Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 1 NOVEMBER 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	Director of Nursing	Verbal	**10.00**
CHAIR'S BUSINESS					
2.	Apologies for Absence – Mrs V Harris, Mr R Beeken, Mr D Fradgley	Information	Chair	Verbal	**10.30**
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1	**10.35**
4.	Minutes of the Board Meeting Held on 4 October 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	Deputy Chief Executive	Verbal/ Appendix 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.	Safeguarding Adults Annual Report 2017/18	Approval	Director of Nursing	ENC 8	**11.25**
11.	Safeguarding Childrens Annual Report 2017/18	Approval	Director of Nursing	ENC 9	**11.35**
12.	Looked After Children Annual Report 2018/18	Approval	Director of Nursing	ENC 10	**11.45**
13.	Winter Plan	Discussion	Director of Strategy & Improvement	Verbal	**11.50**
VALUE COLLEAGUES					
14.	Guardian of safe working	Information	Medical Director	ENC 11	**12.00**

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
BREAK – TEA/COFFEE PROVIDED					**12.10**
RESOURCES					
15.	Integrated Performance Report	Discussion	Director of Finance & Performance	ENC 12	**12.15**
PARTNERS					
16.	Partnership update	Information	Director of Strategy & Improvement	ENC 13	**12.40**
GOVERNANCE AND COMPLIANCE					
17.	Quality and Safety Committee Highlight Report and Minutes	Information	Committee Chair	ENC 14	**1.05**
18.	Performance, Finance & Investment Committee Highlight Report & Minutes	Information	Committee Chair	ENC 15	**1.10**
19.	POD Highlight Report & Minutes	Information	Committee Chair	ENC 16	**1.15**
20.	**QUESTIONS FROM THE PUBLIC**				
21.	**DATE OF NEXT MEETING** Public meeting on **Thursday 6 December 2018** at 10.00 a.m. at the Manor Learning and Conference Centre, Manor Hospital				
22.	**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 – 1st November 2018			
Declarations of Interest			**AGENDA ITEM: 3**
Report Author and Job Title:	Jackie White Interim Trust Secretary	**Responsible Director:**	Danielle Oum
Action Required	Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	The report presents a Register of Directors' interests to reflect the interests of the Trust Board members. The register is available to the public and to the Trust's internal and external auditors, and is published on the Trust's website to ensure both transparency and also compliance with the Information Commissioner's Office Publication Scheme.		
Recommendation	Members of the Trust Board are asked to: Note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Register of Directors Interests at October 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
		Chair: Midlands Landlord whg
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 Matthew Lewis	Medical Director	Spouse is a partner in General Practice in Great Barr.
		Director of Dr MJV Lewis Private Practice Ltd.
Mr Philip Thomas-Hands	Chief Operating Officer	Non-executive Director, Aspire Housing Association, Stoke-on-Trent.
		Spouse, Nicola Woodward is a senior manager in Specialised Surgery at University Hospital North Midlands.
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: 25 October 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 4TH OCTOBER 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
Ms C Griffiths	Director of People & Culture
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
Mr N Rashid	Divisional Director of Medicine and Long Term Conditions
Mr A Yates	Associate Non-Executive Director
Mrs J White	Interim Trust Secretary
Miss J Wells	Senior Executive PA (Minutes)

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

133/18 Patient Story

Mr Keith Benfield and his wife Mrs Jo Benfield attended the meeting to share their recent experience.

Mr Benfield advised that he contracted a water infection in January which required a visit to A&E and discussed that he had been seen in a reasonable time. He was subsequently admitted to the Urology ward.

Mr Benfield commented that the nurses were very good and put him at ease, his follow up appointments were made before he left and everyone was kind and helpful.

Mr Benfield expressed that as he had a urology problem he felt embarrassed, however he was put at ease by the nurses. Mr Benfield advised that he attended the Trust on three occasions and he received continuity of care which he felt was a good experience. He would be visiting the Trust again shortly for an

operation.

Dr Dunderdale thanked Mr and Mrs Benfield for sharing their experience and was pleased to hear a positive and complementary story. Dr Dunderdale asked whether any elements could have been improved.
Mr Benfield replied that there wasn't. He advised that the staff were so helpful, adding that he had left his car parked in the hospital car park when he was admitted, which was later collected by a relative without any problems. .
Mr Benfield added that whilst on the ward, there was a patient who was very difficult and rude to the staff, though the team continued to provide sufficient care and ignored his comments.

Mr Rashid thanked Mr Benfield for attending the meeting to share his story and was particularly pleased to hear about his experience within A&E. Mr Rashid advised that following his positive experiences so far, hopefully he felt less nervous and had confidence in the team looking after him when attending for his operation.

Professor Beale queried whether the continuity in care was a factor in the positive experience. Mr Benfield replied that it was.

Mrs Benfield asked whether the staff could receive a recognition award. Mr Beeken replied that they could and would see to it that they did.

Ms Oum thanked Mr and Mrs Benfield for sharing their experience with board members.

134/18 Apologies for Absence

Apologies were noted from Mrs P Furnival, Associate Non-Executive Director

A formal welcome to the Trust was made to Catherine Griffiths, Director of People and Culture.

Mr N Rashid, Divisional Director of Medicine and Long Term Conditions attended as deputy for Mr A Khan, Medical Director.

135/18 Declarations of Interest

There were no additional items to declare.

136/18 Minutes of the Board Meeting Held in Public on 6th September 2018

The Board approved the minutes of the meeting held on the 6th September 2018 as an accurate record.

137/18 Matters Arising and Action Sheet

The Board reviewed the action sheet.
Mrs Baines advised that there were a number of actions from the minutes which had not been captured in the action sheet and

asked that these be noted.

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

138/18 Chair's Report
Ms Oum presented the report which was taken as read.

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

139/18 Chief Executive's Report
Mr Beeken presented the report and highlighted the following key points;

- The CQC had expressed concern regarding the A&E department at Russell's Hall Hospital and Mr Beeken advised members that he had sought assurance from Ms Joshi that the issues highlighted at Russell Hall Hospital had been considered by the Trust at the Trusts CQC Preparation Steering Group.
- The Trust were seeking clarity from the CQC as to the process for removing the Section 29a notice as the recommendations had been met. It was disappointing that the notice had not yet been reversed.
- A Board to Board meeting with Walsall CCG had taken place with a professional strategic session focusing on integrating care within Walsall.
- Invites had been sent to colleagues to attend the Staff Award ceremony which was an evening dedicated to staff excellence and professionalism against the Trust values.
- NICE guidance had been issued regarding falls and fragility fractures. There were concerns that the local authority intended to decommission the falls prevention service within the borough and the impact this would have on patients and the Trust.

Board Development

Mrs Baines advised that there were a number of actions that came out of the Board to Board meeting and queried how they were being followed up.

Mr Fradgley confirmed that all Executive leads had received their relevant actions and work was underway address these.

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

140/18 Monthly Nursing and Midwifery Safer Staffing Report
Dr Dunderdale introduced the report and the following key points were highlighted;

- Average fill rates were moving nearer to 95%.
- Care hours per patient Trust median improved to 7.1.
- A Nursing Workforce Transformation Programme was underway and would detail triangulated establishment reviews.

Mr Heer referred to the report and asked Dr Dunderdale if she could advise him what the report was telling him as he was unsure regarding whether the Trust was doing better or worse than the previous month or other Trusts.
Dr Dunderdale replied that the report continued to be refined and that there had been an improvement in care hours however the national data was out of date which did raise questions in terms of what information was included within the report.

Mr Heer noted that the data reflected that the Trust was significantly over on Care Hours per Patient Day and queried whether more hours were being covered than necessary.
Dr Dunderdale replied that inconsistencies in the data were being reviewed and that the work being undertaken on the establishment review and Nursing Workforce Transformation Programme would help assist in this.

Ms Oum observed that the Children and Young People's Service appeared to be managing their rosters particularly well.

Ms Oum advised that an overview of the whole report would be reviewed at Trust Board in December.

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

141/18 CQC Preparedness Update

Mr Beeken presented the update and members noted that a weekly forum with divisional teams continued to be held, focusing on care, best practice and environmental improvements.
There were areas of concern in relation to documentation consistency and mental capacity assessment. A self-assessment against key domains had been undertaken along with the Enable East review the Trust was able to focus on the areas of most risk.
A Board Development session would be held to review Use of Resources. **Board Development**

Mr Beeken drew attention to appendix B outlining the regulatory requirements and must dos, advising that they formed part of the Patient Care Improvement Plan.

Mr Thomas-Hands advised that he had attended two staff meetings in relation to CQC preparedness which were very positive.

Ms Oum encouraged staff to self-assess themselves and to look

at areas that required further improvement and how they could be managed in a sustainable way.

Mr Gayle asked how the actions identified from the Enable East review were being acted upon.
Mr Beeken replied that documentation was now a focal point of weekly audits. Work focusing on patient flow was being led by Mr Thomas-Hands was underway and environmental change work was underway in ED.

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

142/18 Safe Nurse Staffing Levels

Dr Dunderdale presented the report, highlighting in particular section 2 relating to managers being empowered to make decisions on staffing for their areas. The following key points were highlighted:

- Reviews had taken place which involved staff in the form of 3 half day 'speed date' sessions to create a triangulated approach and an objective process with an evidenced based approach. Topics covered the following:
    - Acuity in the safer nursing care tool would be triangulated with care hours.
    - Occupancy information and core bed base ratios and quality flags.
    - Ward leaders empowered to make decisions.
    - Line of sight and floor footage.
    - Built in escalation.
    - Recognising the threshold of staffing numbers and skill mix.
- There was intention to undertake a second stage review.
- Trainee Nursing Associates to be integrated into Registered Nurses with a skill mix of a 1-8 ratio.
- Section 3 outlined the staffing numbers and skill mix process. E-rostering was pivotal and steps taken to ensure that it was monitored.
- Recognising rostering is only effective with the correct management and leadership.
- Section 4 outlined control processes which was key in terms of implementation and monitoring weekly through the transformation programme.
- Establishment reviews would be completed at least every 12 months or following changes within the establishment.
- Section 10 entailed the next steps. Consideration to be given to a Response Team which is the formation of an internal team that can be moved round on a rotation. Training would be given and would include exposure of different areas.
- Bank and e-rostering process was key. Erostering Software needed to be reviewed to ensure we have the

best system for our needs.

- Recruitment and bank processes to be streamlined are more timely.
- A review of the role of Sisters and Change Nurses to take place and their management and leading of ward staffing teams in the ward environment.

Ms Oum thanked Dr Dunderdale for the detailed report, advising it was clear there was a lot of on-going work.

Mrs Harris acknowledged that there was some really positive work underway. Mrs Harris queried whether Vitalpac was helpful. Dr Dunderdale replied that Vitalpac was an enabler to quality.

Mr Gayle observed that there were a number of initiatives and asked whether there was confidence that staff were engaging with them.
Dr Dunderdale responded that the establishment reviews had been an inclusive process which had been welcomed by Sisters and Matrons.

Dr Dunderdale advised that she would be reviewing the efficiency of the current roster system with a view to moving to the Allocate system already in place for Medical staff. Mr Fradgley stated that Allocate had been the preferred supplier for the rostering. It was utilised within the Trust but not for the purpose of nurse staffing. It would need to be tested against other providers prior to any implementation.

Mr Dunn asked whether there was an agreed timescale and sufficient capacity and capability within the teams to meet the objectives.
Dr Dunderdale replied that she had secured resource to provide additional support – Angie Davies had joined the Trust on a 6 month secondment as an Associate Director of Nursing Workforce and was making significant headway. There was intention to set up weekly operational meetings and a monthly oversight meeting. Mr Dunn would be the Non-Executive Director to provide support, confirm and challenge.

Professor Beale acknowledged the amount of work undertaken and questioned why the work had not been completed in this detail before.
Dr Dunderdale stated that lots of work had been done previously and acknowledged the national NHSI team who provided clear guidance.

Mr Heer advised that it had taken several months to get to this position and welcomed a predictive analysis, escalation and insight on a timely basis.

Mr Yates welcomed the recommendation on reducing the length

of the recruitment process.
Dr Dunderdale added that she was working with Ms Griffiths to review the bank arrangements.

Mr Beeken reiterated that the review and transformation programme would irradiate custom and practice that was not best practice.

Ms Oum welcomed the inclusivity and rigor and was pleased that teams were working together for solutions.

Resolution
The Board:

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

143/18 Establishment Review Medicine

Dr Dunderdale presented the report and members noted that a comprehensive review of ward nursing levels has been undertaken in 2 stages:

1) A Base Nursing review, designed to rapidly identify any areas where nursing levels were inadequate to guarantee safe care, which is now completed, and
2) An Optimal Nursing review, designed to comprehensively redesign establishments to ensure that nursing establishments and shift arrangements delivered the optimum balance of care quality and efficient use of resources.

The output of this review was set out in the paper which reflected a revision for the Medical Wards, core bed base.

Professor Beale noted the number of care hours until recently was lower than average and worried that reducing the workforce would impact those figures negatively.
Dr Dunderdale replied that quality of care was not just about the number of nurses but enabling them to deliver the right level of care and supporting them.
Ms Griffiths agreed that there was a strong appetite on staff wellbeing and managing sickness.

Mr Caldicott stated that the model hospital data required a deep dive to review the contradictions in data.

Ms Oum thanked members for their comments and supported the approach. Staff were on the journey and steps needed to be taken to ensure they were equipped and supported to deliver the best care. The report would be reviewed again at Trust Board in December.

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

144/18 Establishment Review Surgery & Critical Care

The report was reviewed as part of the Medicine paper and would be reviewed again at Trust Board in December.

Resolution

The Board received and noted the content of the report.

145/18 Integrated Performance Report

Partnerships

Mr Fradgley advised that Rapid response vacancies were planned to up to capacity until the end of October.
Further data in relation to localities would be added to the report.

Ms Oum asked if there was more recent data available.
Mr Fradgley replied that invalidated could be included in future if this would be appropriate.

Quality and Safety Committee

Dr Dunderdale advised that conversations had taken place in relation to quality indicators and deep dives around falls as there appeared to be an increased in the number of falls.

Professor Beale added that the Quality & Safety Committee had not been quorate and that he would be looking at the governance arrangements.
Ms Davies confirmed that the quoracy had been refreshed as part of the revised Committee Terms of Reference and were included on the agenda.

Mr Heer referenced the pressure ulcer data and a number of blank spaces, asking for the information to be omitted from the report if it was not complete.

Ms Oum emphasised the concern raised in the Chief Executives report in terms of the falls team being decommissioned.

Mr Thomas-Hands informed that during September, ward 10 started operating a new falls service which was reporting to the A&E Operational Group where feed back would be provided.

Performance, Finance & Investment Committee

Mr Caldicott stated that there were significant financial concerns, the Trust had endorsed a financial recovery plan and needed to ensure that it delivered. There were concerns with temporary workforce in medical and nursing areas which were considerably high for the time of the year.
Focus was also on CIP delivery with Outpatients being behind plan.

Dr Dunderdale informed of the introduction of the Nursing Workforce Transformation Programme with weekly operational

meetings and oversight which would feed in to the relevant committees. The outline plan had been shared with Executive Directors.

Mr Gayle asked how the Medical workforce was being addressed as it was not clear.
Mr Rashid replied that Meridian had visited the Trust to conduct an initial view. A business case had been produced and submitted to NHSI for funding. Focus would be on job planning exercises.

Mr Dunn asked for medical staffing to be addressed with the same rigor as nursing.

With regard to productivity, Mr Thomas-Hands stated that there had been increased performance within Outpatients, though it was not quite enough and Theatres had shown improvement.

Mr Gayle asked whether Outpatients were using the systems and processes which KPMG initially introduced and
Mr Thomas-Hands confirmed that they were using the systems that KPMG recommended, though the resources available were limited.

Operational Performance
Mr Thomas-Hands reported that ED 4 hour performance was 84%.
The whole annual leave policy would be reviewed in readiness for next summer.
Rearranged management of ICS to assist with 4 hour performance.
18 weeks achieved at 89%. The aspiration of the team was to achieve 92% in November
Cancer performance was not achieved at 81%. This was due to a breakdown of Mammography equipment during August. A screening unit and mammogram unit has been commissioned as a short term interim solution.

Ms Oum requested that the Performance, Finance and Investment Committee undertake an assessment on areas of performance which were not making progress. Patient DNA rate was given as an example as it had shown signs of improvement but was not on target.

POD
Ms Griffiths reported good compliance of PDRs and mandatory training.
Over 20 engagement workshops were planned in relation to the Trust values.
An Equality and diversity and inclusion lead was now in post at the Trust for the next 6 months.

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

146/18 Partnership update
Mr Fradgley referred members to his report and highlighted the

following key points:

- MDT - Appendix 1 documented the additional four practices that were to come online. Further work was progressing in relation to locality-based MDT adoption.
- Shared Care Record – A project board had been established and focusing on a pilot area and wider deployment plan. Conversations were taking place with the Royal Wolverhampton NHS Trust with a view to managing elements of the borough jointly.
- Estates Forum – The Trust participated in a recent workshop to understand the collective challenges. Further consideration needed to be given to a shared coordination space.

Mr Beeken queried whether mental health Trusts were involved in the one public health discussions.
Mr Fradgley replied that they were invited but did not attend.

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

147/18 Standing Financial Instructions, Standing Orders, Scheme of Delegation

Ms Davies advised that a review of the delegated limits within the Standing Financial Instructions had been undertaken.. Members noted that the limits had been raised
to push delegation down to allow teams to make decisions but ensuring that appropriate governance was in place.

Ms Davies confirmed that limits were benchmarked against similar hospitals and the risk appetite.

Mr Caldicott clarified that any approvals above £250k needed oversight through a Trust Board sub-committee. Approvals of £750k would be reviewed at the Performance, Finance and Investment Committee followed by Trust Board for visibility.

Mr Heer questioned whether similar Trusts in financial deficit were considered as part of the benchmarking and asked for clarity as to why limits had been raised.
Mr Beeken replied that the limits were raised to aid decision making issues as current limits were problematic and, disengaging staff.

Mr Caldicott confirmed that delegated authority down to divisions had not changed and remained at up to £25k.

Mr Heer and Professor Beale commented that they did not feel the rational for raising the limits was sufficient enough.

Mr Fradgley advised that there was a business case process in place that put a lot of rigor through the process but it did stifle innovation.

Ms Oum summarised that the paper would not be approved at this stage without further clarification on the rationale for raising the limits and an update on implementation of the accountability framework. **JD**

Resolution
The Board:

- **Received and noted the content of the report.**
- **Did not approve the SFI and requested further clarification.**

148/18 Board Committee review of Terms of Reference

Ms Davies referred members to her report which presented the updated Committee Terms of Reference that had been reviewed by the relevant committees.

Professor Beale commented that the Quality, Patient Experience and Safety Committee duties were very detailed and these should be reduced in line with other Committees.

Mr Heer called for a regular assessment of Committee effectiveness and asked for this to be incorporated into the Terms of Reference.
Ms Davies replied that work was underway to review Committee effectiveness and an assessment would be completed in February 2019. **JD**

Resolution
The Board:

- **Received and noted the content of the report.**
- **Approved the Terms of Reference.**

149/18 Brexit Assurance

The paper was taken as read.
Ms Oum requested that a further update be received by the Board which sets out how the Trust is managing the risks and areas of concern.

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

150/18 STP - ICS roadmap and STP governance

Mr Beeken referred members to his report which set out to provide members with the STP journey to becoming an "Integrated Care System" (ICS). Mr Beeken advised that 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". The paper also set out the agreed governance model for the STP.

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

151/18 Highlight Reports and Minutes
The highlight reports and minutes were Received for information.

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

152/18 Questions from the Public
There were no questions from the public.

153/18 Date of Next Meeting

The next meeting of the Trust Board held in public would be on Thursday 1st November 2018 at 10:00a.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

Resolution:
The Board resolved to invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960.

ENC 3

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
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	**Complete** Ms Blackwell discussed with Mrs Furnival who was going to arrange a meeting in her role as Director of Social Services	
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.	
121/18 Integrated Performance Report	Model Hospital to feature as a topic at Board Development.	Trust Secretary			
128/18 Quality & Safety Committee Highlight Report	The committee would review the process and QIs with regard to the quality impact assessment.	Director of Nursing	01/11/2018		

ENC 3

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
129/18 Performance, Finance & Investment Committee Highlight Report	Terms of reference to be reviewed in order to agree emergency action in the event of not being quorate.	Trust Secretary/ Director of Governance	01/11/2018		
138/18 Chief Executives Report	A Board Development session focusing on Walsall together would be planned.	Trust Secretary			
141/18 CQC Preparedness Update	A board Development session focusing on Use of Resources would be planned.	Trust Secretary			
147/18 Standing Financial Instructions	Further rationale required regarding the assurance of accountability framework and how it would be managed.	Director of Governance	01/11/2018		
148/18 Terms of Reference	Associate NEDs to be included in the Terms of Reference.	Director of Governance	01/11/2018		

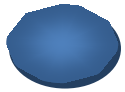
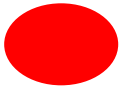
Key to RAG rating

ENC 3

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

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

 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 – 1st November 2018			
Chair's Report			**AGENDA ITEM: 6**
Report Author and Job Title:	Danielle Oum, Chair	**Responsible Director:**	Danielle Oum, Chair
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The report contains information that the Chair wants to bring to the Board's attention and includes a summary of the meetings attended and activity undertaken by the chair since the last Board meeting. In keeping with the Trust's refocusing on core fundamentals, this report has been restructured to fit with the organisational priority objectives for the coming year. With regard to the priorities 3 and 4, I have embarked on a programme of engagement with colleagues and stakeholders to communicate our organisational focus as well as gather perspectives and triangulate information to contribute to Board assurance.		
Recommendation	Members of the Trust Board are asked to: Note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Chair's Update

PRIORITY OBJECTIVES FOR 2018/19

1. **Continue our journey on patient safety and clinical quality through a comprehensive improvement programme**
   I had the pleasure of attending the Diabetes in Pregnancy Study Day and welcoming the Regional Lead for Diabetes UK who gave a national perspective on the topic.
   I attended the Quality and Safety Committee to receive an update on the enhanced QIAs and was assured of the committee's role within the QIA process.

2. **Improve our financial health through our robust improvement programme**
   I met with members of the finance team during my Board Walk and discussed the issues and pressures they faced within the department.

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 recently closed and longlisting took place last week.

4. **Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts**
   Richard and I met with Healthwatch for a quarterly catch up meeting.

Meetings attended / services visited
Finance team
One to one meetings with Executive Directors
Appraisals with Non-Executive Directors
Engagement Lead
Regional Talent Board briefing

I also attended 'Trust's Got Talent' and enjoyed watching a range of acts delivered by our talented colleagues. Well done to all who took part.

RECOMMENDATIONS
The Board are asked to note the report

Danielle Oum

November 2018

NEW NATIONAL GUIDANCE, REPORTS AND CONSULTATIONS

The following guidance and policy actions, which have been received from the wider regulatory and policy system during October, 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
	Have your say on wholly owned subsidiaries NHSI are consulting on proposals to change the way they approve and trusts report subsidiary companies. This will enable them to ensure only business cases that create value for the sector proceed, whilst continuing to respect NHS freedoms and innovation	Action	Director of Strategy / Director of Finance & Performance
	Apply for the NHS Energy Efficiency Fund for LED lighting The government has made £46 million available for trusts to improve and expand the use of LED lighting across your services, to save the NHS money and provide a better-quality experience for patients, staff and visitors. The funding can help Trusts reduce their electricity use, cut their energy bills and deliver the Carter recommendations	Action	Director of Finance
	Ward leader's handbook Directors of nursing — can use this new handbook to support local development programmes aimed at improving the leadership skills of nurses working in wards irrespective of the setting. Individual ward leaders can use this handbook as part of their professional development discussions	Information	Director of Nursing
	Stop the Pressure: updated definition and measurement framework Following feedback from trusts, NHSI have updated our pressure ulcer definition and measurement recommendations.	Information	Director of Nursing
	New emergency care video series Hear about good emergency care practice in health and care teams with NHSIs new series of videos, which cover:	Information	Chief Operating Officer

	• embracing risk and enabling patient choice • frailty • acute assessment • emergency department streaming • clinical decision units • board rounds		
	Doctors encouraged to use biosimilar versions of adalimumab to help save the NHS £150 million Doctors are now being asked to consider equally effective and safe biosimilar versions of adalimumab (brand name Humira®) after the patent on the drug expired yesterday (Tuesday 16 October). Biosimilar versions of adalimumab are expected to be available to NHS patients from December this year and could help save the NHS at least £150 million per year by 2021. Find out how you can implement the use of biosimilars using the implementation toolkit.	Review	Medical Director
	Plans to test EU Settlement Scheme The Home Office last week announced plans to test the EU Settlement Scheme with all health and social care workers. This means EU citizens working in the health or care sector will have early access to the scheme before it is rolled out more widely in 2019. NHS Employers will be working with us, the Department of Health and Social Care and the Home Office to produce and disseminate communication materials to help you best support your colleagues who need to register for the scheme. The scheme does not open until Thursday 29 November, but it is vital you start preparing now by both identifying those staff who need to register and ensuring they are aware.	Review	Director of People & Culture
	Cohort 2 applications now open for the NHS Digital Academy The NHS Digital Academy, through a partnership with Imperial College London, the University of Edinburgh and Harvard Medical School, provides a fully-funded year-long learning programme (Post Graduate Diploma in Digital Health Leadership) for digital change leaders.	Review	Director of Strategy & Improvement

	The first cohort of 100 delegates from around the health and care system in England started in April 2018 and includes chief clinical information officers, chief information officers and many others charged with leading digital change, from both clinical and non-clinical backgrounds. Find out more and apply now for cohort 2 , commencing in April 2019.		
	NICE fellowships and scholarships: applications now open NICE is looking for exceptional people with a passion for health and care to join its prestigious fellows and scholars programmes. Up to 10 scholarships and 10 fellowships will be awarded this year. Both roles are unpaid and undertaken alongside successful candidates' existing jobs and other responsibilities. Find out more and apply by Friday 9 November.	Review	Medical Director
	Amendment to the medical agency price caps The medical agency price caps have been amended in line with the recently approved pay rise for medical staff. This ensures continued compliance with the Agency Worker Regulations and the change applies to those staff on medical contracts (pay groups). If you have any queries, please email nhsi.agencyrules@nhs.net.	Action	Director of Finance & Performance / Director of People & Culture / Medical Director
	Have your say on the national tariff proposals 2019 This week NHSI published their proposals for the 2019 national tariff. The proposals include a change of the default way of paying for urgent and emergency care (moving away from episodic prices), recalculated market forces factor values and options for how the tariff might be used to fund the new NHS supply chain organisation. If you have any queries, please email pricing@improvement.nhs.uk. You can also find out more about our maternity and blended payment proposals by watching recordings of our recent webinars.	Information	Director of Finance & Performance
	More than words – spoken communication in the NHS Improving spoken communication across the	Information	Director of Strategy & Improvement

	NHS requires action from many people. A new paradigm is needed that addresses not only the structure and format of what is said, but also how a person should adapt their spoken communication to ensure they deliver information in a way that is appropriate for the person being addressed. NHSI have commissioned a working group to provide a better understanding of the issues surrounding both good and poor spoken communication of safety critical information. They have published a summary of the group's findings and the six key areas identified as presenting challenges to spoken communication, as well as the group's report.		
	Opportunity to build quality and service improvement capability Applications are now open for the latest cohorts of our ACT Academy's QSIR College (quality, service improvement and redesign) programme in Leeds and the South West. The programme offers health systems and NHS organisations the opportunity to build sustainable service improvement capability by developing candidates to skill up others across their system/organisation.	Information	Director of Strategy & Improvement
	NHS Partnerships Summit 2018 Thursday 15 November, London The annual partnerships summi will focus on how NHS/independent sector partnerships can help deliver the vision of the forthcoming NHS 10-year plan and ensure that every pound of NHS funding is spent wisely. NHS Improvement Chair Dido Harding is confirmed as the keynote speaker, and the summit will also feature speakers from NHS England, NHS Digital and the CQC.	Information	Director of Strategy & Improvement
	Empowering young people in health and care Friday 9 November, 3 Carlton House Terrace, London Youth volunteering and social action benefits the young people involved, their communities and healthcare providers. Volunteer managers, patient experience board leads and trust directors – join this NHS England and #iwill campaign event to explore how more	Information	Director of Strategy & Improvement

	young people can be supported to make a difference in health and care . Confirmed speakers include Ruth May, Executive Director of Nursing, NHS Improvement, Prof. Stephen Powis, Chief Medical Director, NHS England and the NHS Youth Forum.		
	Lord Carter's report on ambulance services' operational productivity The report, published last week, found if more patients are treated at the scene by paramedics, or better assessed over the phone when dialling 999 (avoiding the need for an ambulance when it is safe to do so), the NHS could treat patients closer to home and reduce unnecessary pressure on emergency departments and hospital beds. Offering safe and quicker care could save the NHS £300 million a year by 2021, with a further £200 million of savings through improvements in ambulance trusts infrastructure and staff productivity.	Information	Director of Finance & Performance
	New Model Ambulance compartments on the Model Hospital To help you deliver the recommendations of Lord Carter's report, we also released Model Ambulance compartments on the Model Hospital to help trusts identify opportunities to improve efficiency. The new version of the Model Hospital tool, now including Model Ambulance, is easier to use and has been produced in collaboration with trusts. It now features bespoke productivity opportunities, clear comprehensive metrics and new support articles, videos and tips. NHSI are also hosting a webinar to help you make the most of the new features.	Information	Director of Finance & Performance
	ACT2improve interactive improvement tools These new tools include digital versions of the sustainability model, process templates and stakeholder analysis – and offer a quicker, digital way to process your data. The tools are fully interactive, and you can collaborate on projects across organisations and share the results with others in your project group.	Information	Director of Strategy & Improvement
	Government Digital Service consultation on	Information	Director of

	the EU web accessibility directive The Public Sector Bodies (Websites and Mobile Applications) Accessibility Regulations 2018 came into force on 23 September 2018. These regulations mean public sector websites and mobile apps will need to be accessible to all users, especially those with disabilities, and meet common accessibility standards by the following dates: • all new public sector websites created or substantially changed after September 2018 should be compliant by September 2019 • all existing public sector websites should be compliant by September 2020 • all mobile applications should be compliant by June 2021 In the first stage, public sector websites published after the 22 September 2018 have until 22 September 2019 to become compliant, unless doing so would impose a disproportionate burden or the content or organisation is exempt . The regulations also require public sector bodies to publish an accessibility statement on their website giving details of any parts of the website or app that are not accessible, an explanation of why, and links to accessible alternatives where appropriate.		Strategy & Improvement
	Launch of life sciences industry (LSI) professional registration To help Trusts manage risk in your organisation,a new national register has been launched to provide NHS organisations with assurance that industry partners have been approved against a national framework before giving them access to NHS premises. The implementation group, formed by NHS England, recommends that chief executives, medical and nursing directors ensure life sciences industry personnel can demonstrate they are LSI register accredited before being granted access to NHS premises and that your trust embeds this requirement as part of your standard governance and safeguarding arrangements.	Information	Director of Governance
	Overseas nurses and midwives able to apply	Information	Director of

	to work in the UK immediately after qualifying As part of ongoing changes being made by the NMC to the international recruitment process, NMC has announced EU nurses and midwifes no longer need one year post registration experience to be eligible to apply to go on the register. All those applying to work in the UK from outside the EU will still be required to show they're safe to work and that they can communicate effectively in English. These changes are part of a much wider ongoing review looking at how the NMC can improve the experience for people applying to work in the UK from overseas.		Nursing
	New impact report on diabetes The report explores how NICE guidance has been implemented by the healthcare system and what progress has been made to improve outcomes for those with diabetes or at risk of developing the disease. This is the fifth in a series of impact reports reviewing 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 shared her thoughts about the report.	Information	Medical Director
	New social care and support guide The new guide to social care contains information for people who might need social care, their families and carers, to help them understand their options and access services. You can signpost people to the information, or reuse it on your own website through a free syndication service which pulls up to date content directly from nhs.uk.	Information	Director of Strategy & Improvement

MEETING OF THE PUBLIC TRUST BOARD – 1st November 2018			
Monthly Nurse Staffing Report- September 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 ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	This report outlines the monthly nurse staffing for September 2018. The report includes data, narrative, the actions being taken, and analysis around triggers related to staffing and triangulated data from the Nursing and Midwifery dashboard. The average fill rate for registered nurses (RN) in September 2018 was 95.2% for day shifts and 95.2% for nights shifts in comparison to August 2018 when it was 95.1% for days and 94.6% on nights. Shift fill rates have slightly increased this month for RNs on days and nights. The fill rate for Care Support Workers (CSW) decreased in September 2018 to 91.3% on day shifts and to 96.6% on night shifts. Ward 15 RN fill rate on days was below 90%, safety was maintained by the senior sister providing clinical support to staff. The registered nurse fill rates on Ward 19 (Critical Care) was below 90% on days and nights and the fill rate on ward 18 (HDU) was also below the 90% fill rate target on nights due to maternity leave and staff sickness; no temporary staffing cover was required on nights due to the ability to plan staffing against activity whilst still maintaining nationally recommended levels of staffing for this area. The lower Registered Midwifery (RM) fill rate on days and nights on 24/25 was contributed to by high levels of maternity leave and gaps in staffing which could not be filled by temporary staffing requests. Midwifery applies a flexible staffing model and move staff between Delivery and the ward when required to ensure safe staffing and patient care is maintained. CSW cover was less than 80% on HDU (days and nights), ward 23 on days and 24/25 on days. HDU and 24/25 have maternity leave which impacted staffing levels and Ward 23 had staff sickness. The analysis of incidents identified no correlation between staffing related incidents and quality KPI's. A total of 53 staffing red flag events were reported by the clinical areas in September 2018. These are reported as part of the risk assessment for staffing undertaken by the ward staff when there are gaps in staffing on a shift. The red flags reported 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.		
Recommendation	The Trust Board is requested to discussion and information.		
Does this report mitigate risk included in the BAF or Trust Risk	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.		

Registers? please outline		
Resource implications	Resources are needed from all teams to focus on efficient and safe scheduling and allocation of nursing staff and the prompt action to resolve shortfalls in staffing whenever possible to mitigate the risk to patient care and safety	
Legal and Equality and Diversity implications	None	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☒	

MONTHLY NURSE STAFFING REPORT

1. PURPOSE OF REPORT

This is the 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. This report provides evidence that processes are in place to record and manage Nursing and Midwifery staffing levels across the hospital settings and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care.

This report outlines the monthly nurse staffing for September 2018

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 and excludes ambulatory care, short stay and ED. The full NHS Digital upload is provided in Appendix 1.

The average fill rate for registered nurses in September 2018 was 95.2% for day shifts and 95.2% for nights shifts in comparison to August 2018 when it was 95.1% for days and 94.6% on nights. Shift fill rates have increased slightly this month for RNs on days and nights. The fill rate for Care Support Workers (CSW) decreased in September 2018 to 91.3% on day shifts and to 96.6% on night shifts compared to 92.4% on day shifts and 97.7% on nights in August 2018.

Of the 23 areas reported on during September 2018:

- 3 areas recorded less than 90% shift fill rate on days for RNs, these were Ward 15, 19 and 24/25
- None of the clinical areas had an RN fill rate below 80% on day shifts
- On nights 3 areas recorded less than 90% shift fill rate on nights for RN/RM; these ward 24/25 (Midwifery) ITU and HDU.
- Ward 24/25 (Midwifery) had an RM fill rate below 80% on night shifts

The lower RN fill rate on Ward 18 (HDU) was due to Maternity leave, no temporary staffing cover was required on nights due to the ability to plan staffing against activity whilst still maintaining nationally recommended levels of staffing for this area. For ITU, there was staff sickness but again, no temporary staffing cover was required on nights due to ability to plan staffing against activity. The Registered Midwifery (RM) shortage on nights on ward 24/25 was contributed to by high levels of maternity leave and gaps in staffing which could not be filled by temporary staffing requests. Midwifery applies a flexible staffing model and move staff between Delivery suite and the ward when required to ensure safe staffing and patient care is maintained.

CSW cover was less than 80% on (days and nights), ward 23 on days and ward 24/25 on days. The lower CSW fill rate on HDU was due to maternity leave. Some shifts did not require cover due to staffing levels being appropriate for patient care levels. The ward 23 CSW shortage 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. Ward 24/25 had CSW shortage due to maternity leave and these shifts could not be filled despite requests for temporary staffing cover.

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 RN fill rate has remained stable for the last 3 months. The fill rate for RNs on days has been consistently above 90% for the last 12 months and this was maintained in September 2018. For nights the fill rate has been consistently above 90% since January 2018.

Figure 1

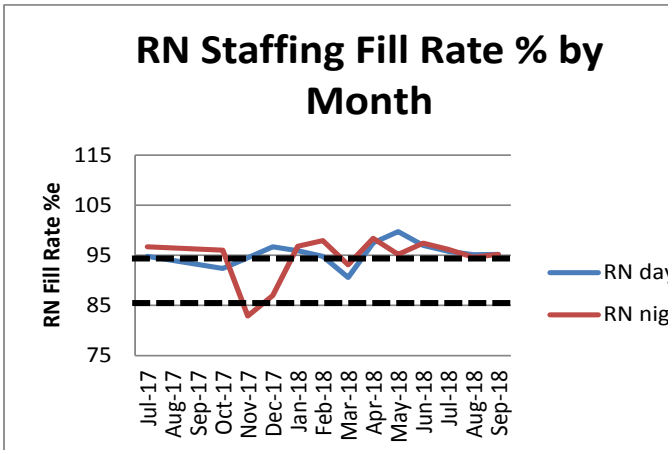


Figure 2

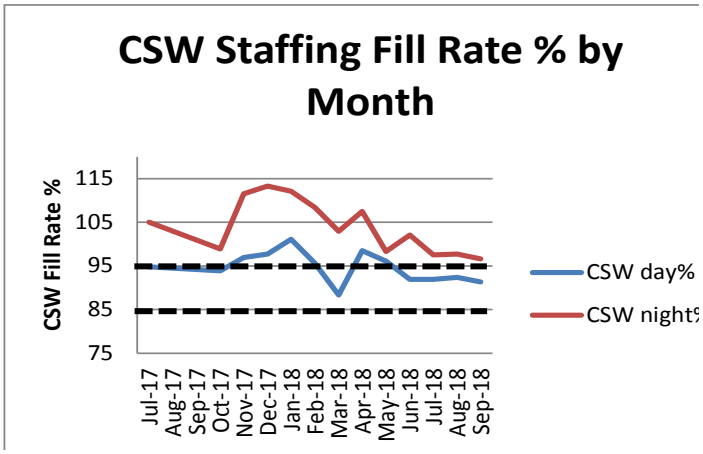


Figure 2 shows that the fill rate for CSWs on both days and nights has decreased with day shift fill at 91.3% and night shift at 96.6%. Corporate Nursing are revising the Bank recruitment processes and reviewing incentives and pay rates applicable to this group of staff during October 2018.

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

Table 1 shows a review of those wards where the staffing fell below the 90% target for 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 1

Ward	Hospital Acquired Pressure Ulcer	Falls	Serious Incidents	Complaints	FFT Score	Number of Staffing incidents	Any correlation between staffing incidents and KPI dates?
15	1	5	1 (pressure ulcer unstageable)	0	100%	0	No
16	0	6	0	0	91.7%	4	No
18	0	0	0	0	100%	1	No
19	0	0	0	0	100%	0	No
23	0	0	0	0	98%	0	No
24/25	0	0	0	0	91%	3	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. There was no correlation between staffing incidents and pressure ulcer incidents for these wards during September 2018. 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 September are currently going through the RCA investigation process.

All the staffing related incidents reported on the Trust Safeguard incident reporting system for September 2018 were reviewed to identify any correlation with patient harms. In total there were 32 ward staffing related incidents reported which related to low staffing due to gaps on ward rosters which could not be covered by temporary staffing in Septmebr compared to 50 reported incidents in August 2018.
These are outlined in Table 2 below:

Table 2

Ward	Number of staffing related incidents	Level of Impact	Any correlation to other reported incidents?
Ward 1	5	No/low harm	None
Ward 2	9	No/low harm	None
AMU	5	No/low harm	None
ASU	1	Low	None
Ward 16	4	No/low harm	None
HDU	1	No harm	None
Ward 20a	2	No/low harm	None
Ward 21	1	Low harm	None
Ward 24/25	3	No/low harm	None
Ward 28	1	No harm	None

On review of the reported staffing incidents in September 2018, none of the reported staffing incidents correlated with days when another patient related incident was reported such as a fall.

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 53 red flag events in September 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 is consistent with August 2018 when 56 red flags were reported. The Director Nursing is developing a Nursing Metrics Review to increase the oversight and narrative on standards of care. The outcomes of these reviews will inform this board report on an ongoing basis.

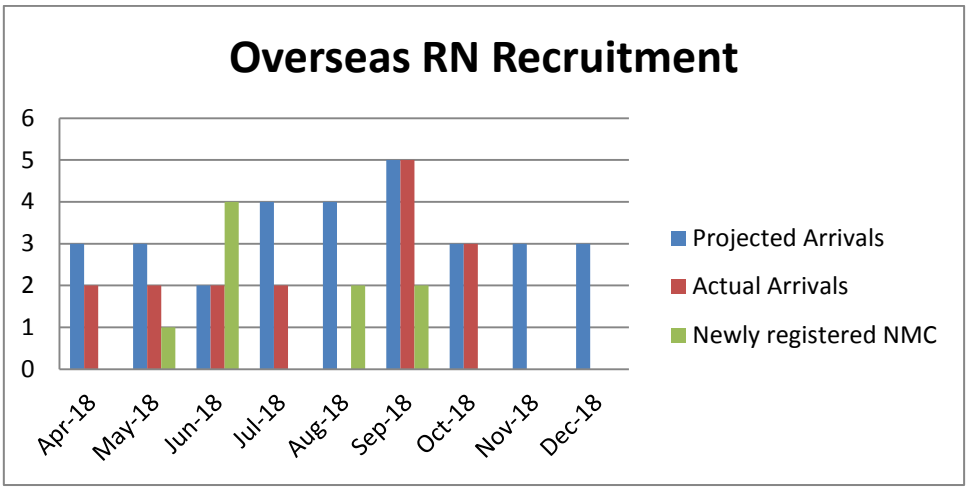
4.0 Update on Vacancies and Recruitment

The current vacancies from ESR in September 2018 (excluding theatres) are:

Division	Vacancy
SURGERY	23.74 WTE
MLTC	38.37 WTE
WCCS	13.02 WTE

There was a reduction in vacancies in MLTC in September with 11.82WTE new registered nurses starting in the Trust. There were also 5WTE new starters in WCCS. However, surgery saw an increase in their vacancies with the largest number being on the Acute Surgical Unit. There is a new workstream being established by the Associate Director of Nursing for workforce to address nursing recruitment and retention.

The Trust continues with recruitment of RNs from overseas, with the number recruited to date shown in Figure 2:



In total the Trust has appointed 16 out of a projected 24 overseas nurses and 9 have now passed their OSCEs and are working as RNs in the Trust.

5.0 RECOMMENDATIONS

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

- The current Trust performance in relation to local and national safe staffing KPIs
- The overall Trust fill rate for RNs and CSWs remains above the 90% target
- The comparison of staffing incidents and patient safety incidents did not show correlation with deficits in staffing in September 2018

7.0 CONCLUSIONS

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

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

Appendix – Fill rates Nursing, Midwifery and Care staff

Sep-18

Dept		Day		Night		Day		Night		CHHPD													
	RN WTE Vacancy rate %	Av. fill rate - RNs (%)	Av. fill rate - care staff (%)	Av. fill rate – RN	Av. fill rate - care staff (%)	Av. fill rate - substantive RN (%)	Av. fill rate – Substantive care staff (%)	Av. fill rate – substantive RN (%)	Av. fill rate - substantive care staff (%)	RN	Care Staff	Overall	Staffing Related Incidents	% safety thermometer harm free care	Falls	Pressure Ulcers grade 2	=Pressure ulcer garde 3	Unstageable/or deep tissue injury	CDIFF	MRSA NUMBER OF DAYS WHERE RED FLAGS OCCURRED	COMPLAINTS	FFT(%)
Acute Surgical Unit		93.4%	91.1%	99.1%	97.7%	67.78%	65.82%	50.80%	42.94%	3.6	3.4	7.0	1	97.50%	7	1	0	0	0	0	0	89.6%
Paediatric Assessment Unit		100.0%	92.2%	100.0%	97.8%	98.36%	75.90%	100.00%	76.14%	55.7	78.7	134.3	0	N/A	0	0	0	0	0	0	0	0	N/A
Ward 01		99.3%	91.5%	91.1%	93.0%	76.61%	60.41%	62.20%	33.14%	2.2	2.8	5.1	5	97.06%	10	1	0	0	0	0	5	0	100.0%
Ward 02		94.8%	91.5%	98.9%	100.0%	85.63%	67.87%	58.43%	58.89%	2.3	2.6	4.8	9	82.35%	6	0	0	0	0	0	4	1	92.0%
Ward 03		100.9%	94.7%	100.0%	100.0%	91.28%	66.80%	71.67%	64.44%	1.7	2.6	4.3	0	100.00%	7	1	0	0	0	0	4	1	91.1%
Ward 04		101.2%	99.4%	100.0%	97.8%	77.84%	40.16%	73.33%	54.55%	2.4	3.4	5.8	0	90.48%	4	1	0	0	0	0	7	0	100.0%
Acute Medical Unit		97.3%	90.7%	99.5%	97.1%	78.28%	72.51%	66.03%	69.12%	4.0	4.1	8.0	5	100.00%	9	1	0	0	0	0	6	0	95.6%
Ward 07		96.7%	93.3%	97.8%	97.8%	9569.00%	85.66%	88.64%	72.23%	3.5	3.4	6.9	0	100.00%	3	0	0	0	0	0	7	0	96.9%
Surgical Assessment Unit		96.8%	99.5%	-	-	55.09%	82.73%	-	-	-	-	-	0	100.00%	0	0	0	0	0	0	0	1	95.1%
Ward 09		95.3%	93.5%	97.8%	94.7%	71.33%	69.63%	56.82%	42.25%	2.9	3.4	6.3	0	100.00%	0	0	0	0	0	0	3	0	90.0%
Ward 14		95.1%	90.1%	100.0%	96.6%	33.31%	43.60%	39.34%	12.65%	2.5	2.8	5.3	1	N/A	10	0	0	0	0	0		0	76.0%
Ward 15		89.7%	90.1%	98.9%	97.2%	76.25%	85.61%	48.31%	88.41%	2.7	2.5	5.2	0	88.89%	5	1	0	1	0	0	4	0	100.0%
Ward 16		95.4%	87.5%	96.7%	94.7%	61.75%	76.17%	33.33%	68.06%	3.1	2.7	5.8	4	100.00%	4	0	0	0	0	0	5	0	91.7%
Ward 17		95.2%	97.8%	100.0%	100.0%	83.75%	88.06%	43.33%	85.94%	3.1	2.4	5.6	0	88.89%	1	1	0	0	0	0	2	2	100.0%
Ward 18		90.5%	68.6%	87.3%	63.3%	90.80%	100.00%	91.60%	73.68%	15.7	2.3	18.1	1	100.00%	0	0	0	0	0	0	0	0	100.0%
Ward 19		89.9%	-	88.3%	-	87.76%	-	85.53%	-	26.4	0.0	26.4	0	100.00%	0	0	0	0	0	0	0	0	100.0%
Ward 20A		91.1%	97.9%	100.0%	100.0%	72.16%	52.78%	58.33%	90.00%	4.3	2.7	6.9	2	100.00%	3	0	0	0	0	0	0	0	100.0%
Ward 20B/20C		94.0%	91.3%	100.0%	100.0%	82.57%	82.51%	63.33%	83.33%	3.9	3.3	7.1	0	100.00%	1	0	0	0	0	0	1	0	100.0%
Ward 21		100.0%	-	93.3%	-	99.17%	-	83.04%	-	6.7	0.0	6.7	1	100.00%	1	0	0	0	0	0	0	0	98.3%
Ward 23		121.9%	67.8%	98.3%	103.3%	100.00%	83.96%	94.92%	87.10%	4.6	2.5	7.2	0	86.67%	0	0	0	0	0	0	0	0	97.8%
Wards 24/25		84.4%	71.4%	75.5%	85.3%	98.92%	53.22%	93.44%	44.28%	4.2	2.0	6.2	3	100.00%	0	0	0	0	0	0	0	0	90.9%
Ward 28		100.0%	100.0%	100.0%	100.0%	95.88%	85.71%	89.17%	90.48%	10.7	1.2	11.9	1	100.00%	0	0	0	0	0	0	0	1	N/A
Ward 29		93.7%	103.0%	101.1%	107.9%	71.70%	91.17%	35.16%	91.07%	3.1	2.9	6.0	0	100.00%	9	1	0	0	0	0	5	1	97.6%
TOTAL FILL RATE		**95.2%**	**91.3%**	**95.2%**	**96.6%**	**80.70%**	**70.50%**	**68.99%**	**60.61%**														

Fill Rate				**Safety Thermometer key**				**FFT**	
> 90%				Over	> 94%			Over	> 96%
> 80% <90%				Over	<94%			Below	< 96%
Below< 80%				Under	<85%				

MEETING OF THE PUBLIC TRUST BOARD – 01 November 2018			
CQC Preparedness Update			**AGENDA ITEM: 9**
Report Author and Job Title:	Suzie Loader Improvement Consultant	**Responsible Director:**	Richard Beeken Chief Executive
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☐ (select the relevant action required)		
Executive Summary	This paper aims to summarise to the Board, the actions the trust has taken over the past month to improve the quality of care for patients, whilst simultaneously preparing the organization for the next CQC inspection. The paper outlines the key issues for September 2018 as follows: 1. The Trust received the Provider Information Request (PIR) for information from the CQC on the 16 October 2018, which denotes *the start of the inspection process*. Information relating to 'services & locations' was submitted to meet the deadline of the 18 October 2018. The remaining information requires submission by 5pm on the 06 November 2018 – the trust has this in hand and aims to meet the deadline. 2. The CQC could visit the trust at any time to carry out unannounced spot inspections, or may choose to undertake a more announced formal inspection, which will be followed up 2 weeks later by the well-led inspection. 3. The CQC have changed the way that they want to engage with the trust. Originally monthly engagement meetings were held, which have been replaced with quarterly meetings. In addition, engagement visits are being organised with specialties, the first of which is planned for the Medicine Division on the 15 November 2018. 4. Improvements have been made to the PCIP, which is being supported by a new business intellegence software which allows the trust to identify at a glance where the issues are, facilitating drill-down into the detail. 5. Key issues of compliance relating to regulatory, must and should do actions are as follows: a. VTE performance has dipped down to 94.3% b. Documentation has improved slightly c. Appraisal compliance has dipped slightly to 89.73% d. DNACPR & MCA compliance has improved from 60% - 80% e. Number of expired clinical guidelines has increased from 78-89 f. Number of expired SI actions has increased by one this month g. Mandatory training has dipped slightly to 85.21% h. Best Practice has moved from amber to red, due to continued lack of compliance with NAPSIPS, CAS alerts & expired clinical guidelines i. The number of out of date policies is significant and will be		

	monitored from now on j. Concerns regarding information governance have been surfaced and are now being managed tightly. An IG compliance checklist has been circulated to ward and department managers.	
Recommendation	Members of the Quality & Safety Committee / Trust Board are asked to: o Discuss and challenge the content of this report	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 11: That our governance remains "inadequate" as assessed under the CQC Well Led standard.	
Resource implications	Undertaking this work will require people's time on a regular basis; particularly participation in peer review audits and board development.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☒	

CQC Preparedness Update: Highlight Report

Purpose

1. This report aims to provide a summary update to Trust Board on work which has been undertaken to improve the quality and safety of care delivered to patients during September 2018, whilst simultaneously preparing the organisation for its next CQC inspection.

Recommendations

2. The trust board are asked to:
   - Discuss and challenge the content of this report

The Report

3. This report covers the Patient Care Improvement Programme (PCIP), PCIP outcomes, and preparation for the forth-coming CQC inspection.

The Patient Care Improvement Programme (PCIP)

4. A Standard Operating Procedure (SOP) describing the oversight and governance of the PCIP has been ratified and is in the process of being implemented. Key elements of the SOP include:
   - That there should only be one improvement plan for each core service / care group, and any improvement issue (irrespective of whether it relates to the previous CQC inspection or not) needs to be monitored via this plan and its associated governance processes
   - Ownership of the PCIP sits with the individual core service / care group.
   - The divisions are responsible for overseeing delivery of the Care Group PCIPs.
   - The Director of Governance is now the lead executive for the PCIP

5. The PCIP is in the process of being reviewed with the Care Groups and Divisions to ensure the issue is clear and there are relevant SMART actions, desired outcomes (which are measurable) and evidence of effectiveness (once achieved). Work to 'theme' the issues and resulting actions has just commenced, with the aim of reducing the overall number of actions, whilst addressing the root causes in order to achieve sustainable improvement over a wider area.

6. Key issues of compliance relating to regulatory, must and should do actions are as follows:

Issue	Improve / decline
VTE performance has dipped down to 94.3%	
Documentation has improved slightly	
Appraisal compliance has dipped slightly to 89.73%	
DNACPR & MCA compliance has improved from 60% - 80%	

Issue	Improve / decline
Number of expired clinical guidelines has increased from 78-89	
Number of expired SI actions has increased by one this month	
Mandatory training has dipped slightly to 85.21%	
Best Practice has moved from amber to red, due to continued lack of compliance with NAPSIPS, CAS alerts & expired clinical guidelines	
The number of out of date policies is significant. Policy update and review will be monitored tightly from now on	
Concerns regarding information governance have been surfaced and are now being managed tightly. An IG compliance checklist has been circulated to ward and department managers.	

Detailed compliance data was presented to the Quality & Safety Committee in October. For the first time, this data was represented by SPC (statistical process control charts).

Progress with the PCIP actions

7. As well as monitoring evidence of improvement via compliance against KPI's, the trust also monitors the number of actions achieved against set timescales.

8. The application of a new business intelligence tool has allowed the progress of actions developed in the PCIP, to be reported from core services. The next phase of development aims to expand this reporting to different levels within the trust: Care Groups, Directorates, and eventually Trust-wide.

9. The chart and table below outlines progress against the 198 actions identified within the PCIP. It demonstrates that 45.5% of actions have been completed and assurance gained via evidence provided; with a further 17.1% of actions completed (i.e. 62% completed), but awaiting full assurance. However 9.6% of actions have either not been completed within the time specified or progress is unknown. Now that the trust has this information, it is working with the Core Services, Care Groups and Divisions to identify what is happening with this last group of actions and what support is needed to progress them.

RAG Status	No.	%
Action complete and assurance gained	90	45.5%
Action complete assurance not or only partially gained	34	17.1%
Action on track, expected to complete on time	41	20.7%
Some slippage or evidence awaited, expected to complete on time	14	7.1%
Status Not Known	11	5.6%
Target date missed / actions unachievable	8	4.0%
Total	198	100.0%

CQC Inspection Preparation

10. The Trust received the Provider Information Request (PIR) from the CQC on the 16 October 2018, which needs to be submitted by 5pm on the 06 November. Before information is submitted, it will be ratified by the relevant executive and then by the executive team as a whole, prior to submission.

11. Because the trust has received the PIR request, this indicates the start of the CQC inspection process. The CQC will hold an internal meeting to review the contents of the PIR submission 9 weeks after submission date (w/c 17 December 2018) and from the information presented, will decide what the forth-coming inspection will look like. It could be either announced or unnannounced and could be done in one visit, or a series of shorter unnannounced visits. Either way, the announced Well-Led inspection should follow 2 weeks after the inspection has finished. It is anticipated that the Use of Resources inspection will happen just before the CQC inspection, but as yet the trust hasn't been notified of dates.

12. In preparation for these inspections, 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.

13. Staff engagement sessions have commenced – the feedback from these so far has been very positive. The Quiz has gone down particularly well.

External Peer Review (Enable East)

14. Last months' report highlighted the results from the external review conducted the the 'not-for-profit' organisation, Enable East. The full report has now been received and circulated across the organisation and Divisions and Care Groups have been asked to address issues which relate directly to them, identifying additional actions to include in the PCIP. Those areas which received positive feedback were to celebrate this with their staff.

Board self-assessment against the Use of Resources Framework

15. The Use of Resources Framework (CQC, 2018) self-assessment was conducted by the executive team on the 23 October. Specific actions have been identified, which are being added to the well-led action plan – this will be presented to Board at the November Board development session.

Conclusion

16. The pace of change needs to improve, if some of the fundamental aspects of care are going to be addressed prior to the impending CQC inspection – this has been the focus of the CQC Preparation Steering Group for the last couple of months. However, there are also some areas of improvement identified, which need to continue. Preparation for the CQC inspection will be stepped up now the organisation has a clearer idea of timescales, with focus being placed on submission of the PIR in the first instance.

MEETING OF THE TRUST BOARD – 1st November 2018			
Safeguarding Adult Annual Report			**AGENDA ITEM: 10**
Report Author and Job Title:	Jennifer Robinson – Adult Safeguarding Lead Nurse. Diane Rhoden – Senior Corporate Nurse, Quality & Safeguarding.	**Responsible Director:**	Dr Karen Dunderdale, Director of Nursing
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	Enclosed is the Safeguarding Adult Annual Report for 2017 – 2018. **Key points of the reports are:** • Training – 3 levels of training from 1 level were introduced in January 2017. Training levels in 2018 to Level 1 – 94%, Level 2 72.66% and L3 77.05% although this fell short of the required 90%. • Prevent training March 18 Level 1 – 98.26% and 76% for HealthWrap, short of the required 85% • Concerns generated by the Trust continue to highlight that Neglect is the biggest category for concern with the majority of concerns taking place in the persons own home. • Safeguarding concerns are received regarding care given by the Trust however no concerns have progressed to a Section 42 Enquiry – main areas of concern are pressure ulcers and discharge arrangements. • Audits continue to be undertaken of the quality of the safeguarding referrals in 2017-18 of the 76 audited 62 were good or outstanding. How to make a good referral continues to be a priority. It also needs to be noted that this audit is not reflective of the total concerns generated as a copy of the concern form submitted is not always forwarded to the safeguarding team to review. The requirement for staff to forward a copy of the concern for submitted is reiterated during training • Deprivation of Liberty applications has seen a decrease in 2017-18. DoLs is included in safeguarding adult training with bespoke sessions for wards as required. DoLs authorisations continue to be a concern with just 2% in 2017-18 being authorised. This is due to the increasing pressure on Local Authorities since the Cheshire West court case and their inability to meet their statutory responsibilities to undertake an assessment within the identified timescales. **Key priorities for 2018-19:** • Training - negotiations with the CCG have seen compliance		

	for Adult Safeguarding Training reduced to match NHS England PREVENT target of 85% both Adult Safeguarding Training and PREVENT will continue to be monitored. • Audit and Learning from audits will continue both single agency and multi-agency • A review of electronic flags and best interest assessor training will be reviewed to assist with the DoL's process • A review of how service user feedback of the safeguarding process will be undertaken in collaboration with the Adult Safeguarding Board	
Recommendation	The Trust Board is requested to approve the report	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There is no risk implications associated with this report."	
Resource implications	There are no resource implications associated with this report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☐	

Walsall Healthcare NHS
NHS Trust

Safeguarding Adults-

Annual Report

2017-2018

CONTENTS

1.0 Introduction

1.1 Walsall Healthcare NHS Trust is committed to ensuring all patients within the organisation are protected from harm and abuse ensuring that safeguarding of vulnerable adults remains a priority within the organisation.

In recognising that the Trust is a partner in the delivery of safeguarding measures within the wider context of health and social care; this report:

- Describes how Trust strategy aligns with local and national priorities.
- Illustrates working together with partners in safeguarding activities.
- Describes the incidence and prevalence of safeguarding concerns relating to or identified by the Trust.
- Identifies governance processes to ensure organisational learning and avoidance of harm.

Part 1 of the Care Act 2014 came into force on 1st April 2015; this establishes a clear legal framework as to how Local Authorities and other agencies should protect vulnerable adults at risk of abuse or neglect. The Care Act statutory guidance Chapter 14 'Safeguarding' replaces the guidance previously issued under 'no secrets'.The Care Act (2014). The underlying principles of safeguarding adults Remain and are central to the safeguarding process, namely:

National guidance identifies that organisations should:

- Use the safeguarding principles to shape strategic and operational safeguarding arrangements.
- Set safeguarding within strategic and operational objectives.
- Use integrated governance systems and processes to prevent abuse occurring and to rescind effectively where it is taking place.
- Work with the Local Adult Safeguarding Boards and relevant parties to create safeguards for those who are being abused or exploited.
- Provide leadership for safeguarding adults.
- Ensure accountability and use learning to facilitate improvements.

1.2 Safeguarding team structure

The Adult Safeguarding Team currently consists of 2.0 WTE registered nurses;

- Band 8a.
- Band 7
- Named Doctor who provides expert advice as required (no specific time allocated)

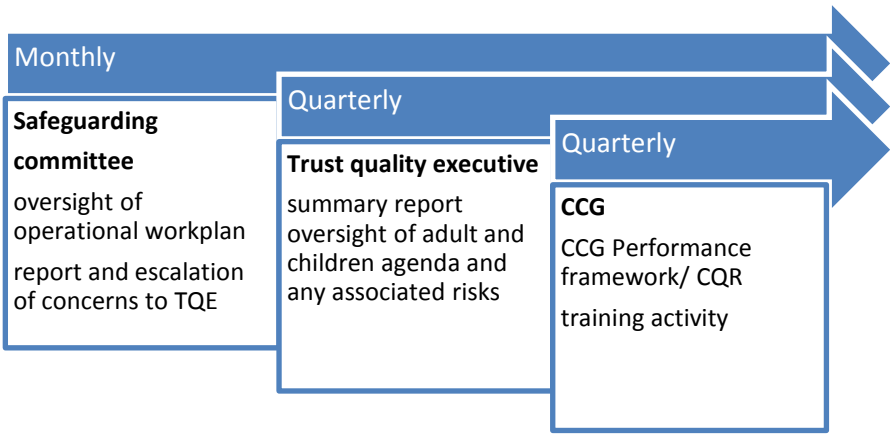
The Lead Nurse has responsibility for:

- Maintaining policy / procedure and associated updates.
- Advising on the training requirements for staff within the Trust to support the educational framework of Walsall Safeguarding Adults Board and the NHSE Intercollegic competency framework
- Delivering education and training on induction
- Disseminating good practice and learning points across the organisation.
- Acting as a source of advice and support.
- Liaising with other agencies as a first point of contact for safeguarding issues.
- Coordinating enquires into safeguarding concerns received and ensuring completion of associated action plans.
- Maintaining regular attendance at the partnership board sub groups.
- Promoting staff to access multi-agency training to achieve level 2 competencies.
- Supporting the Trust in governance arrangements.

2.0 Governance arrangements

2.1 Trust Safeguarding Committee

The Safeguarding Committee maintains a work programme in support of regulatory requirements and the local Walsall Safeguarding Adult Board (WSAB) ensures the trust exerts its duties as part of the multiagency arrangements. The attendance at the Trust safeguarding committee is from the Corporate Nurse for Quality and Safeguarding and the Lead Nurse for Safeguarding Adults who have maintained consistent attendance and enabled monitoring of governance related issues, regular report submission and monitoring of the risk register

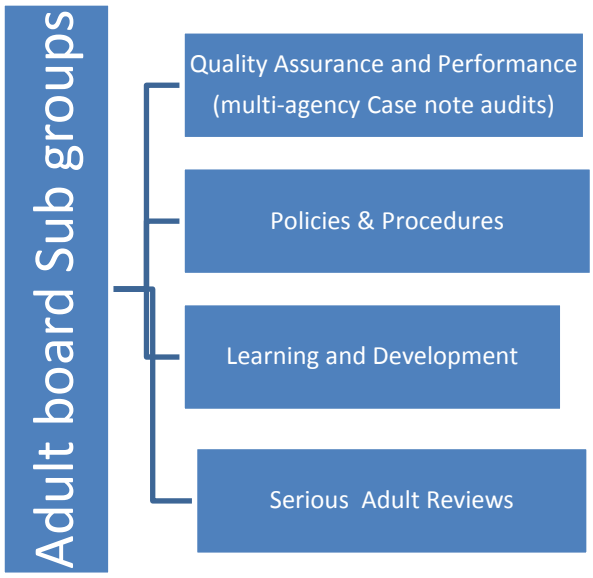


2.2 Safeguarding Adult Board

Walsall Healthcare NHS Trust must demonstrate that they are meeting their statutory Responsibilities in accordance with: Care Act 2014

This can be demonstrated by maintaining regular attendance at the Walsall Safeguarding Adult Board (WSAB) meetings.

WSAB meets quarterly and additionally operates a number of sub groups to take forward the associated work of the board these are ; Quality Assurance and Performance, Policy and Procedure (joint with Walsall Safeguarding Children Board WSCB); , Learning and Development (joint with WSCB) and Serious Adult Review . The Trust represents regularly on all of these forums and is an active participant in associated board development, planning and training events.



3.0 Partnership Working

3.1 Serious Case Reviews / Safeguarding adults reviews

The Care Act 2014 states that a Serious Adult Review (SAR) should be initiated when:

- There is reasonable cause for concern about how agencies worked together to safeguard an adult; and
- The adult has died and the Local Safeguarding Adults Board suspects / knows that the death resulted from abuse or neglect; or
- The adult is still alive, and the LSAB knows or suspects that the adult has experienced abuse or neglect.

During 2017/18 the Trust took part in 5 reviews, providing an individual management report for each; of these:

- 4 Multi-agency case reviews
- 1 serious adult review

Initial learning has been actioned and the trust continues to work towards and complete the respective multi-agency action plans.

In addition, Walsall Healthcare NHS Trust submitted a new request to the safeguarding adults' board for consideration for a serious adult review

3.2 Multi-agency Audits / Single-agency audits –

The Safeguarding Team continues to be engaged in the WSAB Multi-agency Audit Process which take place on a quarterly basis.
Each specified theme requires Walsall Healthcare contribution to an overarching Walsall Safeguarding Adults action plan; however if there are any specific actions In relation to Walsall Healthcare NHS Trust these are shared with Service Leads;
Ten cases are randomly be selected by the local authority representative
Dependent on the identified theme. For 2017/18 themes audits were based around:

- Section 42
- Concerns
- Self-Neglect

4 multi-agency audit meetings have taken place during 2017/2018, general themes Were identified from a multi-agency perspective :

- In general there was little evidence of Making safeguarding personal (MSP) at the start and during ongoing investigations.
- Mental Capacity assessments / documentation were poor at the time of referral and during the investigations.
- Documentation on MOSAIC could have been more comprehensive and there was a significant lack of information entered.
- Documentation around decision to take to section 42 was poor.
- Decision to take or not to take to section 42 investigation wasn't consistent and there was a lack or rationale documented to evidence decisions taken.
- In general desired outcomes were not discussed and therefore could not be formally concluded.
- One of the cases audited was on an outdated form (WSS 220)
- One of the concerns was sent to the Access Team via Fax

Learning specifically for Walsall Healthcare Trust

- MCA assessments inconsistent
- Identification/ description of bruising- needs to be improved
- little evidence of Making safeguarding personal (MSP) at the start and during ongoing investigations

The following actions have been implemented by Walsall Healthcare NHS Trust:

- Continue to audit concern forms in relation to the quality of their completion specifically in relation to Making safeguarding personal
- Include Making Safeguarding Personal as part of level 3 training

4.0 Policy and procedures

4.1 Safeguarding Adults Policy

Policy was reviewed to reflect the 'making it personal 'agenda;

4.2 Mental Capacity and Deprivation of Liberty Safeguards policies

Both policies have been reviewed as part of the recommendation from the internal audit undertaken September 2016. These policies been updated and both policies have been ratified and uploaded onto the intranet

5.0 Learning and Development

The CCG performance framework has set targets for each level of training for 2017/18 (appendix 2). Safeguarding adults training is reported in relation to:

- % staff who have accessed level 1 safeguarding adults awareness within 6 weeks of commencement to the Trust
- % Staff who are compliant with level 1 training
- % Staff compliance with level 2 training
- % Staff compliant with level 3 training

The intercollegic document from NHS England identifies staff groups required to access specific levels of safeguarding adults training and this guidance has been adopted by the Trust. Currently safeguarding adults training is delivered as detailed in section 5.1

5.1 Safeguarding Adults

Level	Mode of delivery	Requirement
1	Awareness Training is delivered internally, face to face on trust induction as a 40 minute session for all new starters. An e-learning package is available for staff that access corporate update	within 6 weeks of induction
2	Level 2 training is accessible via (a)national e learning package (B) a workbook.) c) Face to face sessions are offered as an alternative to staff groups on request.	3 yearly competency
3	Level 3 safeguarding adults are delivered a face to face classroom based sessions.	Staffs are required to undertake 6 hours safeguarding training over a 3 year period and attend a refresher training session to maintain their competence. Safeguarding training passport is promoted a method to capture and evidence their safeguarding training with a recommendation to ensure annual review with their manager as part of their annual review.

Level	% compliance 2017/18	Target
1	**94%**	90%
2	**72.66%**	90%
3	**77.05%**	90%

5.2 PREVENT

PREVENT training is in line with the NHS England Prevent training and competency framework which outlines levels of training requirements for identified staff groups

- Basic awareness (Level 1&2)
- Prevent- Health Wrap (Level 3)

Basic PREVENT awareness is delivered as part of the safeguarding session on Trust induction utilising the regional training template slides to develop the Presentation. An e learning package has been developed for inclusion in corporate update based on the awareness slides;

Prevent Health Wrap sessions are delivered as a 1 hour individual session and as part of Safeguarding Adults' level 3 training

At the end of 2017/18 the trust training compliance in relation to PREVENT was:

Title	%compliance 2017/18	target
Basic Prevent awareness	98.26%	90%
Prevent Health Wrap	76%	85%

PREVENT Level 3 has been particularly difficult to achieve over the last 12 months; however the Trust scheduled additional training sessions for 2017/18. Prevent health wrap is also delivered as part of level 3 safeguarding adults training or a 1 hour session.

5.3 Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS)

MCA and DoLS are included as part of Clinical update and Level 2 & 3 Safeguarding Adult training. An e learning package is also available for staff to access. Ad hoc sessions are also available at the request of staff groups as necessary

MCA and DoLS training compliance at the end of 2017 /18 is detailed below

: Title	%compliance 2017/18	target
MCA	97%	90%
DoLS	88%	90%

Whilst the MCA and DoLS have shown a marginal increase in compliance, there has been a cleansing of the compliance suite to ensure that the appropriate staffs have been identified to receive the training.

The Learning and Development Department continue to reconfigure the competencies for staff in relation to safeguarding adults along with the corporate senior nurse for quality and safeguarding; this was necessary to ensure that staff had been correctly identified as requiring training. A monthly non-compliance report is now being provided to streamline the process; this is provided to the Corporate Senior Nurse for Quality and Safeguarding and Lead Nurse for Safeguarding Adults to ensure close monitoring of non-compliance is in place for 2017-2018. This data has more recently been shared with Care Groups this has led to a cultural shift in respect of the monitoring of training, this puts ownership on staff members and their Line Managers to ensure that safeguarding training is monitored and feeds into the PDR process.

Appendix 2 provides a more detailed review of the training data.

6.0 Safeguarding Activity

The Operational Safeguarding Lead continues to collate statistics on a monthly basis Which detail:

- Incidences of alleged abuse
- Incidences of alleged abuse by location
- Incidences of alleged abuse by category.

The safeguard module within the Trust Safeguard Incident Reporting System is used as a mechanism to collate data. Appendix 3 provides a more in depth review of the data. Each concern in relation to the Trust is investigated and a detailed report submitted to Social Services to assist them in their enquiry. Teams involved in the incident receive feedback on the outcome of the investigation and are supported in the development of any required action plan.

Where concerns are raised to the Trust about other care providers or third parties, these are shared directly with other NHS services and also with Social Services depending on the level of risk or harm.

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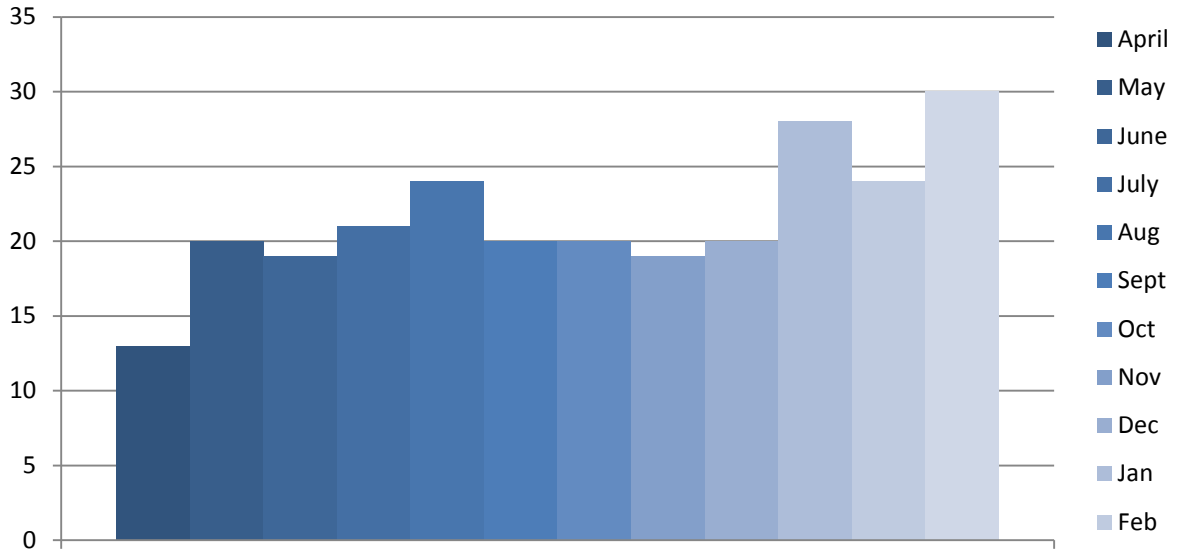
6.1 Number of concerns generated:

Concerns 2017/18 = 258

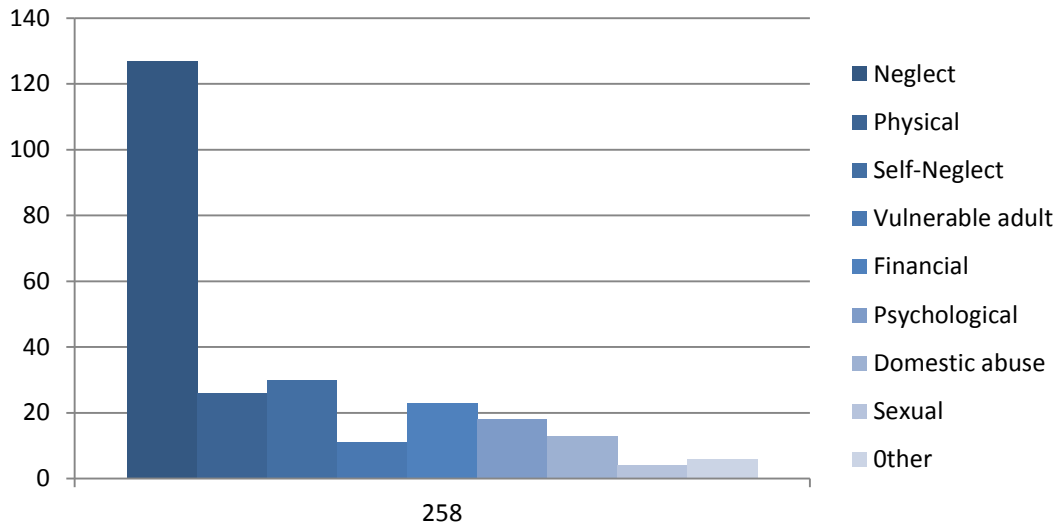
Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total	13	20	19	21	24	20	20	19	20	28	24	30	258



6.2 Category of reported alleged abuse 2017/2018

Of the 258 concerns generated during 2017/18 these can be categorised into:

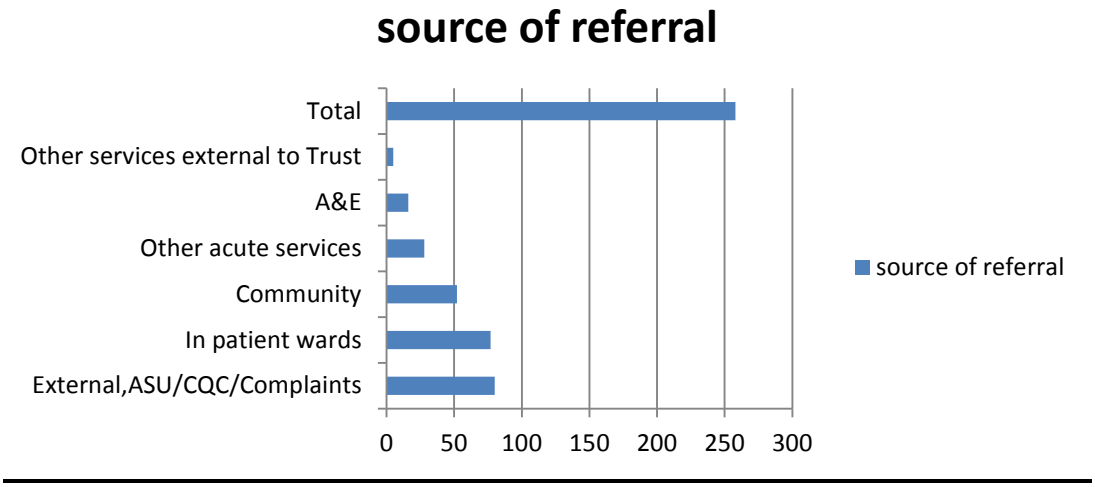
Neglect	Physical	Self-neglect	Vulnerable adult	Financial	Psych	Domestic abuse	Sexual	other
127	26	30	11	23	18	13	4	6



6.3 Number of Concerns received by area:

Of the 258 concerns were received- concerns came from the following areas:

Referral area	Number of Concerns
external sources ASU/CQC/ NHS Complaints / complaints	**80**
in patient Wards	**77**
Community	**52**
Other acute services	**28**
A&E	**16**
Others services external to Trust, GP, WMAS, SW	**5**
Total	**258**

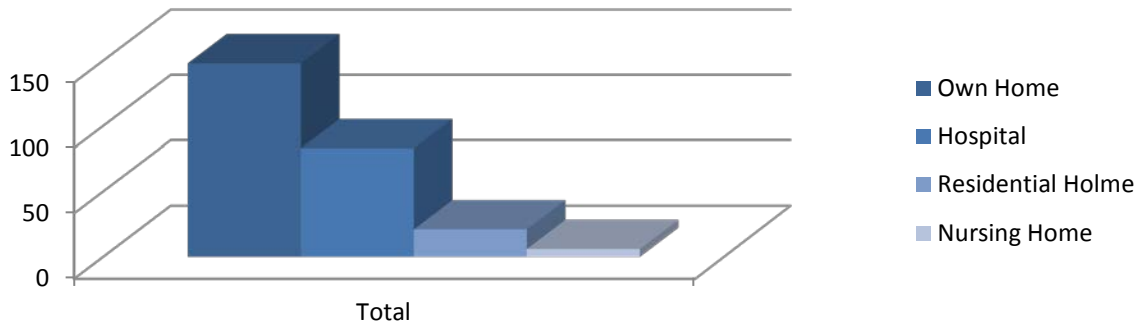


The majority of the concerns were received from external sources

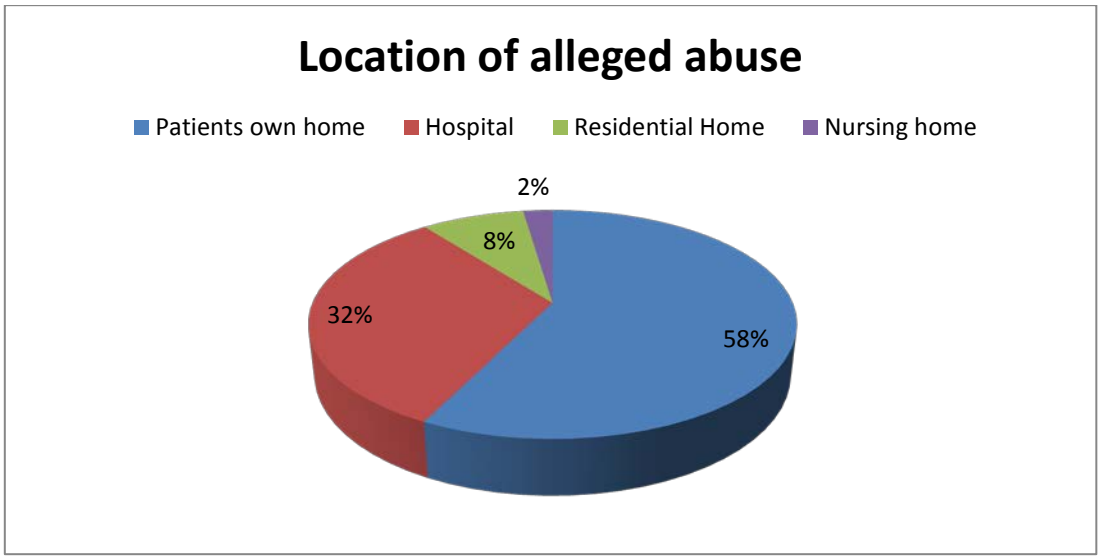
6.4 Incidences of reported alleged abuse by location

Appendix 5 details data in relation to location of abuse by month, however the concerns received primarily relate to incidences which occur in the patient's own home.

Patients own home	Hospital	Residential home	Nursing home
148	83	21	6

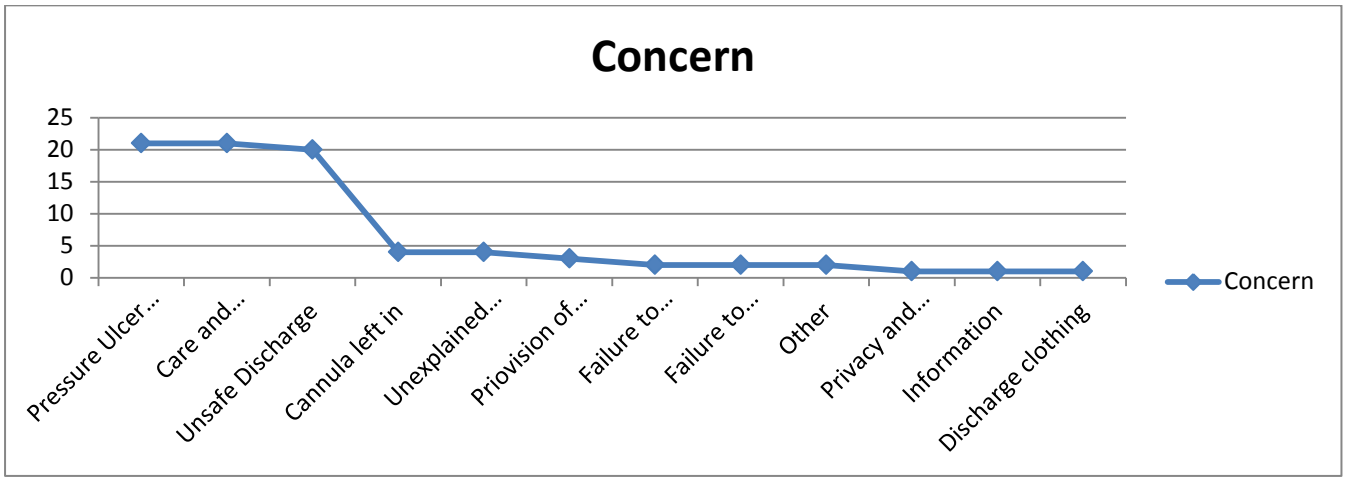


The chart below represents the fact that 58% of concerns reported relate to the person in their own home.



6.5 Incidences of reported alleged abuse in relation to care provided within Walsall Healthcare NHS Trust

The Trust received external concerns relating to care provision in 2017/18, these primarily relate to allegations of neglect; the themes arising are reflected in the chart below: 5 of these incidences were reported internally by staff via the incident reporting system



For each concern received in relation to the Trust the concern is reviewed and a report submitted to social services to assist them in their enquiry. Detailed reports were undertaken in relation to all of the allegations and submitted to social Care for review. The identified ward / area support the review process and feedback on the outcome of the review to their teams... There is no established process as yet in Walsall for feedback in relation to whether or not the concern was progressed

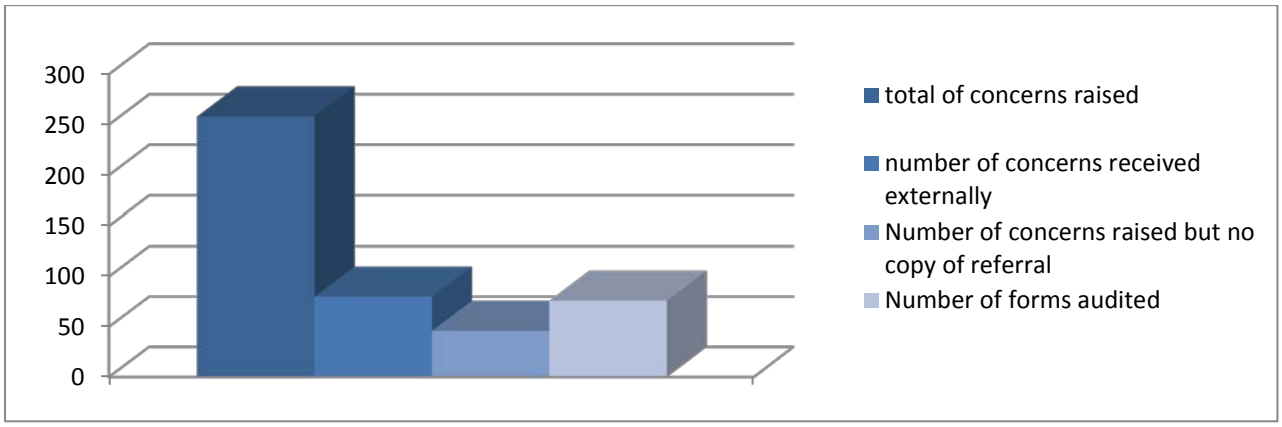
through to a section 42 enquiry although this is being reviewed by social services as part of their review of the effectiveness of adult safeguarding procedures. However, none of the concerns received during 2017/18 resulted in a formal safeguarding enquiry.

7.0 Single agency audit activity

7.1 A monthly audit into the quality of referral forms completed and submitted by staff is undertaken. A detailed review of the audit can be found in Appendix 7. 75 forms were available to audit during 2017/2018.

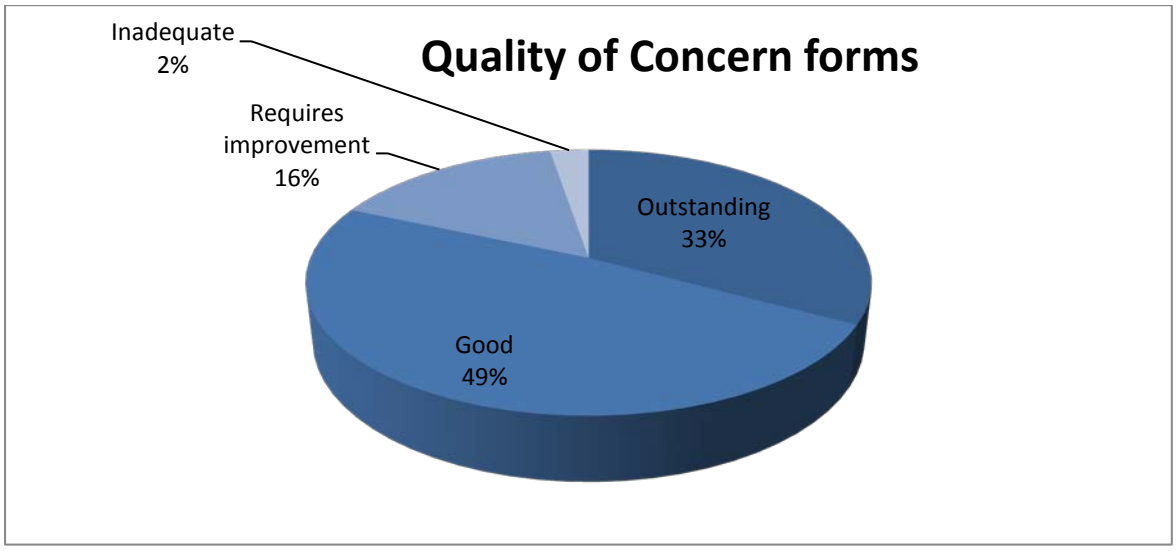
7.2 Audit results

Of the concerns generated during 2017/18, 76 forms were available to review for audit. The lead nurse was aware of 46 concerns that were raised by staff, but no copy of the referral form was forwarded for and therefore not available to audit. The table below reflects the breakdown of the number of concerns verses number of forms available to audit



Of the 76 forms audited the outcomes are detailed:

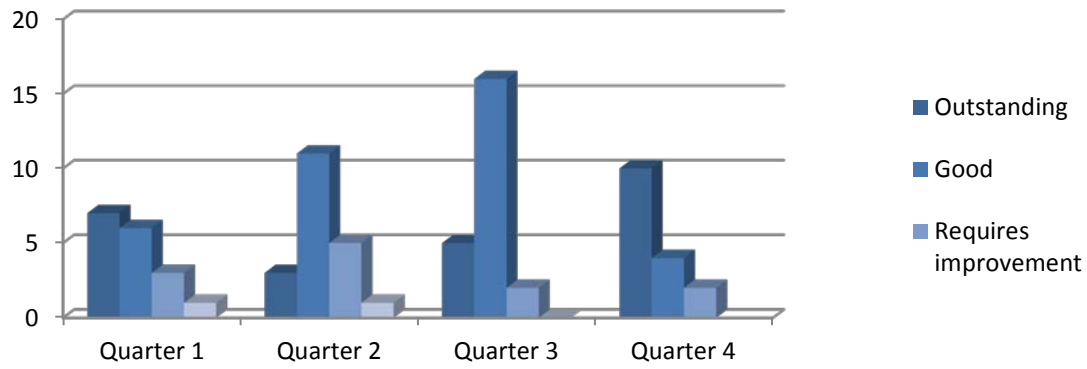
Good	Outstanding	Requires improvement	Inadequate	Total
37	25	12	2	76



7.3 Quarter comparisons

The table below details the audit outcomes per quarter.

category	quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Outstanding	7	3	5	10	25
Good	6	11	16	4	37
Requires improvement	3	5	2	2	12
Inadequate	1	1			2
Overall total	**17**	**20**	**23**	**16**	**76**
forms	**17**	**20**	**23**	**16**	**76**
Concerns	**52**	**66**	**59**	**82**	



7.4 Audit Outcomes

The audit reflects the fact that 82% of the forms completed have been categorised as good or outstanding. The areas for continued improvement relate to documentation to evidence a discussion with the person or their representativeregarding agreed outcomes, this is the section of the form that reflects

compliance towards the 'making safeguarding personal' agenda. The number of concern forms available to audit is low in comparison to the number of concerns that were submitted. The requirement to forward a copy to the Lead Nurse for Safeguarding Adults is noted in the safeguarding adults' policy and is reiterated during training.

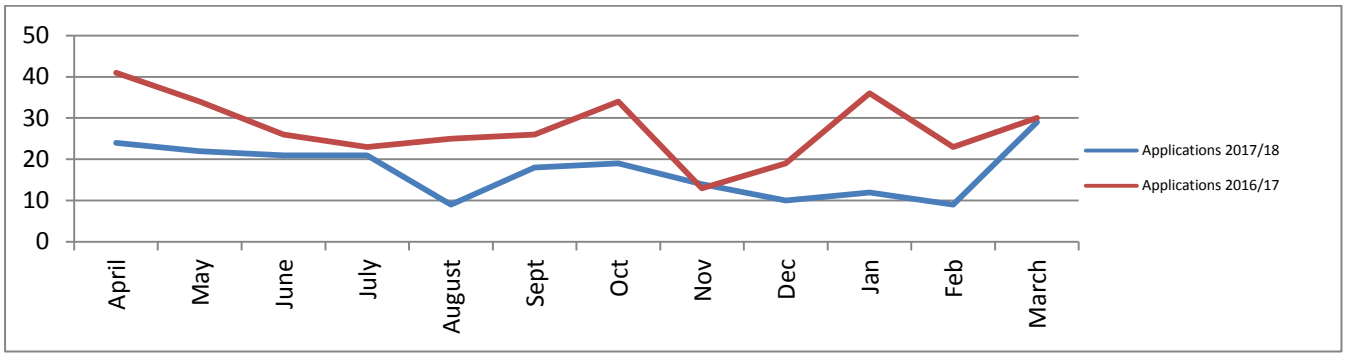
Awareness sessions will continue to be undertaken with staff groups to go through the form and this will be an opportunity for the lead nurse to formally go through the documentation with staff.

- The audit will continue to take place for each referral received
- Feedback will be given on receipt of each referral
- Reinforcement to be given to staff to follow policy and forward copy of referral to lead nurse to review and audit

8.0. Deprivation of Liberty Safeguards

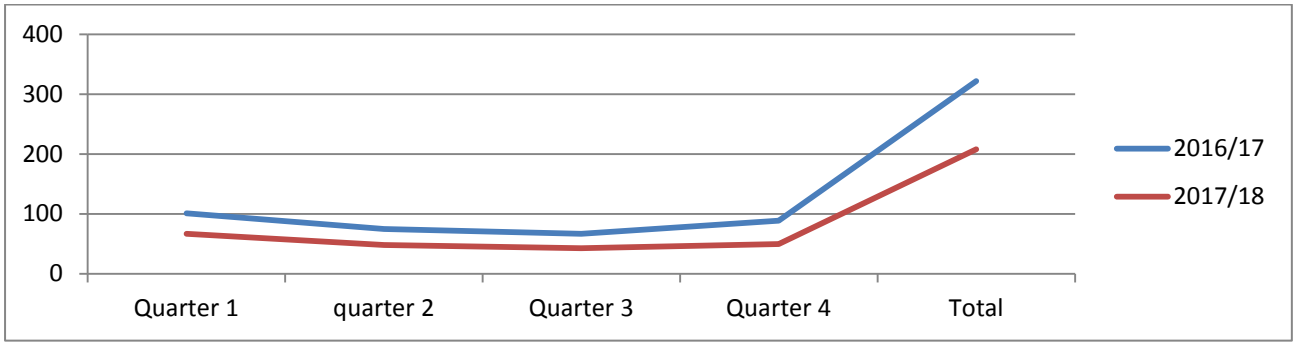
8.1 Applications 2017/18

During 2017/2018 208 applications for deprivation of liberty safeguards were submitted. This is a decrease of 124 on the 332 applications submitted for 2016/17. The graph represents the month on month comparison



8.2 Comparison by quarter for 2017/18

The graph below represents the total applications for 2017/18 compared to applications submitted during 2016/17.



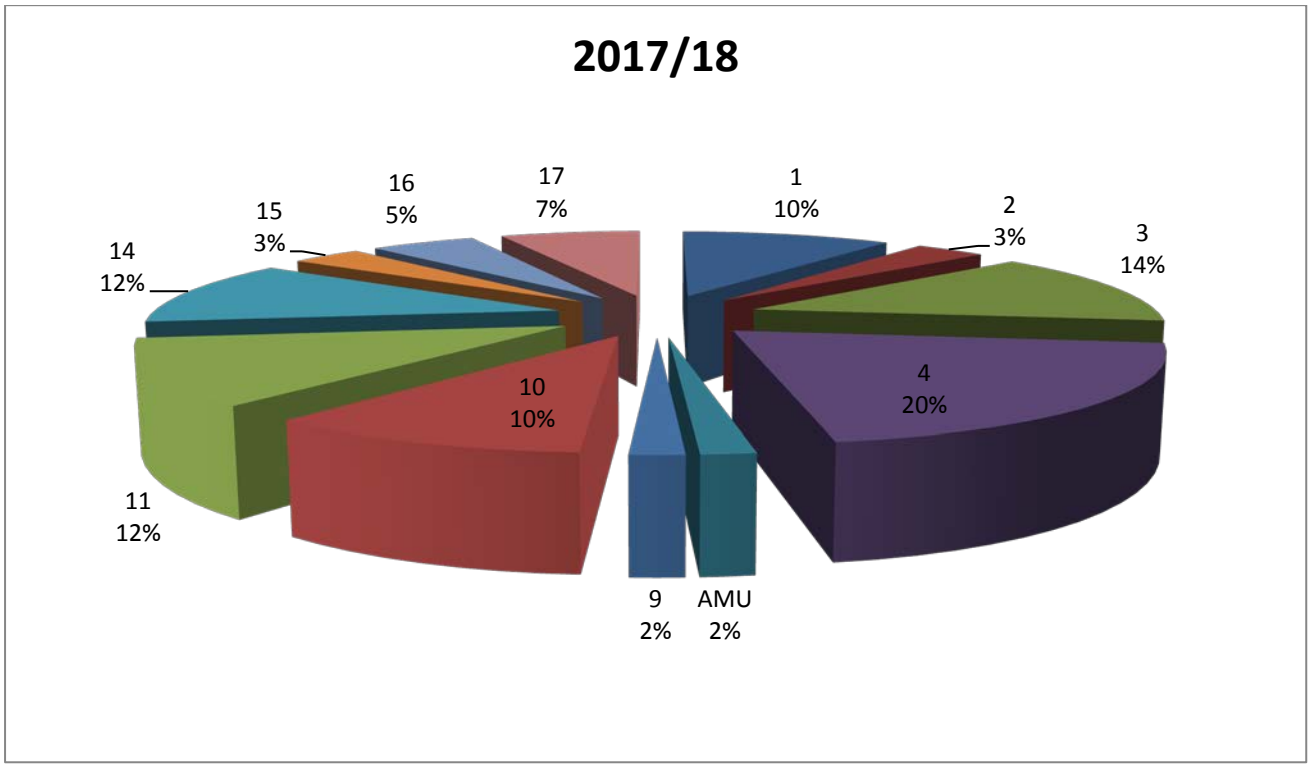
The number of Applications submitted has seen a gradual decrease through Quarter 1, 2, 3 and 4 compared to applications submitted for 2016/17. During quarter 1 8 Applications were also submitted from ITU/ HDU. No further applications were Submitted from critical care areas. This was due to the court of appeal ruling in Relation to *Ferreira v Coroner of Inner South London*, 26 January 2017 in which the Judge made it clear that "…any deprivation of liberty resulting from the administration

Of life-saving and therefore should not raise issues regarding a deprivation of liberty. No DoLS within critical care areas

During quarter 4, 2 applications were submitted from Surgical assessment unit

8.3 Application 2017/18 by ward comparison per quarter

Quarter	Wards																	
	1	**2**	**3**	**4**	**5/6**	**7**	**9**	**10**	**11**	**12**	**14**	**15**	**16**	**17**	**20a**	**20b**	**23**	**29**
1	6	2	8	12	1		1	6	7		7	2	3	4				
2	2	7	15	5	4		4		4		3	1	2					1
3	3	3	7	6	1		6	10	1		1		3	2				
4		2	25	1	2	1	3	2		1	4	2		3			1	1
Total	11	14	55	24	8	1	14	18	12	1	15	5	8	9			1	2

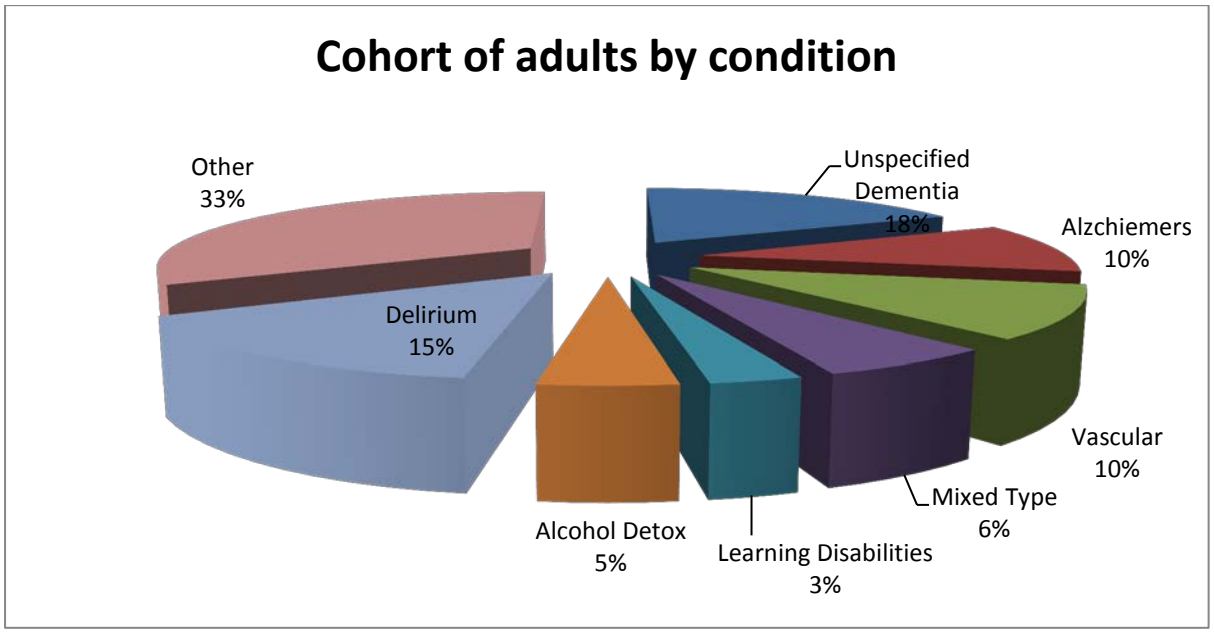


20% of the total applications submitted came from ward 4.

8.4 Applications relating to patient diagnosis

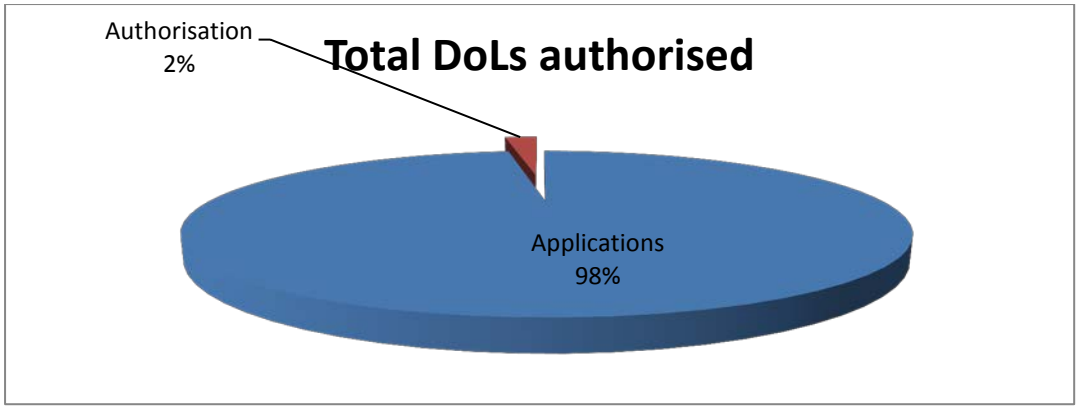
During 2017/18 applications in relation to Deprivation of liberties safeguards Relate Primarily to adults with dementia and adults in acute confusion/ Delirium. The Breakdown is reflected in table:

	Dementia				Learning disabilities	Alcohol Detox	Delirium	other
	Unspecified dementia	Alzheimer's Dementia	Vascular Dementia	Mixed				
April	7	1	4	1	1	1	5	4
May	4	4	1			1	2	10
June	1	2	2	3	1	1	3	8
July	3	1	1	1	1	4	5	5
August	2		2				2	3
Sept	2	3	5	2	1	1		4
Oct	8	3		1		1	6	
Nov	2	7		1	2		1	2
Dec	22	1	3	1			1	1
Jan	2	1	3		2	1	1	2
Feb	3	2		1				3
Mar	9	1	1	2	2	1	10	3
Total	45	26	22	13	10	11	36	45



8.5 DoLS Authorisations

Since the introduction of the acid test 2014, the supervisory body has seen an increase in the number of applications submitted. The initial 7 day period to allow an assessment to take place has been extended to 14 days. The Trust has seen an increase in the number of patients discharged prior to a formal assessment being undertaken by the best interest assessor. 5 of the applications (2%) were formally approved by the supervisory body. 1 DoLS was not approved as the person regained their capacity at the point of assessment and therefore DoLS was not appropriate.



8.6 Partnership arrangements with the supervisory body

The last 12 months has seen the development of closer working relationships with ward staff and the DoLS team within Walsall council. The assessors have conveyed a very positive response when they attend ward areas and are able to identify areas of good practice:

- staff are open and engaging in terms of providing information regarding the patients care and treatment
- Evidence of patients being cared for in the least restrictive way and in their best interests.
- Increased incidences during the later end of the year where staffs are communicating more with the team when the urgent authorisation period is coming to an end.

8.7 Ongoing Actions for 2018/19:

- Continue to schedule ward based DoLS sessions to support staff in identification and submission of the paperwork
- Undertake audit in relation to the operational processes to embed in practice.
- Continue to reinforce to staff the requirement to notify the DoLS team of any changes in the person's circumstances.
- Continue to reinforce to ward staff requirement to complete an incident form to notify Lead nurse of DoLS application
- Implement electronic notification
- Review report in relation to law society review of DoLS
- Continue to utilise the skills of the MCA/DoLS project team to support with training and awareness for clinical teams

9.0. Key achievement for 2017/18

The annual report for 2016/17 identified the topics detailed below as priorities for 2017/18 safeguarding adults work plan. Each priority has been reviewed to assess progress towards them.

Area of Intervention	Rationale	Outcome	RAG rating
Identify Programmed Activity time for the Adult Safeguarding Lead Doctor; to undertake safeguarding adults training to the medical workforce	To ensure that the medical workforce comply with their safeguarding responsibilities	new locum consultant was appointed to act as the adult safeguarding lead Doctor with programmed activity time for their safeguarding duties	
Accurate reporting of the safeguarding adults training strategy to ensure compliance with competency framework	To ensure training is fit for purpose, effective, up to date, in adherence with national guidance and attendance is monitored.	Monthly data of compliance received from L&D and forwarded to divisional leads to review. Training non-compliance also received	
Complete scoping work and set trajectories for training compliance as detailed in the Quality Framework;	Ensure accurate reporting of training compliance via the monthly HR reporting process to safeguarding committee to meet requirements set within safeguarding adults CCG Performance framework	Monthly training data received and discussed at safeguarding committee and also the Clinical Quality review meeting with the CCG. Scoping work undertaken on a quarterly basis.	
Continue to Monitor and audit the quality of the Safeguarding Adults concerns submitted by staff	Quality assurance necessary to demonstrate effective referral, timely intervention and escalation / action as required and to support staff when referrals demonstrate a level of poor quality; ensuring this is addressed timely and that intervention is swift	Monthly audit taken place and quarterly reporting to the divisional teams. General improvement in the quality of concern forms received although not all concern forms have been forwarded to review.	
Engage in multi-agency audit as part of quality and assurance agenda	To demonstrate quality assurance in terms of knowledge, skill and competency to improve outcomes	100% attendance at the multi-agency case note audit meetings.	

Area of Intervention	Rationale	Outcome	RAG rating
The team will work towards the WSAB Business Priorities for 2017 to 2018 and ensure attendance at these forums	To ensure trust is engaged in partnership board safeguarding priorities	Regular attendance at the board and sub group meeting maintained throughout 2017/18	
Develop a Safeguarding Adults audit Programme.	Quality assurance to evidence application of training into practice.	Audit in relation to the quality of concern forms received.	
To continually review policies and procedures; timely and demonstrating evidence based / national directive	To provide robust policies to support the workforce.	Policies review as necessary. and currently in date	
Identification of areas of risk in relation to safeguarding adults which can be incorporated into the safeguarding risk log	Ensure effective arrangements are in place to support safeguarding work plan in relation to escalation to safeguarding committee as necessary.	Risks reviewed and any new risks identified are discussed at the Trust safeguarding committee	
Establish a process whereby service user – experience can be sought	To assess if making safeguarding personal is embedded	No formal process has been established to obtain the service user experience. Maintains a key priority for the Board.	
Implementation of the alert on Fusion to identify when a DoLS application has been made	To promote an organizational awareness of the current DoLS status and ward staff ownership of the process.	Fusion DoLS register currently accessible only via safeguarding team. Plan roll out quarter 2 2018/19.	
Review Access training for staff to become Best interest assessors.	To ensure that the organisation is prepared for the outcome of the Law commission DoLS review	Access to BIA course identified as part of the training needs analysis for 2018/19	
Dissemination of the National Audit of Dementia Care audit results	To review the care of adults with dementia in hospital	Audit results received and disseminated by the clinical lead to the Trust Dementia steering group and audit session.	

10.0. Key Priorities for Adult Safeguarding 2018/19

The following have been identified as priorities for 2018/19 whilst continuing to sustain the achievements of 2017/18.

Area of Intervention	Rationale
Implementation of the alert on Fusion to identify when a DoLS application has been made	To promote an organizational awareness of the current DoLS status and ward staff ownership of the process.
Review Access training for staff to become Best interest assessors	To ensure that the organisation is prepared for the outcome of the Law commission DoLS review
Establish a process whereby service user – experience can be sought	To assess if making safeguarding personal is embedded
Achievement of Safeguarding training trajectories identified by CCG: • Level1 • Level 2 • Level 3	To ensure workforce has skills and competence to recognise safeguarding concerns and report as necessary to ensure adults are safe from abuse and harm
Achievement of training trajectory in relation to • Prevent basis awareness • Prevent Health Wrap	To ensure that staff are able to recognize vulnerable adult, young people and children who may be at risk of radicalisation
Undertake audits in relation to: staff understanding of safeguarding practice • MCA • DoLS • effectiveness of safeguarding adults level 3 training	To ensure patient care is reflective of policy, practice and legislation

12.0 Conclusions:

This report has summarised the significant range of actions and processes in place to provide an assurance that Adult Safeguarding is compliant with both statutory and professional requirements.
It provides assurance that safeguarding is embedded within the organisation and has clear plans and priorities for improvement.

Appendix 2- **WHT Adult Safeguarding 2017/18 and 2018/19 Framework**

Frequency	Item	Lead	Trajectory		Format
			2017/18	2018/19	
Monthly figures but with a Quarterly report which gives details and narrative to the figures. Identifies learning + actions for improvement as appropriate. **Q1 Aug 17** **Q2 Nov 17** **Q3 Feb 18** **Q4 May 18** **Q1 Aug 18** **Q2 Nov 18** **Q3 Feb 19** **Q4 May 19**	**Safeguarding Adults Training Level 1** • No. of new staff requiring safeguarding training as part of induction within 6 weeks of commencing employment. • No. of new staff compliant with safeguarding training within 6 weeks of commencing employment. %	Corporate Senior Nurse Quality and Safeguarding	Q1 100% Q2 100% Q3 100% Q4 100%	Q1 100% Q2 100% Q3 100% Q4 100%	Month on month data, run charts data with trend lines.
	Safeguarding Adults Training Level 1 • No. of staff requiring refresher training (Quarterly) • % compliance with Level 1 refresher (Monthly)	Corporate Senior Nurse Quality and Safeguarding	Q1 95% Q2 95% Q3 95% Q4 95%	Q1 95% Q2 95% Q3 95% Q4 95%	Month on month data, run charts data with trend lines.
	Safeguarding Adults Training Level 2 Year 1 - One hour Year 2 - Two hours Year 3 - Three hours • No. of staff requiring training (Quarterly) • % compliance (Monthly)	Corporate Senior Nurse Quality and Safeguarding	**Year 2 of 3 year target** Q1 40% Q2 55%	**Year 3 of 3 year target** Q1 60% Q2 75%	Month on month data, run charts data with trend lines.

			Q3 75% Q4 95%	Q3 85% Q4 95%	
	Safeguarding Adults Training Level 3 Year 1 - One and half hours Year 2 – Three hours Year 3 – Four and half hours • No. of staff requiring training (Quarterly) • % compliance (Monthly	Corporate Senior Nurse Quality and Safeguarding	**Year 2 of 3 year target** Q1 40% Q2 55% Q3 75% Q4 95%	**Year 3 of 3 year target** Q1 60% Q2 75% Q3 85% Q4 95%	Month on month data, run charts data with trend lines.
	Safeguarding Adults Training Level 4 • No. of staff requiring training (Quarterly) • % compliance (Monthly)		Q1 100% Q2 100% Q3 100% Q4 100%	Q1 100% Q2 100% Q3 100% Q4 100%	
	Deprivation Of Liberty (DOL's)				
	• No. of staff requiring training (Quarterly) • % training compliance (Monthly) • No of DOL's referrals generated by the Trust (Monthly)	Corporate Senior Nurse Quality and Safeguarding	Q1 95% Q2 95% Q3 95%	Q1 95% Q2 95% Q3 95%	Month on month data, run charts data with trend lines.

			Q4 95%	Q4 95%	
	Mental Capacity Act (MCA) • No. of staff requiring training (Quarterly) • % training compliance (Monthly)	Corporate Senior Nurse Quality and Safeguarding	Q1 95% Q2 95% Q3 95% Q4 95%	Q1 95% Q2 95% Q3 95% Q4 95%	Month on month data, run charts data with trend lines.
	PREVENT				
	• No. of staff requiring training (Quarterly) • % training compliance (Monthly) • L3 No. of staff requiring training (WRAP) • L3 training % compliance (WRAP) • No of referrals	Corporate Senior Nurse Quality and Safeguarding	Q1 90% Q2 90% Q3 90% Q4 90%	Q1 90% Q2 90% Q3 90% Q4 90%	Month on month data, run charts data with trend lines.
	Domestic Abuse • No. staff requiring training (Quarterly) • % training compliance (Monthly)	Corporate Senior Nurse Quality and Safeguarding	Q1 90% Q2 90% Q3 95% Q4 95%	Q1 95% Q2 95% Q3 95% Q4 95%	Month on month data, run charts data with trend lines.
Quarterly report with month on month data	**Safeguarding Adult Concerns** • No of internal notifications • No of referrals via multi-agency procedures • No of s42 Adult Safeguarding Investigations as led by the provider • No of domestic abuse referrals generated by	Corporate Senior Nurse Quality and Safeguarding			

with details that gives narrative to the figures. **Identifies learning + actions for improvement as appropriate.** **Q1 Aug 17** **Q2 Nov 17** **Q3 Feb 18** **Q4 May 18** **Q1 Aug 18** **Q2 Nov 18** **Q3 Feb 19** **Q4 May 19**	the Trust • No. of referrals submitted to MARAC by the Trust			
	Position of Trust • No. of Position of Trust referrals generated in relation to Trust employees	Corporate Senior Nurse Quality and Safeguarding		
	Domestic Homicide Reviews (DHRs) • Total no. of on-going DHRs • No. of newly-instigated DHRs • To include progress report on associated Action Plan	Corporate Senior Nurse Quality and Safeguarding		
	Safeguarding Adult Reviews (SARs) • Total no. of on-going SARs • No. of newly-instigated SARs • To include progress report on associated Action Plan	Corporate Senior Nurse Quality and Safeguarding		
	Safeguarding Adults – Multi-agency Records Review • WHT-specific learning from Records Review • Evidence of Multi-agency Working Activity	Corporate Senior Nurse Quality and Safeguarding		

Frequency	Item	Lead	Trajectory	Format
Bi-Annually **Sept. 17** **March 18**	Audit of Safeguarding Adult practices- to include understanding of service user perspective	Corporate Senior Nurse Quality and Safeguarding	5 cases to be reviewed each quarter and learning included in the quarterly report.	

Sept. 18 March 19			1 case to be reviewed in-depth and presented at Safeguarding Committee twice a year as scheduled	

Frequency	Item	Lead	Trajectory	Format
Annually (September)	Safeguarding Adult Annual Report	Corporate Senior Nurse Quality and Safeguarding	Full report submission combined report with Safeguarding Children Report to be presented to CQR meeting	September 2017
	Compliance against Autism Statutory Guidance https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/422338/autism-guidance.pdf	Corporate Senior Nurse Quality and Safeguarding		September 2017
	Safeguarding Adult Board (ref WSAB) Self-assessment Audit Report	Corporate Senior Nurse Quality and Safeguarding		

Appendix 3 Details of concerns each quarter 2017/2018

Quarter 1

During quarter 1 to date there have been 52 concerns received which relate primarily to neglect - the breakdown is as follows:

Month	alerts	Neglect	Financial	Physical	Domestic abuse	Sexual	Psychological	Vulnerable adult	Self-Neglect	Other
April	13	8	2	2					1	
May	20	3	4	4	2		2	1	3	1
June	19	8	1	3	2	1	1		3	
Total	**52**	**19**	**7**	**9**	**4**	**1**	**3**	**1**	**7**	1

Location of alleged abuse

	Neglect	Financial	Physical	Domestic abuse	Sexual	Psychological	Vulnerable adult	Self-Neglect	other
Hospital	**7**		**1**						
Home	**9**	**7**	**5**	**4**	**1**	**3**	**1**	**7**	**1**
Nursing home	**1**								
Residential home	**2**		**3**						
Total	**19**	**7**	**9**	**4**	**1**	**3**	**1**	**7**	**1**

Quarter 2

During quarter 2 to date there have been 65 concerns received which relate primarily to neglect - the breakdown is as follows:

Month	alerts	Neglect	Financial	Physical	Domestic abuse	Sexual	Psychological	Vulnerable adult	Self-Neglect	Discriminatory + organisational
July	21	8	3	2	1		5		2	
Aug	24	16	3	2		1	1			1
Sept	20	9	2	4	1		2		1	1
Total	**65**	**33**	**8**	**8**	**2**	**1**	**8**		**3**	**2**

Location of alleged abuse

	Neglect	Financial	Physical	Domestic abuse	Sexual	Psychological	Vulnerable adult	Self-Neglect	other
Hospital	16		1						**2**
Home	12	8	6	2	1	8		3	
Nursing home	1		1						
Residential home	3								
total	**32**	**8**	**8**	**2**	**1**	**8**		**3**	**2**

1 incident of neglect related to a concern within a day centre setting

Quarter 3

During quarter 3 to date there have been 59 concerns received which relate primarily to neglect - the breakdown is as follows:

Month	alerts	Neglect	Financial	Physical	Domestic abuse	Sexual	Psychological	Vulnerable adult	Self-Neglect	other
Oct	20	7	4	2	4	1		2		
Nov	19	10		1				2	4	(2 CI)
Dec	20	7	2	3	1			2	5	
Total	**59**	**24**	**6**	**6**	**5**	**1**		**6**	**9**	**2**

Location of alleged abuse

	Neglect	Financial	Physical	Domestic abuse	Sexual	Psychological	Vulnerable adult	Self-Neglect	other
Hospital	13		4						**2**
Home	5	6	2	5	1		6	9	
Nursing home									
Residential home	6								
Total	**24**	**6**	**6**	**5**	**1**		**6**	**9**	**2**

Quarter 4

During quarter 4 to date there have been 82 concerns received which relate primarily to neglect - the breakdown is as follows:

Month	alerts	Neglect	Financial	Physical	Domestic abuse	Sexual	Psychological	Vulnerable adult	Self-Neglect	other
Jan	28	20	1			1	2		4	
Feb	24	12	1	3	1		3	1	3	
Mar	30	19			1		2	3	4	1
Total	**82**	**51**	**2**	**3**	**2**	**1**	**7**	**4**	**11**	**1**

Location of alleged abuse

	Neglect	Financial	Physical	Domestic abuse	Sexual	Psychological	Vulnerable adult	Self-Neglect	other
Hospital	35		1		1				
Home	6	2	2	2		7	4	11	**1**
Nursing home	1								
Residential home	9								
Total	**51**	**2**	**3**	**2**	**1**	**7**	**4**	**11**	**1**

1 physical abuse concern occurred within the hospital setting. A patient with dementia was being supported by a carer from an agency and staff witnessed a concern in relation to an alleged physical abuse. Of the other concerns reported 1 was a prevent referral

Walsall Healthcare NHS
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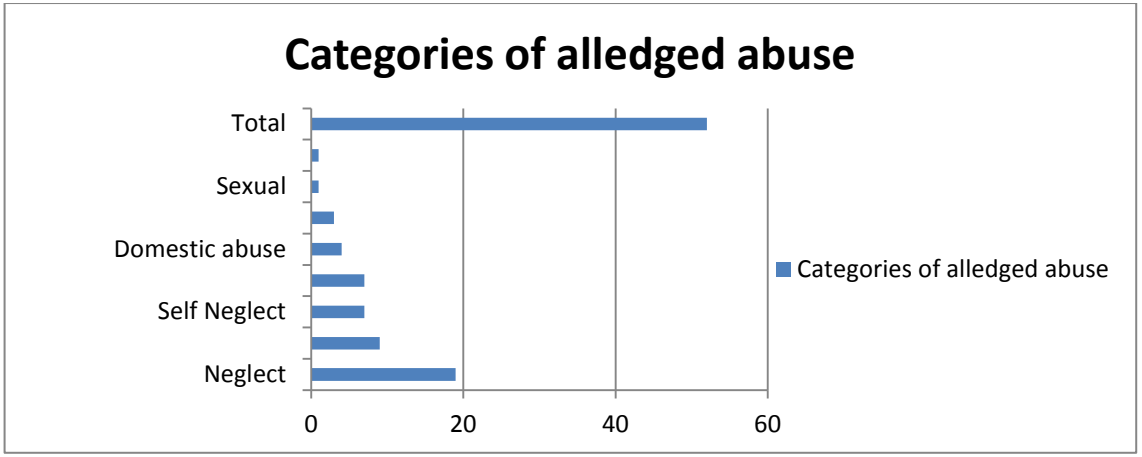
Appendix 4 Category of abuse per quarter

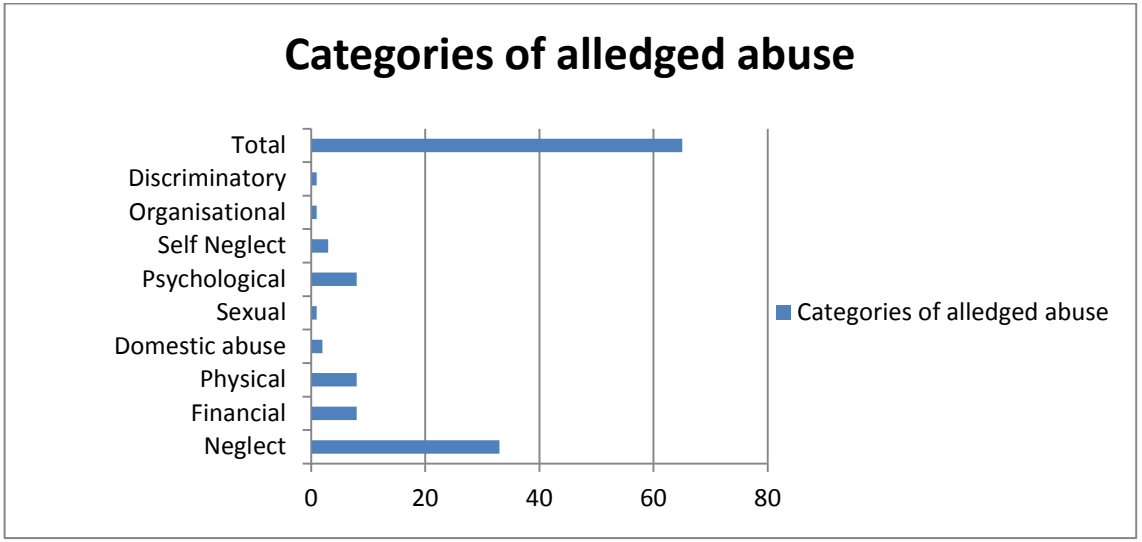
Quarter 1 : (April 2017 –June 2017)

Category of alleged abuse	Number of Concerns =52
Neglect	19
Physical	9
Self Neglect	7
Financial Abuse	7
Domestic abuse	4
Psychological	3
Sexual	1
Vulnerable adult	1
Total	**52**



Quarter 2 : (July 2017 –September 2017)

Category of alleged abuse	Number of Concerns =65
Neglect	33
Financial	8
Physical	8
Domestic abuse	2
Sexual	1
Psychological	8
Self-Neglect	3
Organisational	1
Discriminatory	1
Total	**65**



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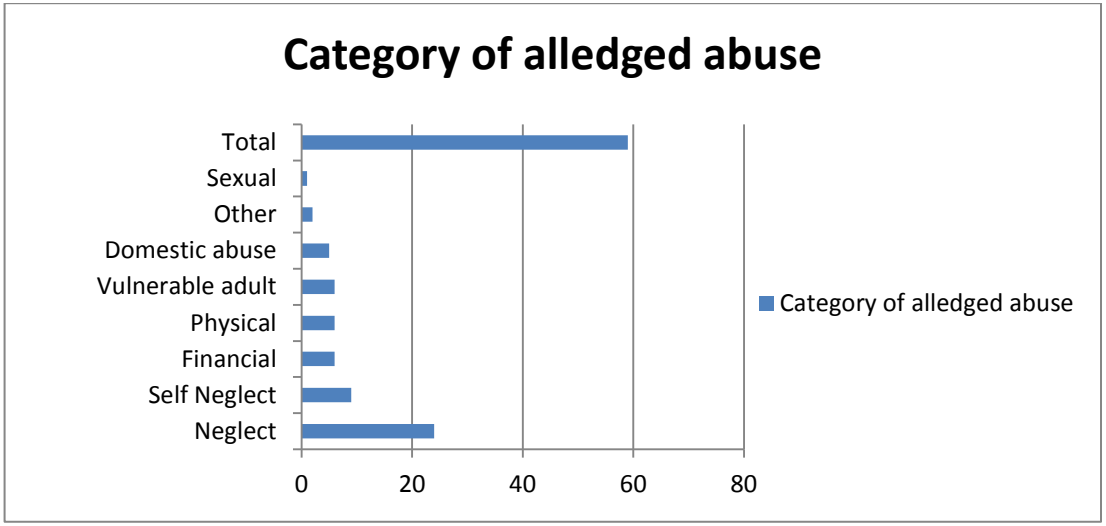
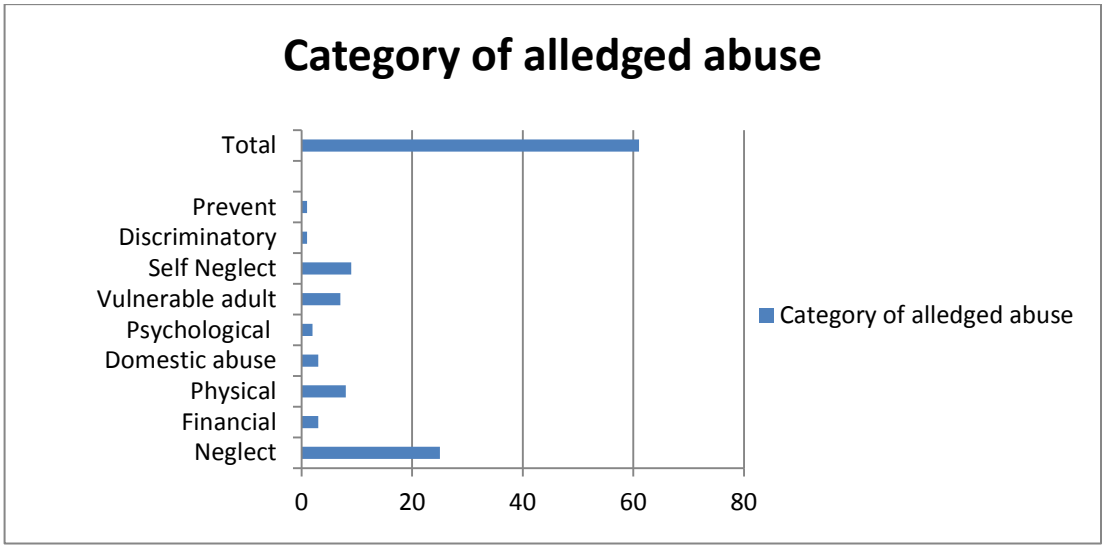
Quarter 3 : (October 2017 -December2018)

Referral area	Number of Concerns =59
Neglect	24
Self-Neglect	9
Financial	6
Physical	6
Vulnerable adult	6
Domestic abuse	5
Other	2
Sexual	1
Total	**59**



Quarter 4 : (January 2018 –March 2018)

Referral area	Number of Concerns =82
Neglect	51
Financial	2
Physical	3
Domestic abuse	2
Psychological	7
Vulnerable adult	4
Self-Neglect	11
PREVENT	1
Sexual	1
Total	**82**

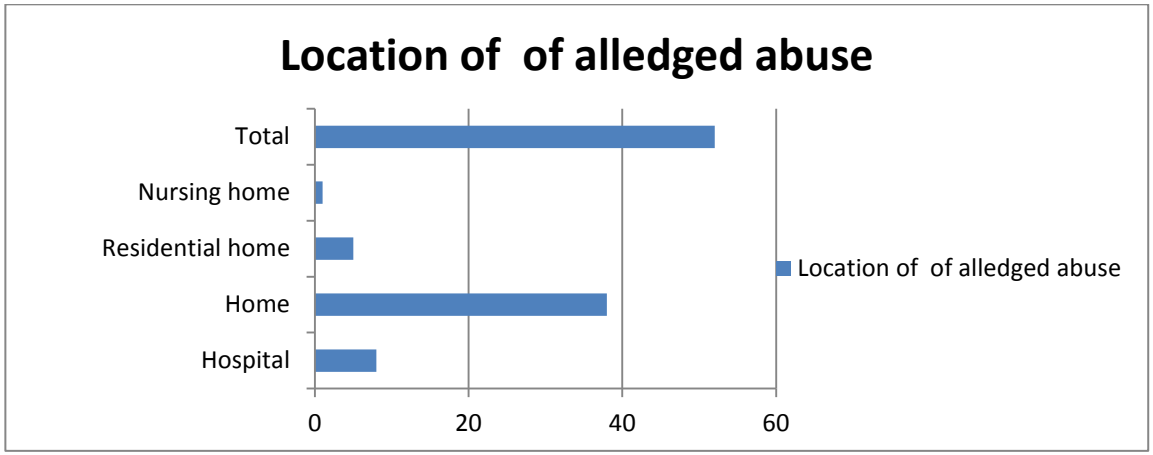


Walsall Healthcare NHS
NHS Trust

Appendix 5 Location of alledged abuse

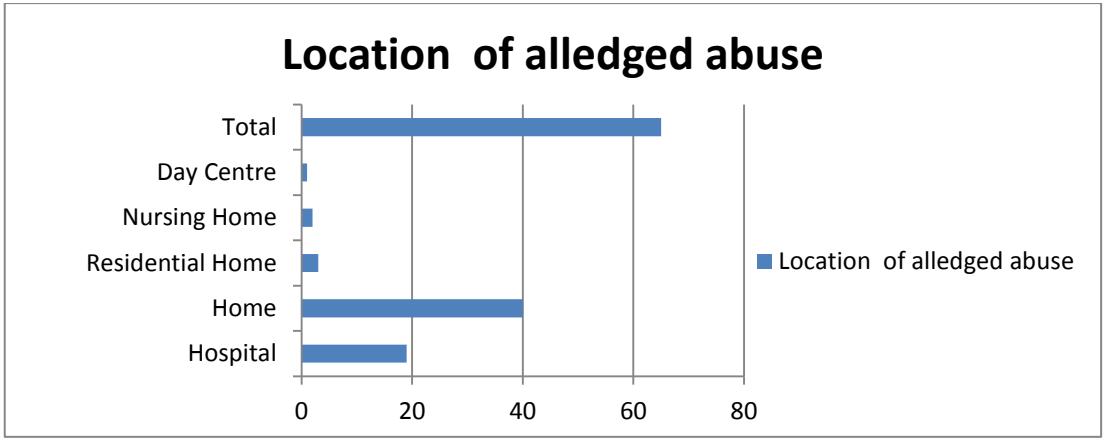
Quarter 1 : (April 2017 –June 2017)

Location of alleged abuse	Number of Concerns =52
Hospital	8
Home	38
Residential Home	5
Nursing home	1
Total	**52**



Quarter 2 : (July 2017 –September 2017)

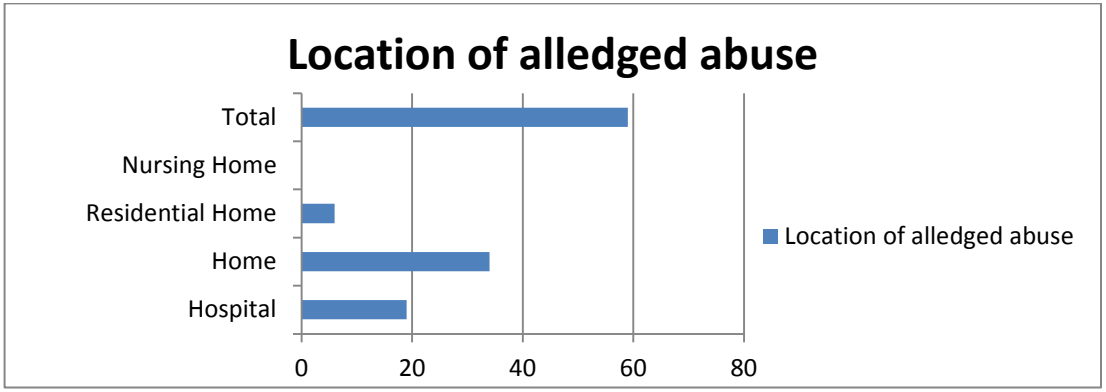
Category of alleged abuse	Number of Concerns =65
Hospital	19
Home	40
Residential Home	3
Nursing Home	2
Day Centre	1
Total	**65**



Walsall Healthcare NHS
NHS Trust

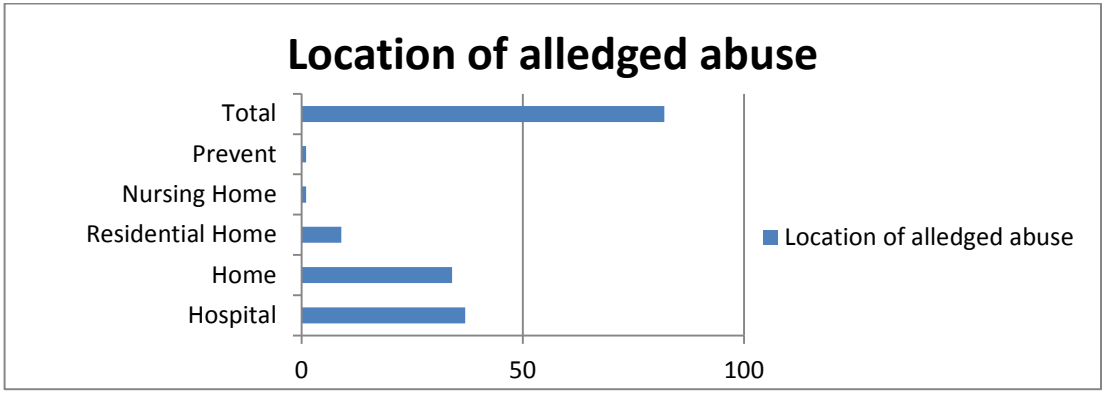
Quarter 3 : (October 2017 –December 2017)

Category of alleged abuse	Number of Concerns =59
Hospital	19
Home	34
Residential Home	6
Nursing Home	0
Total	**59**



Quarter 4 : (January 2018 –March 2018)

Category of alleged abuse	Number of Concerns =82
Hospital	37
Home	34
Residential Home	9
Nursing Home	1
PREVENT	1
Total	**82**



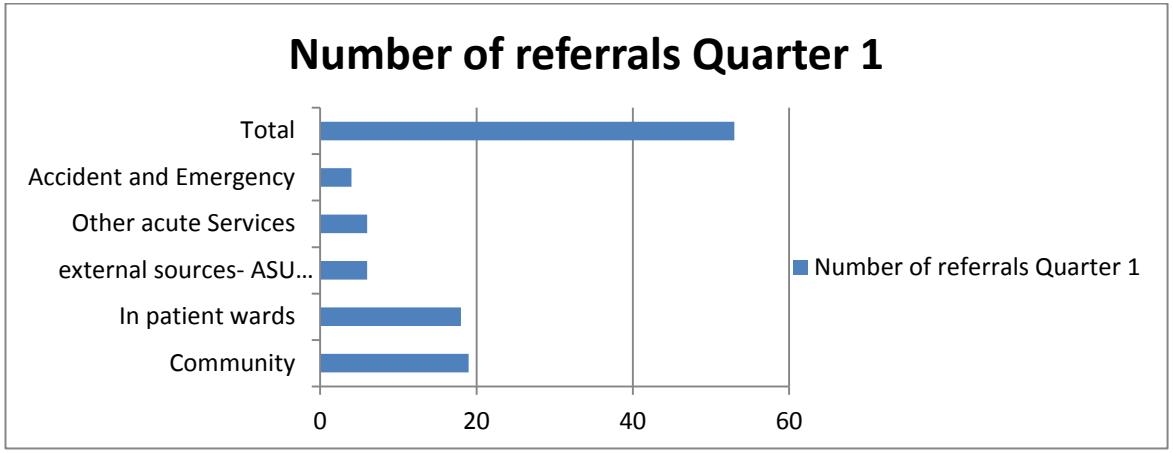
1 physical abuse concern occurred within the hospital setting. A patient with learning disabilities was being supported by a carer from another care provider and staff witnessed a concern in relation to an alleged physical abuse. Of the 2 other concerns reported 1 was a prevent referral and 1 concern related to discriminatory abuse by a family members towards a patient in the care of the hospital.

Walsall Healthcare NHS
NHS Trust

Appendix 6 Source of referrals

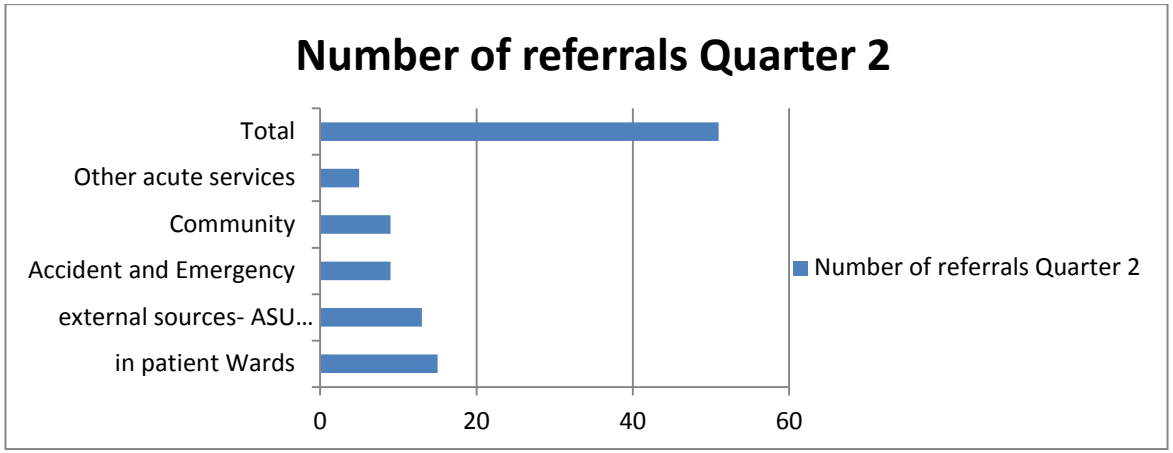
Quarter 1 : (April 2017 –June 2017)

Referral area	Number of Concerns =52
community	11
In patient wards	22
external source ASU/CQC/ NHS Complaints / complaints	8
Other acute services	7
Accident and Emergency	4
Total	52



quarter 2 : (July 2017 –September 2017)

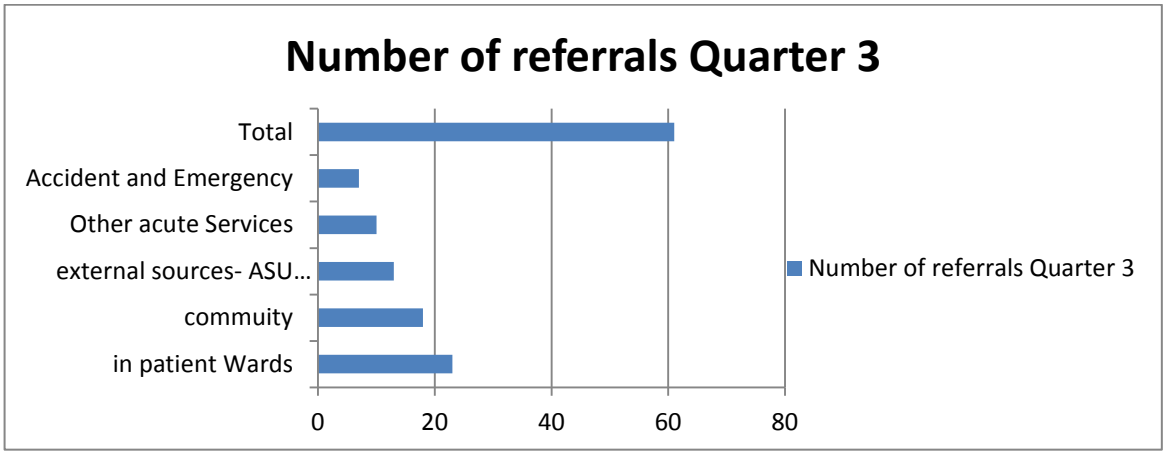
Referral area	Number of Concerns =65
in patient Wards	19
external source ASU/CQC/ NHS Complaints / complaints	18
Accident and Emergency	3
community	18
Other acute Services	7
Total	65



Walsall Healthcare NHS
NHS Trust

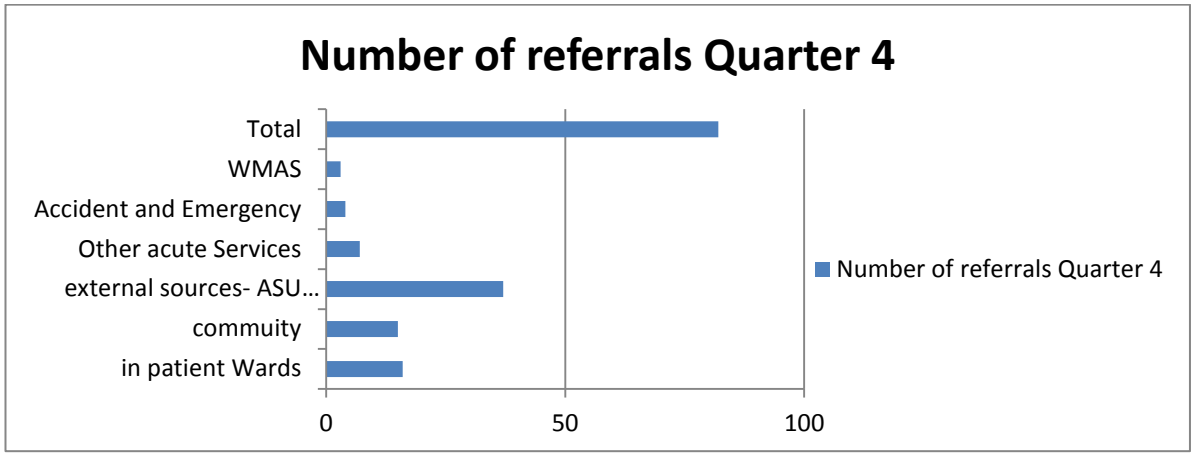
Quarter 3 : (October 2017 -December2017)

Referral area	Number of Concerns =59
in patient Wards	20
community	8
external source ASU/CQC/ NHS Complaints / complaints	17
Other acute Services	7
Accident and Emergency	5
GP	1
Social Worker	1
Total	59



Quarter 4 : (January 2018 –March 2018)

Referral area	Number of Concerns =82
in patient Wards	16
community	15
external source ASU/CQC/ NHS Complaints / complaints	37
Other acute Services	7
Accident and Emergency	4
WMAS	3
Total	82

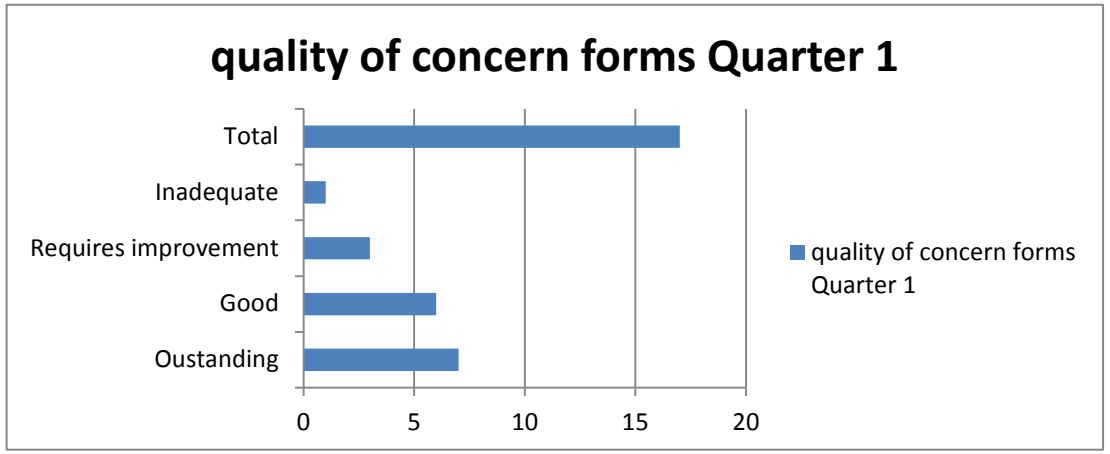


Walsall Healthcare NHS
NHS Trust

Appendix 7 Quality of concern forms audit

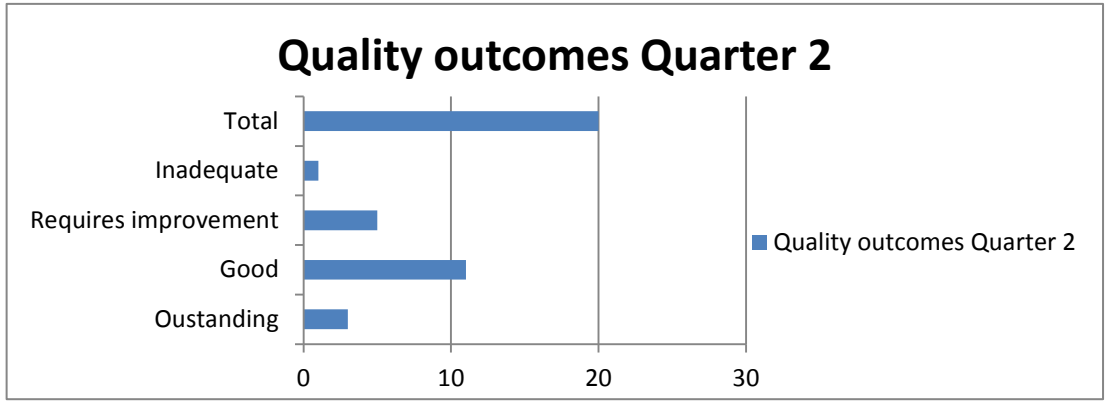
Quarter 1 : (April – June 2017)✔

Referral area	Number of Concerns =52
Forms available to audit	16
Forms not available to audit	14
External concerns	8
Incident Forms	7
Concern raised pre-admission	2
Ambulance	1
refs but no care +support needs	4
Total	52



Quarter 2 : (July – September 2017)

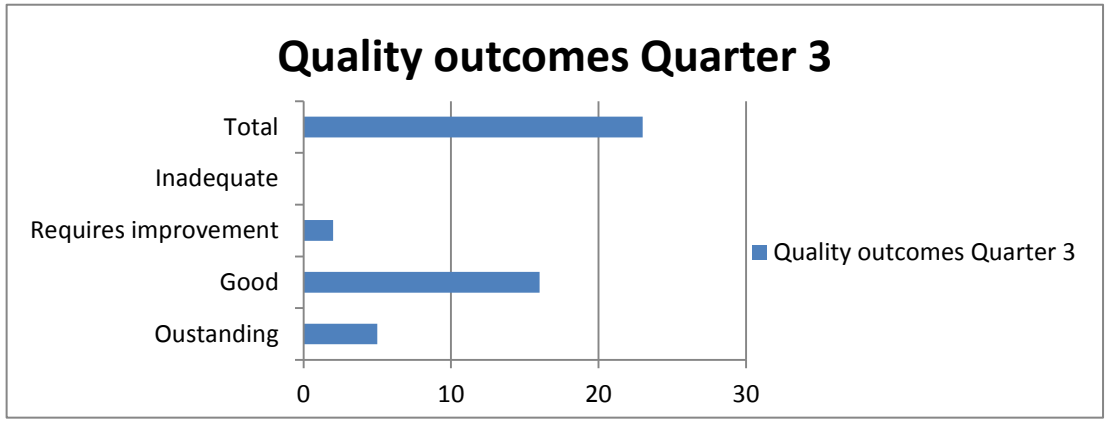
Referral area	Number of Concerns =65
Forms available to audit	20
Forms not available to audit	10
External concerns	18
Incident Forms	10
Concern raised pre-admission	1
Ambulance	3
2 duplicate, 1 not submitted	3
Total	65



Walsall Healthcare NHS
NHS Trust

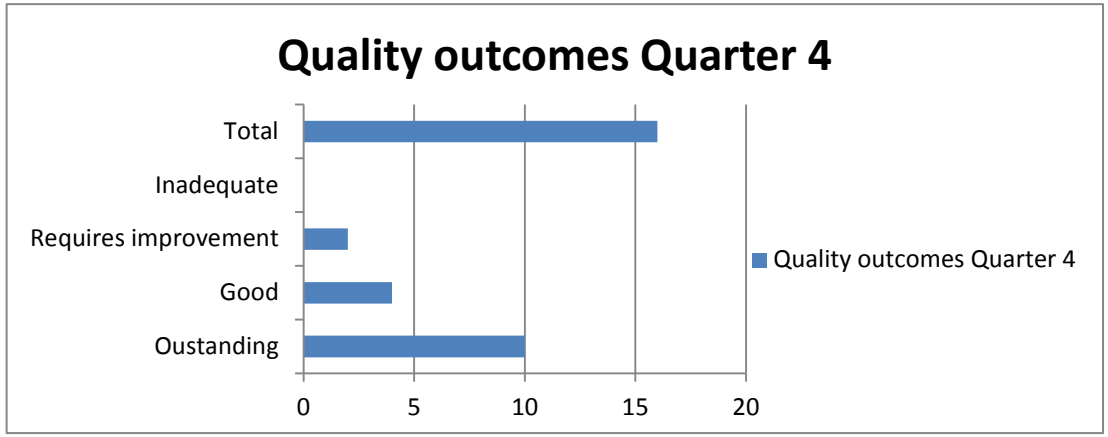
Quarter 3 : (October - December 2017)

Referral area	Number of Concerns =59
Forms available to audit	23
Forms not available to audit	11
External concerns	17
Incident Forms	2
Ambulance refs	4
Concern raised pre-admission	2
Other	
Total	**59**



Quarter 4 : (January - March 2018)

Referral area	Number of Concerns =82
Forms available to audit	16
Forms not available to audit	11
External concerns	37
Incident Forms	12
Concern raised pre-admission	
ambulance ref	5
Duplicate (not included)	
PREVENT	1
Total	**82**



Walsall Healthcare NHS
NHS Trust

Review of concerns received per quarter 2017/18

	Total concerns	External concerns	Forms available	Aware of concern but no form	Incident report	Ambulance ref	Pre-admission concern	Prevent	Duplicate (not included in overall total)	Other
Quarter 1	52	8	16	14	7	1	2			4
Quarter 2	65	18	20	10	10	3	1		2	3
Quarter 3	59	17	23	11	2	4	2			
Quarter 4	82	37	16	11	12	5		1	2	
Total	258	80	75	46	31	13	5	1	(4)	8

Walsall Healthcare NHS
NHS Trust

Deprivation of Liberty Safeguards applications per quarter 2017/18

Quarter 1	Applications	Wards
April	24	Ward 1, ward 3(x4), ward 4(x2) , Ward 9, ward 10 (x3), ward 11(x2), ward 14 (x6), ward 17, ITU (X2), HDU(X2)
May	22	ward 1 (x2).SDS, Ward 3 (x2),ward 4 (x4), ward 10(x3) , ward 11(x2) ,ward 14, ward 16, ward 17 (x3), ITU (x3) ,
June	21	ward 1 (x3), ward 2, Ward 3 (x2), ward 4 (x6), AMU, ward 11 (x3), ward 15 (x2), Ward 16 (x2),HDU,
Total	**67**	

Quarter 2	Applications	Wards
July	21	Ward 1(x2),ward 2(x3), ward 3 (x2), ward 4 (x3), AMU (X3),ward 11(x2), ward 14 (x3),Ward 15, ward 16, ward 29,
August	9	SDS (x2), Ward 3 (x2),ward 4 (x2), ward 9(x3)
September	18	ward 2 (x2), Ward 3 (x11), AMU, ward 9,ward 11 (x2), Ward 16
Total	**48**	

Quarter 3	Applications	Wards
October	19	Ward 1(x3), ward 2 (x2), ward 3(x3), ward 4 (x4) , Ward 9 (x3), ward 10 (x2), ward 16(x2),
November	14	ward 2, ward 4, ward 9 (x3), ward 10(x6) , ward 11, ward 16,ward 17,
December	10	AMU, ward 3 (x4) ward 10 (x2), ward 14,ward 4, ward 17,
Total	**43**	

quarter 4	Applications	Wards
January	12	Ward 2 (x2), Ward 3, Ward 4, Ward 9 (x2), Ward 10 (x2) , Ward 12,Ward 15, Ward 17(x2),
February	9	ward 3 (x6), ward 14(x3)
March	29	ward 3 (x18), AMU (X2), Ward 7,ward 9, ward 14,ward 15, Ward 17, SAU (X2),ward 23, ward 29
Total	**50**	

MEETING OF THE TRUST BOARD – 1st November 2018			
Safeguarding Children Annual Report			**AGENDA ITEM: 11**
Report Author and Job Title:	Elizabeth Tandy – Lead Nurse Safeguarding Children Diane Rhoden – Senior Corporate Nurse	**Responsible Director:**	Dr Karen Dunderdale, Director of Nursing
Action Required	Approve ☒ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	Enclosed is the Safeguarding Children Annual Report for 2017 – 2018. **Key points of the reports are:** • Training has proven difficult in reaching compliance. By March 2018 figures were Level 1 92.05% Level 2 73.20% & Level 3 69.88%. Missing the Trust target of 90% • MASH – 2017-18 this saw the team integrated into the MASH in the Civic Centre in Walsall Town. This coupled with a substantial increase in referrals has seen the lone worker in MASH not able to meet demand for information, hence the Team have been providing support from base impacting on other work streams. • Review and Refresh of the Safeguarding Children Team – the integration into MASH has significantly impacted on the workload of the team, a review and refresh of the Team and workload has taken place and a corresponding business case to enable the Team to have a presence of 2 people situated within the MASH. • Audits – both single agency and multi-agency audits have been affected during 2017-18, due to capacity issues within the Safeguarding Children Team. Assistance has been given from the Health Visiting Team for multi-agency audits and MASH audits are attended. • CQC inspection January 2018 – for the time period of this report the report from this visit was awaited, however it supported the business case for the Safeguarding Team and work around children in A&E and a redesign of the paediatric casualty card has taken place. • Serious Case reviews (SCR) – in the past year there has been 2 SCR's and the continuation of another from the year before. Action plans of learning have been produced and are currently being implemented. There have also been a number of reviews that have fallen below the remit of SCR but the Board has undertaken a learning review **Key priorities for 2018-19:**		

	• Training - negotiations with the CCG have seen compliance for Children Safeguarding Training reduced to a target of 85%. Training will continue to monitored ensuring up to date and pertinent to the audience • To be a part of the Multi-agency training particularly around Thresholds • MASH – to maintain the presence in MASH, working with the Multi-Agency partners to better protect the children of Walsall • Recruitment – to build the team to capacity in order to complete the work streams associated to Safeguarding Children • Action recommendations for the CQC safeguarding inspection Jan 2018 (report expected early 2018- 2019) • To continue to monitor compliance to Supervision and Increase compliance from that seen in 2017-2018. • CP – IS - This is required to be live within the early part of 2018 – 2019	
Recommendation	The Trust Board is requested to approve the report	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report."	
Resource implications	There are no resource implications associated with this report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☐	

Walsall Healthcare NHS
NHS Trust

Safeguarding Children

Annual Report

2017- 2018

CONTENTS

1. Introduction

1.1. Walsall Healthcare Trust continues to take Safeguarding Children and the partnership working across the borough as a fundamental part of its role within Walsall. The Senior Corporate Nurse – Quality and Safeguarding attends the Safeguarding Children Board and along with the Safeguarding Children Team there is representation across the various sub-groups of the Walsall Safeguarding Children Board.

1.2. The internal Safeguarding Committee is chaired by the Deputy Director of Nursing and is attended by the key leads within the divisions both acute and community. The committee reports into the Trust Quality Executive meeting and the Quality and Safety Committee which then feeds into Trust Board. At the time of writing this report this structure is being reviewed. The Senior Corporate Nurse – Quality and Safeguarding attends the Clinical Commissioning Group Safeguarding Quality Review Meeting where performance, issues, concerns or new guidance is discussed as a Health Economy.

1.3. The statutory duties and Trust responsibilities for safeguarding children are set out in the Children Act 1989 and 2004 and Working Together to Safeguard Children 2015.

1.4. The annual report covers the period April 2017 – March 2018 and will demonstrate how the Safeguarding Team support the Trust in fulfilling its obligations towards vulnerable children. It will also provide assurance that children are effectively protected and staff are supported when working with complex cases.

1.5. Walsall Healthcare Trust has been inspected by the CQC in January 2018. The report has not been generated within the timescale of this annual report, however once received any recommendations will be action planed and monitored via the Safeguarding Committee.

2. National Guidance and Key Legislation

2.1. Key Legislation

- Children Act 1989
- Human Rights Act 1998
- Sexual Offences Act 2003
- Data Protection Act 1998
- United Nations Conventions on the rights of the child 1990

- Children Act 2004; statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11
- The Care Standards Act (2009)
- Children and Young Persons Act 2008
- Human Rights Act 1998
- Article 5 - Right to Liberty and security
- Article 8 - Respect for Private and family life
- Article 14 - Prohibition of discrimination
- Mental Capacity Act 2005
- Care Act 2014

2.2. **National Guidance**

- Who Pay's Establishing the Responsible Commissioner (DOH 2007)
- Looked After Children: Knowledge, Skill and Competencies of Health Care Staff Intercollegiate Role Framework (RCPCH 2015)
- Statutory Guidance on Promoting the Health and Well-being of Looked After Children (DOH / DFE 2015)
- Healthy Child Programme (2009)
- Quality Standard for the health and well-being of looked after children (NICE 2013)
- Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (2013)
- When to Suspect Child Maltreatment NICE Guidance (2009) revised (2012)
- What To Do If You're Worried a Child is Being Abused (DOH 2003)
- Working Together to Safeguard Children; a guide to inter-agency working to safeguard and promote the welfare of children (HM Gov 2015)
- Information sharing; advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Gov 2015)
- Safeguarding Children and Young People: Roles, Responsibilities and Competencies for Health Care Staff: Intercollegiate Document 3rd Edition: (March 2014)
- Quality Commission; Not seen, not heard, A review of the arrangements for child safeguarding and health care for looked after children in England. (2016)
- Deprivation of liberties safeguards (2009)
- Francis Report (2013)
- Wood report (2016)

3. Walsall Healthcare NHS Trust Safeguarding Children Team

3.1. The Safeguarding Children Team aim to ensure that all children are effectively protected when using services provided by Walsall Healthcare

NHS Trust and that processes are robust for early detection and referral processes. Working Together (2015) highlights that staff working within the Trust:

- Understand risk factors and recognise children and young people in need of support and/or safeguarding.
- Recognise the needs of parents who may need extra help in bringing up their children and know where to refer for help.
- Recognise the risks of abuse or neglect to an unborn child.
- Communicate effectively with children and young people and stay focused on the child's safety and welfare.
- Liaise closely with other agencies including other health professionals and share information as appropriate.

The Safeguarding Children Team:

- Provide advice, support and guidance to members of staff regarding safeguarding children matters.
- Ensure relevant policies and procedures are in place to support all staff.
- Provide supervision to staff to support areas of challenging work ensuring the focus of work remains on the safety and wellbeing of the child.
- Provide training and education for all staff to support them with their safeguarding work.
- Support staff in the production of statements to court or attendance at court for matters relating to safeguarding children.
- Undertake a programme of audit to provide assurance.
- Work closely with key stakeholders and other agencies to safeguard children.

3.2. Safeguarding Children Team; April 2017– March 2018

3.2.1. The Safeguarding Children Team has seen a continued period of instability during the course of the past 3 years. Changes to the management structure and increase in workload, particular in the MASH (Multi-agency Safeguarding Hub) have provided significant challenge for the team, and impacted on the overall availability of the team to provide a consistence proactive service. Recruitment to vacancies that became available from existing posts was prolonged, coupled with long term sickness meant that significantly, for all of this annum the team's capacity was reduced. Positively, the improvements made over the course of the previous 2 years in terms of the integration of the Looked After children service with the Safeguarding Children Team have continued and the review and development of processes and procedures have ensured the day to day functioning of the team has clear structure and stability. The

team have demonstrated resilience during this challenging period, and remained committed to the overall functioning of the safeguarding children agenda. A business case to increase the capacity in the team has been produced and is current under review

4. Summary of Key Progress for 2017-2018

Area of Intervention	Rationale	Update
Monitor the quality of referrals submitted to the Local Authority.	Quality assurance.	Due to capacity issues within the Team with the integration into the MASH hub audit did not take place in Q3 & Q4 2017 / 18. Once the team is established fully it is anticipated that this will again be initiated.
Continue to improve communication across all areas, maintaining good attendance at multi-agency forums.	To provide a cohesive team with knowledge of WSCB Business, WHT priorities and progress.	Attendance at WSCB board meetings has been maintained throughout 2017 – 2018. The majority of sub-groups have been attended.
Monitoring of data sets and spreadsheets continue to be accurately maintained and effective for looked after children and safeguarding children.	To provide accurate and concise quarterly and annual reporting.	Accurate monitoring continues
Ensure that Safeguarding Training is effective in line with RCPCH guidance, updating as required. Monitoring and compliance of training figures.	To ensure training is fit for purpose, effective, up to date, in adherence with national guidance and attendance monitored.	Training compliance has proven to be difficult for the time period of the report. A planned review and refresh will be taken forward throughout the coming year.
To ensure new system of monitoring Safeguarding Supervision is effective, accurate and that interventions in non-compliance are timely.	To ensure staff receive Supervision in accordance with Walsall Healthcare Training Strategy.	Safeguarding supervision monitoring continues however due to capacity within the Safeguarding Team this has seen a decline in performance, this will be reviewed during the coming year
Clear focus is evident in accordance with the	To ensure Safeguarding remains a key focus for	Safeguarding has maintained a key focus for the

Safeguarding Strategy 2015 to 2018.	Walsall Healthcare NHS Trust.	organisation, with a review and refresh of the Safeguarding Children Team in Q4 2017 / 18. Outcomes of which will be taken forward during 2018-19
Engage in multi and single agency audit and review section 11 data as a continual process.	To demonstrate quality assurance in terms of knowledge, skill and competency.	Due to capacity within the Safeguarding Children Team it has not been possible to undertake all the required audits to ensure quality assurance. This was recognised by the organisation and formed part of the review and refresh of the safeguarding team. The health Visiting service have assisted with Multi-agency review audits.
To continually review policies and procedures; timely and demonstrating evidence based / national directive.	To provide robust policies to support the workforce.	At time of writing report the Safeguarding Children Policy is under review.
To be a key member of MASH Walsall.	Multi--agency contribution to the MASH development; facilitating effective contribution and ensuring pathways in terms of health colleagues are developed and implemented.	2017 / 18 saw the integration of WHT into the Walsall MASH. This has proven a difficult time for the Team with a 1 WTE Named Nurse sitting permanently within Walsall Civic Centre. Workload has increased significantly and this has formed part of the review and refresh that has taken place of the Team and its workload and will be actioned during 2018-19

5. Safeguarding Children Activity

5.1. Supervision

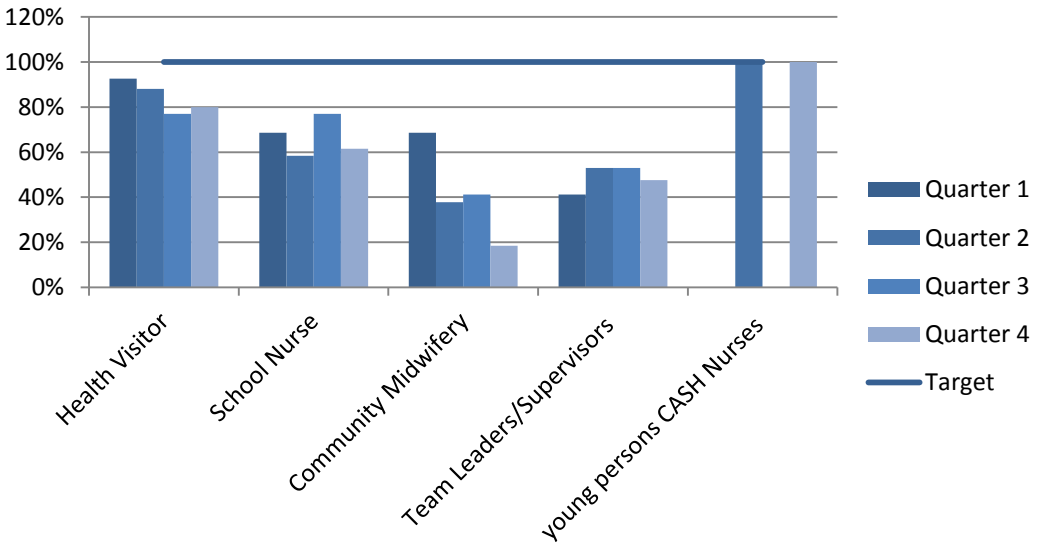
5.1.1. Safeguarding supervision involves a retrospective review of safeguarding cases with a trained safeguarding supervisor. The process provides a structured format in a one to one or group setting that involves both reflection and direction regarding case management. The aim of

this framework is that it will support a variety of models of clinical supervision that can be developed in accordance with local circumstances and staff developmental needs; improving overall accountability and standards of practice at the frontline.

5.1.2. The Safeguarding Supervision Policy (2014) identifies that case holders for child protection should receive supervision on a quarterly basis comprising of a 1:1 meeting.

5.1.3. Data

Service area	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Health Visitor	93%	88%	77%	80%
School Nurse	69%	58%	77%	62%
Community Midwifery	69%	38%	41%	18%
Team Leaders/Supervisors	41%	53%	53%	48%
Sexual Health	0%	100%	0%	100%



5.1.4. Management of supervision

During this annum there has been several obstacles which have prevented the uptake of supervision being 100%; Figures for supervision demonstrate overall challenge to many services within the Trust with reduction in capacity negating completing challenges and demands on service. This was escalated and a risk assessment in place to provide controls in relation to the risk. The need to increase the number of supervisors in the Trust was recognised and supervisor training was provided in the latter part of the annum, this was well

attended evaluated well. The development of new supervisors is a priority moving in the 2018-2019.

5.2. Training

5.2.1. Training Strategy

In accordance with legislation, statutory guidance and recommendation of professional bodies it is expected that all individuals who work in NHS organisations are trained and competent to be able to recognise when a child may require safeguarding from harm and abuse and to know what to do in response to a concern (Children Act 2004; HM Govt., 2013; RCPCH, 2014). The strategy provides guidance for managers and staff on the level of training required and how often staff must attend. It is recognised that all staff groups will have different training needs to fulfil their duty depending on their level of contact with children and young people.

5.2.2. Training Compliance 2017-2018

- **Level 1** Safeguarding Training is accessed via e-learning on ESR.

- **Level 2** Safeguarding Training continued to be offered via taught sessions and e – learning. Staff was also given the option of working through a training booklet in order to achieve competency during a period in which the access to the e- learning was being reported as an issue. The learning and development unit have supported this intervention and rectified the issue timely. is anticipated that this will lead to an overall improvement however Line Managers on receipt of non-compliance information are expected to ensure that staff attend the next available session or ensure staff have access to e-learning.

- **Level 3** compliance has been variable over the course of the year. The safeguarding team have continue to maintain availability of training to meet the needs of this cohort of staff, however it is evident that attendance has not been consistently maintained by head of services. This is a Trust priority to improve overall level 3 compliance rates and work will continue to be on-going

5.2.3. Training data

Level 1 Training Compliance

Division	Safeguarding Children Level 1				
	No. of Staff Fully Compliant	No. of Staff Compliant Which Are Due to Expire	No of Staff Non-Complaint	Total No of Staff eligible	Percentage Fully Compliant
Corporate	312	16	30	358	92.05%
Estates and Facilities	321	8	11	340	97.04%
Medicine & Long-Term Conditions	87	11	14	112	87.50%
Surgery	199	11	28	238	88.46%
Women's, Children's & Clinical Support Services	247	13	30	290	89.86%
WH Trust Overall	1166	59	113	1338	92.05%

Level 2 Training Compliance

Division	Safeguarding Children Level 2				
	No. of Staff Fully Compliant	No. of Staff Compliant Which Are Due to Expire	No of Staff Non-Complaint	Total No of Staff eligible	Percentage Fully Compliant
Corporate	65	6	37	108	87.69%
Estates and Facilities	44	0	7	51	88.00%

Medicine & Long-Term Conditions	493	20	292	805	67.07%
Surgery	357	10	204	571	68.13%
Women's, Children's & Clinical Support Services	300	20	44	364	88.76%
WH Trust Overall	1259	56	584	1899	73.20%

Level 3 Training Compliance

Division	Safeguarding Children Level 3				
	No. of Staff Fully Compliant	No. of Staff Compliant Which Are Due to Expire	No of Staff Non-Complaint	Total No of Staff eligible	Percentage Fully Compliant
Corporate	36	1	35	72	50.70%
Estates and Facilities	N/A	N/A	N/A	0	N/A
Medicine & Long-Term Conditions	112	7	154	273	46.06%
Surgery	42	1	46	89	48.31%
Women's, Children's & Clinical Support Services	523	35	132	690	83.95%
WH Trust Overall	713	44	367	1124	69.68%

Overall Training Compliance 2017-2018

Division	Safeguarding Level 1	Safeguarding Level 2	Safeguarding Level 3
Corporate	50.70%	87.69%	50.70%
Estates and Facilities	97.04%	88%	N/A
Medicine and long term conditions	87.4%	67.7%	46.6%
Surgery	88.46%	68.13%	48.31%
Women, children and clinical support	83.95%	88.76%	83.95%
WH Trust overall	92.05%	73.20%	69.68%

Overall Training Compliance 2016-2017 for comparison

Division	Safeguarding Level 1	Safeguarding Level 2	Safeguarding Level 3
Corporate	97.24%	86.36%	84.29%
Estates and Facilities	88.76%	26.00%	N/A
Medicine and long term conditions	92.86%	58.19%	72.78%

Surgery	94.87%	60.47%	71.03%
Women, children and clinical support	96.18%	88.98%	83.42%
WH Trust overall	93.95%	70.11%	77.64%

5.2.4. Non-compliance reports continued to be provided on an on-going basis for the last 12 months, this is provided to the Named Nurses for Safeguarding Children to ensure that close monitoring of non-compliance.

5.2.5. There are currently enough training sessions being provided by the Named Nurses to enable staff to attend the correct level of training, this is continually monitored and adjusted accordingly.

5.2.6. Plans for 2017 – 2018

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- Sessions are continually revised by the Named Nurses to ensure correct numbers of sessions are in place, additionally feedback reports are provided by the Learning and Development Centre.
- The Training Strategy continues to be embedded in departments by the Safeguarding Team to ensure staff are accessing multi-professional and diverse training opportunities to assist in improving their safeguarding knowledge base.
- Service Leads / Team Leads will need to ensure that staff within their departments has met their correct level of competence for Safeguarding Training, this continues to be a requirement as part of the PDR process.
- The Learning and Development Centre are ensuring that correct compliance is monitored and are working with the Safeguarding Team to embed any changes in process.
- The Named Nurses will ensure that training continuously reflects National Guidance.
- The overall reduction in compliance has been monitored as an on-going component of non-compliance reporting. The Team continue

to encourage staff access e-learning which is available and accessible via ESR.

- The Team will continue to encourage a range of 'suites' of training to enable staff to expand their knowledge and expertise around the sphere of safeguarding in addition to encourage use of the training passport.

5.3. Quality Assurance of Multi Agency Referral Form (MARF) to the Local Authority

5.3.1. Continued review of referrals to Children Services is deemed necessary to ensure that referrals are reviewed and feedback provided to individual services.

5.3.2. Referrals made by employees of the Trust are expected to ensure a copy is forward to the Safeguarding Team, and practitioners are continually encouraged to adhere to this part of the Trust Safeguarding children policy.

5.3.3. However during this year the safeguarding team have been unable to completed formal audit to evidence overall status of the quality of referral to children's services. Despite this the Safeguarding team have responded to those that require improvement or have been inadequate on the receipt of the MARF into MASH, this has been facilitated by the Named Nurse allocated to the MASH work stream.

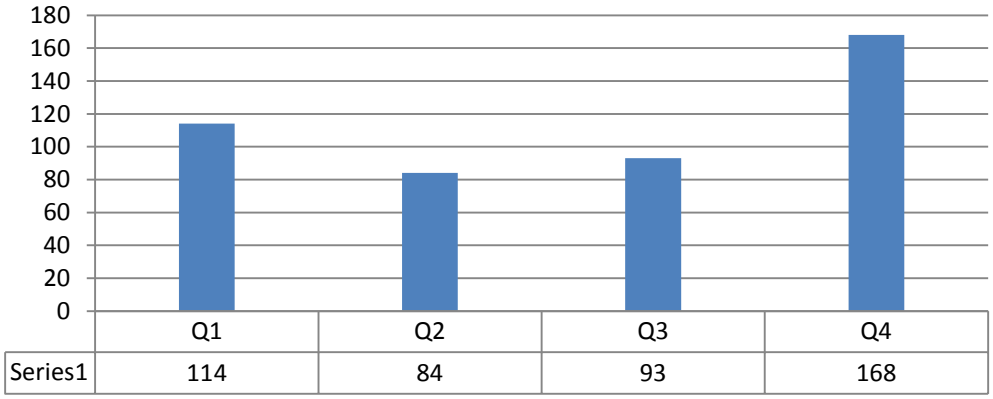
5.3.4. Although, the team would have preferred to have been in a position to complete proactive preventative work within the Trust, the team have continued to offer advice, support and guidance in the completion of a MARF for all staff. A revised MARF that was available in December 2017 prompts the referrer to seek advice, support and guidance and has links to documents that support the completion of the MARF.

5.3.5. MASH management group (multi –agency) have also began an audit programme which includes quality and assurance of referrals to MASH. The main theme that has been identified from these audits is continued lack of understanding of thresholds and communication of concerns. Ofsted Inspection in Q3 found that referrals from professionals are timely, however a high proportion either do not meet the threshold for statutory intervention or are insufficiently detailed for managers to make a decision about the next steps. Previous action plans to improve quality of referral have not delivered the desired impact. This has been recognised by the Local Safeguarding Children Board as a priority, as it is evidenced that previous action plans to improve quality of referrals have not delivered

the desired impact. The Trust have contributed to the development of a new threshold document that is due for publication in 2018-2019 and will be involved in its launch and deamination both within the Trust but with the wider Multi agency.

5.3.6. The main referral source of the Trust continues to be Accident and Emergency; the main reason for referrals continues to reflect the parental trilogy of risk factors (mental health, domestic violence, substance misuse) and emotional abuse for the child, which includes self-harm, suicidal ideation and overdose.

5.3.7. Number of referrals to Children's services from the Trust



5.3.8. Area of Referral during 2017- 2018

Referral Area	Total number of referrals
Health Visitors	47
School Health Team	5
Sexual Health	5
Accident and Emergency	162
Community Midwives	159
Safeguarding Team	2
Acute - other	30
Acute - Paeds (ward 21/PAU	25
Community - other	23
referral not identified	1

5.3.9. Action 2017-2018

- To ensure that timely escalation of inadequate referrals continues.
- To support staff when referrals demonstrate a level of poor quality; ensuring this is addressed timely and that intervention is swift.
- To continue to review training to support improvement of the quality of referrals evaluate.
- Named Nurses within the MASH - Continue to Review information in the MASH will multi agency colleagues to determine the actions taken and outcome of the MARF's submitted by WHT staff in real time.
- Contribution to the review of threshold document and continued commitment to the launch and dissemination of the practical guidance within going forward into 2018- 2019.

5.4. Multi – Agency Safeguarding Hub Activity (MASH)

5.4.1. The MASH, which was introduced 2015 has continued to develop. The Trust committed to having a Named Nurse representing the Trust within the secure room in Q4 of 2016-2017. The requirement for those working within the room to have non- police personal vetting, did impact on the Team's ability to work within the room during this period. Staff covering the MASH work stream did not have the vetting and therefore worked outside the room but close by. Increase in the number of staff vetting did occur during this period, however sickness prevented this having an impact on an increase in a Nurse being in the same room as Multi – agency colleagues. This was mitigated through continuous communications with colleagues within the MASH room and did not impact on the sharing of information from WHT systems and services.

5.4.2. During this period the amount of requests for information to support the screening of referrals received by the MASH significantly increased, it was evidenced that the workload required the cover of 2 FT WTE nurses.

5.4.3. There are a significant amount of electronic systems utilised by the Trust which are access by the Named Nurse routinely within the MASH, this has presented a number of Information Technology (IT) issues to maintain a reliable connectivity as well as the time factor of reviewing so many systems has also increased the pressure on the Team. Requests for information from Dudley and Walsall Mental Health Trust have also been undertaken by the Named Nurses during this year, as the MASH is yet to have Mental Health service representation within. The Team have highlighted the risks associated to not having this expertise in the room to support the identification and analysis of information on this area of practice.

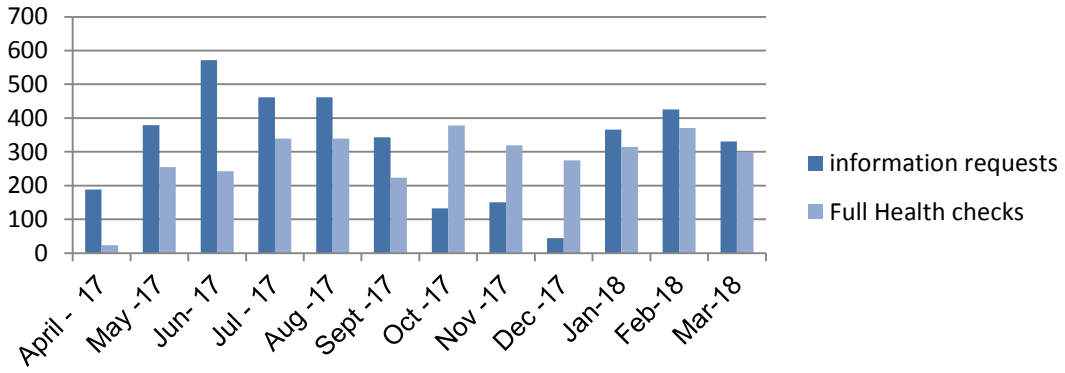
The activities undertaken by the Named Nurse within MASH include:

- **Information request –** demographics of the child, GP registration, related parties/people living within the home

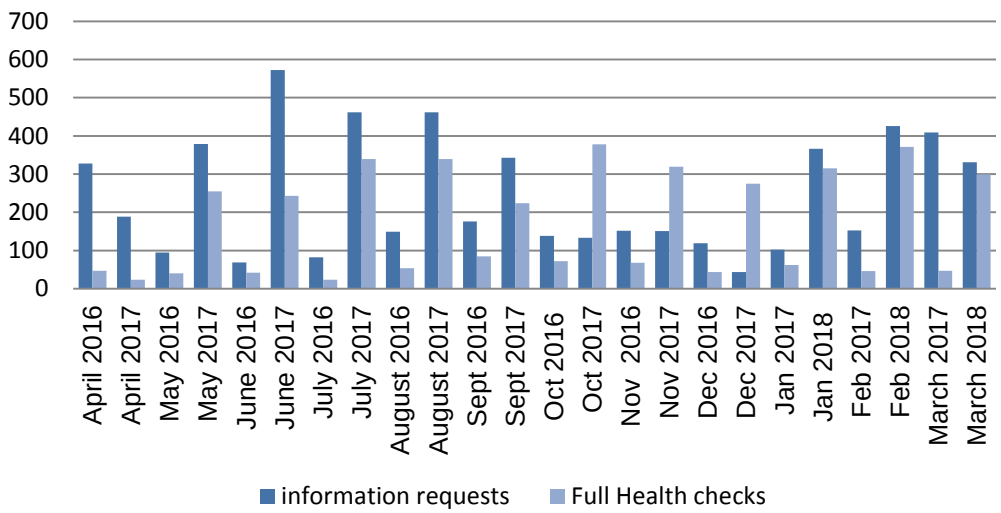
- **Full Health Checks –** along with the above this includes full health check such as A&E attendances, immunisation, all hospital attendances, and conversations with allocated WHT health practitioners such as Health Visitors, School Nurse, Paediatrician, A&E and Ward staff etc. This may also mean contact with non- WHT practitioners such as GP and DWMHT

- **Strategy Meetings -** Multi-agency meetings held to make decisions based on information gathered, a discussion takes place as to what child protection actions are required. A meeting can take as little as fifteen minutes to over an hour for complex cases. The Named Nurse may have further actions to complete as an outcome of the meeting.

5.4.4. Number of Information sharing requests and full health checks completed by WHT MASH representative per month 2017-2018



5.4.5. Comparison of Information requests and full health checks completed by WHT MASH representative between 2016-2017 and 2017 - 2018



5.5. Child Protection Conferences

5.5.1. Initial conferences

Initial Conferences – Midwifery (2017-2018)				
	Q1	Q2	Q3	Q4
Total No. Conferences	32	27	16	21
Total No. children	32	27	16	21
HP present	27	16	10	16
Report Provided (per child)	15	16	12	10

Initial Conferences - Health Visiting (2017-2018)				
	Q1	Q2	Q3	Q4
Total No. Conferences	47	67	40	44
Total No. children	65	89	54	61
HP present	56	80	43	51
Report Provided (per child)	53	80	43	53

Initial Conferences - School Nursing (2017-2018)				
	Q1	Q2	Q3	Q4
Total No. Conferences	66	99	41	51
Total No. children	126	202	78	101
HP present	91	150	65	53
Report Provided (per child)	84	173	58	67

5.5.2 Review conference

Review Conferences – Midwifery (2017-2018)				
	Q1	Q2	Q3	Q4
Total No. Conferences	14	17	23	12
Total No. children	14	17	23	12
HP present	9	12	12	7
Report Provided (per child)	6	6	10	6

Review Conferences - Health Visiting (2017-2018)				
	Q1	Q2	Q3	Q4
Total No. Conferences	67	96	115	84
Total No. children	83	131	147	101
HP present	63	111	99	74

Report Provided (per child)	70	120	103	84

Review Conferences - School Nursing (2017-2018)				
	Q1	Q2	Q3	Q4
Total No. Conferences	82	135	138	121
Total No. children	148	229	266	212
HP present	96	57	114	34
Report Provided (per child)	126	107	55	23

5.5.3 Annual summary of conference compliance 2017-2018

Initial conferences	School Nursing	Health visiting	Midwifery
Total No. Conferences	733	560	162
Health Professional present	660	577	109
Total No. Children	1362	731	162
Report Provided	693	606	81

	School Nursing	Health Visiting	Midwifery
% of non-attendance at conference	52%	21%	33%
% of no health reports provided	49%	17%	50%

5.5.4 Annual summary of conference compliance 2016-2017

Review conferences	School Nursing	Health visiting	Midwifery
Total No. Conferences	631	531	164
Health Professional present	705	520	95
Total No. Children	1155	715	164
Report Provided	773	489	77

	School Nursing	Health Visiting	Midwifery
% of non-attendance at conference	39%	28%	42%
% of no health reports provided	33%	32%	53%

5.5.5 The Figures for 2017 to 2018 respresents each child discussed at a Child Protection Conference for the year. There has been a 16% increases in conferences this year with a 22% increase of children discussed. There has been several exceptions and explanations provided with regards to internal and external processes, which continues to be;

- Late notification of Initial conferences
- Conferences being cancelled
- Walsall Healthcare Trust (WHT) unaware of conferences
- Capacity/staff issues within teams

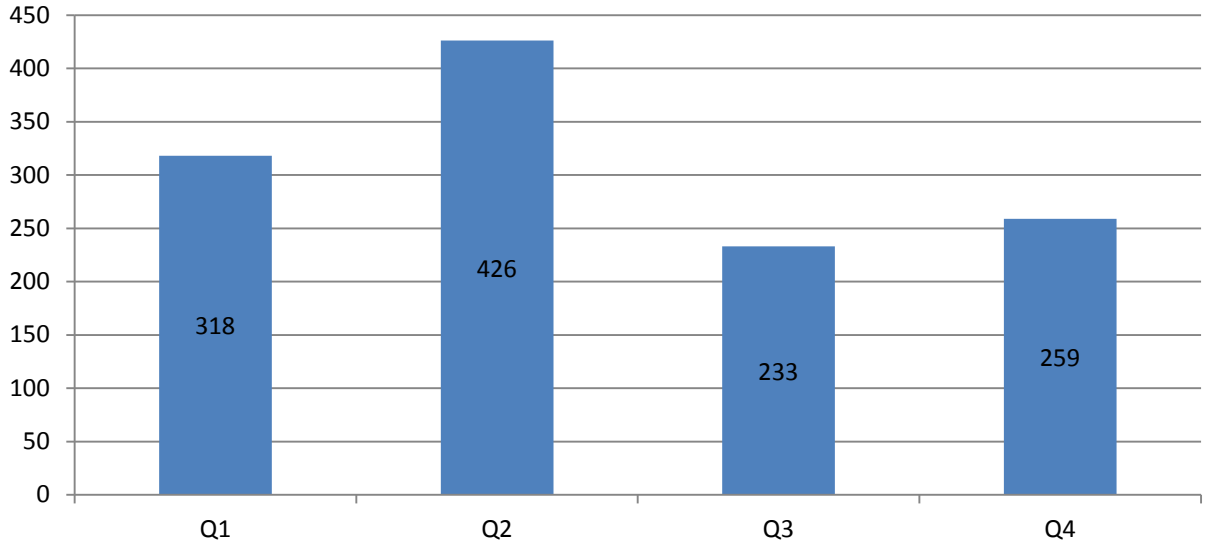
The Safeguarding Chidlren Team continue to enforce processes and esculate any concerns externally with the Local Authority to ensure the WHT are notified timely. Invites continue to be sent electronically. These invites are sent to the central point of access and so practioners can be allocated and notified in a more timely way. WHT staff exception report any conference non attendances to the safeguarding children team or Service Leads to ensure that the information is captured internally.

5.6 September 2017 School health service intiated a new process to support with capacity in the service and to comply with commissioning contracts in respect of early intervention. School health practitioners attend all initial child protection case conferences and offer a health assessment for all children. Following the health assessment each child will be categorised into

- Unmet health needs - service provided by School Health
- Unmet health need other- allocated to additional professional and close to School Health service.
- No unmet health need- School health closes the referral.

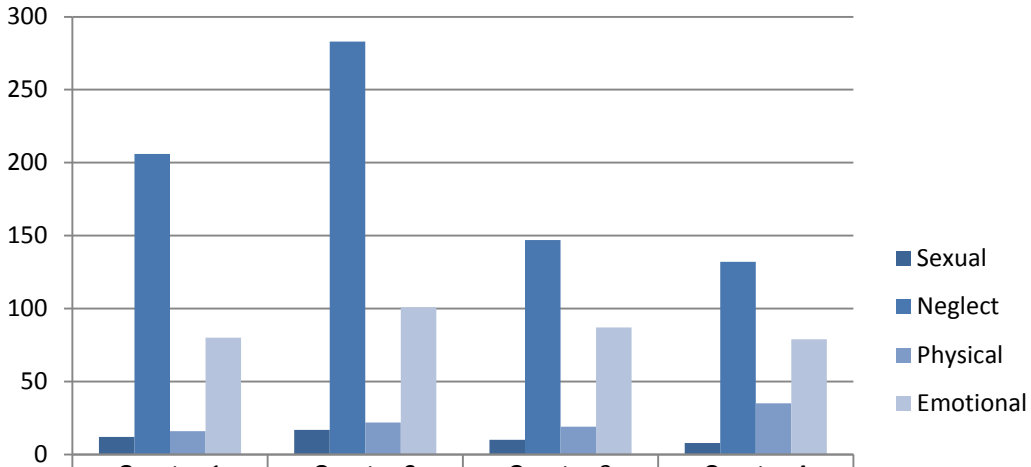
School Health ensures outcome decisions are monitored via supervision and communication with the pertinent multi- agencies and allocated social worker.

5.6.4 Children Placed/De-Registered on Plan Activity



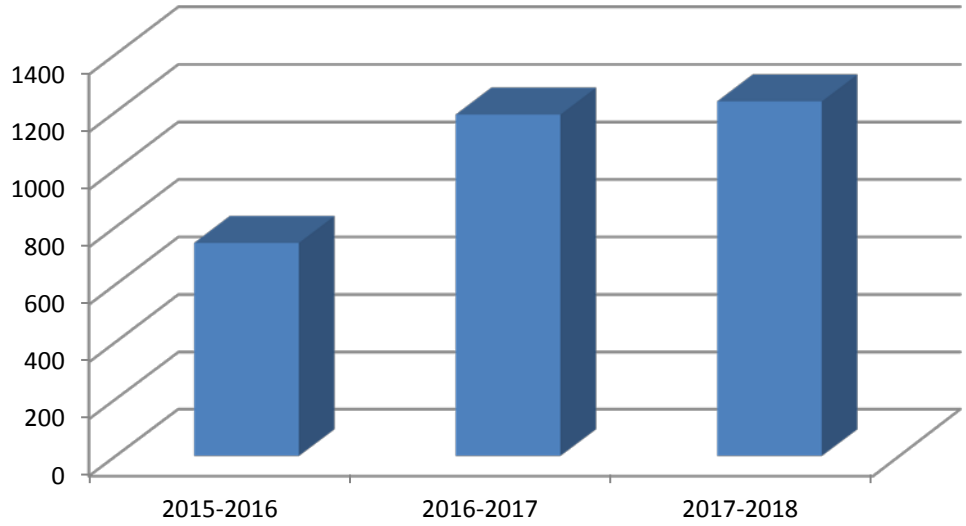
The above data sets continue to be monitored through the Named Nurse and Administrative and data collection which continues to demonstrate that the most common reasons why this is occurs is related to emotional and neglect reasons which continus to be the same theme for five years. To ensure that the Safeguarding Team have awareness around decision making relating to children being removed from Child Protection (CP) plans; the data provides a consistent picture in terms of numbers of children becoming looked after; additionally enhanced support through a child in need (CIN) plan continues to feature most significantly for children who are no longer subject to a CP Plan.

5.6.5 Category of children placed on a CP plan (2017-2018)



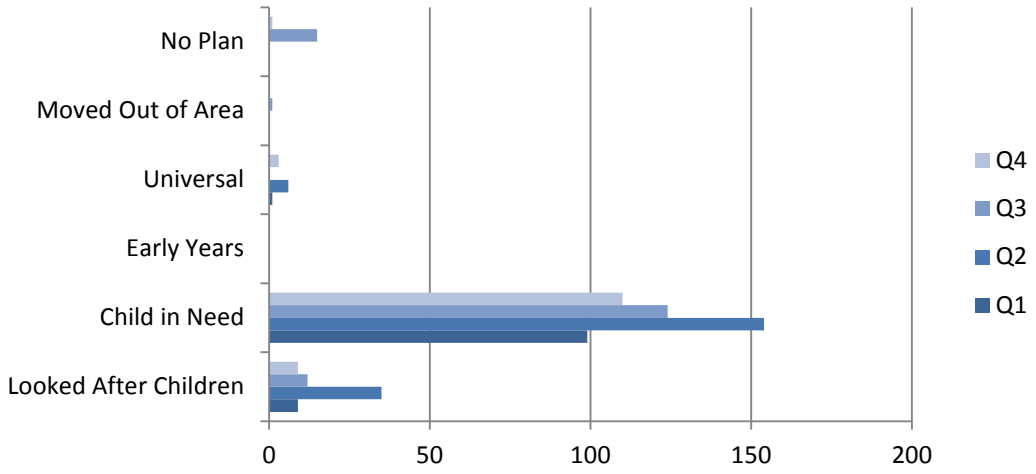
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Sexual	12	17	10	8
Neglect	206	283	147	132
Physical	16	22	19	35
Emotional	80	101	87	79

5.6.6 2015-2018 children placed on a CP plan



5.6.7 Numbers of children placed on a CP Plan has signigicantly increased in comparison to previous years. WHT has seen a 66% increase in chidlren subject to a child protection plan since 2015. The dominat category of abuse is Neglect with a 51% increase and physical abuse with an 80% increase since 2016-2017 and emotional abuse decreasing by 41%.

5.6.8 Categories of chidlren de-registered of a child protection plan

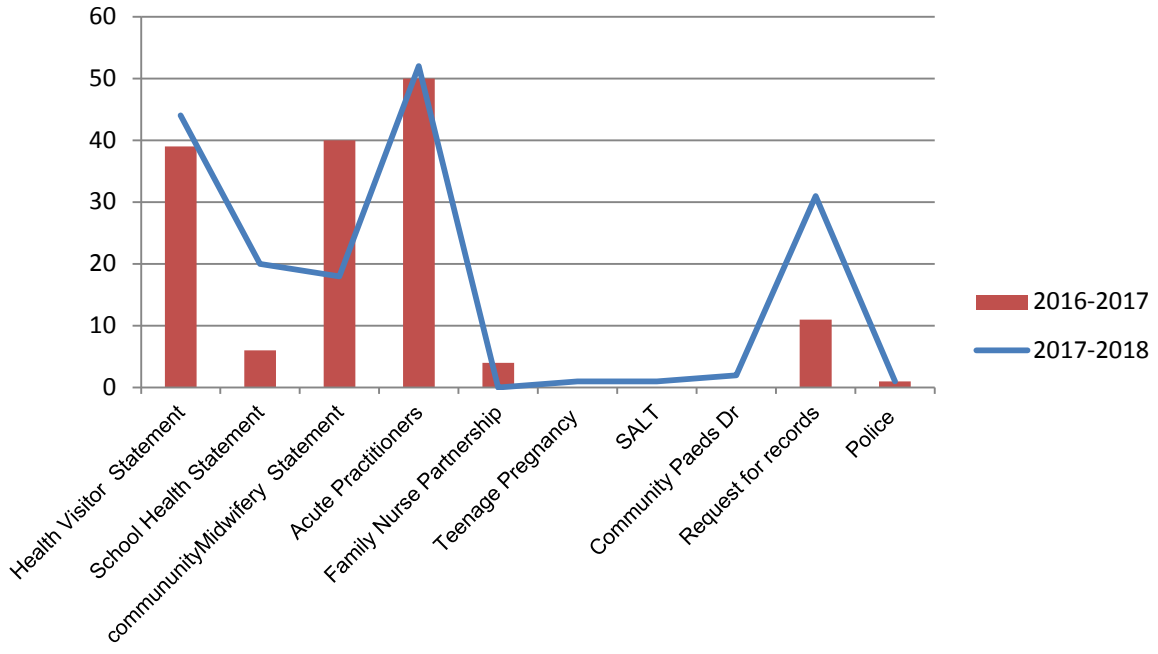


5.6.9 Numbers of children de-registered from plan continue to follow the 'step down' process in accordance with Local Safeguarding Children Board (LSCB) guidance. There was a significant increase in children being 'looked after' in Q3 and children steeping down to child in need.

5.7 Court Statement Activity from April 2017-March 2018

Court statements requests significantly increased throughout 2017-2018 as a result of several serious child abuse incidents during this period.

	2017-2018
Health Visitor Statement	44
School Health Statement	20
Communality Midwifery Statement	18
Acute Practitioners	52
Family Nurse Partnership	0
Teenage Pregnancy	1
SALT	1
Community Paeds Dr	2
Request for records	31
Police	1



5.6.1 The above charts provide an overview of statement requests and comparison from 2016-2017. There was a significant increase of 181% of record requests from Police due to on-going criminal investigations which also triggered a surge of statement requests from all professionals, however this impacted School Health significantly as a 233% increase was noted from 2016-2017.

5.7 Multi-agency Audits / Single-agency audits

5.7.1 On behalf of the WSCB and in accordance with the underpinning principles of the Learning & Improvement Framework as defined in Working Together 2015, the Safeguarding Children team as part of the Multi-Agency Audit Group has agreed to deliver a programme of Audits of multi-agency activities to safeguard children. Within this annum the Team were support by the Health Visiting Service in completion of audits and attendance at meetings. The learning from the Audits informs the Safeguarding team in day to day practice of providing advice, support and guidance within the Trust, informs training and supports multi agency response to the improvement of practice and highlighting good practice. The Safeguarding Children board produced audit summary flyers that were communicated within the Trust and accessible via the Safeguarding Children intranet page.

5.7.2 The Audit involved the auditing of 15 cases per quarter, a total of 60 throughout the year.

The 2017/18 Audit programme was:

- Quarter 1 - Focused upon the theme of 'Neglect'
- Quarter 2 - Review of previous cases
- Quarter 3 – Thresholds
- Quarter 4 Considered children with a disability

5.7.3 Summary of Quarter 1 'neglect' Audit

Areas of Good Practice:

- There was evidence of progress with families when children were subject of a Child Protection Plan.
- There was evidence of good multi-agency working in most of the cases.
- When action is taken and children are removed, this has a positive impact upon their lived experience with evidence of substantial improvements when they become looked after.

Key Learning Points:

- The audit process has once again shown the value of multi-agency auditing with the discussions highlighting the failure to share information that was not evident in the written records.
- There are a number of specific learning points with regard to;
- Child(ren) in Need; There is substantial evidence that when cases 'step down' to Child in Need' they are not being progressed in accordance with the Standards, with a lack of;

- Visits recorded on file
- Child in Need planning with; no Child in Need meetings, Child in Need plans not being completed or if completed not updated.
- Evidence of any progress with cases drifting until a further incident results in the case escalating
- Management oversight and supervision.
- A closure summary on cases and little evidence of the rationale for the decision, which is unhelpful if the case re-opens in the future as this is a good starting point when considering a new referral.

- Neglect;
- There is evidence that professionals are not recognising unacceptable living conditions with the police using their powers to remove children when there has been recent or current agency intervention.
- This audit suggests that Children's Services can take too long to intervene and remove children from circumstances and conditions that incrementally will impact upon their development – with an overoptimistic view of what parents can achieve. All agencies should be concerned when professionals have been involved in a family for a prolonged period of time.
    - A culture needs to develop where professionals can respectfully challenge one another.
    - The impact of a parent's mental health and domestic abuse upon children's development must be understood and fully considered.
    - Individual Agency's should communicate, particularly where there is evidence of non-engagement; superficial or disguised compliance.

5.7.4 Summary of Quarter 2 Audit – Review of previous Cases

The cases had previously been audited under the category of; either CSE; Early Help or Domestic Abuse as being the primary risk factor in the case.

Areas of Good Practice:

- Since the initial audit things had improved for most of the children and young people.
- There was evidence of good multi-agency working in most cases.
- As with the previous quarter audit, when action is taken and children are removed, this has a positive impact upon their lived experience with evidence of substantial improvements when they become looked after.
- Good evidence of the 'voice of the child' in most cases.

Key Learning Points:

- Lack of supervision and management oversight is again a significant factor.
- Recording - in terms of quality and timeliness continues to be an issue.
- Information shared by young people is not always acted upon in terms of 'intelligence sharing'
- Communication with placements is not always good enough
- This audit again suggests that Children services can take too long to intervene and remove children from circumstances and conditions that suggests a lack of understanding of the incremental impact of neglect and an overoptimistic view of what parents can achieve. All agencies should be concerned when professionals have been involved in a family for a prolonged period of time.
- A culture needs to develop where professionals can respectfully challenge one another.
- The DNA (was not brought) policy in respect of impact on the child requires more consideration
- Lack of understanding of the legality of a placement – specifically, the need to follow the Regulation relating to a Placement with a Parent.
- Ensuring that all appropriate agencies are invited to CP Conferences

5.7.5 Summary of Quarter 3 Audit of ' Thresholds'

This Audit was conducting in 3 parts, reviewing thresholds from various points in the safeguarding process – referrals in to MASH, when Threshold for child protection not met at Child protection conference, and when a child is deemed to no longer require a child protection plan.

Areas of Good Practice:

- There is some evidence of good inter agency working
- There is evidence that the CP Planning process has had a positive impact for some families.

Key Learning points

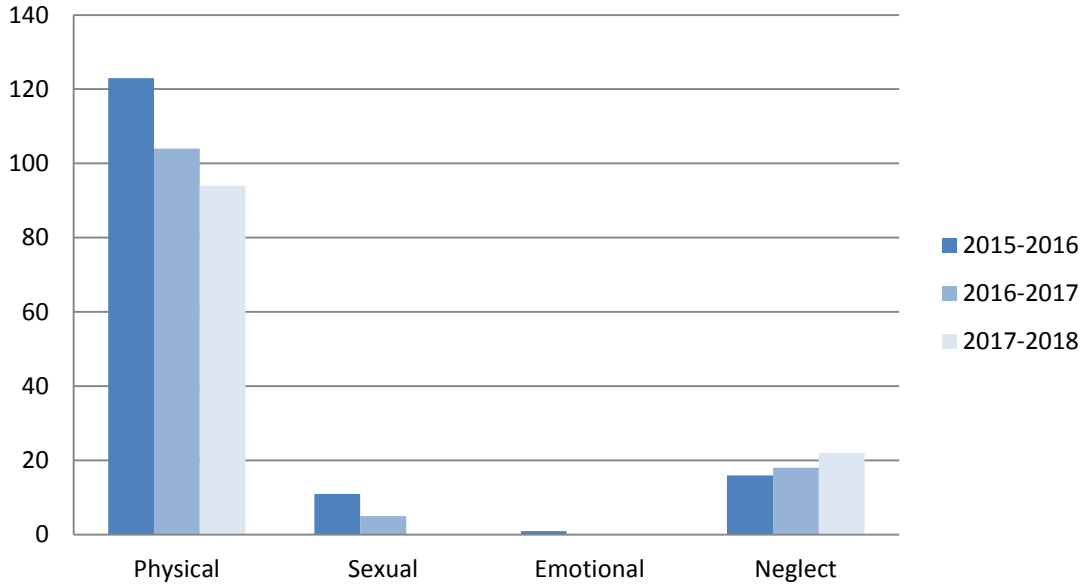
- Further emphasis on gaining the whole picture of a child's experience through assessment
- Plans need to be SMART and monitored closely to prevent drift but also to evidence improvements
- Adherence to Policy and process from all roles within the multi agencies
- Need for greater Supervision and managerial oversight

5.7.6 Summary of Quarter 4 Audit 'children with a disability'

- Overall, the auditors concluded that the service to children with disabilities was generally good and identified the following areas of good practice;
- There is evidence of some good work and in particular, there is evidence of a child's lived experience improving as a result of our intervention.
- There is evidence of good partnership working and positive relationships between professionals and families in some cases.
- One case evidenced an excellent Analytical Chronology that could be used as a case exemplar.
- One case evidenced really good post 18 support with the young man doing really well in a 'Shared Lives' placement.
- Evidence of stability in cases where there has been a long term social worker is improving outcomes for those children.
- Evidence in some cases of professionals talking to each other and working together

5.8 Child protection medicals

Month	Physical	Sexual	Emotional	Neglect	Total
Apr-17	7	0	0	2	9
May-17	13	0	0	0	13
Jun-17	6	0	0	0	6
Jul-17	5	0	0	3	8
Aug-17	9	0	0	7	16
Sep-17	8	0	0	0	8
Oct-17	7	0	0	0	7
Nov-17	7	0	0	3	10
Dec-17	13	0	0	0	13
Jan-18	14	0	0	7	21
Feb-18	2	0	0	0	2
Mar-18	3	0	0	3	6
Total	**94**	**0**	**0**	**22**	119



5.8.1 The Starfish Suite continues to be used for the majority of child protection medicals. The aim of the suite is that children with suspected child abuse or neglect who require medical assessment will receive an appropriate, comprehensive, accurate and timely assessment by a suitably qualified and experienced clinician in a family friendly setting. The West Midlands Paediatric Sexual Assault Service (PSAS) is referred to when there is suspicion of child sexual abuse; allowing a timely specialist response where concern is evident.

It is intended that every child:

- Sees an appropriately experienced doctor.
- Receives quality assessment and care.
- Is involved in all decisions, as appropriate to age and understanding.
- Has links to services for post trauma, therapeutic support.
- Receives a personalised service which is safe, effective, accessible, and culturally sensitive.

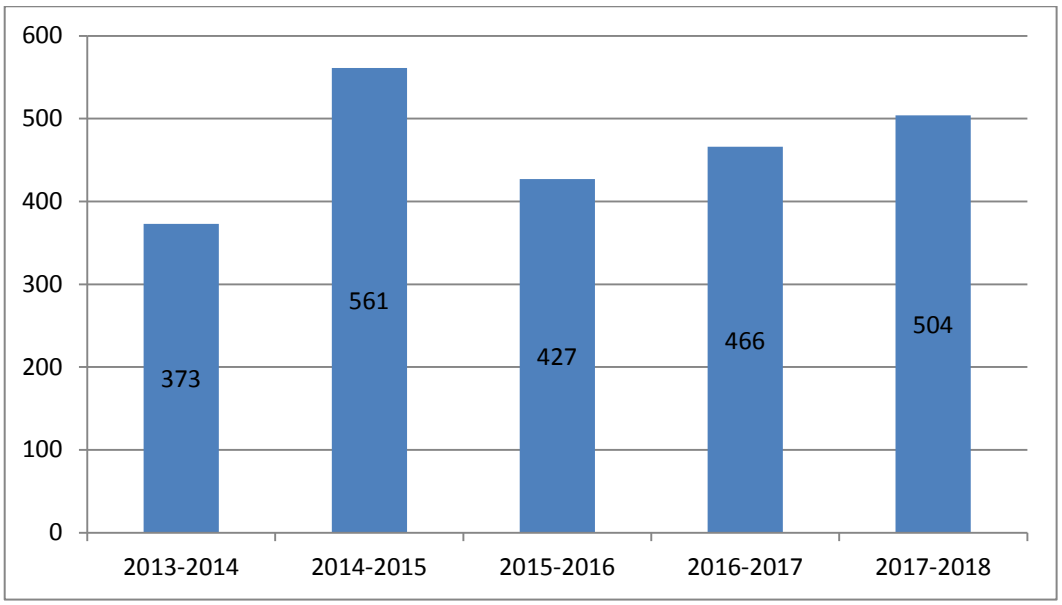
5.8.2 Figures demonstrate an overall reduction in medicals this year by a further 9% from last year. A notable reduction is evident in all but one of the categories of abuse; Neglect.

5.9 Safeguarding and Domestic Abuse

MARAC Data 2017 to 2018

The following data set relates to high risk incidents reviewed by MARAC; cases remain relatively consistent across Quarters with a 22% increase from Q1 to Q4. High risk cases continue to be discussed at the fortnightly Multi Agency Risk Assessment Conference (MARAC) meetings. A total of 504 cases were discussed during 2017-2018 which is an 8% increase from the previous year.

Domestic Abuse MARAC Data (2017-2018)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total no. of incidents discussed	118	104	137	145
Number of Children in Household (including unborn)	168	264	246	263
Victim aged 16-17 years	2	4	9	3
Male Victims	3	5	3	5

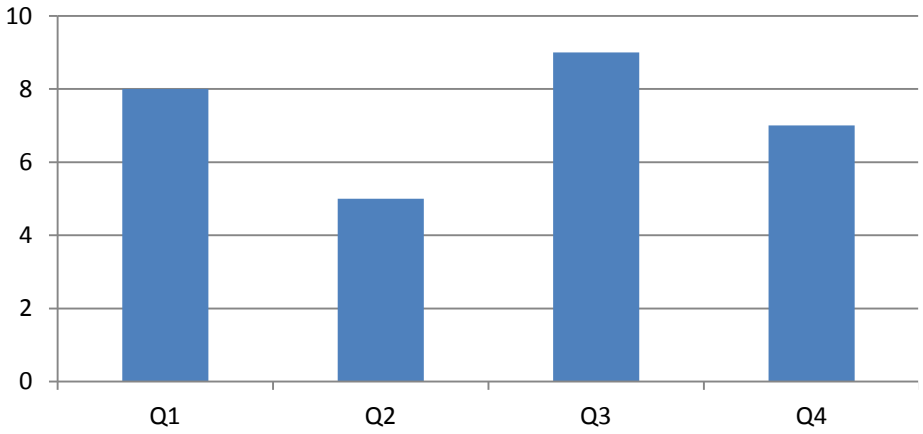


5.10 Female Genital Mutilation

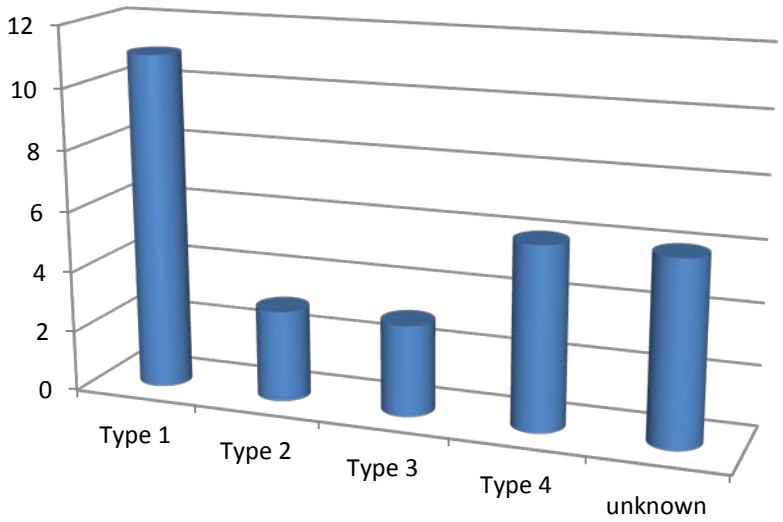
The Female Genital Mutilation (FGM) Enhanced Dataset supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England. The UK government is committed to preventing and ending Female Genital Mutilation (FGM) in the UK. It is illegal and is child abuse. It violates the rights of girls and women.

We support the Department of Health's FGM Prevention Programme by submitting data quarterly to the Clinical Audit Platform (CAP).

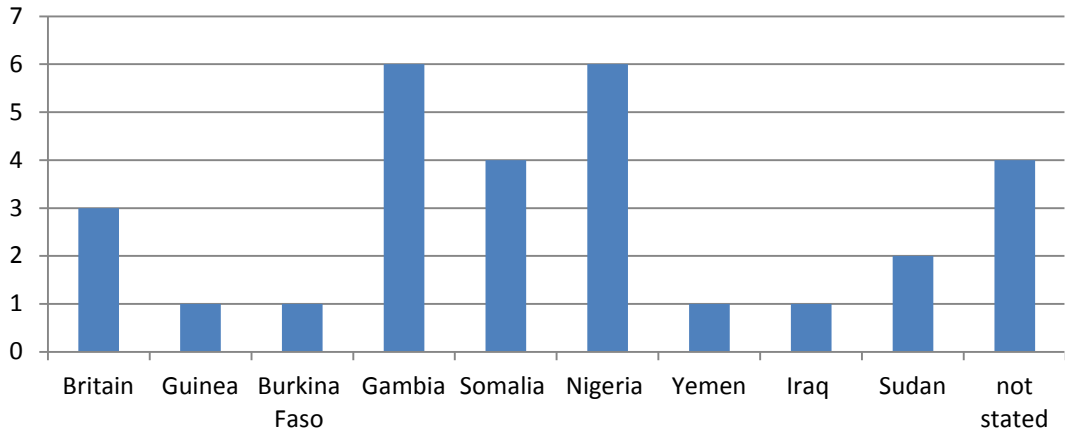
Number of Notification referrals for FGM within the Trust



Type of FGM



Country of origin



5.10.1 The mandatory reporting of FGM for under 18 years placed on individual practitioners, which began in October 2015, continues to be disseminated throughout the Trust via both the Children's and Adult Safeguarding Training programme at all levels. The Safeguarding team have continued to highlight this requirement in update sessions completed with A&E, Maternity and Paediatrics specifically, but other area of the Trust continue to receive communications from the Safeguarding team to promote compliance.

5.10.2 Information on FGM is also available on both the Child and Adult intranet page

Actions 2017-2018

- To ensure local and Clinical Audit Platform is maintained for each quarter by the Named Midwife Safeguarding Children
- Named Midwife to continue liaison with the FGM support group six monthly
- Monitor and manage the FGM alert system implemented on the acute electronic record
- FGM policy (2015) has been reviewed and updated to reflect national updates, ratification to be sort on the receipt of regional guidance particularly on the decision making to refer to children's services on the identification of FGM in an adult, in respect of an unborn Female and females within the family.
- E-learning for FGM continues to be accessible as a useful resource to assist with Level 3 RCPCH e-learning modules for Level 3 are accessible through ESR.

- Sessions are continually revised by the Named Nurses to ensure correct numbers of sessions are in place, additionally feedback reports are provided by the Learning and Development Centre.
- The Named Nurses will ensure that training continuously reflects National Guidance on FGM, and communicate updates accordingly.

6.0. Serious Case Review

6.1. During 2017 to 2018 there was two new serious case reviews initiated for Walsall; Walsall Healthcare Trust completed an Individual Management Review (IMR) for the first. The terms of reference are yet to be agreed for the second but has a timescale for completion within Q2 of 2018-2019. It is a similar case for these two as the latter one done in 2016-2017 in that the full report will not published until the conclusion of on-going criminal investigations. A Trust action plan was developed for the latter and will be for future ones on the identification of learning. Progress will be monitored through Safeguarding Committee and Local Safeguarding Childrens Board.

6.2. Walsall has seen a significant rise in the number of SCR being required in recent years, this has increased the amount of IMR requests for the Safeguarding Team to fulfil as timely as possible. The complexity of the work demands focus and high levels of analysis to support the SCR author in their review. Practically this has put further strain on the Safeguarding Team's work streams and assurance activity.

7. Child Death Overview Panel (CDOP)

7.1. Since 1st April 2008 all Local Safeguarding Children Board's (LSCBs) are required to review the deaths of all children in their area, as outlined in 'Working together to safeguard children' 2015.

7.2. The CDOP has continued to work in partnership across Walsall and Wolverhampton. The function is to establish procedures to ensure a co-ordinated response to all child deaths and to review all unexpected deaths.

7.3. A report will be made available in relation to CDOP for 2017-2018 accessible through Walsall Safeguarding Children Board.

7.4. It is anticipated that changes to the CDOP arrangements will be set out in revised statutory guidance to be published early 2018-2019

7.5. The Trust continues to have request from the CDOP to completed relevant paperwork for information sharing to support the panel in its decision making and reporting. The Trust also facilitate rapid response meeting as required, in co- coordinating with the Local Safeguarding Board.

8. Key Focus for Safeguarding Children Team 2017 to 2018 update

8.1 The following provides a status of the actions in relation to the Annual Report for 2015 to 2016. 'Amber' areas have been discussed further within the report.

Area of Intervention	Rationale	Status
Monitor the quality of referrals submitted to the Local Authority.	Quality assurance.	
Ensure that Safeguarding Training is effective in line with RCPCH guidance, updating as required. Monitoring and compliance of training figures.	To ensure training is fit for purpose, effective, up to date, in adherence with national guidance and attendance monitored.	
To ensure system of monitoring Safeguarding Supervision is effective, accurate and that interventions in non-compliance are timely.	To ensure staff receive Supervision in accordance with Walsall Healthcare Safeguarding Supervision policy	
To be a key part of the Walsall MASH, from within the MASH room	Multi--agency contribution to the MASH development; facilitating effective contribution and ensuring pathways in terms of health colleagues are developed and implemented. Trust representation within the MASH room will further enhance the screening process and decision making.	
To continually review policies and procedures; timely and demonstrating evidence based / national directive.	To provide robust policies to support the workforce.	

To continue to support the statement request process, monitoring the quality and adherence to timescale given. Continue to monitor the amount of request received	To ensure the courts have the requested information timely to support the decision making in respect of the protective actions required for a child. To ensure that capacity in the team is sufficient to the provision of advice support and guidance given by the safeguarding team	

9. Key Focus for Safeguarding Children Team 2018 to 2019

Area of Intervention	Rationale	Status
Action recommendations of the Trust Review and Refresh in respect of increasing capacity in the team via recruitment	Increased capacity to support the Team's ability to provide assurance the that Trust's safeguarding responsibilities are being met	
Action recommendations for the CQC safeguarding inspection Jan 2018 (report expected early 2018- 2019)	to ensure that children safeguarding within the Trust meets the expectations of the CQC in all areas	
To be a key part of the Walsall MASH, from within the MASH room	Multi--agency contribution to the MASH development; facilitating effective contribution and ensuring pathways in terms of health colleagues are developed and implemented. Trust representation within the MASH room will further enhance the screening process and decision making.	
To continue to monitor compliance to Supervision Increase compliance from that seen in 2017-2018	To ensure supervision and managerial oversight is available as per safeguarding supervision policy To ensure that	

Develop the competencies and confidence of new supervisors	Supervisors of safeguarding supervision are available to deliver good quality, effective supervision	
Continue to support the WSCB in the delivery of Multi – agency Training agenda, Particular focus on thresholds	to give Trust employee's the opportunity to gain enhanced training experience/ learning opportunities from a Multi-agency perspective	
CP – IS This is required to be live within the early part of 2018 – 2019 The local authority went Live in March 2017	CP- IS will support the identification of vulnerable children who attend Trust services by sharing information of child protection and Looked after children within England	
Monitor the quality of referrals submitted to the Local Authority.	Quality assurance.	
To continually review policies and procedures; timely and demonstrating evidence based / national directive.	To provide robust policies to support the workforce.	
Ensure that Safeguarding Training is effective in line with RCPCH guidance, updating as required. Monitoring and compliance of training figures. Action plan for increasing compliance of training from that seen in 2017-2018	To ensure training is fit for purpose, effective, up to date, in adherence with national guidance and attendance monitored. Increase in the compliance levels to support the Trust with meeting it's statutory safeguarding responsibilities	

MEETING OF THE TRUST BOARD – 1st November 2018			
Looked After Children Annual Report			**AGENDA ITEM: 12**
Report Author and Job Title:	Donna Smith – Named Nurse for Looked After Children Diane Rhoden – Senior Corporate Nurse	**Responsible Director:**	Dr Karen Dunderdale, Director of Nursing
Action Required	Approve ☒ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	Enclosed is the Looked After Children Report for 2017-2018 **Key points of the reports are:** • High levels of Looked after children remain 637 as March 2018 • 177 new children into looked after service in 2017 -18 resulted in difficulties reaching 80% performance • Deep dive into performance that does not reach 80% - included within the appendix of report • Challenges both in service and with School nursing service affecting Review Health Assessments • Continue to work with Local Authority and CCG to improve communication links resulting in more timely assessments. **Key priorities for 2018-19:** • Investment secured for recruitment. • To continue to work to support the Corporate Parenting Board Business including the Corporate Parenting Strategy to support the health of children who are looked after. • Attend the Health work stream as a key partner • To monitor the health needs of children placed out of borough and ensure that needs are addressed; ensuring attendance at the Complex Health Needs Monitoring Group. (CLAm) • To continue to develop the role of the Transition and Leaving Care Health Advisor to improve the engagement of care leavers. • To continue to develop and implement Health history passports for Care leavers • Implement post 18 health interviews • Work in partnership with Walsall Teenage Pregnancy team attending operational group • To continue to monitor GP information into Initial and Review Health Assessments.		

Recommendation	The Trust Board is requested to approve the report	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report."	
Resource implications	There are no resource implications associated with this report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☐	

Walsall Healthcare NHS
NHS Trust

Looked After Children Health Team

Annual Report

April 2017 – March 2018

Contents

Executive Summary

This is the Ninth Annual Report which focuses on the health needs of Looked After Children (LAC), produced in response to the Department of Health Statutory guidance on Promoting the health and well-being of Looked After Children (DCSF / DOH 2015) and the requirement to produce a report on the delivery of service and progress achieved for the health and well- being of children in care. This report is not inclusive of the CAMHS element pertaining to the health of Looked After Children.

The report covers the period of 1st April 2017 to 31st March 2018, providing an overview of the achievements and progress made during the year; describing progress made towards key performance indicators and highlighting some of the key challenges facing the service.

The period April 2017 to March 2018 has been a difficult but progressive period in terms of quality assurance and change for the Looked After Children Health Team. A review of process and procedure has seen a complete change in the functionality of the team within Walsall Healthcare Trust and by sustaining clear direction through effective leadership has allowed definitive improvements in the quality of training, health assessments, improved working and processes with Local Authority partners and improving timely assessment of children who are looked after.

One of the main challenges facing the service during the year has been a temporary reduction in staff levels due to sickness. A further pressure has been capacity issues within School Nursing services from September 2017 to March 2018 which has impacted on the ability to undertake Health Assessments within timescales. There has also been a decrease in Initial Health Assessments being completed within 28 days from entering care

In Walsall the number of Looked after Children for the period is

- March 2018 – 637 of these children 420 were placed within Walsall boundaries with 217 placed outside of the Walsall area.

1. Introduction

1.1 It is evident that Looked After Children and Young People often enter care with a worse level of health than their peers, in part due to poverty, abuse and neglect that they have experienced (DOH 2015). There appears to be greater long term challenges in relation the health, social and educational outcomes in comparison to the general population. Furthermore, there is a plethora of evidence to support the view that children and young people in care with unmet health needs are at risk of experiencing on-going poor health, educational and social issues when leaving care (DOH 2015). The purpose of the Looked After Children Health Team Annual Report is to provide a service overview and demonstrate progression in terms of service change and quality assurance. This report will be utilised as a service update for Walsall Healthcare Trust, Walsall Clinical Commissioning Group and Walsall Local Authority Corporate Parenting Board.

1.2 The report will summarise achievements and current challenges within the service, however will also identify recommendations which will enhance overall quality for Looked After Children. This report will see challenges of introducing service change to streamline process, implement mechanisms to enhance quality assurance and develop the service to be fit for purpose. Although a difficult year progress is evident.

2. National Policy and Legislation

Meeting the health needs of Walsall Looked After Children and Young People is directed by key policy and legislative frameworks which inform Local Authorities, Healthcare Trusts and Clinical Commissioning Groups demonstrating shared responsibility for good outcomes.

Statutory Guidance on Promoting the Health and Well-being of Looked after Children (DOH / DCSF 2015)
The Children and Young Person's Act (2008)
Who Pay's Establishing the Responsible Commissioner (DOH 2007 Updated September 2017)
The Care Standards Act (2015)
Children Act 1989
Children Act 2004
Healthy Child Programme (2009)
Quality Standard for the health and well-being of looked after children (NICE 2013)
Working Together to Safeguard Children (2015)
Intercollegiate Role Framework (RCPCH 2015)
Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (2015)
Children NSF Standard (2004)

Key Legislation

Children Act 1989
Human Rights Act (1998)
Data Protection Act (1998updated 2018)
United Nations Conventions on the rights of the child (1990)
Children Act (2004)

3. Looked After Children Health Service

3.1 The service has seen a temporary reduction in workforce in this year; due to this unforeseen event the team have implemented robust prioritisation of workload and management; with a focus on service delivery and process management to ensure progression for the forthcoming year. The small team which includes administrative support acts as an overarching service for quality service provision for Looked After Children and Young People. The team continue to work across boundaries dependent on individualised health needs and detailed care planning to ensure that health needs are met irrespective of where a children or young person is placed.

3.2 In addition to the provision of health assessments, the team provide:

- Expert advice regarding health needs and inequalities for looked after children
- Direct case management of children and young people with complex health, predominantly those in a residential care setting or those leaving care
- Bespoke health promotion in a range of settings
- Training to professionals in addition to foster carer training
- Delivery of care to children and young people placed in Walsall by other authorities
- GP Training
- Placement support for Student Health Visitors and Nurse's

3.3 The Looked after health team as of April 2018

Designation	WTE / Session
Designated Doctor	2 x 4 hrs adoption plus ad hoc as required
Consultant Community Paediatrician X 2	1 x 4 hr 2 times monthly (LAC sessions are provided by paediatricians ensuring that twenty 45 minute clinic slots are available per month)
Named Nurse for Looked After Children	1.0 WTE
Health Advisor for Transition and Leaving Care (TLC)	1.0 WTE

3.4 Main Team Base

Blakenall Village Centre is the predominant base; however links are evident, Corporate Parenting (Town-End House) and Safeguarding Children (Essington Lodge)

4. Funding of Service

The funding of the Looked after Children Team is within the Community Block Contract. Over the past few years the number of looked after children has risen by approximately 150 children, this has not been reflected in the Team that manages this service. Conversations with contracting have taken place with the outcome that the LAC service will be looked at as part of the wider project around the block contract. Concerns have been raised during the Review and Refresh of the Safeguarding and Looked after Children Review regarding the capacity of the Team to manage the service and the CQC raised concerns following their visit in January of 2018. A business case has been agreed and a further Band 6 secured, this post is currently moving through the recruitment process.

5. Numbers of Looked After children

5.1 The following data depicts the fluctuating numbers of Looked after children entering care specific to April 2017 – March 2018.

5.2 There were 637 Looked After children at 31st March 2018 compared to 645 March 2017, this figure fluctuated with a peak of 673 children Looked After in August 2017

Number of Looked After Children by age group:

2017-18

	Under 1 year	1 to 4 years	5 to 9 years	10 to 15 Years	16 to 17 years	Grand Total
Apr-17	43	120	146	234	92	635
May-17	42	113	148	237	96	636
Jun-17	46	106	147	238	97	634
Jul-17	41	109	150	244	101	645
Aug-17	50	112	155	253	103	673
Sep-17	53	105	155	253	101	667
Oct-17	50	110	152	258	95	665
Nov-17	49	105	150	260	96	660
Dec-17	41	112	149	259	95	655
Jan-18	40	113	153	258	86	650
Feb-18	41	109	146	253	88	637
Mar-18	41	114	144	245	93	637

5.3 The above table and chart demonstrates that the majority of children in the care of Walsall Local Authority continues to be within the 10 to 15 year age range; closely followed by the 5 to 9 age group, this data is consistent with figures reported in 2016-17.

Number of Looked After Children by Ethnicity:

At 31st March 2018

Ethnicity	March Number	Percentage
White (A1-A5)	459	72%
Mixed (B1-B4)	92	14.5%
Asian (C1-C4)	40	6.5%
Black (D1-D3)	33	5.0%
Other (E1-E2)	13	2.0%
Total	**637**	**100%**

5.4 The above figures continue to mirror local and National trend indicating that the majority of children under the care of Walsall Local authority are from a white ethnic background.

Number of Children Looked After Children by gender

2017-18

Month	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Male	338	338	338	344	357	352	352	349	345	339	331	329
Female	297	298	296	301	316	315	313	311	310	311	306	308
Total	635	636	634	645	673	667	665	660	655	650	637	637

5.5 Walsall continues to follow a similar profile to that outlined nationally with a higher proportion of males in care; this follows a similar profile to 2016 – 2017. The numbers of children entering care has been steady with a stable rate during the past two years

Children Looked After by Placement:

2017-18

In-House Provision	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Foster Carers	191	184	185	184	193	194	193	188	194	193	194	191
Residential	25	26	27	26	33	29	29	30	29	29	28	29
Friend or Relative	129	124	121	126	121	118	119	120	123	124	122	126
Placed for Adoption	32	33	27	29	29	24	23	21	22	19	16	16
Placed with Parents	52	49	47	43	55	55	60	61	61	66	61	57
Independent Living	3	4	2	2	0	0	0	0	0	0	0	0
Short Term Placements or Others	1	1	1	1	2	1	1	1	1	1	1	1
External Provision	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
IFA Foster Care	156	167	174	179	184	191	193	191	177	173	168	167
Residential	44	46	49	52	53	52	44	46	46	45	45	48
Remand	2	2	1	3	3	3	3	2	2	2	2	2

6. Key Performance Indicators

6.1 The revised Looked After Children Service Specification has remained unchanged from 2016

6.2 The Key Performance Indicators reflect quality assurance for children who are looked after.

Performance Indicator	***Indicator***	***Threshold***	***Method of Measurement***	***Frequency of Monitoring***
Support the reduction in rate of unplanned pregnancy of the under 18 looked after population	Offer sexual health advice to all looked after children aged 13yrs+	100% offer	TLC Advisor to provide quarterly data to performance	6 Monthly
Service-user experience of looked after healthcare	Offer minimum of annual service-user enquiry relating to the experience of healthcare	55% Return	Reports submitted to speciality quality team	Annual as minimum standard
Personalised Care Planning	Completion of initial health assessment within 28 days of a child becoming looked after	80%	Performance team to provide data	Quarterly, currently reported at Board level
	% of looked after children aged < 5yr with up to date statutory health assessment (every six months)	90% compliance by Health Visiting Service; monitored by LAC Health Service	Performance team to provide data	Quarterly – currently reported at Board level
	% of looked after children aged 5yrs - 16yrs with up to date statutory health assessment (Annually)	90% compliance by School Health Service; monitored by LAC Health Service	Performance team to provide data	Quarter currently reported at Board level
	% of looked after children aged	80% compliance	Performance team to	Quarterly - currently

	16yrs-18yrs with up to date statutory health assessments (Annually)	by School Health Service and LAC Health Service monitored by LAC Health Service	provide data	reported at Board level
	% of all review statutory health assessments returned to the LAC administrator for processing within a 6 week turnaround	90% compliance by School Health Service and Health Visiting Service	LAC team to provide	Quarterly - currently reported at Board level
	% CYP who are looked after have received a dental check (every six months)	80%	LAC team to provide	Annually
Training	All practitioners undertaking statutory review LAC Health Assessments are suitable trained	100% of health professionals have received training; delivered and monitored by the LAC service	Attendance monitored by LAC service	Two Yearly completion – updates provided by LAC service

6.3 The OC2 data updated for 2017-18 in collaboration with the Key performance indicators is detailed below, The data provided for children with up to date dental checks remains consistent with previous years recorded.

6.4 There is a reduction identified in the data for up to date Health Assessments. This is a direct impact due to 50% reduction within the immediate LAC health team, reduced support from School Health Team in borough and reduced capacity with out of area LAC health teams nationally;

6.5 The data also reflects an increase in refusals for uptake of health assessments in the Transition and Leaving Care age group. The TLC Health Advisor has had two significant periods of extended sickness absence hence this has impacted upon this particular age range of children.

Please note: Immunisation data is collated directly from Vaccination UK as of 2015

Table 5

OC2 Data	2012 -13	2013-14	2014-15	2015-16	2016-17	2017-18
Number of CYP looked after longer than 12 months	489*	395	454	498	493	502
Percentage of < 5yrs with up to date health assessment	92.7*%	83.1%	89.2%	87%	88.3%	88%
Percentage of CYP looked after with up to date immunisations	98%	93.4%	92.1%	X	X	X
Percentage of CYP looked after longer than 12 months dental check	92.7*%	89.4%	96%	97%	95%	91%
Percentage of CYP looked after longer than 12 months who have received a Health Assessment	92.7*%	96.2%	91.6%	93%	91%	89%
Percentage of CYP with a substance misuse problem	1.8%	1.3%	2.2%	1.2%	1.4%	1.8%
Percentage of CYP who have received a carer SDQ return	67*%	35.2%	98.8%	X	73%	81%

7. Progress to date

7.1 Initial Health Assessments

The LAC Health Team co-ordinate the Initial Health assessment clinics they are maintained at Base and operate five 45 minute clinic slots over a four week period equating to 20 available appointments per month, this is negotiable between the LAC health team and the community paediatricians dependent upon demand of the service

7.2 Timely notification from the Local Authority is essential as children and young people enter care or have a change of circumstances whilst in care such as placement change or reach the end of a care episode. The Looked After Children Health Team is reliant upon swift notification to ensure a smooth health transition for the child or young person. This has been an issue during this time period, there have been a number of staff changes within local authority including an amalgamation of the Local Authority Administration team which has ultimately lead to late notification and failure to follow process, The LAC Health Team have worked with Local Authority colleagues to review administrative processes and provided training to ensure that time scales are met.

7.3 More robust communication links have been established with Local Authority partners to ensure that health remains a key component of the Children's Services agenda.

7.4 April 2017 – March 2018 177 children entered care within Walsall.

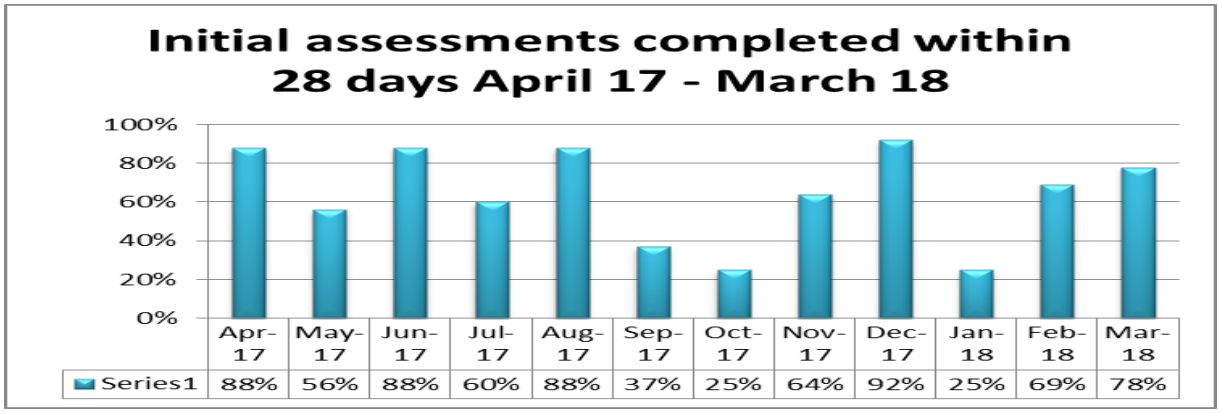
7.5 The following table demonstrates the numbers of initial health assessments conducted within 28 days of entering care during 2017 to 2018:

7.5.1 The overall figure's for Children entering care being seen within 28 day's fell to 33.3% achievement of the target for April 17 – March 18, Exception reports are provided to Walsall Healthcare Trust monthly when activity is below 80% and the exception report for the year is included as appendix 1

7.5.2 177 Initial Health assessments were offered 2017-18 3 young people refused and one Did Not Attend the appointment booked

7.5.3 It is noted during August 2017 there was an unprecedented number of children entering care, this had a direct impact upon the service, Community Paediatricians offered an extra 13 clinic slots to support with this particular cohort of children

7.5.4 Exception reports were submitted for year 2017-18 with detailed analysis regarding failure to meet the 80% target required for the team, this included external influences affecting service delivery including late/non notification/ paperwork from Local authority incurring a delay to the service



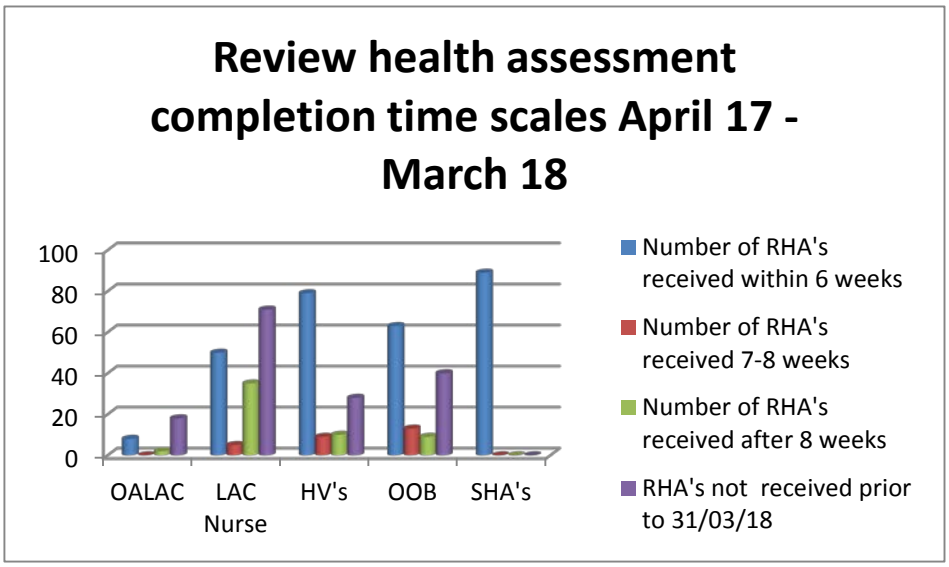
Exceptions 2017-2018

DNA	1
YP Refused to attend	2
Appointment Cancelled	4
Out of Borough delays	1
Delayed paperwork form LAC to initiate IHA	2
Delay due to child in hospital	2
Not informed by SW of child being accommodated	38
No clinic slots available within time scales	3
Seen in special school agreed with consultant	1
late arrival unable to appoint due to clinic capacity	1

8.0 Review Health Assessments

8.1 The past year has proved a challenge due to staff capacity, The LAC Team continue to liaise with operational and clinical leads within Health Visiting and School Nursing to ensure that looked after health assessments are prioritised, the volume of review health assessments requiring completion has led to difficulties in respect of timeliness of turnaround

The tables below demonstrate the direct impact of staff capacity issues both within the immediate team and externally.



8.2 Due to local service delivery a continued challenge remains evident in the service with regards to the timely completion and return of completed health assessments for looked after children placed out of borough, pending health assessments are monitored via the Safeguarding administrative team.

8.3 A number of LAC Teams within surrounding areas have had reduced capacity to undertake health assessments for Walsall Looked After Children placed in respective areas; Walsall LAC team have therefore used a proactive rather than reactive approach and have undertaken health assessments to avoid delays in addressing health needs of out of borough children. This is monitored to ensure that as capacity improves; health needs are assessed locally.

8.4 The training provided by the Looked After Children Health Team has been reviewed and refreshed to assist teams, Audits continue around the quality of health assessments; this will serve as a useful tool when making decisions around adjustment of training, administrative process change and reviewing the current Review health assessment paperwork in its current format.

8.6 March 2018 - 806 Initial/Review Health assessments requested 648 were Completed at the end of equating to 80% IHA/RHA returned.

9.0 GP Feedback

9.1 A request for health information from the individuals GP is requested immediately to support Initial Health assessments and is requested one month in advance of a Review Health assessment.

9.2 GP's both in/out of borough have provided health information timely for Review Health Assessments. It has been identified a delay can occur for receipt of information for Initial Health Assessments, a factor may be due to the LAC health team appointing children into Initial health assessments within a short timeframe noting three children were accommodated into IHA clinic within three days of entering care.

9.3 A success rate of 87% GP Health Information received in 2017-18 a reduction on 2016-17

9.4 GP's in borough have received Information sharing Training in partnership with CCG and LAC health, this continues on a two yearly basis

10. 0 Immunisations

Immunisations are completed via Vaccination UK and directly provide data to support the OC2 data – it is noted via GP feedback and vaccination summary's provided there has been an improvement of the uptake of school leaver boosters DTP and Men ACWY vaccinations, this may also be due to children requiring to remain in Education until 18 years of age, enabling the immunisation team access to engage with the young person.

11. Transition and Leaving Care (TLC)

11.1 A Transition and Leaving Care action plan is in place this has been reduced due to reduced capacity within the immediate LAC health team

11.2 Key area of focus from April 2017 – March 18 has been:

- Notable increase in declines of health assessments of leaving care age group
- Teenage pregnancy
- Health history promotion and uptake

11.3 Due to long term sickness absence of the Health Advisor for TLC a Band three Health Support Worker has supported for ten hours per week from October 2017. The main focus of this work has been promotion and distribution of Health History Passports and support for LAC/TLC young people pregnant or parents. This work has seen a 78% uptake of Health History Passports completed for Cohort April 2017 – March 2018.

11.4 Key area for Focus 2018 -2019 will be:

- Redesign and implementation of post 18 health interviews
- Ongoing Health History passport distribution
- Sexual health advice and guidance
- Robust links to the social work teams and personal advisors working in partnership with the TLC health advisor
- Supporting children placed out of Borough
- Supporting with registering with GP, Optician and Dentist

12. Training

12.1 Training continues to form a major component of the role for named professionals within the service and includes specific programmes with health professionals, social workers and foster carers. The service has worked in collaboration with the CCG, Local Authority and Public Health

12.2 Foster carer training is completed Bi annually with sessions completed September 2017 and February 2018,The LAC team have provided training regarding child development, Emotional Health and Attachment and Relationships Sexual health

12.3 The LAC team has completed annual training sessions for Student social workers in partnership with Teenage Pregnancy team and Local Authority September 17 and March 18

12.4 83% of health professionals are currently up to date with Looked After Children Health training. (RCPCH intercollegiate LAC guidance 2015) The team continue to support Health professionals with bespoke training as identified following Quality Assurance of assessments

12.4 The LAC team attend Group team meetings on a quarterly basis at the request of Local Authority group managers, delivering training regarding current LAC health processes.

12.5 The service has previously provided a two week Safeguarding and Looked After children programme of experience for 3rd year student nurses from the University of Wolverhampton however due to capacity

within the immediate team the team made the decision to halt the current offer until we can provide an enhanced programme of learning.

13.0 Continued work plan

13.1 The Named Nurse for looked after children continues to attend the Children Looked After Monitoring group (CLAm) which is chaired by the Designated Nurse for Safeguarding/Looked After children in the CCG. Members including CAMHs, Education and Local Authority Commissioners, the group reviews complex cases regarding out of borough placement provision, commissioning and health needs. This will continue 2018-2019

13.2 The LAC team continues to engage within the Corporate Parenting board Health Strategy Work stream, themes include Strength and Difficulties Questionnaire (SDQ) completion and monitoring, Health History Passport uptake, Teenage Pregnancy and reduction of Refusals for Review Health Assessments post 16 years old.

13.3 The Named Nurse for LAC regularly attends the CMOG (Children at Risk of CSE and Missing Operational Group) along with a Named Nurse for Safeguarding Children. This continues to prove to be a vital portal for shared information between partner agencies, identifying groups of at risk individuals.

Key Audits 2017 -18

- Quality assurance of Initial/review health assessments
- GP request for information sharing
- Quality of SDQ;s provided to support RHA’s
- Distribution of health History passports

In addition the Health team support with multiagency audits led by local authority themes include

- CSE
- Neglect
- Child’s voice

Key Areas of Focus 2018-19

To continue to work to support the Corporate Parenting Board Business including the Corporate Parenting Strategy to support the health of children who are looked after. Attending the Health work stream as a key partner	To continue to meet the health needs of looked after children; engaging in work to improve outcomes.	
To monitor the health needs of children placed out of borough and ensure that needs are addressed; ensuring attendance at the Complex Health Needs Monitoring Group. (CLAm)	To ensure that good communication between CAMHS and the Looked After Health Team to ensure positive outcomes for children.	
To continue to develop the role of the Transition and Leaving Care Health Advisor to improve the engagement of care leavers.	Improve accessibility to health care and timely intervention when health needs are evident.	
To continue to develop and implement Health history passports for Care leavers	To offer basic health information for the care leaver and promote independence in managing own health needs	
Implement post 18 health interviews	To engage, identify and support the care leaver to access health	
Work in partnership with Walsall Teenage Pregnancy team attending operational group	To ensure pregnant LAC/TLC or young parents are supported to access health/education	
To continue to monitor GP information into Initial and Review Health Assessments.	Allow comprehensive health plans to be formulated which include GP information.	

Looked After Children – Initial Health Assessment exceptions 2017-2018			
PLEASE BE ADVISED THE END OF YEAR TARGET OF 80% WILL NOT BE ACHIEVED FOR 2017-18 THE END OF YEAR RESULT FOR IHA COMPLETION WITHIN 28 DAY'S OF ENTERING CARE 33.33%			
Month	**Performance target**	**Performance Results**	**Reasons not seen within 28 days**
April	88.2%	Target hit	
May	54.55%	Of the 11 assessments completed in May, 6 were recorded as seen within 28 days of entering care and 5 assessments were not done within timescales.	• One child was not seen due to admission to Hospital (Neo-Natal Unit) from birth. Initial health assessment booked into next available clinic on discharge and seen on the 25/05/17. • One young person was accommodated by Local authority 13/03/17. We were not notified, the paperwork was received from the allocated social worker 04/04/17 which was 22 days after entering care. The next available clinic was on the 10/05/17 which he arrived too late for and was turned away as the doctor was in with the next patient. He was then re-booked for the next available clinic and seen on the 24/05/17. • One child was accommodated 07/04/17 and we were notified 18 days later 25/04/2017, child was then booked into next available clinic and seen on the 10/05/17. • One child was accommodated 03/04/17 and we were notified 7 days later 10/04/17, the paperwork was received from the social worker 18/04/17 and booked into the next available clinic and seen on the 10/05/2017. • One young person was accommodated 07/04/17 we were not notified until 25/04/17 paperwork was not received from the social worker until 11/05/17 which was already out of the 28 day target. They were seen on the 24/05/17.
June	88%	Target hit	
July	60%	Of the 15 assessments completed in July, 9 were recorded as seen within 28 days of entering care and 6 assessments were not completed within timescales.	• One child has complex health needs – it was agreed with the allocated social worker in the best interests of the child , the LAC health team would liaise with the community paediatrician allocated to the child's school who would complete the paperwork as a "one off" instance , child was seen 56 days after entering care. • One child was booked into clinic within 26 days of entering care. The child attended IHA 1.5 hours late and due to having a full clinic that day, the Paediatrician was unable to see the child and was rebooked and seen within 54 days of entering care. • One Child – 962A paperwork not received from allocated Social Worker until day 34 of entering care, child was booked into clinic day 38 of entering care and did not attend. The child was seen for IHA 59 day's from entering care. • One child was not seen due to non-receipt of paperwork from allocated social worker until day 50 of entering care. Was seen in next available clinic day 69 from entering care. • Two children booked within timescale 21 days entering care. Both refused to attend appointment – to be re booked within next available clinic which will be out of timescales.

August	88%	Target hit	
Sept	36.66%	This was an expected outcome following an unprecedented amount of children becoming Looked After within the month of August. To compare there is a 100% increase within the cohort compared to August 16. Of the 30 children seen in Initial Health assessment clinic 11 children were seen within timescales 19 were not seen within timescales.	• One child entered care 23/05/17 no notification received from local authority – child"s name entered on an admission list 10/07/17 which was 49 days from entering care. The LAC health team requested the Wss962A and consent form repeatedly from LA which was received 15/08/17 (day 67) child was booked into the next available clinic 13/09/17 114 days after entering care • One child entered care 11/07/17 no notification received from local authority until 29/08/17 via admissions list day 50 of entering care Wss962 A and consent form received day 53 child seen 22/09/17 – 74 days from entering care. • One Child entered care 28/07/17 no notification received until 29/08/17 day 33 received Wss962A and consent 06/09/17 41 days in care child seen 57 day's in care 22/09/17 • Three children entered care 24/07/17 not notification received from local authority until 29/08/17 via admissions list 37 days of entering care Wss962A and Consent form received 01/09/17 day 40 children booked into the next available clinic 22/09/17 61 days entering care. • Three Children entered care 04/08/17 no notification received from LA – children have not appeared on an admission list children were booked into next available clinic 06/09/17 34 days entering care • One child entered care 04/08/17 – no available clinic slot until 13/09/17 Day 38 entering care • One child entered care 04/08/17 – team notified 30/08/17 26 days in care seen in clinic 13/09/17 38 days in care • One child entered care 01/08/17 team was notified 29/08/17 28 days entering care, seen in clinic 13/09/17 43 days in care • Five children were accommodated 01/08/17 team was notified 07/08/17 delay incurred due to large sibling group in one placement, no clinic slots available in August children seen 20/09/17 51 days in care • Two children entered care 09/08/17 not notification received from LA consent and 962A form received 21/08/17 no available clinic slots, children seen in next available clinic 50 days in care 27/09/17.
Oct	25% * Decrease of 11.66% from previous month.	Please see as advised within the Exception report submitted for September the LAC Health team :- **AS A DIRECT IMPACT OF THE CURRENT COHORT POTENTIALLY THE TEAM WILL NOT ACHIEVE 80% + OCTOBER 2017** The team expected a decrease due to the 100% increased Cohort entering care in August – which has ultimately impacted upon the September and October Initial Health Clinics	• One child entered care 31/07/17, no notification was received from LA Wss962A & consent from was received 25/08/17 (26 days of entering care). The child was booked for an adoption/ IHA medical however the allocated social worker did not produce the documentation required for the medical to be completed at this point. The child was seen in IHA clinic 04/10/17 66 days after entering care. • One child entered care 24/07/17, no notification received until 14/09/17. The child was seen 11/10/17 80 days in care. • Two children entered care 17/08/17 – no notification received until 04/09/17. Children were then removed from extended family and booked into IHA clinic 27/09/17. This was cancelled at Carer's request due to a private appointment. Children seen 18/10/17 – 61 days after entering care. • One child entered care 07/08/17 – no notification from LA until 22/09/17 47 days from entering care. Child was booked into next available clinic slot 11/10/17. The child was seen 66 day's from entering care • Three children entered care 05/09/17. Seen 04/10/17 30 day's from entering care, although an extra 13 clinic slots were made available to LAC health in September, the team were unable to accommodate the children within the IHA clinic due to the unprecedented amount of children entering care in August.

		Of the 12 children seen in Initial Health assessment clinic 3 children were seen within timescales 9 were not seen within timescales.	• One child entered care 19/09/17 – seen 18/10/17 30 day's from entering care. The team were unable to accommodate prior to this date due to no capacity within the LAC IHA clinic- **As Above.**
Nov	64% * Increase of 39% from previous month.	Of the 14 children seen in Initial Health assessment clinic 9 children were seen within timescales 5 were not seen within timescales. * Of the five children. Three could have potentially been seen in timescale the overall percentage would have been 86%	• One child was booked into clinic 03/11/17 within timescale, however this was cancelled twice due to Carer having a hospital appointment and surgery. The child was seen day 58 of entering care. • Two children booked into clinic within timescale . Carer cancelled due to mechanical issues with transport. Both children booked into next available clinic slot. • One child entered care in 23/03/2016 and was sectioned at this point. It was agreed it was inappropriate to complete an assessment at this time. IHA was completed 28/11/17. • One child entered care 28/09/17 Wss962A and consent form was not received until 24/10/17. Child was booked into next available clinic slot 08/11/17 34 days after entering care.
Dec	92%	Target hit	
Jan	25% * Decrease of 67% from previous month.	Of the 8 children seen in Initial Health assessment clinic 2 children were seen within timescales 6 were not seen within timescales. * Of the six children. Four could have potentially been seen in timescale the overall percentage would have been 75%	• One child seen day 38 of entering care - seen out of the area in Coventry. • One child offered appointment within time scales 03/01/18 but had to attend court. Booked into next available clinic slot. Seen on day 43. • One child entered care 23/11/17. We were not notified until the WSS962A was received 08/12/17 and was then booked into next available clinic slot 03/01/18 on day 41. • One child entered care 28/11/17. The paperwork was received 15/12/17 and booked into next available clinic slot 03/01/18 and seen on day 36. • One child entered care 23/12/17. We were not notified until WSS962A was received 10/01/18 and was booked into next available clinic slot 24/01/18 and seen on day 32. • One child entered care 12/12/17 we were not notified until the WSS962A was received 09/01/18 and was booked into next available clinic slot 10/01/18 and seen on day 29.
Feb	69% * Increase of 44% from previous month.	Of the 13 children seen in Initial Health assessment clinic 9 children were seen within timescales 4 were not seen within timescales. * Of the four children not seen, one child could have been accommodated within timescales due to receiving	• O ne child entered care 15.12.17 – not notification received from LA until 10.01.18. Child not added to admission list from LA (27 days from entering care). Booked into next available clinic slot 28/02/18. • T wo children entered care 18.12.17 - no notification from LA until 10.01.18 (25 days from entering care). Children not added to admission list from LA. Booked into next available clinic 07.02.18. • O

		notification 7 days from entering care the delay in receiving paperwork from the allocated social worker delayed the process further.	ne child entered care 08.01.18 notification received timely (15.01.18) , however following numerous requests the paperwork was not received until 06.02.18 (30 day's entering care) . Booked into next available clinic 28.02.18.
March	78% * Increase of 17% from previous month.	Of the 9 children seen in Initial Health assessment clinics 7children were seen within timescales 2 were not seen within timescales.	• One child entered care 19.02.18 booked into IHA Clinic 07.03.18 - 16 days of entering care. Child DNA' d appointment and was seen 21.03.18 (30 days from entering care). • One child entered care 12.02.18 notified by LA 20.02.18 no address or contact details provided at this point, did not receive 962A and Consent form until 28.02.18. Child was booked into the next available clinic 14.03.18 (29 days entering care). Staff at residential setting were not able to accommodate this date – child was seen 21.03.18 (36 days entering care).

MEETING OF THE PEOPLE & OD COMMITTEE – 15 OCTOBER 2018			
Quarterly Guardian of safe working hours report			**AGENDA ITEM: 14**
Report Author and Job Title:	Dr Riaz Bavakunji Guardian of Safe Working	**Responsible Director:**	Matthew Lewis – Medical Director
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☒		
Executive Summary	The report covers the following elements: • Introduction and context in respect of the role of Guardian of Safe Working • New Junior Doctor Contract and its implications • Guardians quarterly report • Progress & Concerns		
Recommendation	The Committee is asked to note the actions taken by the Trust and its appointed guardian of safe working.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline			
Resource implications	There are no resource implications associated with this report."		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

Guardian of Safe Working Report April 2018

1. Introduction and background

This paper sets outs the background and context around the introduction of the Guardian of Safe Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust.

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours, during negotiations on the junior doctor contract agreement was reached on the introduction of a 'guardian of safe working hours' in organizations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors. The Guardian role was introduced with the responsibility of ensuring doctors are properly paid for all their work and by making sure doctors aren't working unsafe hours.

The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

The Guardian will:

- Champion safe working hours.
- Oversee safety related exception reports and monitor compliance.
- Escalate issues for action where not addressed locally.
- Require work schedule reviews to be undertaken where necessary

- Intervene to mitigate safety risks.
- Intervene where issues are not being resolved satisfactorily.
- Distribute monies received as a result of fines for safety breaches.
- Give assurance to the Committee that doctors are rostered and working safe hours.
- Identify to the Committee any areas where there are current difficulties maintaining safe working hours.
- Outline to the Committee any plans already in place to address these.
- Highlight to the Committee any areas of persistent concern which may require a wider, system solution.

The Committee will receive a quarterly report from the Guardian, which will include:

- Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade.
- Details of fines levied against departments with safety issues.
- Data on rota gaps / staff vacancies/ locum usage
- A qualitative narrative highlighting areas of good practice and / or persistent concern.

Other new features of the 2016 contract include which are discussed in detail in previous reports:

1. Work Scheduling 2. Exception reporting 3. Requirement for junior .doctor forums to be set up

2. *Guardian of Safe Working Report*

High level data

Current number of doctors / dentists in training on 2016 TCS (18th August 2017)	145	
Lead Employer Trainees	19 posts 16 filled	
LTFT trainees on new contract	13 trainees	

Engagement

Engagement with the junior doctor workforce has been excellent in spite of majority of them associating the guardian role as the person implementing the new contract, to which many are still opposed and refused to put in exception due to fear of being disciplined. This posed a particular challenge some of them were alluding to the fate of whistle blowers in UK and comparing this to a similar process.

CQC and number of reports: A brief verbal report from Guardian was presented to CQC at Consultant focus group at the CQC visit. CQC panel were very appreciative of Walsall creating an open culture which led to over 100 reports. This, then lead to several Listening into action meetings for juniors which was first of its kind in the country. Ongoing support from MD/Chief exec was mentioned at this meeting.

Since previous report the Guardian has adopted the following strategies to resolve issues as well as engage junior doctors.

- Attended Induction to introduce role of the guardian, to promote exception reporting for patient safety and workload issues and explained general rules of reporting and engagement with the process.
- Maintaining regular contacts with key individuals and communicating progress and actions taken
- Regular communication to Educational supervisors/junior doctors face to face and through emails
- Using Trust HR and MLCC to advertise important information to junior doctors via email
- Meeting ESs separately for training and supporting extensively with decision making and solutions
- Met with Elderly care juniors and senior team members

Director of Medical Education (DME) and Guardian worked in collaboration with each other to provide all the relevant information to supervisors across the trust, explaining changes to their roles and responsibilities.

Allocate and Rota software systems

Trust has purchased the new Allocate system for exception reporting, appraisals, rota management. Current excel sheet rota will be phased out soon and go on to health roster and medic online for leave management.

No issues raised by trainees regarding leave management etc. directly to Guardian. This is managed by medical staffing and designated senior at Ward level.

Workload

The implementation of the new junior doctor contract represents a substantial programme of work. In order to manage the workload effectively and efficiently, close working arrangements between Payroll, the Medical Directors' Office and the HR Director will continue in order to support the following key activities:

- Providing expert and timely advice to all junior doctors affected by the implementation;
- Providing training to rota co-ordinators and educational supervisors;
- Reviewing rotas and testing against the 2016 contractual limits on working hours and rest;
- Preparing work schedules to issue to junior doctors prior to transition;
- Ensuring basic pay and other allowances are amended by Payroll;
- Issuing new contracts of employment that reflect the 2016 terms and conditions of service;
- Providing support to the Guardian of Safe Working Hours;
- Managing exception reports received.

Junior Doctors Forum – A requirement of the new contract

JDF with new trainees has formed and had 5 meeting since implementation of new contract.

Dr James Haddock was the first rep followed Dr Al Sukhaini who also has left the trust. The new JDF lead will be proposed by the junior doctors in coming few weeks.

When active again the members will be and should be attended by

1. Director of Medical Education
2. MD
3. JLNC Member
4. JD mess president
5. Junior Reps from various departments.
6. HR representative

Issues related to contract, payment, allocate software, exception reporting, rota gaps, terms of reference and membership will be once again be on agenda. We have agreed previously to meet every 3 – 4 months.

Admin support to organise these meetings will be Guardians admin to ensure smooth running of this mandatory process.

Exception Reports and Fines.

The whole point of the exception reporting system is to allow employers to address issues and concerns as they arise, in real time, and to keep doctors' working hours, both rostered and actual, within safe working limits. If the system of work scheduling and exception reporting is working correctly, in anything other than truly exceptional circumstances, the levying of a fine indicates that the system has failed or that someone – the supervisor, Guardian or the individual doctor concerned – has failed to discharge his or her responsibilities appropriately. Any levying of a fine should therefore be followed by an investigation in to why it was necessary and remedial action to ensure that it does not happen again. The most important thing to remember is that fines should rarely, if ever be applied at all.

From 7th September to 30th April 39 exception episodes from 12 doctors.

- All reports until 30th April are given TOIL or closed with satisfactory outcomes.
- A&E exceptions were not reported which led to a fine and payment.
- There are no genuine immediate patient safety concern which was intervened in all cases by GoSWH

Exception frequency: The number of exceptions have reduced especially from AMU. When TOIL is given it impacts other juniors who are not yet able to report. In some cases, it is same person from same ward given multiple TOILs. We identified a trainee in difficulty from these exceptions in the last report.

The new contract contains safeguards to protect the safety of our junior doctors and patients and ensures doctors are accessing the required education. In the event of a junior doctor submitting an exception report, this must be reviewed by the appropriate supervisor and the actions agreed to prevent it re-occurring. The priority must always be to give the doctor time back in lieu to ensure safety is not breached, therefore payment for additional hours worked should always be discussed and agreed with the appropriate budget holder and should be the exception rather than the rule.

Submitted	Doctor	No. epis	ISC	Rota	Tier	Type
19 Apr 2018 23:25	1	1		Surgery FY1 1:13 F Shift	FY1	Service Support
22 Mar 2018 22:05	1	1		Gen Surgery	Junior trainee	Hours
13 Feb 2018 22:19	2	1	yes	Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Service Support
14 Sep 2017 21:24	2	1		Surgery FY1 1:13 FShift (Dec16) new contract	FY1	Service Support
21 Sep 2017 09:45	3	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
15 Mar 2018 18:04	4	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
31 Oct 2017 11:29	5	5		Surgery FY1 1:13 FShift (Dec16) new contract	FY1	Hours
22 Dec 2017 18:39	6	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
12 Mar 2018 16:08	7	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
21 Sep 2017 09:59	7	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
16 Aug 2017 11:25	8	2		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
18 Aug 2017 19:57	9	1		Gen Surgery Junior 1:8 FS Aug 2017 (NC)	Junior trainee	Hours
24 Apr 2018 07:22	10	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Service Support
12 Apr 2018 18:11	10	1		Mmed MG 1:13 RMO1 all/PART RMO2	Senior trainee	Hours
08 Feb 2018 11:52	10	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
07 Mar 2018 09:33	11	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
28 Feb 2018 18:07	11	1		Surgery FY1 1:13 FShift (Dec16) new contract	FY1	Hours
28 Feb 2018 15:22	11	1	yes	Surgery FY1 1:13 FShift (Dec16) new contract	FY1	Pattern
28 Feb 2018 15:17	11	1	yes	Surgery FY1 1:13 FShift (Dec16) new contract	FY1	Pattern
22 Dec 2017 18:39	11	7		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
19 Dec 2017 18:51	11	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
19 Dec 2017 18:46	11	4		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
19 Dec 2017 18:38	11	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Hours
19 Dec 2017 18:36	11	1		Medicine FY1 1:18 Full shift (Dec16) new contract	FY1	Service Support
16 Apr 2018 22:08	12	1		Gen Surgery Junior 1:8 FS Aug 2017 (NC)	Junior trainee	Hours
	Total	39		Exceptions		

Department	No. episodes	Actions entered by CS/ES/Trainee	Solutions put in place
Cardiology	1	0	Escalated to CD
EC	15	0	Commenced HOT week system
Urology	5	0	Reorganization discussions in progress
Gastro	11	0	TOIL + Fines
Gen Surg	2	0	TOIL recommended
Medical On call	5	0	Escalated to CD/MD to be discussed at Committee
	39	0	

Exception reports (response time)
Due to the nature of pre-population of data and limitations of software, Allocate. It is has been impossible to get this data accurately. I can assure the trust that 90% reports led to meeting with trainee within recommended times. All Immediate Safety concerns actioned within 24 hours. Nationally this has been raised to the software company at Guardians Meeting at London regarding limitations of the software.

Work Schedule reviews

O&G work schedule done and adjusted in salary for middle grade.

TOIL report / Fines and work schedule review/ Rota

A&E Rota and fines details below

Grade	Total Hours		Cost per Shift Enhanced Rate	4 x enhanced Rate	Total Hours	Rate (1.5 enhanced rate)	Pay to Doctor
F2	30	24.7	£741.00	£2,964.00	30	37.05	£1,111.50
GPVTS	20	29.22	£584.40	£2,337.60	20	43.83	£876.60
GPVTS	20	29.22	£584.40	£2,337.60	20	43.83	£876.60
GPVTS	20	29.22	£584.40	£2,337.60	20	43.83	£876.60
F2	20	24.7	£494.00	£1,976.00	20	37.05	£741.00
F2	20	24.7	£494.00	£1,976.00	20	37.05	£741.00
					130.00		£5,223.30
Grade	Total Hours	Rate	Cost per Shift	4 x Rate	Total Hours	Rate (1.5 basic rate)	Pay to Doctor
F2	30	18.03	£540.90	£2,163.60	30	27.03	£810.90
GPVTS	20	21.34	£426.80	£1,707.20	20	32.01	£640.20
GPVTS	20	21.34	£426.80	£1,707.20	20	32.01	£640.20
GPVTS	20	21.34	£426.80	£1,707.20	20	32.01	£640.20
F2	20	18.03	£360.60	£1,442.40	20	27.03	£540.60
F2	20	18.03	£360.60	£1,442.40	20	27.03	£540.60
					130		£3,812.70
F1	2	17.48	£34.96	£139.84	2	26.22	£52.44
							£3,865.14

IMMEDIATE SAFETY CONCERNS

Several reported but on investigation none of them were real ISC as support was available.

Vacancy report / Rota Gaps

	Vacancies by month (Deanery training posts)						
Specialty	Grade	Dec 17	Jan 18	Feb 18	March 18	Total gaps (average)	Number of shifts uncovered
A&E	F1	0	0	0	0	0	0
A&E	F2	0	0	0	0	0	0
A&E	ST1/2	2	2	2	3	2.25	9
A&E	ST3/6	2	2	2	3	2.25	9
Anaesthetics	F1	0	0	0	0	0	0
Anaesthetics	F2	0	0	0	0	0	0
Anaesthetics	ST1/2	3	3	3	3	3	12
Anaesthetics	ST3/6	1	1	1	2	1.25	5
Medicine (Includes Psych)	F1	0	0	0	0	0	0
Medicine	F2	0	0	0	0	0	0
Medicine	ST1/2	3	3	2	3	2.75	11
Medicine	ST3/6	0	0	0	1	0.25	1
Obs &Gynae (Including GUM & Radiology)	F1	0	0	0	0	0	0
Obs &Gynae (Including GUM & Radiology)	F2	0	0	0	0	0	0
Obs &Gynae (Including GUM & Radiology)	ST1/2	0	0	0	0	0	0
Obs &Gynae (Including GUM & Radiology)	ST3/6	1	1	1	1	1	4
Paeds	F1	0	0	0	0	0	0
Paeds	F2	0	0	0	0	0	0
Paeds	ST1/2	0	0	0	1	0.25	1
Paeds	ST3/6	0	0	0	0	0	0
T&O	F1	0	0	0	0	0	0

T&O	F2	0	0	0	0	0	0
T&O	ST1/2	1	1	1	1	1	4
T&O	ST3/6	1	1	1	3	1.5	6
Surgery (Includes ENT & Urology)	F1	0	0	0	0	0	0
Surgery (Includes ENT & Urology)	F2	0	0	0	0	0	0
Surgery (Includes ENT & Urology)	ST1/2	0	0	0	1	0.25	1
Surgery (Includes ENT & Urology)	ST3/6	1	1	1	1	1	4
Total		15	15	14	23	16.75	67

Agency Locum

Locum bookings (agency) by department at 10.06.17				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
A&E	120	120	1095.5	1095.5
Gen Medicine	36	36	342.50	342.50
General Surgery	18	18	221	221
O&G	43	43	517	517
Paediatrics	36	36	398	398
T&O	12	12	150.50	150.50
Total	265	265	2724.5	2724.5

Where possible, staff are re-organized and moved around to reduce the requirement for paid locum shifts.

Normal working days are left uncovered and request are made for any Out of Hours shifts

Locum bookings

Locum bookings (bank) by department to					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
A&E	124	4	120	34.5	34.5
Acute Medicine	12	12	0	90.5	90.5
General Medicine	150	114	36	870.80	870.80
General Surgery	35	17	18	176	176
Obs & Gynae	69	26	43	228.50	228.50
Paediatrics	51	15	36	118	118
Trauma & Orthopaedics	17	5	12	48	48
Total	458	196	265	1566.30	1566.30

Locum bookings (agency) by grade 01.11.2017 to 31.03.18				
Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F2	246	246	2564	2564
ST1	103	103	1035.50	1035.50
ST2	54	54	599.50	599.50
ST3	561	561	5327.50	5327.50
ST4	93	93	1086	1086
ST5	89	89	855	855
ST6	145	145	1507	1507
ST7	54	54	654	654
ST8	2	2	18	18
Total	1347	1347	13646.50	13646.50

Networking

The Guardian has attended National NHS employers' conferences as well as Regional Guardian Conferences. He is part of a network of guardians in the region and nationally. Guardian has established a fine working relationship with his New DME / New TPD (FY1) / MD / JD reps / LNC chair and BMA LNC.

He has also got good rapport and has sufficient authority to take quick actions for ISC along with Educational supervisors and CDs support. All local Guardian network attended.

GoSWH also has access to MD and Chief Exec for urgent matters.

Issues arising :-

- *Recruitment issues are aligned to nationwide issues. Local solutions include rota and service redesign, senior support and MTI doctors. Anaesthetics, Medicine and O&G all have middle grade recruitment issues.*
- *Allocate must bridge the gap of inefficiencies to cover known gaps in the rotas much in advance.*

Actions taken to resolve issues:-

1. *A&E Rota review undertaken by relevant CD/Medical Staffing; no further concerns from trainees. Payment & Fine applied*
2. *O&G Rota review and work schedule alteration; Payment adjusted*
3. *Recruitment to some unfilled posts as per attached document.*
4. *Overseas Medical Training Initiative doctors employed in various departments*
5. *Procurement of Allocate software with modules for rota and leave management is expected to improve the effective utilisation of the Trust's medical workforce resource.*
6. *Anaesthetics/ITU rota management transferred centrally into the medical staffing team with day to day management undertaken jointly with clinical leads. This was managed by a full time staff*

now this is a part time undertaking by medical staffing.

7. *Regular emails to departments such as Orthopaedics raising no concerns*
8. *Urology junior doctor exceptions due to lack of minimum staffing level. Escalated to CD and Med Staffing.*
9. *Gastroenterology – Junior Doctor gap leading to hours issues.*
10. *Juniors did a data collection exercise of a C shift oncall and presented to MD and to present Committee on problems and solutions.*

GUARDIANS CONCERNS

REPORTING CONCERNS

Delayed or no reporting from some juniors, hence no opportunity to support early and avoidable fines. This was raised by the ES and CDs. Several juniors are reporting 1 week after the exception occurred giving no opportunity to sort issues in a timely fashion. The TC&S gives this option to delay report up to 14 days but local culture could change.

A Serious concern about juniors not reporting to CD in A&E and not following recommended reporting system leading to fines.

ES not updating or closing exception reports even when TOILS are given.

ROTA

Availability of rota in advance was reported by juniors as a problem area. This is addressed by purchase of allocate and moving to Medic Online, Health roster and Allocate appraisal software.

Immediate next steps & Challenges

1. JDF meeting to be organised with new JDF rep
2. Feedback from juniors re: rota and fines utilization

3. Meet with surgical leads re: new ways of providing cross cover for Urology
4. Reducing fines and locums
5. Improving grand rounds attendance (Exceptions not reported but concerns raised)
6. To make a document on reporting and circulate to juniors and ES/CS on timely reporting and meetings.

3. Conclusion

Overall, the Guardian role represents an opportunity for a big cultural move towards a value based approach to trainees. The open culture has been appreciated by juniors as well as CQC.

I can assure the Committee that patient safety in the areas that were reported from has improved both medical and surgical directorates. Junior doctor support have improved dramatically within these areas at Walsall Manor Hospital Trust. However, the minimum staffing and rota gaps remain to be an issue on some days/weeks.

There has been no genuine immediate safety concern since last report.

4. Recommendation

The Committee are asked to read and note this Quarterly report which covers until 30th April 2018 from the Guardian of Safe Working.

Author	**Dr Riaz Bavakunji Guardian of Safe Working Hours**
Executive Lead	**Matthew Lewis – Medical Director**
Date	**21/5/2018**

Walsall Healthcare NHS
NHS Trust

Performance Report

October 2018
(September 2018 Results)

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

Caring for Walsall together

Contents

Walsall Healthcare NHS
NHS Trust

Quality, Patient Experience and Safety Committee

Caring for Walsall together

Quality, Patient Experience 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

Infection Control- There were no C. diff cases or MRSA reported in September 2018 MRSA.

MCA- There is an increased improvement in the completion of the MCA stage 2 as part of the DNACPR process.

Complaints- The percentage of complaints responded to in the agreed timescale has improved in September 2018 and is above the Trust trajectory, new measures are in place to ensure that complaints are responded to within the agreed time scales and escalated when there are concerns in relation to achieving these timescales.

Key Areas of Concern

Falls- Whilst there was a reduction in falls in September 2018 to 85 and the ratio of falls per 1,000 bed days fell to 6.21, which is below the 6.63 target, the ratio in September remains higher than previous months (with exception of August). There is an increasing trend in the number of falls and ratio of falls per 1,000 bed days. There has also been an increase in the number of patients who sustained severe harm following a fall with 3 patients receiving a fracture in September 2018.

Pressure Ulcers- The number of hospital acquired avoidable pressure ulcers in the hospital is an on-going concern.

Key Actions Taken

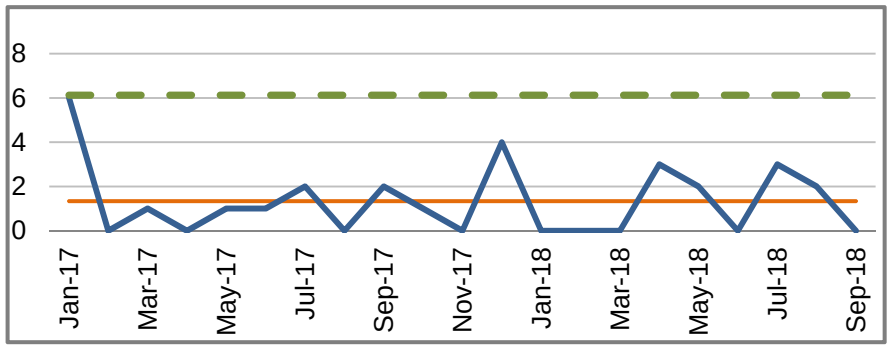
A deeper analysis of falls and pressure ulcers is provided in the Quality Report.

Key Focus for Next Committee

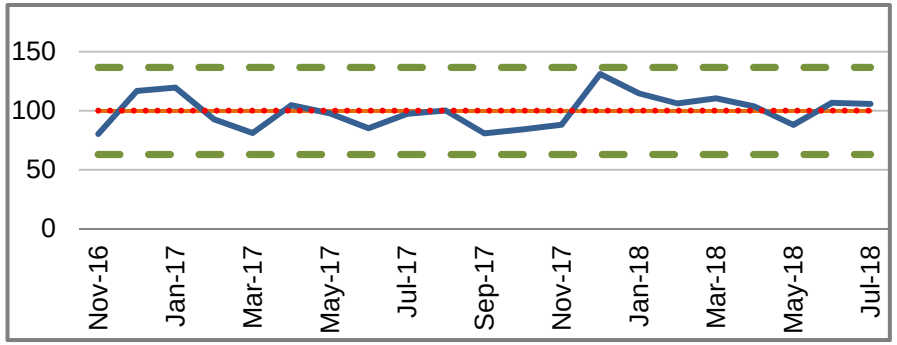
Infection Control as part of Quality report
Friends and Family test and Patient Experience

Quality, Patient Experience and Safety Committee

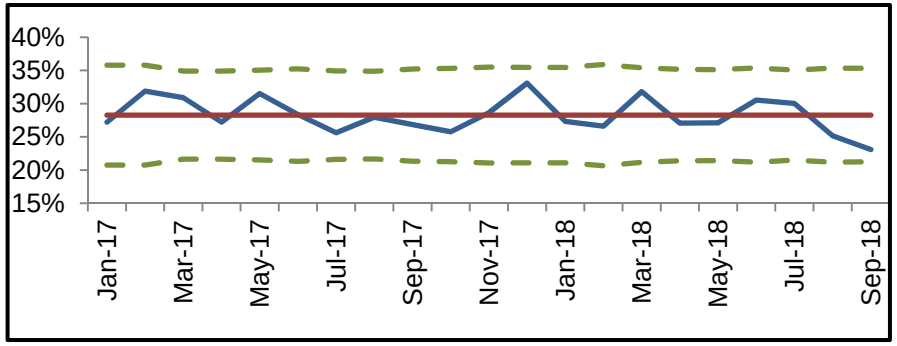
C Difficile



HSMR



C-Section Rates



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. New antibiotic policy is being developed.

HSMR

Medical Examiner appointed. New mortality leads appointed for each Care Group to review deaths. A review of all deaths related to fluid/electrolyte balance for 2017/18 to be undertaken.

Narrative (supplied by Director of Nursing)

C – Section rates show monthly variation. The overall rate for 2018/19 remains below target at 23.1%. The following actions remain in place in relation to C Section monitoring

- 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.

SPC Key — Measure — Mean — Process limit ▲ High or low point ♦ 7 points above or below mean ■ Rising or falling trend

Walsall Healthcare NHS Trust

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE 2018-2019

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no..	HSMR (HED)	103.54	88.00	106.65	105.76				100.00		N
no..	SHMI (HED)								100.00		BP
no	Clostridium Difficile - No. of cases	3	2	0	3	2	0	10	17	11	N
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired Avoidable per 1,000 beddays (current two months figs are unvalidated)	1.07	0.90	0.67	0.75	0.36	0.26				L
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired Avoidable per 10,000 CCG Population (current two months figs are unvalidated)	0.03	0.07	0.00	0.03	0.07	0.00				L
no..	Falls - Rate per 1000 Beddays	5.32	5.62	3.57	5.09	6.94	6.21		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	3	0	0	2	1	3	9	0	8	BP
%..	VTE Risk Assessment	96.34%	96.28%	96.50%	95.57%	95.08%	94.38%	95.69%	95.00%	88.49%	N
%..	Controlled Drug Compliance								100.00%		BP
no..	Midwife to Birth Ratio	1:29.8	1:29.2	1:26.2	1:28.6	1:25.0	1:27.3		1:28	1:26.3	N
%..	C-Section Rates	27.06%	27.12%	30.53%	30.03%	25.17%	23.10%	27.20%	30.00%		BP
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	11.27%	11.07%	10.12%	9.94%	10.64%		10.60%	10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	83.45%	92.29%	90.83%	85.48%	87.24%	82.74%	86.94%	100.00%	89.33%	N/L
%..	Compliance with MCA 2 Stage Tracking	55.00%	81.00%	69.00%	69.00%	68.00%	80.00%		100.00%		BP
%..	Friends and Family Test - Inpatient (% Recommended)	96.00%	95.00%	97.00%	94.00%	95.00%	96.00%		96.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	98.59%	98.29%	98.22%	98.75%	98.29%	97.78%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	76.07%	77.51%	84.47%	89.59%	90.42%	90.38%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	94.43%	93.69%	99.84%	99.92%	99.83%	99.44%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	75.55%	80.32%	83.77%	87.04%	89.53%	90.52%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	78.26%	80.41%	87.98%	89.64%	87.89%	88.72%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	91.67%	92.38%	99.77%	99.26%	98.67%	98.98%		95.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	75.49%	76.93%	88.58%	93.69%	85.37%	85.67%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	74.52%	88.58%	90.62%	92.24%	92.08%	89.92%		85.00%		L

Integration

Integration – 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 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 3 localities with the highest readmissions are East (2.06), South 1 (1.78) and North (1.74) based on rate per 1000 GP population. However recognising that number of readmissions are based on GP caseload and not community nursing caseloads or co-morbidity relevant to current locality MDT working. It is also worth noting that the North Locality and South 2 are the largest teams in terms of practice populations and active locality caseloads therefore comparing this with other localities the number of readmissions may not be overly high.

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

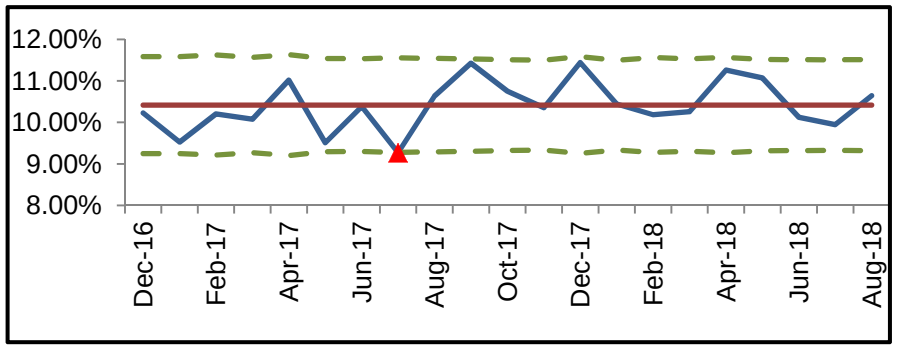
The dashboard now shows the contacts per locality that has been validated. From next month there will also be bed days and a calculation against the population size to reference against.

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 now publication date has been agreed.

Integration

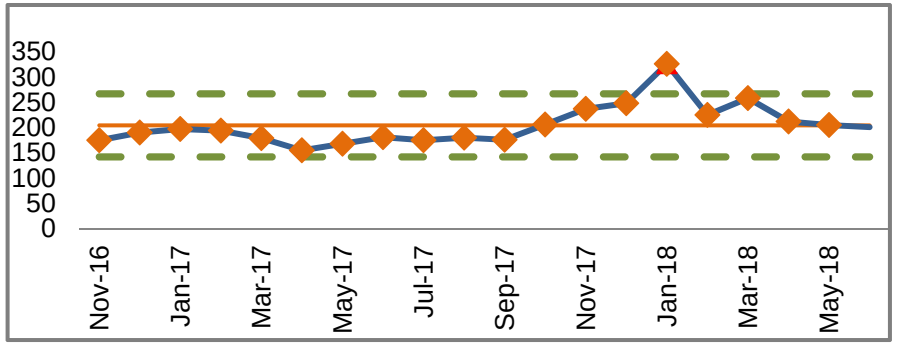
Emergency Readmissions



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

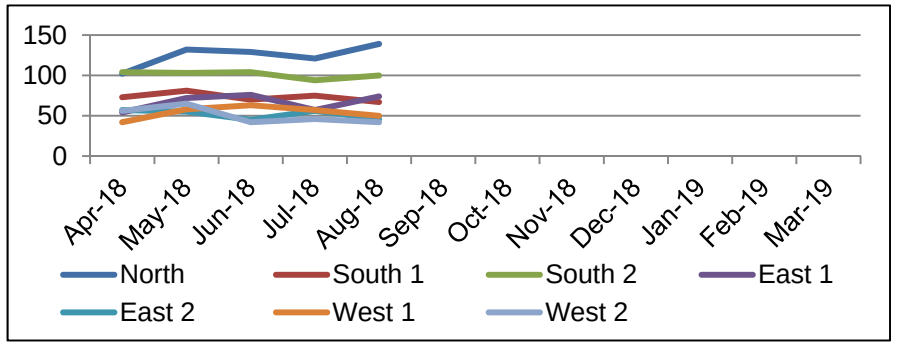
As shown by the graph there is a normal fluctuation month on month, with August at 10.64%, a similar pattern to last year. During Q1 the place based teams were enhanced with the addition of continence specialist. The COPD team are due to join during Q2.

Rapid Response – Avoidable Admissions



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.

Re-admissions by Locality



This chart shows the number of emergency readmissions within 30 days of discharge by locality. The highest readmitting locality continues to be the North however as already noted not all patients being re-admitted may be known to the team. The North team has also the largest practice population and is the only team which has not yet been divided into 2 teams therefore have by far the largest caseload.

SPC Key — Measure — Mean — Process limit ▲ High or low point ♦ 7 points above or below mean ■ Rising or falling trend

Walsall Healthcare NHS
NHS Trust

INTEGRATION
2018-2019

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-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)	11.27%	11.07%	10.12%	9.94%	10.64%		10.60%	10.00%		L
no	Rapid Response Team - Total Referrals (one month in arrears)	222	219	195	195	174	195				L
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission (one month in arrears)	212	205	185	188	162	179				L
%	Rapid Response Team - % of patients referred requiring a 2 hour response who are subsequently seen within 2 hours (one month in arrears)	60.00%	59.00%	54.00%	48.00%	56.00%	59.00%				L
	CARE AT HOME										
%..	ED Reattenders within 7 days	6.80%	7.68%	7.12%	7.46%	7.58%	7.59%	7.37%	7.00%	6.76%	BP
	RESOURCES										
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only	21	26	30	32	31	36				L
no	Average Number of Medically Fit Patients - Trust	49	42	39	36	42	48				L
	PARTNERS										
Rate	Occupied Beddays per Locality - Rate per 1000 GP Population (GP Caseload)	38.89	36.12	35.59	33.17	34.83	31.63				L
no	Nursing Contacts per Locality - Total	18066	19325	18527	19796	19807	18387	113840			L
Rate	Emergency Readmissions per Locality - Rate per 1000 GP Population (GP Caseload)	1.61	1.87	1.75	1.67	1.71	1.56				L
no	No. of patients on stroke pathway in partnership with Wolverhampton - new metric under development										L

Walsall Healthcare NHS
NHS Trust

People and Organisation Development Committee

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

1. Mandatory training and PDR compliance has improved over the past 6 months. Some further analysis to identify hot spots has been completed. Further action planned to achieve further improvement on targets to help sustain the improvements and meet Trust compliance targets.
2. Flu – multi disciplinary team (including staff side) are meeting every week to identify and mitigate any risks to delivering the campaign, group are working effectively together support the health and wellbeing of staff through the up take of the vaccine within the Trust.
3. The Nursing workforce transformation programme is in place, led by Director of Nursing and PODC and JNCC were briefed during October.

Key Areas of Concern

1. Attendance and staff health and wellbeing, sickness levels within the Trust continue to display an increasing trend, in month spikes in absence rates are significant enough to impact on service delivery and sustainability.
2. Equality Diversity and Inclusion – initial review complete and this categorises performance at a high level risk, red rated, therefore assurance is required for the Board on progress on both EDI regulatory compliance and organisational culture in order to mitigate this risk.
3. FTSU governance and assurance for Board are not fully in place, hence Board will require further assurances through PODC.

Key Actions Taken

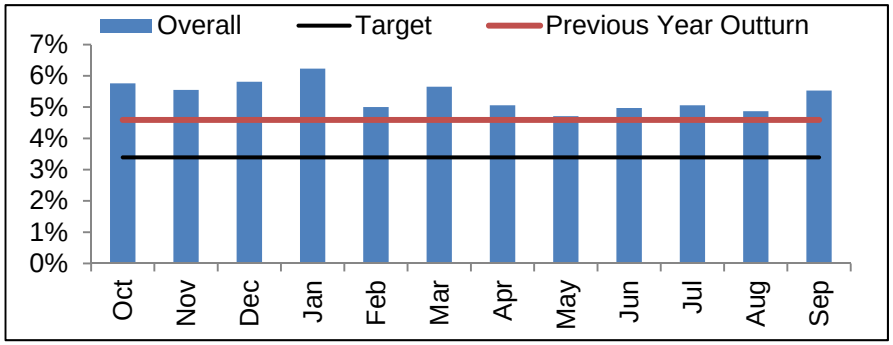
1. Flu campaign – additional resource/capacity required within Occupational Health is being resourced through bank to ensure OCH referrals are not delayed and the flu campaign is fully supported, recruitment in train.
2. On-going requirements for Staff Engagement Lead, proposal in place and view on long term approach being developed.
3. Turnover – review of Exit process and reporting reviewed and approach for development agreed.
4. Update on concerns on sickness levels discussed at PODC – JNCC agreed a detailed review of policy framework and approach and stakeholder engagement workshop – plan to implement new processes and policy framework by end of Q3.
5. Board assurance framework in place categorising key People and OD risks, received and approved by PODC. Corporate risk register is being reviewed to support the BAF.
6. FTSU workshop and self assessment planned for 8th November 2018 with external support quarterly reporting to National Guardian Office in place Q2 reported.
7. Apprentice approach agreed at POD and JNCC, establishes a principle of career pathway for entrants and existing staff groups.

Key Focus for Next Committee

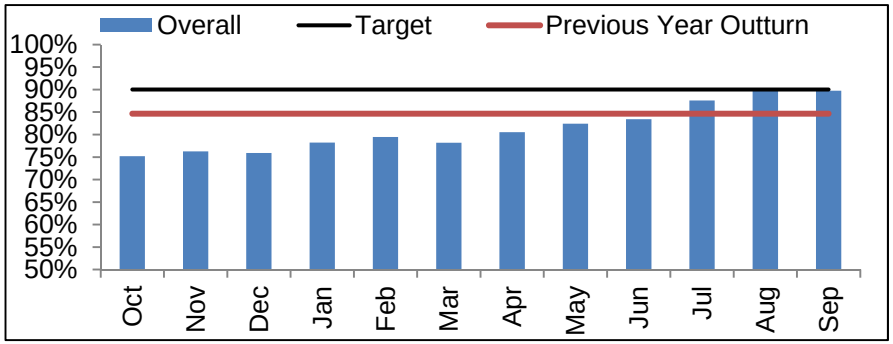
1. EPR - Implications of electronic patient record and business change
2. People Management metrics and development of targets for upper and lower tolerances for key people metrics and use of SPC for reporting.
3. People Strategy review and update of the workforce strategy in line with Trust strategic priorities including Quality Improvement approach
4. Reviews of strategic approach to Equalities and review the Equality Action plan for assurance
5. Review strategic approach to OCH and wellbeing

People and Organisation Development Committee

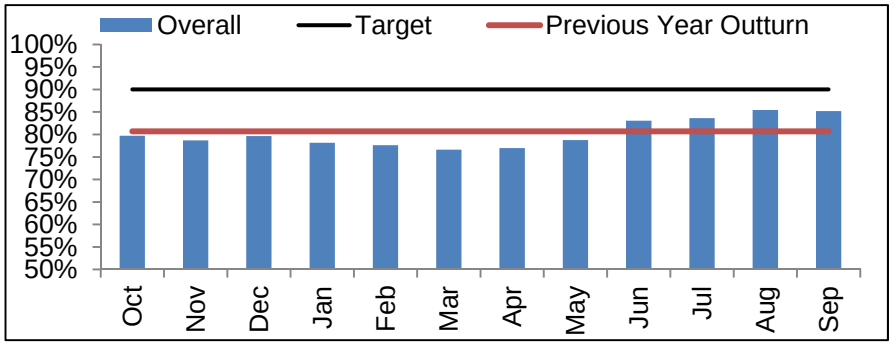
Sickness Absence



PDR Compliance



Mandatory Training Compliance



Narrative (supplied by Director of People and Culture)

Sickness levels remain above Trust target and above previous year outturn month on month. There are areas within nursing and midwifery with significant spikes in sickness absence levels which creates a resourcing risk and potentially affects service sustainability.

PDR appraisal completion rates dipped marginally in month and is consequently rated amber. The appraisal policy is currently being reviewed. The 2018 AFC pay agreement introduces a incremental pay progression dependency upon satisfactory completion of PDR and other criteria. The outlier on PDR completion is Corporate at 78% - detailed performance reports have been sent to the lowest performing areas. Estates are top performing with 96% PDR compliance.

Mandatory training compliance levels have dipped in month and are consequently amber rated. Compliance is below trust target, so analysis continues in order to support targeted improvement action. The key areas of mandatory training that are outliers (below 85%) are Clinical updates 82%, Fire training 78% and information governance 81%. Detailed reports have been sent to managers for follow up.

SPC Key — Measure — Mean — Process limit — High or low point — 7 points above or below mean — Rising or falling trend

Walsall Healthcare NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 2018-2019

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Mandatory Training Compliance	76.99%	78.76%	83.06%	83.63%	85.46%	85.21%	85.21%	90.00%	76.61%	L
.	Equality, Diversity & Inclusion - new metric under development										
.	Equality, Diversity & Inclusion - new metric under development										
	VALUE COLLEAGUES										
%..	Sickness Absence	5.06%	4.71%	4.97%	5.06%	4.87%	5.53%	5.01%	3.39%	5.30%	L
%..	PDRs	80.55%	82.42%	83.41%	87.56%	90.04%	89.73%	89.73%	90.00%	78.17%	L
.	Staff Referral to Occupational Health - new metric under development										
	RESOURCES										
no	Staff in post (Budgeted Establishment FTE)	4125	4114	4125	4121	4123	4121	4121			L
%..	Turnover	9.83%	9.92%	10.33%	9.20%	10.42%	10.94%	10.94%	10.00%	9.13%	L
.	Time to Recruit - new metric under development										

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

Caring for Walsall together

Performance, Finance and Investment Committee – Highlight Page

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

Key Areas of Success

- Attaining national performance standards against Cancer and 6 week diagnostic targets
- 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)
- Business Case to support future provision of the Wide Area Network approved

Key Areas of Concern

- Emergency Department 4 hour wait performance remains below plan
- High levels for medically fit for discharge patients currently occupying bed capacity
- 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, behind trajectory for the Financial Recovery Plan

Key Actions Taken

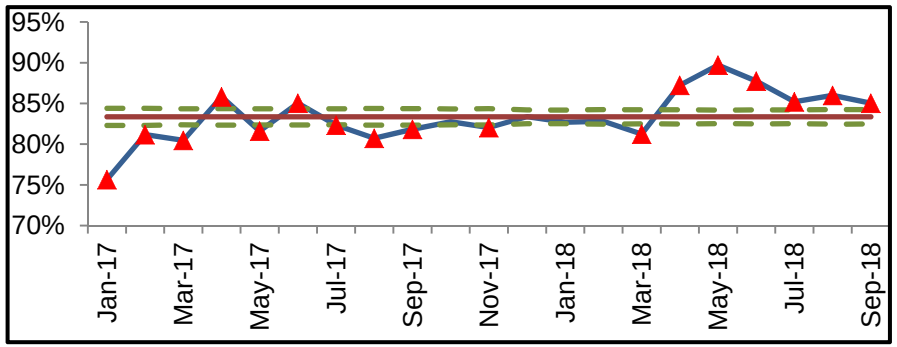
- SAFER deployed within the Trust to support enhanced ED performance, FES re-organised service to start 18th September to reduce elderly admissions, Winter plan workshops to re-align services where appropriate and review escalation systems.
- Financial recovery Plan endorsed through PFIC & Trust Board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

Key Focus for Next Committee

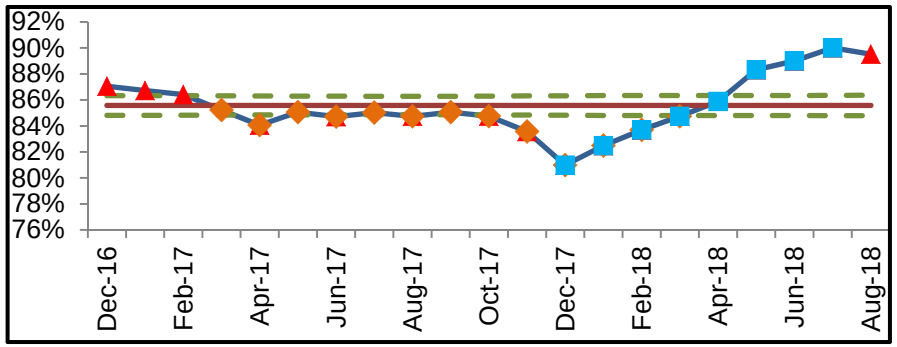
- Continued focus on performance against constitutional standards, focus on ED 4 hour performance
- Delivery of the Financial Recovery Program
    - PFIC to receive a revised forecast outturn based on the outcome of further controls implemented within Nursing and Medical temporary workforce expenditure, the outcome being to offer assurance over delivery of the outturn or recommend a change to forecast delivery for 2018/19
    - Income performance driven by CIP attainment (productivity within Theatres and Outpatients)
- Run rate reductions delivery 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

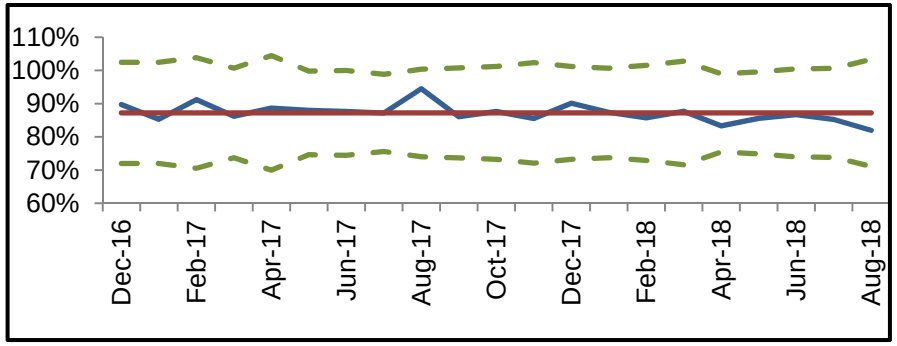
ED - % within 4 hours - Overall (Type 1 and 3)



18 Weeks RTT Incomplete Pathways



Cancer 62 Day RTT



Narrative (supplied by Chief Operating Officer)

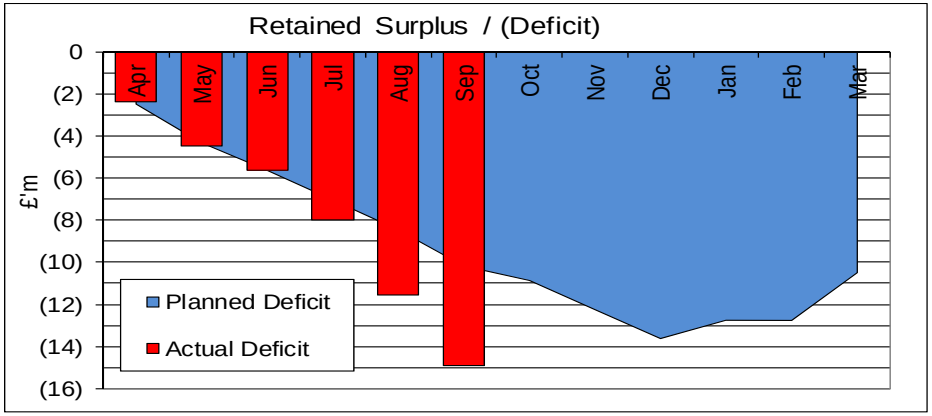
Emergency activity in Walsall continued to be challenging with high attendances above plan for example; over 90 ambulances on 14 days of the month. September also saw daily admissions to the hospital increase to 89. The LOS has shown a reduction consistent with winter plans. Patient flow showed that 79.81% of patients were discharged between 08.00-18.00 but a remaining lower ratio in the morning. SAFER is now mandated and compliance is being monitored. Individuals/areas that are falling below the standard are being supported following discussions. The re-organisation of FES launched on the 18th September focused on admission avoidance.

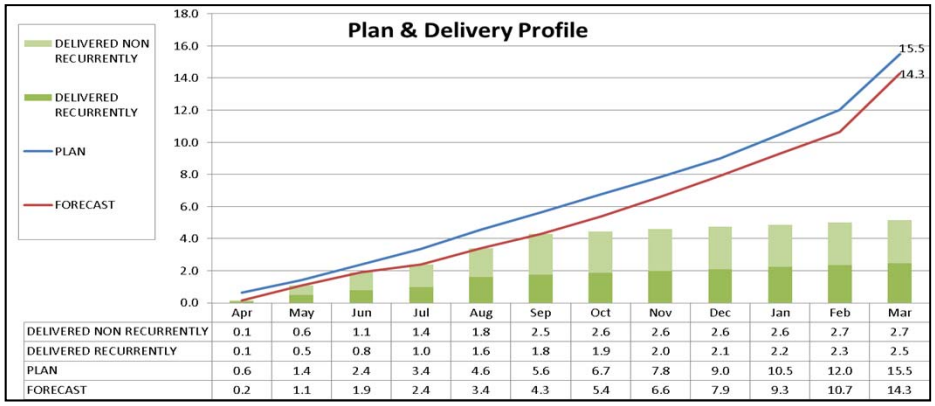
RTT has sustained its improvements and achieved 89% in September. The number of patient pathways has remained stable at 14142. The focus continues on RTT improvement and performance, there were no 52 week breaches in September. There are 38 patients waiting over 40 weeks has reduced from 40 waiting in August. Planning has commenced in relation to performance over the winter period.

Reviewed in September to mitigate risks inherent in low volumes. Confirmed Cancer performance for August shows achievement of all cancer measures except for 62 day referral to treatment and consultant upgrade. The 62 target failed to achieve by 8 breaches, these were made up of 6 complexity and 2 capacity.

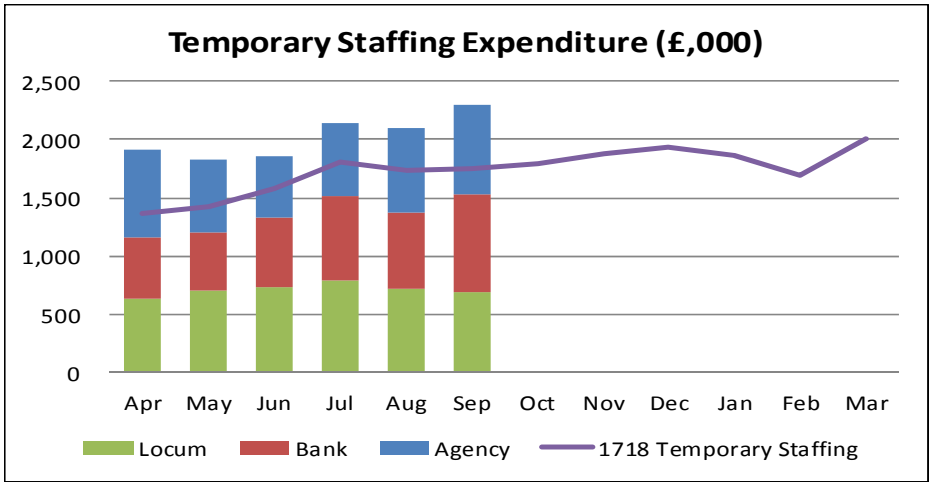
SPC Key — Measure — Mean - - Process limit ▲ High or low point ◆ 7 points above or below mean ■ Rising or falling trend

Financial Performance to September 2018 (Month 6)





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.1	0.6	1.1	1.4	1.8	2.5	2.6	2.6	2.6	2.6	2.7	2.7
DELIVERED RECURRENTLY	0.1	0.5	0.8	1.0	1.6	1.8	1.9	2.0	2.1	2.2	2.3	2.5
PLAN	0.6	1.4	2.4	3.4	4.6	5.6	6.7	7.8	9.0	10.5	12.0	15.5
FORECAST	0.2	1.1	1.9	2.4	3.4	4.3	5.4	6.6	7.9	9.3	10.7	14.3



Financial Performance

- The total financial position for the Trust at M6 is a deficit of £14.9m, resulting in a £4.7m variance to plan .
- The position includes £1.2m of lost PSF (which is recovered in part if the Trust attains plan at the end of quarter 3).
- The contracted income shows an unfavourable variance to plan of £0.8m, the main area of under-performance occurring in Maternity and Adult/Neonatal Critical care and outpatients. Other Operating income reflects the loss of PSF.
- Expenditure is overspent YTD. The main area of overspending is pay (£2.8m) 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 £1.1m.
- 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 is places increased pressure on cash flow and borrowing.

Capital

- The year to date capital expenditure is £6.4m, with the main spends relating to ICCU (£3m), Estates Lifecycle (£1.2m), Maternity (£1.7m) and Community Mobile technology (£0.1m).

Financial Performance - Period ended 30th September 2018

Description	Annual Budget	Budget to Date	Actual to Date		Variance
	£'000	£'000	£'000		£'000
Income					
NHS Activity Revenue	228,734	112,788	111,989		(799)
Non NHS Clinical Revenue (RTA Etc)	530	537	579		42
Education and Training Income	7,230	3,766	3,792		26
Other Operating Income (Incl Non Rec)	15,790	7,530	6,567		(964)
Total Income	**252,284**	**124,622**	**122,927**		**(1,695)**
Expenditure					
Employee Benefits Expense	(176,261)	(87,593)	(90,379)		(2,787)
Drug Expense	(11,699)	(9,112)	(8,956)		155
Clinical Supplies	(17,747)	(9,414)	(9,625)		(211)
Non Clinical Supplies	(15,917)	(8,280)	(8,294)		(14)
PFI Operating Expenses	(5,075)	(2,555)	(2,685)		(130)
Other Operating Expense	(21,148)	(9,874)	(9,898)		(23)
Sub - Total Operating Expenses	**(247,847)**	**(126,828)**	**(129,837)**		**(3,009)**
Earnings before Interest & Depreciation	**4,438**	**(2,207)**	**(6,910)**		**(4,704)**
Interest expense on Working Capital	51	26	24		(1)
Interest Expense on Loans and leases	(8,559)	(4,716)	(4,982)		(266)
Depreciation and Amortisation	(6,560)	(3,280)	(3,020)		260
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(15,069)**	**(7,971)**	**(7,977)**		**(7)**
Total Expenses	**(262,915)**	**(134,799)**	**(137,815)**		**(3,016)**
RETAINED SURPLUS/(DEFICIT)	**(10,631)**	**(10,177)**	**(14,888)**		**(4,711)**
Adjustment for Gains on Donated Assets			13		13
Adjusted Financial Performance (Control Total)	**(10,631)**	**(10,177)**	**(14,875)**		**(4,697)**

Use of Resources Ratings (M6)

Finance and use of resources rating	03AUDITPY	03PLANYTD	03ACTYTD	03PLANCY	03FOTCY
i	Audited PY 31/03/2018 Year ending Number	Plan 30/09/2018 YTD Number	Actual 30/09/2018 YTD Number	Plan 31/03/2019 Year ending Number	Forecast 31/03/2019 Year ending 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	3	1	1

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending September 2018	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	(9,930)
Depreciation and Amortisation	3,020
Donated Assets Received credited to revenue but non-cash	(98)
(Increase)/Decrease in Trade and Other Receivables	2,151
Increase/(Decrease) in Trade and Other Payables	(3,411)
Increase/(Decrease) in Stock	6
Interest Paid	(4,982)
Net Cash Inflow/(Outflow) from Operating Activities	(13,244)
Cash Flows from Investing Activities	
Interest received	**24**
(Payments) for Property, Plant and Equipment	**(6,002)**
Net Cash Inflow/(Outflow)from Investing Activities	**(5,978)**
Net Cash Inflow/(Outflow) before Financing	(19,222)
Cash Flows from Financing Activities	18,046
Net Increase/(Decrease) in Cash	**(1,176)**
Cash at the Beginning of the Year 2017/18	2,277
Cash at the End of the September	1,101

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending September 2018	Balance as at 31/03/18	Balance as at 30/09/18	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Total Non-Current Assets	**140,656**	**144,612**	**3,956**
Current Assets			
Receivables & pre-payments less than one Year	17,214	14,575	(2,639)
Cash (Citi and Other)	2,277	1,101	(1,176)
Inventories	2,277	2,271	(6)
Total Current Assets	21,768	17,947	(3,821)
Current Liabilities			
NHS & Trade Payables less than one year	(30,702)	(27,681)	3,021
Borrowings less than one year	(60,740)	(6,883)	53,857
Provisions less than one year	(432)	(432)	-
Total Current Liabilities	(91,874)	(34,996)	56,878
Net Current Assets less Liabilities	**(70,106)**	**(17,049)**	**53,057**
Non-current liabilities			
Borrowings greater than one year	(127,859)	(197,345)	(69,486)
Total Assets less Total Liabilities	(57,309)	(69,782)	(12,473)
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	-	(14,889)	(14,889)
Total TAXPAYERS' EQUITY	(57,309)	(69,782)	(12,473)

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)	87.22%	89.70%	87.73%	85.21%	85.74%	85.04%	86.82%	95.00%	82.67%	N
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	80.95%	80.65%	76.24%	71.95%	71.68%	71.86%	75.57%	85.00%	65.80%	BP
no	Ambulance Handover - No. of Handovers completed over 60mins	1	5	0	7	4	13	30	0	236	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	93.45%	93.98%	96.08%	97.64%	95.04%	93.05%	94.87%	93.00%	95.45%	N
%..	Cancer - 62 day referral to treatment of all cancers	83.33%	85.58%	86.67%	85.23%	81.97%	85.71%	84.86%	85.00%	88.05%	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	85.89%	88.33%	89.00%	90.01%	89.51%	89.02%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	0	0	0	0	0	0	0	0		N
%..	Diagnostic Waits - % waiting under 6 weeks	99.05%	99.57%	99.79%	99.75%	99.61%	99.83%	99.59%	99.00%	99.06%	N
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission (one month in arrears)	212	205	185	188	162	179				L
no	No. of Open Contract Performance Notices	7	7	8	7	7	7		0	7	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	6.80%	7.68%	7.12%	7.46%	7.58%	7.59%	7.37%	7.00%	6.76%	BP
	RESOURCES										
%..	Outpatient DNA Rate (Hospital and Community)	10.47%	11.03%	10.59%	10.45%	10.59%	10.27%	10.58%	8.00%	12.16%	L
%..	Theatre Utilisation - Touch Time Utilisation (%)	80.91%	83.76%	82.63%	84.44%	81.50%	79.79%	83.58%	75.00%		L
%..	Delayed transfers of care (one month in arrears)	2.97%	4.74%	3.74%	3.65%	4.07%		3.82%	2.50%	2.56%	L
no	Average Number of Medically Fit Patients	98	87	85	88	92	107		80		L
no..	Average LoS for Medically Fit Patients (from point they become Medically Fit)	8.61	10.57	8	9	8	9		5		L
£	Surplus or Deficit (year to date) (000's)	-£2,386	-£4,509	-£5,616	-£8,012	-£11,496	-£14,888	-£11,496		-£23,267	L
£	Variance from plan (year to date) (000's)	-£2,483	-£186	-£18	-£553	-£3,038	-£4,711	-£3,038		-£2,511	L
£	CIP Plan (YTD) (000s)	£806	£1,612	£2,268	£3,182	£4,554	£5,620	£4,554			L
£	CIP Delivery (YTD) (000s)	£168	£1,080	£1,919	£2,391	£3,405	£4,158	£3,405			L
£	Temporary Workforce Plan (YTD) (000s)	£1,459	£2,784	£4,246	£5,935	£7,502	£9,156	£7,502			L
£	Temporary Workforce Delivery (YTD) (000s)	£1,914	£3,743	£5,594	£7,733	£9,836	£12,140	£9,836			L
£	Capital Spend Plan (YTD) (000s)	£1,040	£2,129	£3,183	£4,105	£5,027	£5,842	£5,027			L
£	Capital Spend Delivery (YTD) (000s)	£506	£1,077	£2,542	£3,946	£5,487	£6,391	£5,487			L

Glossary

Glossary

A

ACP – Advanced Clinical Practitioners

AEC – Ambulatory Emergency Care

AHP – Allied Health Professional

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

AMU – Acute Medical Unit

AP – Annual Plan

B

BCA – Black Country Alliance

BR – Board Report

C

CCG/WCCG – Walsall Clinical Commissioning Group

CGM – Care Group Managers

CHC – Continuing Healthcare

CIP – Cost Improvement Plan

COPD – Chronic Obstructive Pulmonary Disease

CPN – Contract Performance Notice

CQN – Contract Query Notice

CQR – Clinical Quality Review

CQUIN – Commissioning for Quality and Innovation

CSW – Clinical Support Worker

D

D&V – Diarrhoea and Vomiting

DDN – Divisional Director of Nursing

DoC – Duty of Candour

DQ – Data Quality

DQT – Divisional Quality Team

DST – Decision Support Tool

DWMHPT – Dudley and Walsall Mental Health Partnership NHS Trust

E

EACU – Emergency Ambulatory Care Unit

ECIST – Emergency Care Intensive Support Team

ED – Emergency Department

EDS – Electronic Discharge Summaries

EPAU – Early Pregnancy Assessment Unit

ESR – Electronic Staff Record

EWS – Early Warning Score

F

FEP – Frail Elderly Pathway

FES – Frail Elderly Service

G

GAU – Gynaecology Assessment Unit

GP – General Practitioner

H

HALO – Hospital Ambulance Liaison Officer

HAT – Hospital Acquired Thrombosis

HCAI – Healthcare Associated Infection

HDU – High Dependency Unit

HED – Healthcare Evaluation Data

HofE – Heart of England NHS Foundation Trust

HR – Human Resources

HSCIC – Health & Social Care Information Centre

HSMR – Hospital Standardised Mortality Ratio

I

ICS – Intermediate Care Service

ICT – Intermediate Care Team

IP - Inpatient

IST – Intensive Support Team

IT – Information Technology

ITU – Intensive Care Unit

IVM – Interactive Voice Message

K

KPI – Key Performance Indicator

L

L&D – Learning and Development

LAC – Looked After Children

LCA – Local Capping Applies

LeDeR – Learning Disabilities Mortality Review

LiA – Listening into Action

LTS – Long Term Sickness

LoS – Length of Stay

M

MD – Medical Director

MDT – Multi Disciplinary Team

MFS – Morse Fall Scale

MHRA – Medicines and Healthcare products Regulatory Agency

MLTC – Medicine & Long Term Conditions

MRSA - Methicillin-Resistant Staphylococcus Aureus

MSG – Medicines Safety Group

MSO – Medication Safety Officer

Glossary

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 – 1st November 2018			
Partnership Update November 2018			**AGENDA ITEM: 16**
Report Author and Job Title:	Daren Fradgley Director of Strategy and Improvement	**Responsible Director:**	Daren Fradgley Director of Strategy and Improvement
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	This paper updates Board Members on the key partnership working undertaken this month. This includes the following • Total Mobile User Group • Intermediate Care Service working • Rotherham shared learning • Western Sussex shared learning		
Recommendation	Board members to NOTE and discuss the contents of this paper.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses the mitigations mapped out in the care at home and partnership risks in the BAF		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Partnership Report

November 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. INTERMEDIATE CARE PATHWAY

The Intermediate Care Service has been under pressure over the last few weeks with the amount of patients that require a response from the service on the rise. In addition to the volume, the complexity of some of the patients has been extremely challenging. To understand the challenges better and work through a series of solutions, the Trust teams have been working with Social Care to establish next steps

Currently there are over 100 patients that are medically fit for discharge but have some form of delay in their discharge pathways. As a result, the following actions are taking place.

- Short term actions to align the way in which the Trust Therapy Teams are working with ICS and Community Therapy Teams. A workshop is being planned to understand the opportunities within the next week so actions can be taken to improve discharge flow. Longer term, work is underway to align the leadership of the Trust and Local Authority Teams to prevent a repeat of this in the future.
- Complex case reviews will be moved to the Locality Teams so that they can focus on longer term support. Staff working in the ICS pathways can then be freed up to establish great flow
- As the ICS services have developed, some additional pressures have become apparent. Quicker turn over of equipment for example which has increased usage. Therefore some work is going on with the teams to establish a better routine and approach to distributing equipment for discharged patients. There are other examples which are all being worked through to make sure that the pathways flow better for our patients.

All of these actions are fundamental to a successful winter plan, therefore, daily reviews of these actions are underway and weekly monitoring meetings have been set up. In future months this will be reported through the Integration section of the performance report.

Expected Outcome :- Improved productivity through the ICS in time for core winter pressures. Reduction of MFFD delays to below 75 before Christmas week

3. TOTAL MOBILE USER GROUP VISIT

This month the Trust hosted the TM user group visit. Five other NHS Trusts along with our Community Teams meet with the supplier and agreed next steps for product development. During the day, opportunities for greater integration between records held by providers were discussed together with best practice that can by shared.

It has been agreed that the Trust will host this group once per year and will participate in other groups around the country.

Expected Outcome :- Continued learning and improved use of the Trusts newly deployed mobile community system. Also a developed support network with other system users.

4. ROTHERHAM RECIPROCAL VISIT

Team members from Rotherham attended Walsall last month and engaged in a series of discussions about our common integration programmes. They are very interested in learning about our locality teams with the use of mobile technology and also our developing Intermediate Care Service. In return the Trust is gaining support on the development of a care coordination service (single point of access) as Rotherham have made significant progress in this area. In conjunction with the CCG, a review team will visit Rotherham and one other site for a couple of days to capture the learning and see how it can be deployed in Walsall. This work is planned for November although a date has yet to be set.

Rotherham have agreed to support the production of stakeholder and public communications on integration since they have already completed this work with successful results.

Expected Outcome :- The Trust has much to learn from Rotherham but immediate support can be gained on stakeholder and trust communications based on the Rotherham material. The visit to look at the care coordination is expected to form the foundation of the planning for a Walsall version of a Care Coordination Service

5. WESTERN SUSSEX IMPROVEMENT VISIT

Members of the Trust Quality Improvement Academy spent a day earlier this month to understand how Western Sussex has embedded their improvement approach into the way that they operate. The Trust, which are considered to be one of the leading examples for Improvement by both NHSI and the CQC, look after one of the frailest populations in the country with great success and are rated outstanding by the CQC

Western has managed to link key work streams together to create an organisation wide improvement approach. This includes Strategic planning, Improvement coaching and mentoring, QI training and day to learning from improvement models. This is then evidenced into outcomes for patients, staff and the organisation.

Following this visit the team have met and considered how to embed witnessed success and learning into our Trust. To this end, the team are building a plan that will strengthen the way in which we deliver and coordinate Improvement work through the QI Academy with the program

approach delivered by the PMO. A full plan will be shared with the Trust Management Board in November for approval.

Expected Outcome :- A Trust plan to coordinate the Improvement activities that have been successful for Western Sussex. The first of which should commence in November following TMB oversight

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6. RECOMMENDATION

Board members are asked to NOTE the information within this report

Daren Fradgley
Director of Strategy & Improvement
25th October 2018

MEETING OF THE PUBLIC TRUST BOARD –1st November 2018			
Quality, Patient Experience & Safety Committee Highlight Report			**AGENDA ITEM: 15**
Report Author and Job Title:	Dr Karen Dunderdale, Director of Nursing	**Responsible Director:**	Russell Beale, Non-Executive Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The report provides a highlight of the key items discussed at the most recent Quality, Patient Experience & Safety Committee meeting held on the 25th October 2018 together with the confirmed minutes of the meeting held on 27th September 2018 (appendix 1). Key items discussed at the meeting were: • Update on Lorenzo EPMA and recommendation for the Trust to formally exit the programme • Update on the Trust's PAS/EPR Digital Future • Development of a Quality Transformation Programme to address quality concerns such as deterioration in VTE, falls and pressure ulcer performance • Approval of the Safeguarding Annual Reports • Breakdown of the mammography equipment and a further discussion about the equipment replacement programme. The meeting was quorate and chaired by Professor Russell Beale, Non-Executive Director.		
Recommendation	Members of the Trust Board are asked to note and discuss the information contained in this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Link to Board Assurance Framework Risk Statement No.1 'That the quality and safety of care we provide across the Trust does not improve in line with our commitment in the Patient Care Improvement Plan'.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	Compliance with Trust Standing Orders		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Quality & Safety Committee Highlight Report

1. PURPOSE OF REPORT

The purpose of the report is to provide a highlight of the key items discussed at the most recent Quality, Patient Experience & Safety Committee meeting held on the 25th October 2018 together with the confirmed minutes of the meeting held on 27th September 2018 (appendix 1).

2. BACKGROUND

The Quality, Patient Experience & Safety Committee reports to the Trust Board on a monthly basis following its meetings. The Board receives the approved minutes from the previous Committee meeting and a highlight report on the key issues raised at the most recent meeting.

3. DETAILS

The Quality, Patient Experience & Safety Committee resolved that the following items would be referred to the Trust Board at its meeting on 1st November 2018:

Lorenzo EPMA Programme

The committee received an update on the Lorenzo EPMA programme and the Director of Strategy & Improvement recommended that the Trust formally exit the programme due to the continuing clinical risk to patients and the significantly reduced financial benefit of Lorenzo ePMA Department Of Health funding ceasing March 2020.

The committee supported the recommendation to exit the programme and the Medical Director advised that the Trust were currently reviewing all electronic systems and would hope to have an e-prescribing module that is reliable and works with the current infrastructure moving forward.

Update on the Trust's PAS/EPR Digital Future

The Director of Strategy & Improvement provided a report on the Trust's PAS/EPR Digital Future and the timetable in making a critical strategic direction underpinning the Trust's Digital Strategy. The report outlined the approach and timetable on the Electronic Patient Record Journey with the intent to test the market following the results of the clinical systems needs assessment to ensure the trust has a fit for purpose EPR digital future that meets current and future challenges.

The committee supported the approach and it was agreed that a Non-Executive Director representative would be nominated to support the EPR Steering Group.

Development of a Quality Transformation Programme

There was a detailed discussion in relation to quality and a number of performance indicators that currently required further focus such as falls, pressure ulcers and VTE. The Director of Nursing confirmed that discussions had taken place with the Deputy Director of Nursing in relation to the development of a quality transformation programme to focus on areas of underperformance and the impact and actions being taken to improve.

Safeguarding Annual Reports

The Safeguarding Annual reports for Adults, Children and Looked After Children were received and approved by the Committee. The reports are included on the Trust Board agenda for final approval.

Breakdown of the Mammography Equipment

The Committee received a detailed report on the recent breakdown of the Mammography equipment and immediate actions that had been put in place to address this. It was noted that Sandwell & West Birmingham NHS Trust had been very supportive in mitigating the equipment failure and all patients who required imaging for both screening and symptomatic reasons had been transferred. The breakdown of this equipment had raised concerns in relation to the overall equipment replacement programme and it was noted that the Director of Strategy & Improvement was currently working with the estates team on the programme. The Committee expressed that there would need to be more pace with this and the Medical Director agreed to liaise with the Director of Strategy & Improvement to offer some support.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note and discuss the information contained in this report and approve the Annual Safeguarding reports

APPENDICES

Appendix 1 – Minutes of the Quality, Patient Experience & Safety Committee meeting held on 27th September 2018.

Appendix 1

MINUTES OF THE QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE HELD ON THURSDAY 27TH SEPTEMBER 2018 AT 9.00 a.m. MEETING SUITE A, WALSALL MANOR HOSPITAL

Present:	Professor R Beale	Non-Executive Director (Chair)
	Mrs A Baines	Associate Non-Executive Director
	Ms J Davies	Director of Governance
	Dr K Dunderdale	Director of Nursing
	Mr P Thomas-Hands	Chief Operating Officer (Item 117/18 onwards)
In Attendance:	Mr G Fletcher	Director of Pharmacy (Item 122/18 only)
	Mrs S Loader	Improvement Consultant
	Mrs D Povey	PMO Interim Lead (Item 119/18 only)
	Mr C Rawlings	Head of Clinical Governance (Item 120/18 only)
	Mrs D Rhoden	Corporate Senior Nurse – Safeguarding (Item 121/18 only)
Apologies:	Mr R Beeken	Chief Executive
	Mrs V Harris	Non-Executive Director
	Mr A Khan	Medical Director

Action

112/18 **Welcome and Introductions**

Professor Beale welcomed everyone to the meeting

Professor Beale advised that in the absence of the Medical Director and a representing clinician the meeting would not be quorate and the lack of a quoracy would be highlighted to the Trust Board.

113/18 **Declarations of Interest**

There were no declarations of interest

114/18 **Minutes of the Meeting Held on Thursday 20th August 2018**

Resolution:
The minutes of the meeting held on 20th August 2018 were agreed as a true and accurate record.

115/18 **Matters Arising & Action Log**

70/18 Dr Dunderdale advised that she would check the previous minutes regarding the ECIP discussion and Quality Impact Assessment and update the action log accordingly.

101/18 Dr Dunderdale confirmed the Serious Incident report had been revised and discussion held with the Director of Governance regarding the move of clinical governance to the Director of Governance, the move would take place

from 1st October 2018. Mrs Baines queried whether there would be clinical oversight of the team, Ms Davies responded that the Head of Clinical Governance and Governance managers were all clinicians and there was a good working relationship between the Medical Director, Director of Nursing and the Director of Governance.

Resolution:
The Committee received and noted progress on actions included on the live action sheet.
Dr Dunderdale to update the action log in relation to item 70/18 **KD**

116/18 **Integrated Performance & Quality Report**

Dr Dunderdale presented the performance and quality report and the following points were noted:

- The full report was received by the Committee

The number of falls has increased in month
Professor Beale expressed the view that the performance report should be more relevant to the committee; Ms Davies advised that she would request that the report be separated for the October meeting. Mr Gayle advised that issues raised at the People & Organisational Development Committee needed to be highlighted through Quality & Safety.

Dr Dunderdale highlighted the number of falls that had occurred during August and confirmed that she would be undertaking a review to understand the context. Trends had been identified with the repeat falls which were due to a few individual patients who were frail, elderly and confused. Specific meetings had been arranged which the Deputy Director of Nursing would chair to discuss what could be undertaken differently. Mr Gayle highlighted that previously 'butterfly bays' had been used, Dr Dunderdale advised that the 'butterfly bays' were still in existence and there were areas of very good nursing practice on the wards. It was noted that the Quality & Safety Committee should have clear oversight of the quality indicators; however, the performance report does not provide the detail beneath the numbers from a quality perspective.

Dr Dunderdale confirmed that NHSI had offered support regarding information analysis at a Leading for improvement event this week and the Trust should avail its self of this option. A discussion took place around the data available to the organisation, Dr Dunderdale assured the committee that work was being undertaken though the performance teams to ensure accuracy and timely information was available. Dr Dunderdale & Mrs Loader to approach NHSI for this support.

Mrs Baines expressed the view that there should be an opportunity to undertake a deep dive of specific elements of the report Ms Davies confirmed that she was undertaking some work on the report and was pleased to hear about the NHSI support, Mrs Loader confirmed that she was concerned about the PCIP report and how it was being managed and felt that NHSI support would be very helpful.

Professor Beale expressed the view that the committee had spent a long time

trying to pare the report down and needed to ensure the correct information was on the dashboard. Dr Dunderdale advised that more detail on falls and skin integrity could be offered at the October meeting. To be a separate agenda item. **KD**

Mrs Baines queried the deterioration in the response rate to complaints, Dr Dunderdale responded that there were no issues in relation to the complaints team; however, the complexity of cases had increased which involved multiple teams. Dr Dunderdale advised that she would discuss with the Complaints Manager around the detail provided for the report and invite him to a future meeting.

Following discussion of the report Professor Beale advised that falls and complaint responses were of particular concern to the Quality & Safety Committee. Mr Gayle also highlighted that the compliance with Friends and Family Test had dropped for August, it was agreed that further detail around the trend was required. The committee highlighted their concerns regarding the missing data in the report around medication storage.

Resolution:
The Committee received and noted the content of the Performance & Quality Report
The Committee resolved to make the Trust Board aware of their concerns regarding falls and complaint responses

117/18 **CQC Preparation Update**

Mrs Loader presented the CQC preparation report and advised of her concerns around the PCIP and the need for a solution to allow for collection of evidence within the document. Confirmation was received that meetings had been arranged with the Care Groups to discuss the detail and track their progress. Areas of concern were highlighted as:

- Documentation
- Completion of MCA forms
- Enable East Peer Review – fundamental standards

The Divisions had been requested to discuss with their teams and return with actions to resolve both issues. Progress to be reported to the October Quality & Safety Committee.

Ms Davies advised that she was currently developing a Standard Operating Procedure and governance process to keep track and be clear about roles and responsibilities. Ms Davies queried board to ward ownership to provide oversight of evidence to demonstrate sustainable change and improvement. It was noted that further resources would need to be identified to help with the programme management.

Ms Davies further advised she had extracted the records management section from the Records Management policy to understand the expectation and professional standards in terms of documentation.

DNA CPR had been discussed with the Medical Director and suggested that a multidisciplinary session should be held on DNA CPR and lessons learned. Professor Beale expressed the view that the Clinical Director's should be taking non-compliance forward with their teams. Members agreed that documentation was a fundamental part of a clinician's role and that behaviour needed to be changed by strong enforcement.

A discussion took place regarding the Enable East report which stated that there was a lack fundamental care for the patient, concern was expressed regarding the need to hold people to account. Dr Dunderdale expressed her concerns and advised that there were pockets of good care but it was not consistent. Dr Dunderdale is leading an event on the 8 November to develop a nursing strategy leading to the commencement of "Pathway to Excellence" as a team work to raise standards and professionalism.

Mr Thomas-Hands and Mrs Davies joined the meeting. Dr Dunderdale outlined her plans to hold the senior nursing staff to account and confirmed that specific actions have been taken and she offered to brief non-executives outside of this meeting.

Mrs Baines queried the strategy for electronic patient records and requested further feedback. The committee further requested an update on the EPR strategy in relation to any quality, patient experience and safety risks.
A discussion followed regarding missing notes, Ms Davies confirmed that discussions had been held at Information Governance Steering Group; however, she confirmed that she was not able to provide assurance that records would never be lost. Discussions were also confirmed at CQC Preparation meetings and work was on-going with Health Records. Mr Gayle expressed his concern about the reputation of the organisation in relation to missing notes, Ms Davies advised that she would discuss with the Medical Director to provide an update at the next meeting. **JD**

Resolution:
The Committee received the CQC Preparation Update and noted and discussed the Enable East Report

118/18 **Update on Follow Up Backlog**

Mr Thomas-Hands presented the follow up backlog report and advised that the organisation had fully declared the position with the backlog to NHSI. Mr Thomas-Hands advised that with the use of robotic software lots of patients had been contacted and validation was ongoing with the clinical teams. Professor Beale thanked the team for all their hard work. Mrs Baines queried the risks whether operational or clinical as less than 20% of people contacted had replied and requested assurance. Mr Thomas-Hands agreed to bring a further update to the meeting in October regarding the risks associated with those patients who had not responded to contact by the teams and in addition how the operations directorate were managing new patients added to the waiting list. **PTH**

Mrs Loader queried whether the Quality & Safety Committee received the harm

review update from the Clinical Harm Group; Mrs Davies advised that this was on the action log for the October meeting.

Resolution:
The Committee received the follow-up backlog report and agreed to receive an update on the risks at the October meeting.

119/18 **Quality Impact Assessment Process**

Mrs Povey attended the meeting to present the Quality Impact Assessment report. Professor Beale advised that the committee were not quorate and therefore were unable to approve the presented enhanced QIAs. Mrs Povey outlined the process for review and the scoring, the committee offered advice regarding clarity of the scoring and it was agreed that the scoring should be amended that additional review was required for schemes that scored greater than 12.

Mrs Baines queried whether there was a process for reviewing a sample of approved schemes to provide quality assurance on the process for determining the need for a QIA. Ms Davies advised that Internal Audit provided an annual report as part of the audit process. Professor Beale queried the process if the scheme changed and the need to undertake a QIA, Mrs Povey advised that the scheme would be reviewed by the team of three and paused or stopped and followed by an impact assessment review. Following discussion it was agreed that the plan would be updated and re-circulated. **JD**

Resolution:
The Committee received and resolved to receive an updated plan. The committee would approve the QIA at its meeting in October.

120/18 **Serious Incident and Never Events Update**

Mr Rawlings attended the meeting to present the update report which informed the Committee of serious incidents and never events reported since the last meeting. Mr Rawlings confirmed that the report had been developed following feedback at the last committee meeting. Mr Rawlings went on to discuss the report.

The provision of future deaths report had been received from the Coroner regarding a gynaecology case and a report had been provided to the Coroner.

Ms Davies confirmed that the team were working on the incident process and practice and had presented a revised governance structure to TMB which included an incident review panel to look at outcome reports from serious incidents.
Mrs Loader highlighted that WMQRS would be visiting the organisation this week and suggested that there should be a regular report to this committee from external visits, it was agreed that a process to enable this needed to be developed and added to the annual cycle of business for the committee. Ms Davies agreed to undertake the review with Dr Dunderdale. Professor Beale raised concerns regarding no consultant review of deteriorating patients from

one of the incidents; Dr Dunderdale suggested that the information from the particular incident should be triangulated with the WMQRS report once received and this would be brought to the committee once available with an associated action plan.

Never Event: Mr Rawlings updated the Committee on a recent never event regarding the use of an air outlet instead of oxygen. The never event is associated with a previous safety alert issued in 2016. The current investigation which will be chaired by Dr Dunderdale would also pick up the issue of the management of safety alerts. The committee were given reassurance from Mr Rawlings that all areas of the trust have been reviewed again in line with the patient safety alert. Education has also been provided to ED staff. Professor Beale asked how the letter in June 2018 from NHS Improvement about this very issue had been acted on. The committee resolved not to speculate but to allow the investigation to concluded and for a report to be presented to meeting in October.

Resolution:
The Committee received and noted the Serious Incident and Never Event Report

121/18 **Joint Targeted Area Inspection (CSAFE)**

Mrs Rhoden attended the meeting to present the CSAFE report and advised that the organisation would be taking part in the multi-agency review, an assessment would be undertaken followed by a meeting with the Local Authority and West Midlands Police to devise an action plan. A discussion took place regarding the review; Mrs Rhoden advised that she felt as part of the Multi Agency Safeguarding Hub (MASH) the Trust were in a better place than previously. Confirmation was received that a progress report would be provided to the Committee in three months' time.

Resolution:
The Committee received and noted the Joint Targeted Area Inspection report and resolved to receive an update in three months' time

122/18 **Controlled Drugs Report**

Mr Fletcher attended the meeting to discuss the Controlled Drugs report which updated the Committee regarding the controlled drugs policy, incidents and key issues in relation to quality and safety.

Mr Fletcher highlighted the following from the report:

- Agreed stock list for all areas that use drugs
- Ensuring there is evidence of unusual activity noted
- Incidents reviewed by the Deputy Director of Pharmacy
- Any suspicion of theft reported to the Police and our good relationship with the police
- the management of errors amended in the drug register on the wards

Mrs Loader queried where the report to the committee had been presented

previously; Mr Fletcher advised that it was discussed at Medicines Management Committee. Dr Dunderdale advised that this committee should have sight of medicines management and there would now be regular reporting to this committee to the Trust Board. In light of the findings in the report Dr Dunderdale advised that she would be raising this at the Nursing Midwifery Advisory Forum in conjunction with registered nurses accountability to the NMC code and the Trusts medicines management policy. Dr Dunderdale said that she would be working with the Chief Pharmacist to identify any individuals who require support to meet their responsibilities. Mrs Loader advised that medicines management should be discussed at CQC preparation meeting and added to the PCIP.

Resolution:
The Committee received and noted the report on Controlled Drugs

123/18 **Presentation from the Adult Community Team**

The Chair welcomed Mrs Chaloner and Mrs Geffen from the Community nursing team to the meeting and a presentation was provided. The following points were noted:

- Positive use and adoption of IT to assist service provision
- Improved mandatory training compliance
- Assisting with the Walsall Together Partnership
- Decommissioning of the contract for the specialist falls service

The members queried what support would be needed to maintain or improve the CQC rating and were there things that could be shared with the acute teams; Mrs Chaloner felt that there was a need for re-design of some services. Mrs Baines queried whether the change in the specialist fall service would mean a loss of staff, Mrs Chaloner advised that the falls team were small and the staff would be re-deployed with a Management of Change in process. A robust conversation was being held with the CCG regarding the risk. Dr Dunderdale confirmed that Executive to Executive conversations had been held about provision for falls through the community team The committee specifically wish to raise their concerns to the board regarding the decommissioning of the community specialist falls service and the potential impact this will have for patients.

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

124/18 **Report on the Communication Plan & Placement of Trainee Nursing Associates**

Dr Dunderdale advised that the report could be removed from the meeting as it would be discussed through the Nursing and Midwifery Forum, a highlight report would be provided to the October Quality & Safety Committee.

Resolution:
The Committee noted the work undertaken on Trainee Nursing

Associates and would be pleased to receive a highlight report from the Nursing & Midwifery Forum in October.

125/18 **Nursing Workforce Work-stream**

Mrs Davies attended the meeting to present the report on the development and implementation of the nursing workforce transformation programme. Mrs Davies advised that she would be setting up weekly operational meetings with a number of key people with a report provided to a monthly oversight meeting and formally to Quality & Safety Committee and also the Performance, Finance & Investment Committee, Mr Gayle suggested that the report should also be received at People & Organisation Development Committee. Dr Dunderdale confirmed that John Dunn would be the Non-Executive Director providing confirm and challenge.

- Mrs Davies described each of the work streams associated with this programme

Resolution:
The Committee received and noted the report on the Nursing Workforce Transformation Programme

126/18 **Risk Appetite**

The committee undertook a review of the risk appetite statement relating to the Quality & Safety committee. The committee acknowledged that the risk appetite had previously been discussed at Trust Board and following discussion the members confirmed they were happy with the risk statement; however, felt that the Trust Board would want to see all of the risks together.

Resolution:
The Committee received and noted the content of the Risk Report

127/18 **Review of Board Assurance Framework**

The committee undertook a reive of the BAF relating to the Quality & Safety committee. Ms Davies advised that she had worked with Dr Dunderdale to re-draft the Board Assurance Framework from its previous presentation to Trust Board. Professor Beale queried whether all the risks from the previous BAF had been carried forward, Ms Davies advised that she would need to look at the previous document and further suggested that a deep dive could be undertaken into the BAF risks, which would need regular review by Quality & Safety Committee. Ms Davies agreed to bring an updated version to the October meeting.

Resolution:
The Committee received and noted the Board Assurance Framework report and resolved to receive an updated version at the October meeting.

128/18 **Monthly Nurse Staffing Report**

Dr Dunderdale presented the report and advised that outcome of the Nursing Establishment Review would be taken to the October Trust Board. Dr Dunderdale also presented a paper on the principles and processes of nurse staffing on our wards. Whilst the committee were unable to approve the paper due to not being quorate they adopted the principles.

Resolution:
The Committee received and noted the report on Nurse Staffing and the principles of staffing on our wards.

129/18 **Mortality Report**

Professor Beale requested that in the absence of the Medical Director, the mortality report be deferred to the October meeting.

Resolution:
The Committee resolved to receive the mortality report at the October meeting.

130/18 **Items to Highlight to the Trust Board**

Resolution:
The Committee resolved that the following items would be referred to the Trust Board at its meeting on 4th October 2018.
The Committee resolved to refer 'Structure of Workforce' to the People & Organisational Development Committee

- Improved position on the follow-up backlog
- Clear reporting of Duty of Candour through the Serious Incident report
- A deep dive around the Integrated Performance dashboard and the plans to include trends
- Electronic patient record
- The need to improve documentation following the Enable East Peer Review
- Controlled Drugs audit
- A review of the risk appetite statement and BAF element
-
- Refreshed Terms of reference for the committee

131/18 **Quality, Patient Experience & Safety Committee – Terms of Reference**

Dr Dunderdale discussed the proposed Terms of Reference and the following amendments were agreed.

- The title of the Committee would be Quality, Patient Experience & Safety Committee
- The non-attendance of the Medical or Nursing Director should not affect the quoracy of the meeting.

Resolution:
The Committee resolved to adopt the Terms of Reference with the agreed amendments

132/18 **Reflections on Meeting: Post Meeting Questions from Trust Meeting Etiquette**

Utilising the Post Meeting Questionnaire agreed as part of the Trust's meeting etiquette Professor Beale sought feedback from the members and attendees.

133/18 **Any Other Business**

There were no further items for discussion

134/18 **Date & Time of Next Meeting**

Thursday 25th October 2018 at 9.00 a.m.,
Seminar Room 10, MLCC

MEETING OF THE PUBLIC TRUST BOARD – 1st NOVEMBER 2018			
Performance, Finance & Investment Committee (PFIC) update report			**AGENDA ITEM: 18**
Report Author and Job Title:	Mr R Caldicott – Director of Finance & Performance	**Responsible Director:**	Mr J Dunn – Chair of PFIC (Non-Executive Director)
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	The report indicates the key messages from PFIC for escalation to the Trust Board, namely; • Trust remains behind original & Financial Recovery Plan (FRP) • Temporary workforce costs are driving adverse position • Cost Improvement Programme requires additional traction to deliver (in particular productivity metrics) Members re-affirmed the plan to be robust; It is now about delivery of the agreed actions (at pace) to recover the financial outturn. Recovery actions centred upon; • Presentation of plans for delivery of Medical temporary workforce controls and the outpatients work-stream • Full re-forecast based on performance against FRP and temporary workforce costs for next Committee, to inform the Board on Forecast Outturn The Trust performance is as follows; • ED performing below trajectory, noting focus needing to be placed upon the medically fit for discharge • Cancer & 6 week diagnostic performing well and delivering national targets, RTT is delivering to local trajectory Committee received and approved the business case for future provision of the Wide Area Network (WAN) and discussed future provision of the PAS/EPR.		
Recommendation	Members of the Board are asked to note the business of the meeting and risk to delivery of the Financial Recovery Programme.		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	This report aligns to the BAF risk associated with delivery of the financial plan, with the risk rated as red at present (high risk of failure to attain delivery).		
Resource implications	There are no resource implications associated with this report		
Legal, Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☒		

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE HIGHLIGHT REPORT

KEY AREAS FOR CONSIDERATION BY THE BOARD

1. INTRODUCTION

The Committee reports to the Trust Board each month following its meeting, this report covering the key issues from the meeting held on the 22nd October 2018.

2. KEY ISSUES

2.1 The meeting was quorate and Chaired by Mr Dunn, Non-executive Director and Committee Chair.

2.2 Financial performance

The Trust has attained a £14.8m deficit as at month 6 (a £4.6m adverse variance to plan) the key driver being the continued high use of temporary workforce (£2.3m in month) with Nursing & Medical expenditure exceeding historic levels.

The Trust is behind trajectory on the agreed Financial Recovery Plan (FRP) and members re-iterated their concerns over delivery of the plan, the schemes needing to be implemented at pace (noting costs included to deliver the winter plan need to be robust).

Members received presentations on the cost control measures for Nursing temporary workforce and a review of the Medical & Long Term Conditions current medical temporary workforce usage and planned changes.

Key Actions: -

a) Presentation of the impact on temporary workforce following enhanced controls
b) A presentation on Medical Workforce to include all Clinical Divisions
c) Full re-forecast based on performance against FRP and temporary workforce costs for next Committee, to inform the Board on Forecast Outturn, to include the impact of the winter plan.
d) The outpatients productivity work-stream to present plan for delivery at the next meeting of members

2.3 Trust performance against constitutional standards

The Trust is performing well against Cancer and 6 week diagnostics targets (attaining national performance standards) with RTT on trajectory. However, the Emergency Department (ED) four hour wait performance was below plan, the Trust reporting high numbers of medically fit for discharge patients occupying current bed capacity.

2.4 Business Case Approval

i. Committee received and approved the business case for future provision of the Wide Area Network (WAN)
ii. Members received a update report on the provision of the PAS/EPR digital future, with a full business to be produced and presented to Decembers Committee

3. RECOMMENDATION

The Board is recommended to discuss the content of the report and raise any questions in relation to the assurance provided.

MINUTES OF THE PERFORMANCE FINANCE AND INVESTMENT COMMITTEE HELD ON WEDNESDAY 26th SEPTEMBER 2018 AT 2.00 P.M. IN ROOM 10, MLCC

Present:	Mr J Dunn	Non-executive Director (Chair of Committee)
	Mr R Caldicott	Director of Finance and Performance
	Mr D Fradgley	Director of Strategy & Improvement
	Mr S Heer	Non-executive Director
	Mr P Thomas-Hands	Chief Operating Officer
	Ms J Davies	Director of Governance
In Attendance:	Mr Q Zada	PMO Director (Up to and including Item 073/18)
	Mr N Rashid	Divisional Director, MLTC Division (From Item 071/18)
	Mr M Dodd	Director of Operations, MLTC Division (Item 071/18 only)
	Ms J Hurst	KPMG (Item 070/18 only)
	Mr C O'Toole	KPMG (Item 070/18 only)
	Mrs C Dawes	Executive Assistant (Minutes)
Apologies:	Mr Beeken	Chief Executive
	Mr A Khan	Medical Director

The Chair opened the meeting and welcomed everyone. Apologies were noted and the meeting was declared quorate. Members were reminded it had been agreed nominated deputies should attend meetings in the absence of Executive members.

ACTION

066/18 **Quorum**
The meeting was declared not quorate in line with Item 5 of the Committee Terms of Reference;

067/18 **Declarations of Interest**
There were no declarations of interest.

068/18 **Minutes of the Meetings held on 17th July 2018, 25th July and 29th August 2018**

Resolution:
The minutes of the meetings held on 17th July and 25th July 2018 were approved as an accurate record and the minutes of the meeting held on 29th August 2018 would be approved at the next meeting.

069/18 **Matters Arising and Action Sheet**

The Committee noted the actions would be covered through the meeting

discussions.

049/18 Review of Standing Financial Instructions: The Director of Governance had circulated the amended levels of delegated authority to the Chairs of PFIC and Audit Committee for comment. The Chair said it would be useful to know the delegated levels of other trusts. The Director of Governance advised that information had been gathered and would be shared by the end of the week. Item complete. **JDav**

058/18 Breakdown of Nursing staff vacancies: The Director of Nursing to attend the next meeting to provide an update on the nursing establishment review. **KD**

Ms Hurst and Mr O'Toole joined the meeting at this point.

070/18 **KPMG Phase 4 Close Out Report**

Ms Hurst and Mr O'Toole were welcomed to the meeting and introductions made.

Ms Hurst explained the KPMG Phase 4 Close Out Report for the FIP2 work undertaken had been updated to reflect the year-end figures and offered to arrange individual meetings to clarify any points within the document if required.

Mr O'Toole gave an overview of the report content advising KPMG had initially been commissioned by the Trust to provide support to mitigate the potential risk of £10m in delivering the 2017/18 Financial Planned deficit of £20.5m. It was noted the Phase 4 Close Out report should be read in conjunction with the Phase 3 Close Out report previously received by the committee.

The committee questioned what the benefit of the KPMG commission was and sought clarification of the delivery against plan figures. Mr O'Toole indicated delivery in year totalled £6.3m supported by KPMG, and a further incremental benefit of £9m.

The Director of Finance challenged the savings delivery, indicating this figure was (although remaining significant) more in the region of the £4.1m indicated by the chart on page 11 showing schemes pre and post CIP. In addition, the full year opportunity could be stated as being a further £4m largely associated with the outpatients and theatres productivity work-stream, rather than the £9m referred to within the report (the detail identified within table 10 of the report).

Mr Heer queried the reasons for non-delivery of the target. Mr O'Toole explained there were a number of reasons including high agency/temporary workforce expenditure, operational pressures, lack of expenditure controls and the decision not to proceed with all proposals put forward by KPMG.

The Director of Finance advised workforce and agency did not deliver within the commission. Though accepted that the decision to change

protocols on booking of agency for all RN vacancies had also adversely affected delivery.

The committee asked about lessons learned and questioned if anything could have been done differently. It was noted more engagement with the Trust to understand skill mix around capacity and capability and ensuring the CEO, Executives and Senior Teams were fully aligned to the expectations prior to commencement of the work.

The Director of Finance reflected on the comments made and added the Trust needed greater clarity from its partner on key milestones and who was the responsible officer to enable them to be held to account, with more focused weekly trajectory reviews that contained this information in more granularity. If capacity and capability was identified as a key concern, then being prepared to take action in the immediacy was needed and one partner oversight would have been insisted upon in hindsight.

The Chair summarised the discussion by thanking KPMG for their engagement and noted there was benefit from their commission. Members were reminded to liaise with KPMG should they require further specific clarification.

The Director of Finance advised KPMG had been commissioned to support a further three pieces of work at a nominal cost as benefits of the FIP2 programme had not been fully delivered:

Resolution:
The Committee:

- **Received and noted the content of the KPMG Close Out Report**
- **Noted KPMG would be supporting a further three pieces of work at a nominal cost, with the fee now payable.**

Ms Hurst and Mr O'Toole left the meeting.

Mr Rashid and Mr Dodd joined the meeting at this point.

071/18 **Divisional Presentation – Medicine & LTC Division**

Mr Rashid and Mr Dodd were welcomed and the Chief Operating Officer explained the purpose of the presentation was to outline the Medicine & LTC Division's current financial position, highlight any concerns and explain their plans to improve their position.

Mr Caldicott highlighted the MLTC Division had signed off the 2018/19 financial plan to include agreement to activity profiles (with a physical signature received from the Divisional Director). However, the current financial position and existing run rate had given rise to significant concerns over delivery of the plan.

The Division were therefore engaged in production of a forecast outturn and then development of the Financial Recovery Programme, with schemes endorsed through Divisional meetings, meetings with the Executive and through the Performance & Finance Executive (PFE) .

The process adopted for articulation of schemes to support financial recovery is that used to identify Cost Improvement in the Trust, in that a Project Initiation Document (PID) was agreed with individual elements that impacted upon the Division signed off by the division prior to being endorsed by the lead Executive Director for the scheme With the schemes endorsed by the full Executive and Quality Impact Assessments completed for each scheme, with escalation to Quality & Safety Committee for any schemes requiring enhanced oversight prior to being implemented.

Mr Dunn asked the Division to explain the current position following the introduction by Mr Caldicott. Mr Rashid reported the MLTC Division were currently £2.2m overspent against a forecasted overspend of £2.43m. This was a better position than in July due to the award of income CIPs, however Corporate schemes had not been delivering.

The forecast outturn based on run rate totalled £5.37m andreas of underperformance related to non-achievement of Outpatients CIP. However, the main drivers of the deficit predominantly centred upon additional temporary workforce contained within the medical locum and temporary nursing expenditure.

A review of the nursing establishment was being undertaken and the implementation of additional controls for temporary workforce. A full review to be undertaken of the MLTC medical staffing workforce and a review of the booking controls and job planning processes.

In addition, Mr Rashid reported the August run rate was currently £130k off plan as a result of high spends in medical and nursing workforce due to additional capacity beds open. The division were working on CIP initiatives and other external areas e.g. Walsall Together.

Mr Dodd agreed that a more radical approach was required to enable the Division to find improvements and savings but currently flagging the risk of delivery.The Chief Operating Officer agreed some schemes were high risk but he was supporting the division in mitigating the risk e.g. changes were being made to the Frail Elderly service (FES).

The Director of Finance raised concern the Division were not offering assurances over delivery when the Executive (including Mr Caldicott) had met with the Division to agree expenditure reductions. Mr Rashid requested additional support in identifying the potential run rate reductions to enable delivery of the Divisional share of the FRP. Mr Caldicott re-iterated that the Executive meeting offered that support and agreed to meet with the Division to understand why they now were identifying risks to delivery of the Financial Recovery Plan.

The Chair summarised discussions by noting the MLTC Division had not assured members they had a sufficiently developed plan to fully underpin the delivery of the FRP and it would be difficult to give assurance to the Trust Board. It was requested the division undertake a review of their plans and confirm what the run rate will be and what would be delivered.

Mr Zada advised a workshop was being arranged for the generation of ideas.

Resolution:
The Committee:

- **Received and noted the Divisional presentation from MLTC Division**
- **Noted there were serious concerns about the delivery of the FRP**
- **Requested the division review plans to confirm what would be delivered**

Mr Rashid remained in the meeting as the designated deputy of Mr Khan.
Mr Dodd left the meeting.

072/18 Financial Performance - 2018/2019 Month 5 Report

The Director of Finance presented the 2018/2019 Financial Report for Month 5 and the following highlighted:

- The Trust was reporting a deficit of £11.5m against a deficit plan of £8.5m, resulting in an unfavourable variance of £3.0m.

- The position provided for £1m loss of Provider Sustainability Funds (which would be recovered in part if the Trust was on plan at the end of Q2).

- The contracted income showed an unfavourable variance to plan of £0.2m (the main area of under-performance was in Maternity and Adult/Neonatal Critical Care, other income reflected the PSF reduction.

- Expenditure was overspent YTD. The main area of overspending was pay (£1.5m) due to temporary staffing costs in Medical and Nursing.

- The Trust's Annual Cost Improvement Programme requirement was £15.5m.

- The CIP plan for M5 was £4.6m and actual delivery was £3.4m resulting in an under achievement of £1.2m YTD. In addition, of this total £1.8m was delivered non-recurrently, placing increased pressure on future financial sustainability.

- The Trust's planned cash holding in accordance with borrowing requirements was £1m. The actual cash holding is £1.9m.

- The Trust's agreed borrowing for 2018/19 was £10.6m reflecting the deficit plan. The majority of this borrowing was for the first half of the year reflecting the increased CIP efficiencies planned for the latter half of the year deliver reduced spending/increased income.

- The deficit higher than plan places increased pressure on cash flow and borrowing.

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

- Total expenditure on temporary workforce in month was £2.1m (£2.1m July 2018). This was the highest level in month temporary workforce expenditure in the previous 12 months.

The Director of Finance confirmed there were two key pieces of work being undertaken, the nursing controls and medical staffing review. KPMG would be providing support and will map the controls in order to bring costs down. A report would be provided for the next meeting. He stressed that if we don't avert at pace the delivery of the Control Total would not be achieved.

Mr Heer queried why grip and controls were not in place and not being fully implemented at this stage of the financial year. The Director of Governance advised steps were being taken to improve methodology with additional support to assist with the nursing review

The Chair commented the planning was more robust than previous years but delivery was not being addressed at pace. He noted there were two major pieces of work to be done (Nursing and Medical reviews) and members need to see a reduction in costs to be assured.

RC/ KD/AK

Resolution:
The Committee:

- **Received and noted the content of the Finance Report**
- **Requested attendance of the Director of Nursing at the next Committee to articulate the control measures being put in place to ensure Nursing temporary workforce expenditure reduces**
- **Requested the Medical Director report at the next Committee measures undertaken to reduce temporary medical workforce costs**

073/18 Financial Recovery Plan 2018/19 and Cost Improvement Programme Update

The PMO Director gave an overview of the Cost Improvement Programme financial performance as at August 2018:

- A CIP of £15m was required in year (income driven through productivity gains)
- The YTD Month 5 savings plan for the Trust was £4.55m, with actual delivery at YTD Month 5 at £3.41m (£1.14m adverse variance to plan)
- £1.8k non-recurrent
- Temporary workforce costs for August totalled £2.1m (£369k higher

than August 2017) and this contributed to overspends in month
- Working with Divisions to fast-track CIP schemes and identification of mitigating schemes

The Chair summarised by noting the excellent progress made in delivery of CIP year to date being higher than in previous years and that further work to be done on pipeline schemes to mitigate the risks and support delivery of the Financial Recovery Plan.

Resolution:
The Committee:
- **Received and noted the content of the 2018/19 Financial Recovery Plan/Cost Improvement Programme Update.**

Mr Zada left the meeting.

074/18 **Constitutional Standards Operational Update**

The Constitutional Standards relating to Emergency Department, Elective Access and Cancer was received and the key the following highlighted:

Emergency/Urgent Care:

- August performance was 85.74% against a target of 88%.
- Medically Fit for Discharge (MFFD) list had risen to almost the March figure at 116, with increases in length of stay.
- August saw continued high levels of ambulances to ED (90+ ambulance arrivals on 11 days in month).
- Admissions per day in August decreased to 87 compared to 88 in July.
- There were no 12 hour breaches.
- Audits had shown an improvement in SAFER working practices in August/September

Elective Access:
- Performance in August was 89.51% against a trajectory of 85.50%. This was a slight decrease from the July performance of 90.0%.
- The outpatient work-stream continues to embed improvements on booking utilisation, reduction in DNA rates and using core capacity to see cancer referrals, whilst keeping WLI clinics to a minimum.
- The trajectory assumed delivery without WLI activity.
- The clinic booking utilisation target of 90% was achieved by 1 of the 3 divisions in August
- There were no 52 week breaches in July.

Cancer:
- All national cancer measures achieved in July. Initial un-validated performance for August shows achievement of all cancer measures with exception of 62 day.
- Equipment issues resulted in patients being diverted to Sandwell for treatment whilst interim measures were put in place.

Diagnostics:

August performance was 99.61% thus achieving the 99% target.

There was a discussion around the annual leave profiling for medical staff over the summer period to ensure performance levels were maintained. It was noted the authorisation protocols would need to be reviewed for next year.

The Chief Operating Officer advised of the management changes within the Medicine Division as additional support was being provided to assist over the winter period. He confirmed the winter plans were going well as a result of the changes being made to the Frail Elderly Service (FES) which will reduce the number of patients being admitted to wards from the Emergency Department.

The Chair summarised by noting the improved performance of the constitutional standards, focus was on MFFD and reducing the length of stay, the plans for winter were going well and equipment issues had affected some cancer treatments.

Resolution:
The Committee:

- **Received and noted the content of the Constitutional Standards Operational Update.**

075/18 **Model Hospital**

The Director of Strategy & Improvement presented a report that explored how the Trust could better use its access to the variety of benchmark data available that will better inform its annual operational plan. This will ensure that it is robust, realistic and achievable.

It was noted the Planning Guidance had been deferred till October but in the absence of the planning guidance the Executive Team would continue to prepare for a draft submission based on last year's guidance plus the additional information. The Director of Strategy & Improvement agreed to develop a timetable when the planning guidance was available. **DF**

The Committee noted the content of the report.

Resolution:
The Committee:

- **Received and noted the content of the Model Hospital report**

076/18 **Performance and Quality Report by Exception**

The Performance and Quality Report was taken as read.
The Chair requested the report be reviewed in full at the next meeting.

Resolution:

The Committee:

- **Received and noted the content of the report.**
- **Agreed to review the full report at the next meeting.**

077/18 **Diabetes Transition Service Business Case**

The Business Case had been withdrawn as due process had not been followed. The Director of Strategy & Improvement will have oversight of all future business cases.

078/18 **Critical Care Out-Reach Business Case**

The Business Case had been withdrawn as due process had not been followed. The Director of Strategy & Improvement will have oversight of all future business cases.

079/18 **Community Child Health Records Business Case**

The Director of Strategy & Improvement gave an overview of the Business Case for Community Child Health Records. It was noted child health records were currently held by the Trust in community bases around Walsall. The storage facilities have been rated as inadequate. The Trust had legal responsibility for the records but they were managed by Walsall CCG. The CQC recognised the risk and safeguarding issues and gave a "Must Do" instruction for the records to be digitised. Funding for the digitisation of records had been agreed by Walsall Public Health.

The committee approved the business case to proceed at the best costs available.

Resolution:

The Committee:

- **Received and noted the content of the report.**
- **Approved the business case to proceed at the best costs available**

080/18 **Committee Terms of Reference and Annual Cycle of Business**

The Director of Governance presented the revised Terms of Reference for approval.

There was a discussion around the membership and the quorate was increased to ensure two NED's are in attendance at all meetings. Furthermore, it was felt that quoracy should be consistent across all sub-committees. The Director of Governance to raise this with the Trust Chair for Trust Board discussion.

082/18 **ANY OTHER BUSINESS**

The Director of Strategy & Improvement advised the Pharmacy SubCo proposal had been progressing with assurance from NHSI but had been withdrawn as the Secretary of State had put a hold on all Sub Cos. Following discussion at the Exec Team meeting it was agreed to continue with the tender process but not award the contract until NHSI give authority to do so.

The committee thanked Mr Rashid for this attendance.

083/18 **Date of Next Meeting**

The next meeting of the Committee would be held on of **Monday, 22nd October 2018 at 2p.m.** in Seminar Room, route 109. (date changed from schedule).

MEETING OF THE PUBLIC TRUST BOARD – THURSDAY 1st NOVEMBER			
People and Organisational Development Committee Highlight Report			**AGENDA ITEM: 19**
Report Author and Job Title:	Catherine Griffiths, Director of People and Culture	**Responsible Director:**	Catherine Griffiths, Director of People and Culture
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	This report details Board Assurance and the Annual Cycle of Business and to: 1. The delivery of the People Strategy which supports employees in the provision and delivery of high quality, safe patient care. 2. The processes adopted to support optimum employee performance in line with the Trust values. 3. The delivery of the Trust's legal and regulatory duties in relation to its employees. **4.** The management of Trust risks related to human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives – these are captured on the Board Assurance Framework and Corporate Risk Register.		
Recommendation	Members of the Trust Board are asked to note the content of the report for information.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	**BAF Risks:** **No 7.** That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff **No 8.** That we are not successful in our work to establish a clinically led engaged and empowered culture. **No. 11.** That our governance remains "inadequate" as assessed under the CQC Well Led standard.		
Resource implications	There are no resource implications associated with this report.		

Legal and Equality and Diversity implications	The Board Assurance Framework reports to People and Organisational Development Committee to identify current implications.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☒	

The People and Organisational Development Committee Highlight report

1. PURPOSE OF REPORT

The purpose of this report is to inform the Board of key issues discussed at People and Organisation Development Committee and of key actions identified.

2. BACKGROUND

The People and Organisation Development Committee is a sub-committee of Trust Board and has an annual programme of business that is developed to provide assurance to the Trust Board on:

5. The delivery of the People Strategy which supports employees in the provision and delivery of high quality, safe patient care.

6. The processes adopted to support optimum employee performance in line with the Trust values.

7. The delivery of the Trust's legal and regulatory duties in relation to its employees.

8. The management of Trust risks related to human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives – these are captured on the Board Assurance Framework and Corporate Risk Register.

3. DETAILS

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

The key issues discussed were:

1. <u>Governance:</u>
   The supporting governance for the Committee was received and noted including the Risk Appetite Statement, the updated Terms of Reference, the Review of Risks and Board Assurance Framework. The Annual Cycle of Business was received and noted with the addition of including Quality Improvement, Walsall Together, LWAB and Black Country Strategy for Learning.

2. <u>Workforce Performance Data & Metrics:</u>
   The Committee received and considered the standard workforce data and metric set with particular focus on current levels of sickness absence, increasing impact of stress, anxiety and depression on absence rates and actions to improve attendance

and to improve staff health and wellbeing. The Committee discussed the transformation work taking place in nursing and the current focus on using the annual leave policy appropriately.

3. Employment Relations – Trends, Issues and Progress:
The Committee received and considered the employment relations report with particular focus upon the length to complete cases and the need to reduce these timescales. In addition the Committee considered the Trust approach to reducing incidents of violence and aggression and measuring this appropriately within the Workforce metrics and towards providing clarity on what constitutes bullying and harassment and increasing awareness and reporting.

4. Nursing Workforce Transformation Programme:
The Committee received and noted the report on the Nursing Workforce Transformation Programme, which outlined the Trust wide programme on transforming the approach to nursing workforce. The Committee noted that the skill mix and establishment review work had been completed with the engagement of ward staff and that detailed work was well advanced on improving the control mechanisms for use of agency workforce. The Committee also noted the work on enhancing the bank within the Trust including prioritisation for filling of shifts and managing vulnerable shifts and the emergent work on collaborative bank. The Committee noted that the Community based workforce would be considered in a later phase of transformation.

5. Strategic People Management Approach:
The Committee noted that a Review of the delivery of the People Strategy 2016-2020 and a review of the Strategic Approach to Equalities would be received at the November meeting.

6. Staff Engagement – Annual and Local Staff Surveys:
The Committee noted the National Staff Survey has been launched within the Trust and received an update on the response rate. The Committee noted the ongoing approach to local staff engagement through the Pulse Surveys and the staff engagement plan. The Committee noted that a Values Based recruitment tool will be available and that the Appraisal approach will also embed the Trust values.

7. Staff Resourcing – Turnover, Exit and Reasons for Leaving:
The Committee noted a report detailing vacancy and turnover rates within the Trust for key hotspot areas of resourcing. The Committee discussion focused on how to improve the exit process and act upon the key themes to improve future retention. There was a further discussion in detail related to the retention of the medical workforce and Committee resolved to receive an update on the medical workforce.

8. Apprenticeships:

The Committee received and noted a report on Apprentices detailing a longer term approach to recruiting and retaining apprentices within the Trust and noted that a briefing report would be taken to JNCC for discussion.

9. Freedom to Speak Up:
   The Committee received an update and assurance that the quarterly reporting to the National Guardian's Office is in place and a workshop will take place in November 2018 to complete the self-assessment for report to Board in December.

10. The Guardian of Safeworking Report:
    The Committee received the report and resolved to receive an update regarding fines at their next meeting.

11. Electronic Patient Record:
    The Committee received an update on the options appraisal regarding EPS and PAS and in particular the business change implications of the programme.

4. RECOMMENDATIONS

The recommendation to Board is to note the content of the report for information.

APPENDICES
People and Organisational Development Committee Minutes (20.08.2018)

ENC 1

WALSALL HEALTHCARE NHS TRUST
MINUTES OF PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE
HELD ON MONDAY 20 AUGUST 2018 AT 15.00
IN MLCC ROOM 11

Present:	Mr P Gayle	Non-Executive Director ***(Chair)***
	Mrs M Belle	Workforce Lead
	Mrs K Dunderdale	Director of Nursing
	Mrs L Ludgrove	Interim Director of OD and HR
Apologies:	Mr R Beeken	Chief Executive Officer
	Mrs D Davis	Head of Education Academy
	Ms M Dytor	Head of HR Operations
	Mr D Fradgley	Director of Strategy and Improvement
	Mrs V Harris	Non-Executive Director
	Mr S Heer	Non-Executive Director
	Mr S Johnson	Engagement Lead
	Mr T Johnson	LiA Lead
	Mr A Khan	Medical Director
	Mrs S McShane	Interim Deputy Director of HR
In attendance:	Mrs K Bendall	Workforce Training Manager
	Mrs K Blackwell	Deputy Director of Nursing
	Ms J Bradley	Service Improvement Programme Manager
	Mrs R Crossey	Head of Business Development and Planning
	Mr A Shaikh	SAS Lead/Tutor
	Miss C White	Executive Assistant ***(Minutes)***

39/18 Welcome and apologies

Resolution

The meeting was confirmed to be quorate and apologies were noted.

40/18 Matters arising

Resolution

No matters arising were raised.

41/18 Minutes of the previous meeting

Resolution

Minutes of the previous meeting were approved following an amendment to page 2, highlighted by the Workforce Lead, as an accurate reflection of the meeting.

42/18 Action log

Resolution

The live action log was reviewed and updates were noted.

43/18 Equality Diversity and Inclusion

Resolution

The Committee Chair advised that Minara Karim had been appointed as the Equality, Diversity and Inclusion Manager (EDI), commencing in September 2018. Committee members were advised that a full update on EDI would be provided to the Committee following the appointment of Minara in September 2018. The Workforce Lead confirmed that a handover discussion would take place following Minara's commencement, with herself and the Workforce Information and Planning Specialist, who had been supporting this work in the absence of an EDI Manager.

44/18 Workforce KPIs

The Interim Director of OD and HR presented the report circulated to members ahead of the meeting, highlighting improvements in 2 of the 3 primary KPI's, where performance was improved to be amber.

The Committee Chair queried if stress related sickness appeared to be work related. The Interim Director of OD and HR advised that this was difficult to confirm, however there appeared to be a variety of work related and home related stress cases.

The Interim Director of OD and HR advised that a Business Case was being created for Occupational Health, to address concerns with resource. It was explained that at present the team did not have sufficient capacity to mitigate sickness episodes. Members also acknowledged that Flu season would commence in September and therefore additional resource was required to support the demand associated with this.

The Director of Nursing queried if data was available to see a breakdown by area for Mandatory training compliance. The Workforce Training Manager confirmed that this information was available and shared with areas on a regular basis. The Director of Nursing queried if Junior Doctors were included in this data, to which members were advised they were not due to frequency of their rotations. Members recognised the importance of capturing this information to monitor compliance on a regular basis for Junior Doctors.

The Director of Nursing requested clarification on what constitutes the figures for bank and locum reporting. The Interim Director of OD and HR advised that she did not have this information during the meeting, however would enquire and feedback a response once confirmed. **LL**

The Workforce Training Manager advised that current PDR compliance was 89%.

Resolution

Members noted the updates provided.

45/18 Mandatory training update

The Workforce Training Manager confirmed that current compliance was 84% and rising, achieving all targets for safe guarding.

The Committee Chair queried if compliance was on track to achieve 90%

compliance, in this financial year. The Workforce Training Manager confirmed that she was confident compliance would achieve 90% by the end of March 2019.

Members were advised that the CCG had lowered compliance targets, acknowledging challenges resulting in the Trust now exceeding targets.

Resolution

Updates were noted by the Committee, however the Director of Nursing commented that it would be beneficial to view a breakdown of compliance at a future meeting, to understand if there were any trends in none compliance to address within certain areas/staff groups. **KB**

46/18 Agency/bank update

The Deputy Director of Nursing confirmed that there were currently 50 vacancies in MLTC, which was increased due to the opening of a winter ward, 19 vacancies in Surgery and 18 Midwifery vacancies. Members were advised that 8 Midwives were scheduled to commence in September 2018 along with 37 newly qualified Nurses. It was explained that although 37 newly qualified Nurses had accepted posts at the Trust, usually only 90% of those who accepted commence with the Trust, due to receiving alternative opportunities at other Trusts.

Members were advised that the Trust had changed supplier for overseas recruitment and had 30 candidates secured for this year. It was added that the Trust were anticipating receiving 19 qualified overseas Nurses in March 2019, once qualified in January 2019.

The Deputy Director of Nursing confirmed that the team were working on retention, and having early conversations with employees to explore why they were leaving and if the anything could be done to prevent this. Members were advised that exit interviews were taking place, however were not consistent. The Workforce Lead added that employees were also being given the opportunity to allow the Trust to stay in contact with them, to continue good relations and encourage employees to return.

The Deputy Director of Nursing advised that the Trust did not appear to be an outlier with regards to the turnaround rate and confirmed that this was regularly monitored. The Interim Director of OD and HR queried if the Trust were looking to implement retention initiatives, to which the Deputy Director of Nursing advised that they were not at present although a review of career trajectory was taking place.

The Director of Nursing commented that she was keen to review this further, to understand themes, in order to provide Board assurance.

The Interim Director of OD and HR highlighted that there was a discussion some months prior to the meeting, with the Executive team, where it was agreed that the Trust, along with surrounding Trusts, would begin charging for registration of new employees. Members were asked to note this, as she believed discussions may have arisen again in coming weeks.

The Deputy Director of Nursing confirmed that the Trust were still reliant on temporary staffing. Members were advised that there were 5 shifts in May 2018, 0 shifts in June 2018 and 22 shifts in July 2018, most of which were required for the Emergency Department due to vacancies, sickness and maternity leave. Members were advised that the Executive team were robustly challenging requests for temporary staffing, recognising that an alternative to Thornbury was required. The Committee Chair queried if there were any alternatives to Thornbury. The Deputy Director of Nursing advised that there was an escalation to process, therefore once the escalation had reached that tier Thornbury were the only remaining option to cover short notice shifts. A discussion was held regarding other Trusts no longer using Thornbury and it was agreed that the Trust required a plan to take the same approach and only use Thornbury if approved by the Chief Executive Officer.

Resolution

Committee members noted the updates provided and asked to receive regular updates regarding this item.

47/18 Consultant vacancy update

Resolution

Due to no representative in attendance for this meeting, the report was accepted as read and members noted that Consultant recruitment was very active and progressing well. The Committee Chair highlighted that there had been challenges with confirming interview panels, due to Non-Executive Director availability. The Interim Director of OD and HR commented that it would be beneficial to review the Consultant interview process.

48/18 Charter for SAS Doctors

Mr Shaikh, SAS Lead/Tutor, attended the meeting to provide information regarding the Charter circulated to members ahead of the meeting. The Charter was accepted as read and was confirmed to be a joint document agreed by the BMA, HEE, NHS Employers and The Academy of Medical Royal Colleges

The following concerns were escalated by the SAS Lead to Committee members;

- Consultant job plans were being reviewed however a review of SAS Doctor job plans had not taken place and were not scheduled to take place until following the Consultant job planning review.
- SAS Doctors did not appear to be having their allocated PA sessions in some areas.
- Opportunities to act up into a more senior post is not offered to SAS Doctors, to support vacancies or rota gaps, although many have sufficient training and experience to do so. It was explained that this was due to a lack of recognition of capability.

The concerns were acknowledged by members. The Interim Director of OD and HR queried how many SAS Doctors there were. The SAS Lead confirmed there to be approximately 100 SAS Doctors, along with 10 to 15 Medical Training Doctors from overseas.

The Interim Director of OD and HR acknowledged that the job plan was not well understood and commented that she felt the Trust could complete the SAS Doctors

job planning review, in parallel to the Consultant job planning review. Members agreed with this comment and asked that the SAS Lead escalated concerns to the Medical Director, to be addressed, as it was advised that concerns had been escalated for the first time at this Committee. **AS**

The Interim Director of OD and HR advised that she had been involved with the implementation of this Charter in Southport, and agreed that it was important to invest in the development of SAS Doctors, recognising their contribution. The Interim Director of OD and HR commented that her recommendation was to implement a development package to better equip and support employees. The SAS Lead confirmed that some areas, such as Trauma and Orthopaedics, had implemented this with positive progress made. The Interim Director of OD and HR queried what the Consultant body view was on this subject. The SAS Lead advised that this was varied across Divisions. The Interim Director of OD and HR recommended that the SAS Lead approached the Medical Director to arrange monthly meetings with the Medical Director and Director of Culture and People, to ensure regularly updates were provided with the opportunity to escalate any concerns. The SAS Lead agreed to discuss this with the new Medical Director, when in post, during October 2018. **AS**

The SAS Lead added that he felt it was also important for SAS Doctors to be included in ward discussions, between Consultants and Nurses, as they were not being currently. Committee members agreed that all ward colleagues should be included in ward discussions.

The Director of Nursing commented that she would be working with the new Medical Director to bring together Senior Nursing, Consultants and SAS Doctors for joint discussions, regarding how to professionally drive the Trust initiative.

Resolution
Committee members full endorsed the SAS charter and supported actions agreed to address concerns with the new Medical Director in October 2018.

49/18 New roles update

The papers circulated to members ahead of the meeting were accepted as read and members were asked for any queries or comments.

The Director of Nursing commented that it was key to review new roles to understand how they could benefit the Trust and support a reduction in temporary staffing.

The Workforce Lead confirmed that sustainability reviews had taken place and were being updated, linking with the admin review, led by Keith Dibble. It was added that a meeting was scheduled for the following week to identify next steps. The Director of Nursing advised that the TNA would highlight any discrepancies or queries regarding competencies. The Workforce Lead confirmed that the team would be reviewing requirements on a case by case basis to understand competence of individuals, with a pilot scheme to look at return on investment and cost implications.

The workforce Lead confirmed that the new roles group was proving beneficial and

would continue to support this project, with multidisciplinary attendance.

Resolution

Committee members noted the updates provided and endorsed the work taking place. The Director of Nursing highlighted her experience in similar projects previously and offered her support moving forward. Committee members agreed to receive quarterly updates on this item.

50/18 Quality Improvement update

The paper circulated to members ahead of the meeting was accepted as read.

The Service Improvement Programme Manager added that the team were looking to introduce a second, first date session, for cohort 2, as requested by employees who had missed the first session but were keen to be involved. It was confirmed that 351 employees were now engaged with QI, with positive feedback from Senior Leaders and 5 employees completing QSAR training to become in-house trainers (none-accredited).

Members were advised that QI had a 45 minute session on Trust induction, moving forward, to engage employees early on.

The Service Improvement Programme Manager confirmed that Hesham Abdalla was the Clinical Lead for QI, who was keen to encourage employees to look at how they could improve their job and service.

The Service Improvement Programme Manager highlighted that there were concerns that resource to support QI, may not be sustainable, however assured members that the team were doing as much as possible.

Resolution

Quality Improvement was fully endorsed by Committee members, who commented that this was a very positive message and approach. The Director of Nursing offered her support with Quality Improvement moving forward and Committee members asked for regular updates to this Committee.

51/18 Staff survey

The Workforce Training Manager confirmed that all Divisions had been asked to identify 5 areas which were of concern, following the recent staff survey. Committee members were advised that these actions had Divisional ownership and accountability, with key themes of work related stress, MSK problems as a result of work and recognition.

Members were advised that QI was being promoted in response to the Staff Survey, along with learning from excellence and promoting the employee self-referral to Physiotherapy service.

It was acknowledged that a high response rate was required to gain a full understanding of the Trusts position, if improvements had been made and where improvements had been made to learn from that.

The Director of Nursing queried if the Staff Survey correlated to the Pulse Check. The Workforce Training Manager advised that the surveys did not correlate, as they were designed to be different.

Committee members acknowledged that there was a specific time period for Staff Survey responses which was 10 September 2018 to 07 December 2018.

Committee members acknowledged that the Trust focus was around the Pulse Check, as this gave live indications to Trust improvements and challenges, however it was recognised that the Staff Survey was a national requirements which influenced CCG targets.

The Workforce Training Manager assured Committee Members that the survey would be launched on, or as close to, 10 September 2018 as possible and "you said, we did" communications were being prepared to remind employees of the improvements made.

Resolution
Committee members noted the updates provided and endorsed the actions and approach outlined.

52/18 Update on annual plan objectives

Resolution
Due to none attendance from the Head of Business Development and Planning, the Interim Director of OD and HR advised that there was an intention to link this to CQUIN, however due to complexity this was not possible and therefore it was agree to use the run rate. Members were advised that there were no significant risks regarding to this report.

53/18 Joint Negotiating Consultative Committee, June and July 2018

Resolution
Minutes from the June and July Committee meetings were accepted as read and no concerns were raised for discussion.

54/18 Local Negotiating Committee, May 2018

Resolution
Minutes from the May Committee meeting were accepted as read and no concerns were raised for discussion.

55/18 Quality and safety key messages

- Committee sighted on mandatory training challenges and actions.
- Committee sighted on Quality Improvement Academy.
- Endorsement of SAS Doctor Charter and Committee support for addressing the challenges escalated.

56/18 Any other business

Committee members thanked the Interim Director of OD and HR for her contribution to the Committee and continued support, acknowledging that this was her final Committee meeting, ahead of leaving the Trust on Thursday 30 August 2018.

57/18 Next meeting

Monday 15 October 2018, 15:00 in MLCC Room 10