	<p>There are no immediate risk implications for the Trust with respect to this report. However, as both the Walsall Together programme progresses and the ICS work across the Black Country develops, we can expect both reputational, financial and service risks to potentially emerge from the radical care redesign and shift of resources from secondary to primary & community care.</p>	
Resource implications	<p>There are no immediate resource implications arising from this report. However, the STP work on ICS development has taken an extraordinary amount of time for CEOs and Strategy Directors across the patch, occasionally limiting their time to lead change internally within their organisations.</p>	
Legal and Equality and Diversity implications	<p>There are no immediate legal or E&D implications associated with this paper.</p>	
Strategic Objectives	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>
	Resources <input checked="" type="checkbox"/>	

Black Country and West Birmingham

Integrated Care System Roadmap



Our vision



**Working together to improve the health,
wellbeing and prosperity of our local population**

Transforming health and care

Over the last two years, the STP has provided us with a framework to transform our local health and care system in the Black Country and West Birmingham. It has enabled us to act systematically and together - to agree and address common challenges in a way that we could not as individual organisations.

Building on our strong track record of delivery and innovation, the STP will work collaboratively with its health and care partners to move towards an Integrated Care System (ICS).



Local context

In the Black Country and West Birmingham we have high performing organisations and are increasingly collaborating between organisations in our local place and across our STP footprint. Our colleagues in primary care are leading the way in developing new ways of working across health and social care, community services, mental health, voluntary and community sector and public health.

However, our local health and care system faces significant challenges. They include: changes in population need; changes in how we organise and provide services; usage of estates and recruitment and retention of our workforce. In addition, we face gaps in care quality, health outcomes and financial sustainability.

Our communities are highly diverse and many people face complex issues that affect their health and wellbeing such as: social deprivation; unemployment; substance misuse and poor lifestyle choices. These issues strongly influence our health population challenges:

- Higher numbers of people experiencing mental health problems
- Adult and child obesity
- Gaps in life expectancy and infant mortality
- Dementia, respiratory disease and diabetes diagnosis
- Substance misuse admissions

Current issues

- Midland Metropolitan Hospital (MMH) development
- Dudley ED CQC concerns
- Walsall clinical workforce sustainability
- Wolverhampton delivery of cancer targets
- Transforming Care agenda
- Unwarranted variation in some mental health services

Drivers for integrated care

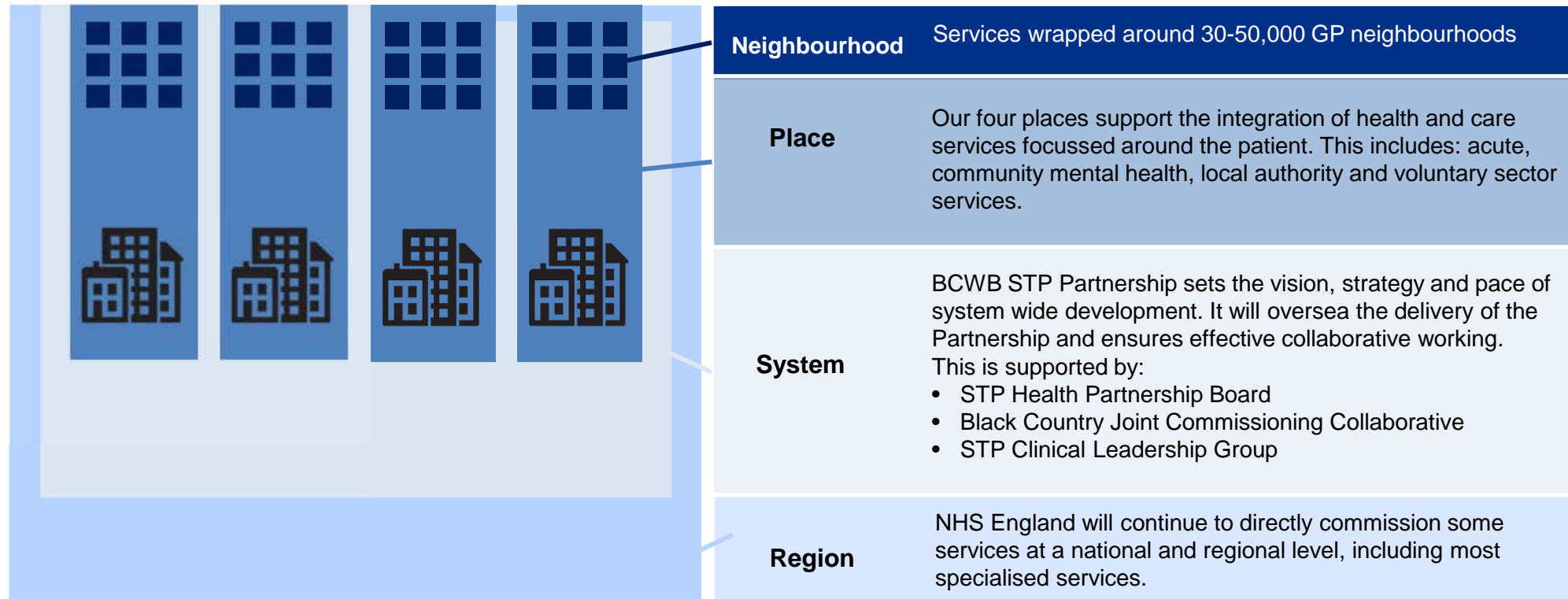


Future model for integrated care

Bringing health, social care and voluntary sector organisations together, to achieve improved health and wellbeing.



Future model for delivering integrated care



Integrated Care in the Black Country and West Birmingham

Integrated Care Alliance Wolverhampton

What is the vision?
The development of a health and care alliance across Wolverhampton with a focus on a place based model.

Who's involved?
City of Wolverhampton Council, Black Country Partnership Foundation Trust, Wolverhampton CCG, The Royal Wolverhampton NHS Trust and local GP practices. Also Healthwatch and Local Medical Committee representatives.

How will it work?
The system-wide alliance will be clinically led and will focus on:

- Shifting resource out of hospital to support more patients at home and in their communities
- Health promotion and disease prevention

It will use financial systems to incentivise changes in care and ensure sustainability.

Population size
Approx. 256,000 people.

Key contacts
Andrea Smith andrea.smith21@nhs.net

Dudley Multispecialty Community Provider (MCP)

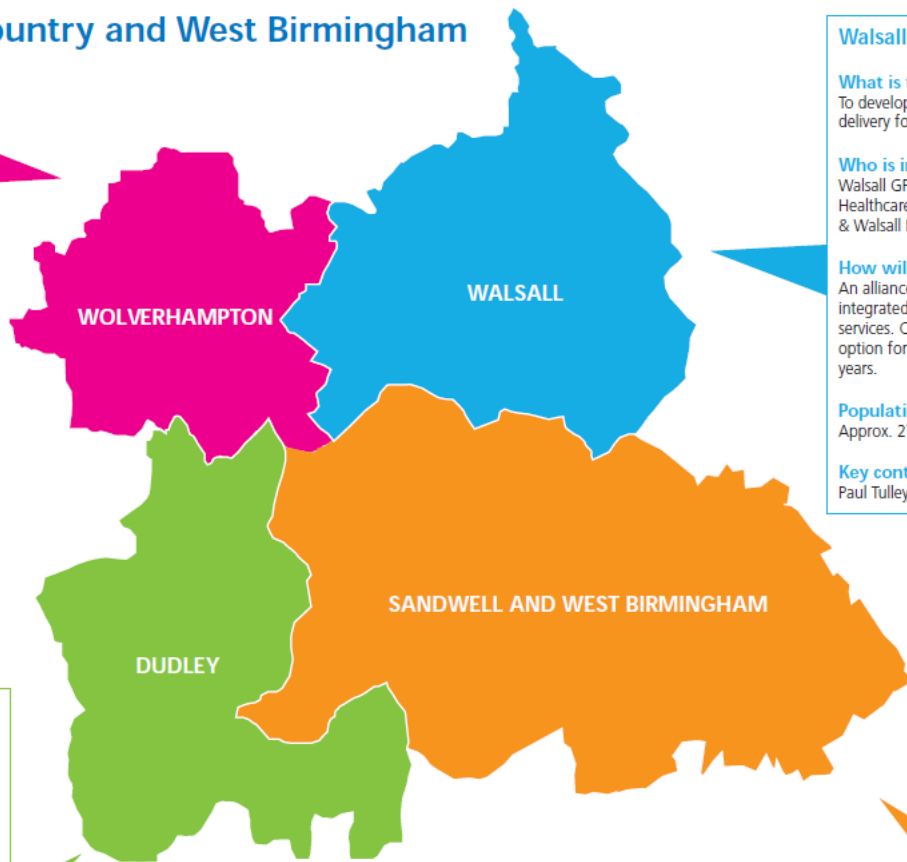
What is the vision?
To integrate primary and community care within a single organisation and so improve access, continuity and coordination of care.

Who's involved?
Dudley CCG and Dudley Metropolitan Borough Council are leading the procurement of Dudley MCP. In dialogue with partnership of four local NHS Trusts and local GPs.

How will it work?
The model is based on an ethos of "community where possible, hospital where necessary" by creating a network of GP-led health and care teams. Network will focus on co-ordination of care across the system.

Population size
Approx. 316,000 people.

Key contacts
Neill Bucktin neill.bucktin@nhs.net
Stephanie Cartwright Stephanie.cartwright1@nhs.net
For more information on the model, visit www.ATBDudley.org



Walsall Together

What is the vision?
To develop an integrated health and care alliance for the delivery for place-based services

Who is involved?
Walsall GP practices, Walsall Borough Council, Walsall Healthcare NHS Trust, One Walsall, Healthwatch, Dudley & Walsall Mental Health NHS Trust and Walsall CCG.

How will it work?
An alliance model with shared governance and integrated management will provide place-based services. Currently, a host provider model is the preferred option for the alliance which will be phased in over three years.

Population size
Approx. 272,000

Key contacts
Paul Tulley paul.tulley@walsall.nhs.uk

Sandwell and Western Birmingham Healthy Lives Partnership

What is the vision?
Providing greater integration between all providers (including: primary, community, mental health and independent providers) to shift care closer to home, improve patient experience to provide seamless and timely services and take lessons learned from the vanguard.

Who will be involved?
Sandwell and West Birmingham CCG, Sandwell and West Birmingham Hospital Trust, Birmingham Community Trust, BSMHFT, BCPFT, Sandwell Council, Birmingham City Council, emerging (new) Primary Care Networks and early conversations with the third sector to allow progressive integration over time.

How will it work?
Focus on keeping local people well and tackling underlying causes of ill health, inequality and vulnerability.

Population size Approx. 572,000

Key contacts Claire Parker claire.parker2@nhs.net Sharon Liggins sliggins@nhs.net Jenna Phillips jenna.phillips@nhs.net

Progress to date across the STP

Individual Placement Support (IPS) service in all localities

Meeting targets for extended **GP access**

Black Country and West Birmingham named **GP retention intensive** support site

Black Country and West Birmingham pilot site for **personalised care**

New Black Country Pathology Service due Autumn 2018

Action plan to **transform maternity** services in place

New Perinatal Mental Health Community Service launching Autumn 2018

Providers working in collaboration
Delivery and commissioning of some mental health services **'as one'** by April 2019

STP Independent Chair and Portfolio Director **appointed**

Maternity Voice Partnerships in each locality

Walsall and Wolverhampton **Stroke Service Reconfiguration**

Strategic objectives for delivering integrated care



Delivering integrated care – Clinical Strategy

Building on our strong place-based integration and financial performance, we are developing an STP clinical strategy which is clinically led. This will:

- Inform service delivery across the Black Country and West Birmingham
- Reduce unwarranted variation and duplication across the system and help address the triple aim.

The strategy highlights 12 priority areas: Cancer; Mental Health; Learning Disability Services; Maternity and Neonates; Children and Young People; Urgent and Emergency Care, Cardiovascular Disease, Clinical Support Services, Pathology, Musculoskeletal conditions; Respiratory Disorders and Frailty. Our current areas of focus are:

- Cancer
- Mental Health
- Learning Disability Services
- Maternity and neonates
- Primary Care

We recognise that effective clinical engagement is fundamental to the delivery of our clinical strategy and integrated care. This will be supported through the STP Clinical Leadership Group.

- Establishing clear, robust and manageable processes to provide clinical leadership and assurance across our programmes of work
- Developing an outcomes-based approach to healthcare and reducing unwarranted clinical variation.

Delivering integrated care - Primary Care

Primary care is at the heart of place based plans and integral to integrated care delivery.

- Clinical champions in our four place based areas
- GPs shaping and forming primary care networks
- GPs working together with secondary care to improve clinical pathways
- LMC engagement in each place and at STP level
- Primary care involved and shaping workforce development in place and at STP level
- Funding for GP clinical fellowship in the STP

Delivering integrated care – Strategic Commissioning

We will move towards strategic commissioning by:

- Working together across the STP/managing the system
- Developing a common outcomes framework
- Developing a model to enable both place and STP-wide commissioning and service delivery
- Commissioners and providers will work together to make services more clinically effective, keeping the patient at the centre of everything we do



Delivering integrated care - Enablers

We will

- develop an STP workforce strategy to support the STP clinical strategy
- develop common IT enablers (e.g. shared information governance) and estates enablers
- develop a shared view of system finances and performance
- deliver care through place based alliances
- collaborate on shared challenges across the STP and share best practice and infrastructure to address these, for example: Performance challenges, cancer and specialist services and urgent and emergency care/delayed transfer of care

In order to support the delivery of our system and place-based plans, we will strengthen and formalise STP governance arrangements and review the STP MoU. This will be signed off by respective organisational Boards to strengthen collective delivery.

Our strategic objectives (1/4)

Strategic Objective	Action	By Whom	By When	Existing STP programmes
Develop a system-wide, sustainable financial strategy	<ul style="list-style-type: none"> • Discuss financial plan monthly with reference to closing the financial gap in line with clinical strategy • Include patient pathways in financial discussions with partners • Financial reporting to happen at place-base rather than organisational level • Formalise risk share protocols – STP level • Draw on learning from other areas around risks and incentives 	Finance Directors	April 2020	<ul style="list-style-type: none"> • Finance
Increase the proportion of system resources allocated to mental health/primary and community care	<ul style="list-style-type: none"> • Review system resource allocation • Differentially invest additional resource 	Each CCG, with Finance Group to monitor progress	Plans in place by April 2019	
Develop a common outcomes framework for strategic commissioning	<ul style="list-style-type: none"> • Population health • Service intervention • Patient experience • Work with local authorities 	Initially by place (CCG leads), then across STP	By Commissioning Intentions, early October 2018 (place) and October 2019 (STP)	<ul style="list-style-type: none"> • Wider determinants of health / prevention • Strategic commissioning / system management
Work with regional STP partners to review the opportunities around specialised and direct commissioning	<ul style="list-style-type: none"> • Define ask of NHSE/I for BCWB joint working • Collaboration with BSoI/BCWB • Develop proposition for NHSE 	Helen Hibbs Mike Sharon Mark Axcell Lesley Writtle	By Commissioning Intentions, early October 2018	

Our strategic objectives (2/4)

Strategic Objective	Action	By Whom	By When	Existing STP programmes
Commission defined specialist mental health and learning disability services and provide once across BCWB	<ul style="list-style-type: none"> Bring mental health services back into the BCWB (to be done at STP level) Shared view on clinical model Develop commissioning strategy 	Mark Axcell Lesley Writtle Steven Marshall	Plans developed by October 2018	Wider determinants of health / prevention Strategic commissioning / system management
Improve resilience, quality and performance of care home sector	<ul style="list-style-type: none"> Review local and national best practice Consider how we commission and contract 	Local authorities Sally Roberts	Due with commissioning strategy October 2018	
Working towards cross-organisation collaboration across primary care, mental health and acute providers	<ul style="list-style-type: none"> Agree required resource, leadership and governance model for STP Establish what support and resource NHSE/I can provide to the STP 	Helen Hibbs Alastair McIntyre	October 2018	Cancer CHC Planned Care Maternity Mental Health Primary Care 7 Day Services TCP UEC Clinical Strategy Personalisation PHBs Children
Develop and implement place-based models <ul style="list-style-type: none"> Improve outcomes and reduce variation across BCWB Share and implement best practice 	<ul style="list-style-type: none"> Establish governance for development and delivery Agree clinical priorities at both place and STP level 	Diane Wake/ Paul Maubach David Loughton/ Helen Hibbs Richard Beeken/Paul Maubach Toby Lewis/Andy Williams	April 2019	

Our strategic objectives (3/4)

Strategic Objective	Action	By Whom	By When	Existing STP programmes
Develop an aligned urgent and emergency care pathway, jointly with the Ambulance Service	<ul style="list-style-type: none"> Ensure embedded in the working practices of ambulance services and other organisations 	Andy Williams	April 2019	Cancer CHC Planned Care Maternity Mental Health Primary Care 7 Day Services TCP UEC Clinical Strategy Personalisation PHBs Children
Make BCWB the best place to work in health and social care	<ul style="list-style-type: none"> Develop health and social care workforce plan and strategy Develop a shared workforce training approach Develop a BCWB professional passport Establish a shared bank of staff across BCWB 	Mark Axcell (HR / LWAB / STP representation)	April 2022	RightCare/GIRFT Aspirant ICS Estates Performance & Assurance Comms & Engagement Information Sharing & Governance IM&T PMO/PSO
Review place-based operating models to develop a common IT/digital strategy and data-sharing approach	<ul style="list-style-type: none"> Create a BCWB clinical portal Use the tech and infrastructure group to address the BCWB single record issue Develop shared information governance Black Country LDR to drive change 	Tony Gallagher Mike Hastings	April 2020	

Our strategic objectives (4/4)

Strategic Objective	Action	By Whom	By When	Existing STP programmes
Improve understanding of the STP for both staff and the population of BCWB	Develop STP level communications and engagement strategy	Alastair McIntyre	November 2018	
Achieve better value from our estate to release resource to care for our patients	Develop estates strategy	James Green	April 2019	
Achieve a single source of truth and system-wide data sharing approach	Develop shared BI service	Mike Hastings	April 2020	
Continue to progress a shared back office approach	Discuss collaboration between Trusts and CCGs	AOs/CEOs	April 2019	

Our ICS roadmap

Our ICS roadmap is structured around five key workstreams. The roadmap outlines the activities, milestones, delivery and resources to ensure we are on track to reach shadow status within 18 months.



Governance and Programme Management

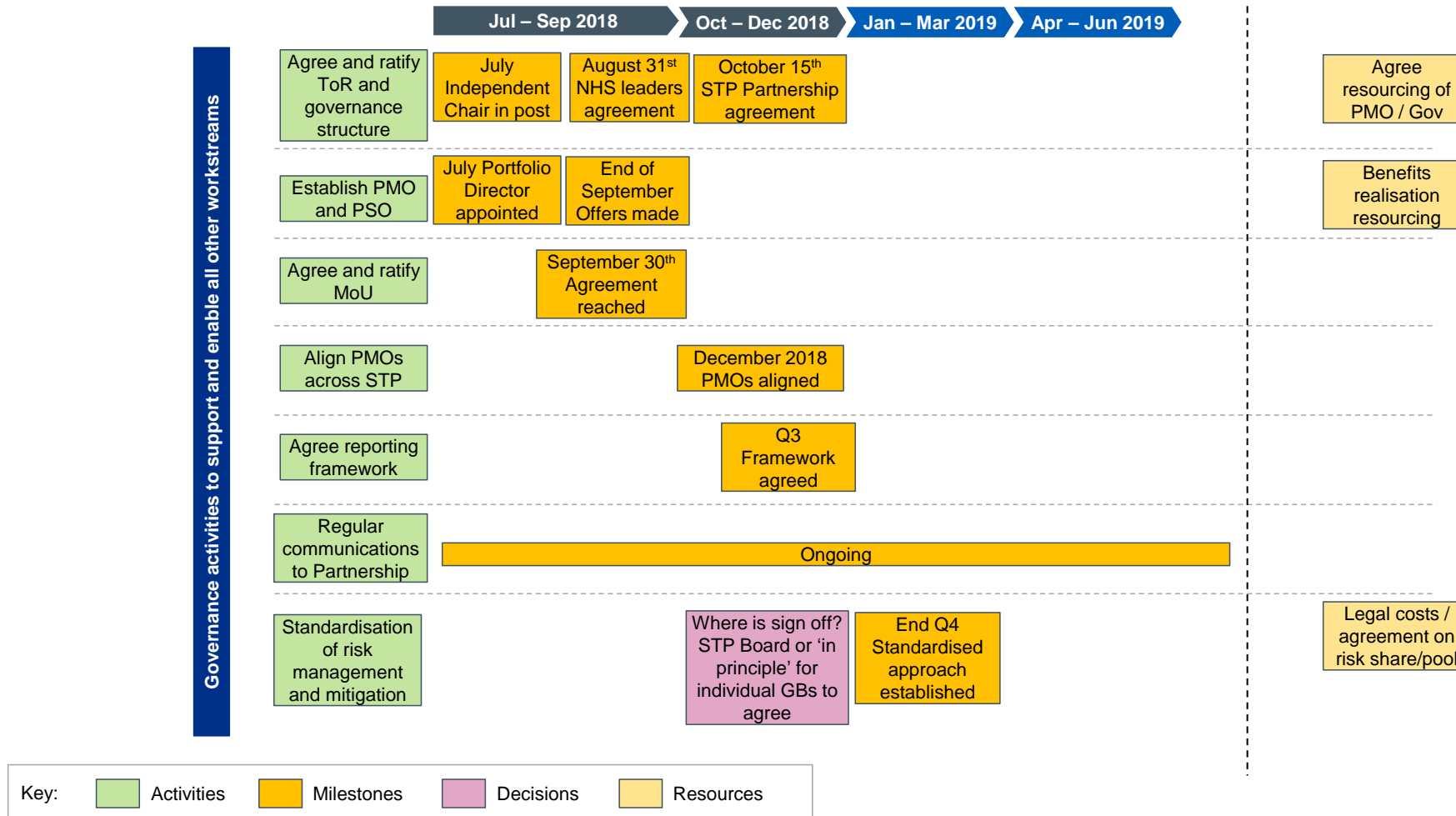
Workstream purpose

- To align leadership and transformation initiatives across the STP and four places
- To enable the STP to effectively implement and deliver new models of care, both at a place and system level
- To support the delivery of current and future transformation plans to enable benefits realisation

Setting the context

- We need to strengthen and clarify our governance arrangements as we progress the STP.
- We need to strengthen our shared resources (funds and people) to enable us to progress the agendas developed at STP level.
- Our PMO needs to work with existing PMO's across the system.
- The STP PMO initially recruiting to x3 roles
- The central PMO will liaise with individual organisations' PMO's as well as aligning to the STP transformation programme workstreams.
- The central PMO will report in to governing bodies and Boards – the regular reporting rhythm needs to be established.

Governance and Programme Management



Actions – Governance and Programme Management

Maturity matrix component	High level objectives	STP action	Lead	Start date (est.)	Finish date (est.)	Outcome / benefit
1. Effective leadership & relationships	Structure STP governance to support and enable ICS plan	Agree and ratify terms of reference and governance structure	Alastair McIntyre	July 2018	October 2018	Clear decision making framework which will enable us to track milestones and delivery of the programme
3. Track record of delivery		Establish PMO and PSO	Alastair McIntyre	July 2018	October 2018	
4. Care redesign		Agree and ratify MoU	Alastair McIntyre	July 2018	September 2018	
3. Track record of delivery		Align PMOs across STP	Alastair McIntyre	July 2018	December 2018	
3. Track record of delivery		Agree reporting framework	Alastair McIntyre	July 2018	December 2018	
3. Track record of delivery		Establish regular communications to Partnership	Alastair McIntyre	Ongoing	Ongoing	
2. Strong financial management		Standardise risk management and mitigation	Alastair McIntyre	July 2019	March 2019	

Strategic Commissioning

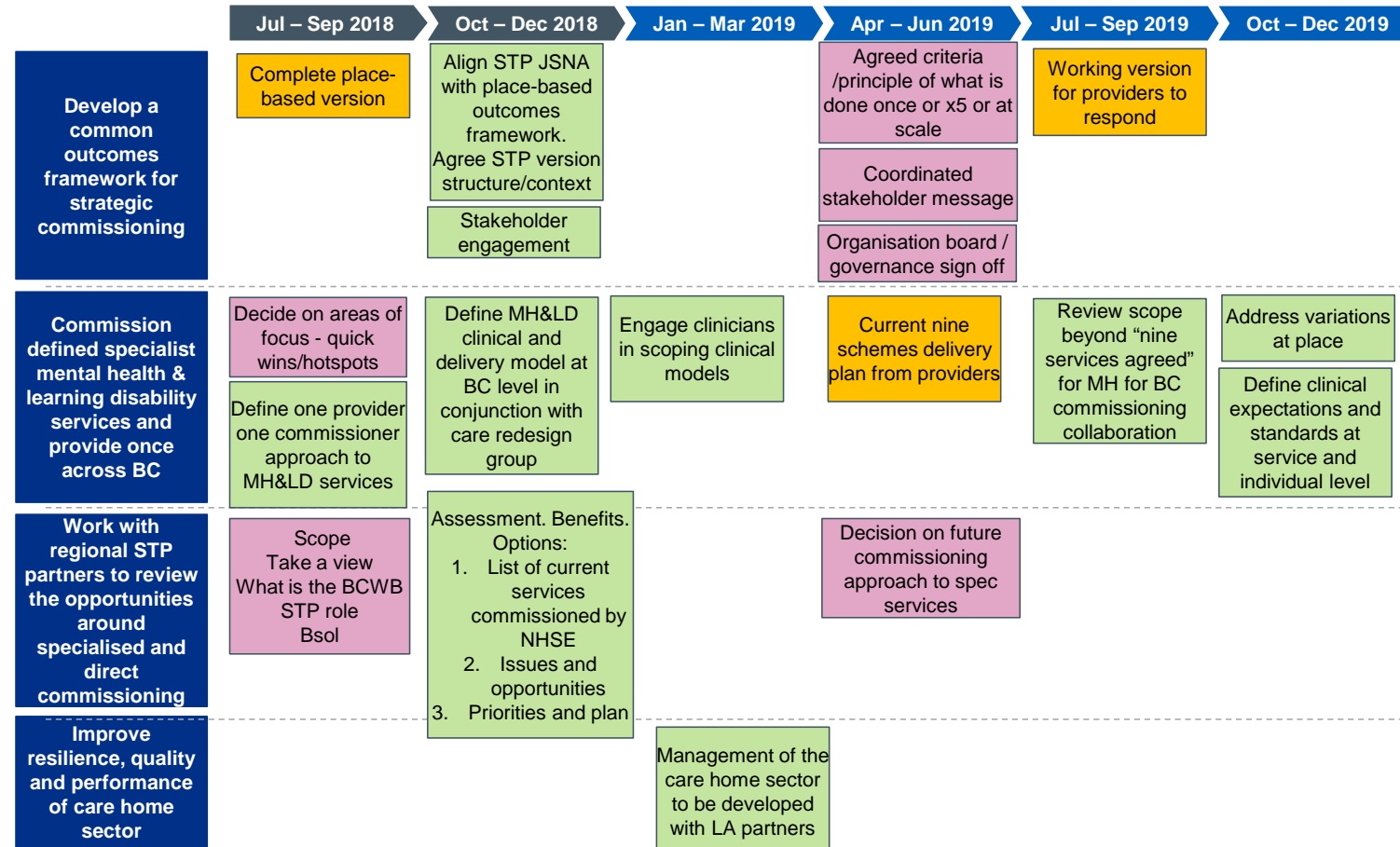
Workstream purpose

- To support the integration of services at both a place and system level
- To support the priorities outlined in the clinical strategy
- To effectively align and share resources across the STP
- To establish, through an STP level common outcomes framework, a minimum set of core outcomes across the system, tailored for each place
- To support providers to develop their tactical commissioning capabilities
- To hold providers to account for the delivery of agreed common outcomes

Setting the context

- We need to be clear on our objectives for STP strategic commissioning – alignment and sharing of resources/best practice and/or commissioning once across the STP.
- When developing the STP level common outcomes framework, we will look for commonalities between existing place-based work, building bottom up and aligning. This will support us to establish a minimum set of core outcomes across BCWB.
- The STP common outcomes framework requires clinical input as well as public and patient engagement during its development.
- Existing mental health work programmes must be built into the STP plan.

Workstream – Strategic commissioning



Key: Activities Milestones Decisions Resources

Actions – Strategic Commissioning

Maturity matrix component	High level objectives	STP action	Lead	Start date (est.)	Finish date (est.)	Outcome/benefit
5. Coherent and defined population	Develop a common outcomes framework for strategic commissioning	Align STP JSNA with place-based outcomes framework. Agree STP version → structure/context.	Paul Maubach	October 2018	December 2018	<ul style="list-style-type: none"> Improved life expectancy Reducing the number of people living with poor health Reducing infant mortality Reduce unwarranted variation
		Stakeholder engagement	Paul Maubach	October 2018	December 2018	
4. Care redesign	Commission defined specialist mental health and learning disability services and provide once across BC	Define one provider one commissioner approach to mental health and learning disability services.	Helen Hibbs	July 2018	September 2018	<ul style="list-style-type: none"> Better access to services Streamlined urgent and emergency care Improved patient experience measures
		Define mental health and learning disability clinical and delivery model at BC level in conjunction with care redesign group.	Helen Hibbs	October 2018	December 2018	
		Engage clinicians in scoping clinical models.	Helen Hibbs	January 2019	March 2019	
		Review scope beyond “nine services agreed” for mental health for BC commissioning collaboration.	Helen Hibbs	July 2019	September 2019	
		Define clinical expectations and standards at service and individual level.	Helen Hibbs	October 2019	December 2019	
Address variations at place level.	Helen Hibbs	October 2018	December 2018			
2. Strong financial management	Work with regional STP partners to review the opportunities around specialised and direct commissioning	Assess specialised commissioning opportunities and benefits. Options: <ol style="list-style-type: none"> 1) List of current services commissioned by NHS 2) Activity/cost/providers/org. of commissioning 3) Issues and opportunities 4) Priorities and plan 	Andy Williams	October 2018	December 2018	<ul style="list-style-type: none"> Delivering financial sustainability and living within our financial envelope Meeting our control total Increasing investment in mental health services
4. Care redesign	Improve resilience, quality and performance of care home sector	Management of the care home sector to be developed with local authority partners	Sally Roberts	November 2018	March 2019	<ul style="list-style-type: none"> Better access to services Improved patient experience measures

Care redesign

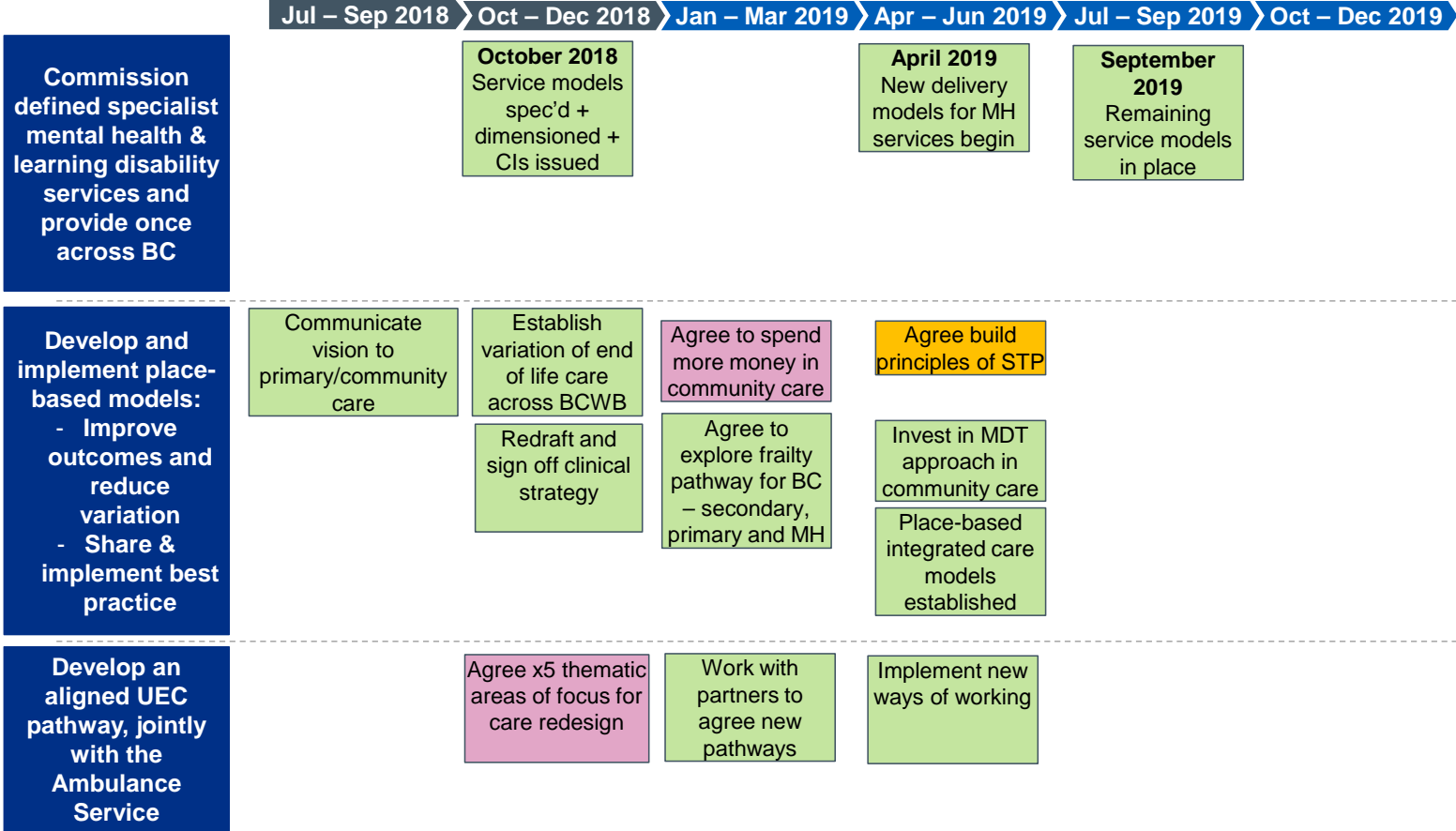
Workstream purpose

- To improve health outcomes across the Black Country and West Birmingham
- To align service delivery through place-based alliances
- To develop a common outcomes framework in close collaboration with the strategic commissioning work stream
- To ensure the sustainability of services across the Black Country and West Birmingham
- To reduce duplication and fragmentation across the system
- To deliver care in a financially sustainable way that supports a skilled and sustainable workforce
- To ensure that the population of the Black Country and West Birmingham have ready access to the right care in the right place at the right time

Setting the context

- Care redesign work will happen at a place-based level, with the STP enabling the four places to share and implement best practice.
- There is an opportunity to address the sustainability of services as an STP:
- What should be the breadth of scope for our clinical strategy?
- How do we define vulnerable services?
- How do we solve the problems?
- Key assumptions:
- Care will be primarily place-based.
- The care redesign work stream will work closely with the strategic commissioning work stream to develop the outcomes framework.
- There needs to be close alignment with our financial strategy (what we can afford) and workforce strategy (what we can deliver).

Workstream – Care redesign



Key: Activities Milestones Decisions Resources

Actions – Care redesign

Maturity matrix component	High level objectives	STP action	Lead	Start date (est.)	Finish date (est.)	Outcome/benefit
4. Care redesign	Commission defined specialist mental health and learning disability services and provide once across BC	Spec and dimension service models and issue commissioning intentions.	Steven Marshall	July 2018	October 2018	<ul style="list-style-type: none"> Improving the health and wellbeing of the population Improved life expectancy Reducing the number of people living with poor health Reducing infant mortality Reduce unwarranted variation Improving the patients experience of health and care services Better access to services Streamlined urgent and emergency care Improved patient experience measures
		Begin new delivery models for mental health services.	Steven Marshall	April 2019	Ongoing	
		Begin delivery of remaining service models.	Steven Marshall	September 2019	Ongoing	
4. Care redesign	Develop and implement place-based models: <ul style="list-style-type: none"> Improve outcomes and reduce variation Share and implement best practice 	Communicate vision to primary and community care.	Leaders in place	July 2018	September 2018	
		Establish variation of end of life care across BCWB.	Leaders in place	October 2018	December 2018	
		Explore frailty pathway for BC across secondary, primary and mental health services.	Leaders in place	November 2018	January 2019	
		Invest in MDT approach in community care.	Leaders in place	April 2019	June 2019	
		Place-based integrated care models established	Leaders in place	July 2018	April 2019	
		Redraft and sign off clinical strategy	Leaders in place	July 2018	October 2018	
4. Care redesign	Develop an aligned Urgent and Emergency Care pathway, jointly with the Ambulance Service	Work with partners to agree new pathways and implement	Andy Williams	July 2018	April 2019	
		Agree five thematic areas of focus for care redesign.	Andy Williams	July 2018	October 2018	

Enablers

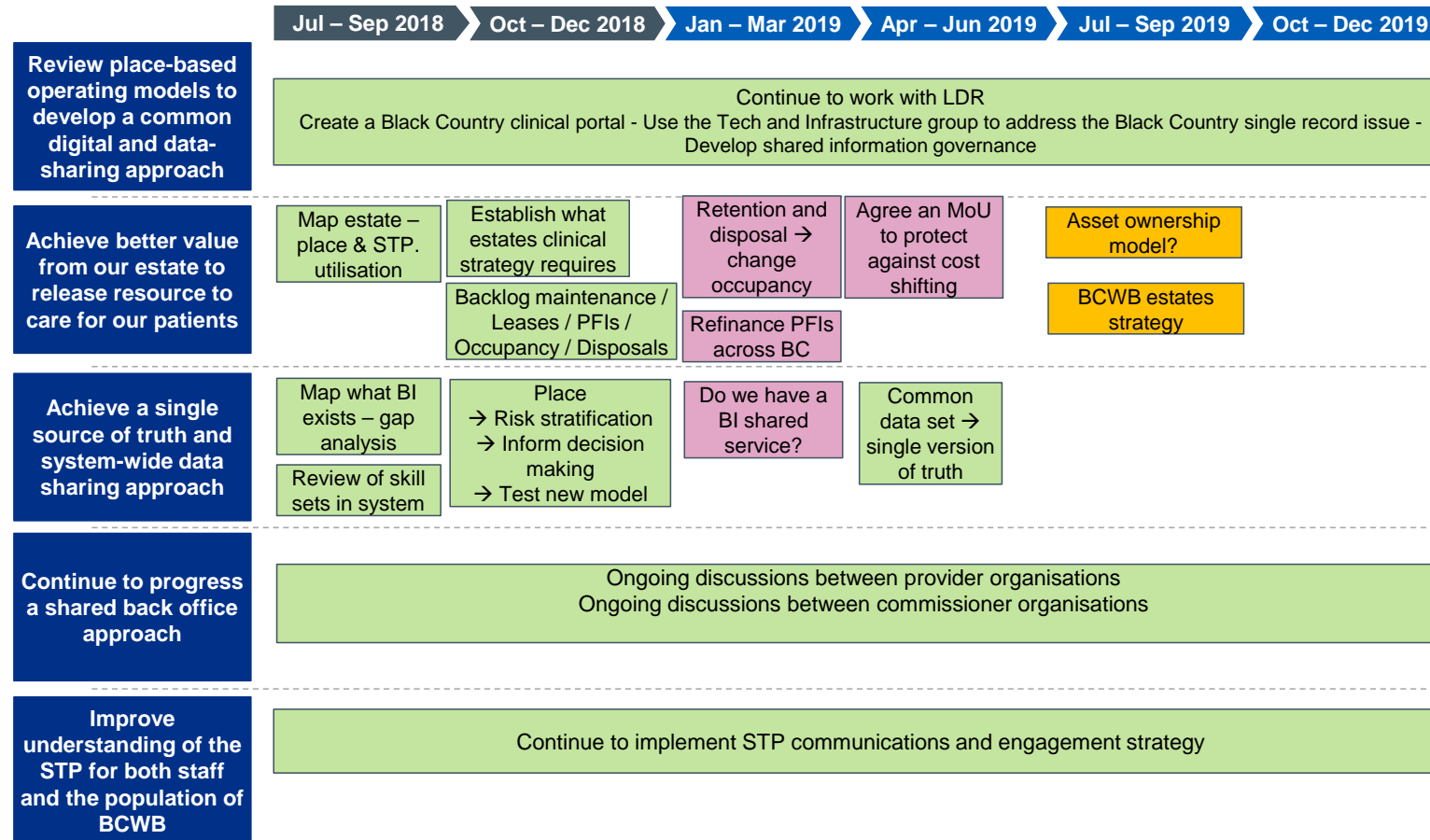
Workstream purpose

- To ensure that the relevant enabling functions are established to support the delivery of place and STP plans
- To ensure that non-clinical functions run as efficiently as possible in order to free up resource to invest in care
- To achieve better value from our estate to release resource for patient care
- To support the effective gathering, sharing and use of data across the STP

Setting the context

- Business intelligence: data sharing groups need to be established, as well as the governance around communication and data sharing across the STP.
 - What will the vehicle for delivery be – MoU? Alliance?
- Current programmes of work around estates and the digital roadmap need to be built into the STP plan.
- We need to look at synergies between existing place-based strategies to support the development of system-level enablers.
- Key assumptions:
 - The enablers work stream is particularly dependent on the care redesign work stream (timelines, resources).
 - Our view on the system operating model should inform requirements.

Work stream – Enablers



Key: Activities Milestones Decisions Resources

Actions - Enablers

Maturity matrix component-	High level objectives	STP action	Lead	Start date (est.)	Finish date (est.)	Outcome/benefit
4. Care redesign	Review place-based operating models to develop a common digital and data-sharing approach	Continue to work with LDR Create a Black Country clinical portal - Use the Tech and Infrastructure group to address the Black Country single record issue - Develop shared information governance	Mike Hastings	July 2018	April 2020	<ul style="list-style-type: none"> Delivering financial sustainability and living within our financial envelope Meeting our control total Increasing investment in mental health services Increasing investment in primary and community care
2. Strong financial management	Achieve better value from our estate to release resource to care for our patients	Map estate at place and STP level and establish utilisation levels.	James Green	July 2018	September 2018	
		Establish the estates need driven by the clinical strategy.	James Green	October 2018	December 2018	
		Backlog maintenance / Leases / PFIs / Occupancy / Disposals	James Green	October 2018	December 2018	
4. Care redesign	Achieve a single source of truth and system-wide data sharing approach	Map what BI already exists and conduct gap analysis.	Mike Hastings	July 2018	September 2018	
		Conduct review of existing BI skillsets across the system.	Mike Hastings	July 2018	September 2018	
		Establish a common data set – a single source of truth.	Mike Hastings	July 2018	June 2019	
		At place level: - Risk stratification -Inform decision making - Test new model	Mike Hastings	July 2018	December 2018	
		Consider shared BI service	Mike Hastings	July 2018	December 2018	
2. Strong financial management	Continue to progress a shared back office approach	Ongoing discussions between provider organisations Ongoing discussions between commissioner organisations	James Green	July 2018	Ongoing	
3. Track record of delivery	Improve understanding of the STP for both staff and the population of The Black Country	Continue to implement STP level communications and engagement strategy	Alastair McIntyre	July 2018 Ongoing	Ongoing Ongoing	

Sustainability

Workstream purpose

- To establish a skilled and sustainable workforce, in order to reduce the reliance on agency staff and to ensure the best possible quality of care for the population
- To ensure the most effective allocation of resources across the system, enabling the right care to be delivered in the right place at the right time
- To support the financial sustainability of the system as a whole for the next 5-10 years and beyond

Setting the context

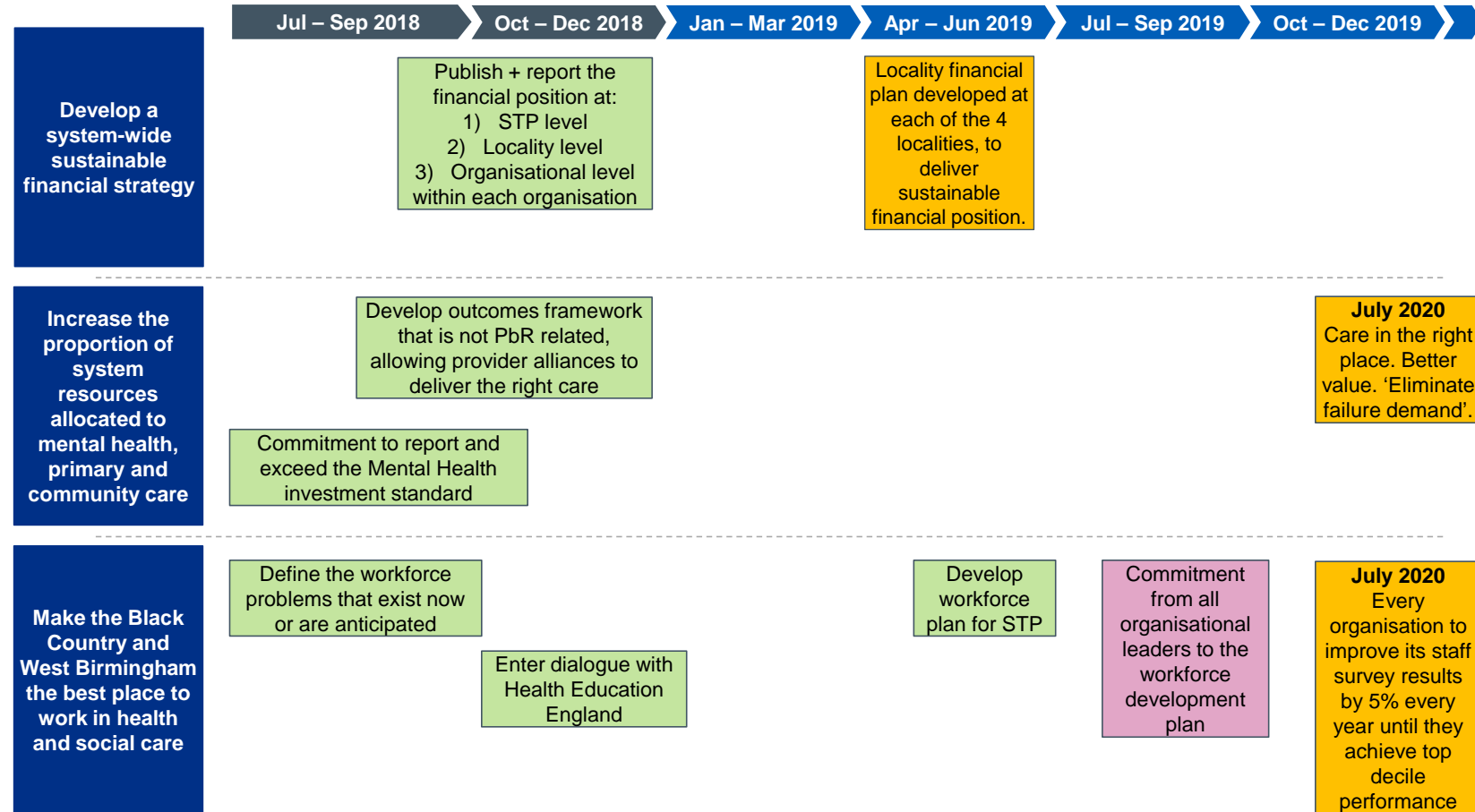
Workforce:

- We need to identify which staff groups / specialties will be a challenge in the next 5-10 years and consider how to pre-emptively address them now e.g. through training programmes.
- Do clinicians have the bandwidth to drive change within their organisations?
 - What can we do to help create the bandwidth and share ownership?
- We should consider the art of the possible – we need to be truly innovative with our education and training approach to establish a sustainable workforce.

Finance:

- We need to develop a system-wide view of our current position as a starting point, moving from an organisational view to a place-based view, consolidated at STP level.

Work stream – Sustainability



Key: Activities Milestones Decisions Resources

Actions - Sustainability

Maturity matrix component	High level objectives	STP action	Lead	Start date (est.)	Finish date (est.)	Outcome/benefit
2. Strong financial management	Develop a system-wide sustainable financial strategy	Publish and report the financial position at: 1) STP level 2) Place level 3) Organisational level	James Green	October 2018	December 2018	<ul style="list-style-type: none"> Delivering financial sustainability and living within our financial envelope Meeting our control total Increasing investment in mental health services Increasing investment in primary and community care
2. Strong financial management	Increase the proportion of system resources allocated to mental health, primary and community care	Develop outcomes framework that is not PbR related, allowing provider alliances to deliver the right care.	James Green	October 2018	December 2018	
		Commit to report and exceed the mental health investment standard.	James Green	Ongoing	Ongoing	
3. Track record of delivery	Make the Black Country and West Birmingham the best place to work in health and social care	Define the workforce problems that exist now or are anticipated.	Mark Axcell	August 2018	October 2018	<ul style="list-style-type: none"> Improving the patients experience of health and care services Better access to services Streamlined urgent and emergency care Improved patient experience measures
		Develop workforce plan for STP.	Mark Axcell	April 2019	June 2019	
		Enter dialogue with Health Education England	Mark Axcell	October 2018	December 2018	

Milestones, Governance and Benefits Realisation



Key milestones and activities for the system - December 2018

Governance and Programme Management

- Governance, terms of reference, memorandum of understanding for STP signed off
- Portfolio director and PMO in place
- PMOs aligned across the STP
- Reporting framework agreed

Strategic Commissioning

- Commissioning and delivery of nine mental health services across the STP

Care redesign

- Clinical strategy signed off
- Commissioning intentions issued and service specifications agreed for new MH services
- Agreement on resources for MH providers for 18/19 to match or exceed MH investment standard

Enablers

- Continue to implement the STP communications and engagement strategy
- Continue to work on the Local Digital Roadmap (LDR)

Sustainability

- Digital strategy progressed across the STP
- Publish and report on financial position at STP, locality and organisational level
- Define current workforce problems and enter dialogue with HEE

Key milestones and activities for place - December 2018

Governance and Programme Management

- Governance agreed for place-based integrated care models x4

Strategic Commissioning

- x4 place-based outcomes framework complete

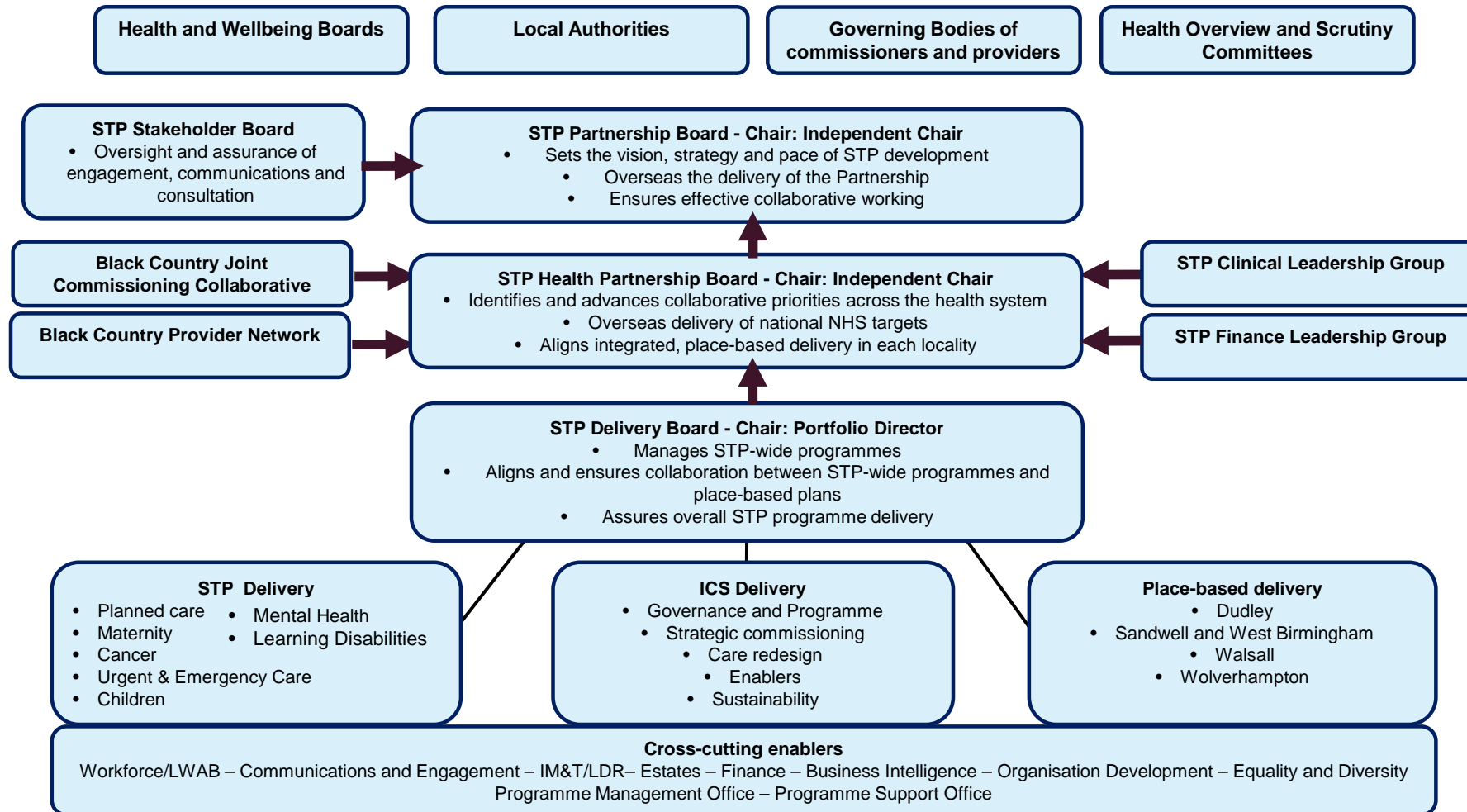
Care redesign

- Continue to develop x4 place-based integrated care models

Enablers

- OBC for Midland Met approved

Proposed Governance



2023 benefits realisation

Delivering financial sustainability and living within our financial envelope

- Meeting our control total
- Increasing investment in mental health services
- Increasing investment in primary and community care

Improving the health and wellbeing of the population

- Improved life expectancy
- Reducing the number of people living with poor health
- Reducing infant mortality
- Reduce unwarranted variation

Improving the patients experience of health and care services

- Better access to services
- Streamlined urgent and emergency care
- Improved patient experience measures

Integrated, collaborative and patient-centred



What support do we need to deliver integrated care?

Priority areas support request:

System development

- Access to some continued external consultancy support to assist with programme delivery
- Single regulatory framework
- Half day service review for BC to review and understand assurance processes and timelines
- NHSE/I to support STP regarding specialised commissioning

Provider development

- Workshops for development learning from early wave ICS sites
- Forum to share best Practice
- What other development support is available for provider organisations?

Thank you.

