MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 6 DECEMBER 2018 AT 10.00 A.M.
IN THE LECTURE SUITE, MLCC, MANOR HOSPITAL, WALSALL

For access to Board Reports in alternative accessible formats, please contact the Director of Governance via 01922 721172 or jenna.davies@walsallhealthcare.nhs.uk

A G E N D A

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
1.	Patients and Carer audio feedback Story	Learning	Director of Nursing	Verbal	**10.00**
CHAIR'S BUSINESS					
2.	Apologies for Absence	Information	Chair	Verbal	**10.30**
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1	**10:32**
4.	Minutes of the Board Meeting Held on 1 November 2018	Approval	Chair	ENC 2	**10:35**
5.	Matters Arising and Action Sheet	Review	Chair	ENC 3	**10:40**
6.	Chair's Report	Information	Chair	ENC 4	**10:45**
7.	Chief Executive's Report	Information	Chief Executive	ENC 5	**10.50**
SAFE HIGH QUALITY CARE					
8.	Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Director of Nursing	ENC 6	**11:00**
9.	CQC Preparedness Update	Information	Chief Executive	ENC 7	**11:10**
10.	Nurse Staffing Establishment Review	Information	Director of Nursing / Director of Finance & Performance	ENC 8	**11:20**
VALUE COLLEAGUES					
11.	Freedom to Speak Up Guardians Report (Whistleblowing)	Discussion	Freedom to Speak up Guardians	ENC 9	**11:30**
12.	Pledge	Approval	Director of People & Culture	ENC 10	**11:40**
BREAK – TEA/COFFEE PROVIDED					**11:45**
RESOURCES					

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
13.	Performance Report	Discussion	Director of Finance & Performance	ENC 11	**11:55**
14.	Winter Plan	Approval	Director of Strategy & Improvement	ENC 12	**12:15**
PARTNERS					
15.	The Black Country and West Birmingham Sustainability & Transformation Partnership Memorandum of Understanding	Approval	Chief Executive	ENC 13	**12:25**
16.	Partnership Update	Information	Director of Strategy & Improvement	ENC 14	**12:35**
GOVERNANCE AND COMPLIANCE					
17.	Risk Appetite	Approval	Director of Governance	ENC 15	**12:40**
18.	BAF and Risk Register	Discussion	Director of Governance	ENC 16	**12:50**
19.	Review of the Standing Orders, Standing Financial Instructions and Scheme of Delegation	Approval	Director of Governance	ENC 17	**13:00**
20.	Fit and Proper Person Policy	Approval	Director of Governance	ENC 18	**13:10**
21.	Quality and Safety Committee Highlight Report	Information	Committee Chair	ENC 19	**13:20**
22.	Performance, Finance & Investment Committee Highlight Report	Information	Committee Chair	Verbal	**13:25**
23.	POD Highlight Report	Information	Committee Chair	ENC 20	**13:30**
24.	Audit Committee Highlight Report	Information	Committee Chair	ENC 21	**13:35**
25.	**QUESTIONS FROM THE PUBLIC**				**13:40**
26.	**DATE OF NEXT MEETING** Public meeting on **Thursday 7 February 2019** at 10.00 a.m. at the Manor Learning and Conference Centre, Manor Hospital				
27.	**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 – Thursday 6th December 2018			
Declarations of Interest			**AGENDA ITEM: 3, ENC 1**
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 November 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: Health watch Birmingham
		Committee Member: Health watch 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.
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.

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).
		Non-executive Director Black Country Partnership NHS Foundation Trust
		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: November 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 1ST NOVEMBER 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
Professor R Beale	Non-Executive Director
Mr P Gayle	Non-Executive Director
Dr K Dunderdale	Director of Nursing/Deputy Chief Executive
Dr M Lewis	Medical Director
Ms C Griffiths	Director of People & Culture
Mr R Caldicott	Director of Finance

In Attendance:

Mrs A Baines	Associate Non-Executive Director
Ms J Davies	Director of Governance
Ms A Winyard	Director of Operations - Surgery
Miss J Wells	Senior Executive PA (Minutes)
Ms D Rhodes	Senior Nurse for Quality & Safeguarding (for agenda items 10-12)

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

154/18 Patient Story

Mr Kuldeep Singh, Patient Experience Manager and Ms Louise Mabley, Lead for Patient Experience introduced a video of patient Kiren Sundal who shared her experience of her recent admission to AMU and Ward 23. Kiran has Cerebral Palsy and Spastic Quadriplegia, and therefore she is unable to walk or transfer independently. Kiren highlighted the following concerns;

- Nurses training in manual handling was poor.
- Delay in providing equipment
- Kiren's mother slept on a chair for four days and was not offered drinks or food.
- The bathroom was not appropriate for Kiren's needs.
- Delay with medication.
- The nurses did not listen to Kiren's wishes.
- Poor communication between other departments caused delays.

Kiren added that a number of the nurses were polite, in particular Julie Field, Sister in Charge who was instrumental in sourcing the

equipment required.

Kiren advised that she believed the hospital could do more to support people with complex conditions. A breakdown in communication caused her stay to extend to two weeks. Kiren made the following suggestions for improvement;

- Reviewing case notes to plan equipment requirements and support needed.
- More in depth training.
- Carers having access to services in terms of sleeping arrangements and food.

Board members were then shown a video of the staff involved in Kiren's care on Ward 23 giving their reflection and feedback.

Emily Ley, Ward Sister and Jessica Myatt, Clinical Support explained that Kiren was an outlier patient and the ward was not equipped for patients with complex needs including access to appropriate bathroom facilities. They advised that staff on the ward recognised that they needed to address manual handling needs, which had been escalated but unfortunately the required equipment was in use elsewhere.
With regard to Kiren's mother's needs as a carer, staff advised that spare beds were not always accessible but that on reflection they should have approached other departments to see if there was any beds available. Staff asked Directors for a policy detailing the availability of carer's beds.
It was recognised that Kiren experienced discomfort following bloods being taken. On reflection staff felt it would have been more appropriate to have requested a Phlebotomist which was Kiren's request.
Kiren articulated that she felt isolated with communication in terms of her care. In some cases the nursing team did not always have new information to share. There was an issue with doctors not always responding to bleeps.

Mr Singh informed that Kiren did not make a formal complaint but wanted the Trust to learn from her feedback in order to make improvements for patients with complex needs.

Ms Oum asked the Patient Experience Team to pass on her thanks to Kiren for sharing her feedback.

Mrs Baines asked whether community teams were approached in relation to shared care arrangements and support.
Mr Singh replied that there were no arrangements in place with other teams.

Ms Oum asked members for comments and questions highlighting that responses should be primarily generic rather than specifically relating to Kiran.

Mr Heer observed that good communication was lacking.

Professor Beale stated that the trust should have been able to look after Kiren sufficiently well without the need of her mother providing care.

Mr Caldicott addressed the need for an escalation model in order to reduce length of stays being extended by delays.

Ms Oum informed that there was an underlying issue around compassion. Kiren was clearly able to articulate for herself but other patients with complex needs may not.

Dr Dunderdale observed that Kiren articulated lots of aspects of her care were good and the nursing team did escalate a number of the issues. There was a national campaign called Johns campaign around caring for carers which would be introduced.

Dr Dunderdale thanked the staff members for sharing their reflections though there was a need to hear feedback in relation to what had been done and what would be done following Kiren's feedback. Dr Dunderdale was meeting with ward leaders and matrons the following day to set out what the Trust should be delivering in terms of quality of care at the bed side.
There was a need to respond in a timely manner to outlying patients and a number of actions had been fed back to the Quality and Safety Committee.

Ms Oum requested that how decisions were made around outliers and prioritising patients was discussed at the Quality, Patient Experience and Safety Committee.

Mr Singh informed that the story would be shared with the wider teams involved in order to learn lessons from this case. **Q&S**

Dr Lewis extended his appreciation to Kiren for sharing her experience and her suggestions of improvements. Focus should remain on the amount of time she spent at the trust as a result of delays and its impact. Dr Lewis asked that the video was shared with junior doctors for learning purposes, particularly in relation to responding to bleeps.

155/18 Apologies for Absence

Apologies were noted from;

- Mrs V Harris, Non-Executive Director
- Mr R Beeken, Chief Executive
- Mr D Fradgley, Director of Strategy & Improvement
- Mr P Thomas-Hands, Chief Operating Officer
- Mrs J White, Interim Trust Secretary
- Mr A Yates, Associate Non-Executive Director
- Ms P Furnival, Associate Non-Executive Director

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A formal welcome to the Trust was made to Dr Matthew Lewis, Medical Director

156/18 Declarations of Interest and quorum

There were no additional items to declare.

The meeting was quorate in line with Item 3.11 of the Standing Orders, Reservation and Delegation of powers and Standing Financial Instructions; no business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and members (including at least one member who is also an Officer Member of the Trust and one member who is not) is present.

157/18 Minutes of the Board Meeting Held in Public on 4th October 2018

The Board approved the minutes of the meeting held on the 4th October 2018 as an accurate record.

158/18 Matters Arising and Action Sheet

The Board reviewed the action sheet.

Apologies had been received from Mr Fradgley, therefore an update would be required at the next meeting.

Resolution

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

159/18 Chair's Report

Ms Oum presented the report which was taken as read.

Resolution

The Board received and noted the Chair's report.

160/18 Chief Executive's Report

Dr Dunderdale gave a verbal report in her capacity of Deputy Chief Executive;

- Dr Dunderdale was a judge at Trust's got Talent which raised £675 for the Well-Wishers charity. It was a good opportunity for the workforce to integrate with board members.
- Attended an engagement event discussing the long term plan for the NHS.
- Performance of patient flow for the week ending 28th October saw the best performance figures since 2016. The Trust was on track to maintain 90% in month. Site Safety meetings rather than bed meetings were being held. Involvement of the MDT was seeing a positive impact and extended thanks to the staff involved. Teams

were focused on maintaining momentum and delivery.
- The PIR from the CQC was received on 16th October. The Trust was on track to submit a final submission 6th November.

Dr Dunderdale added that National Guidance was attached.

Mrs Baines referenced the guidance and asked for an outline advising the items that the Trust was progressing. **JD**
Ms Davies informed that a process was being explored in order to track actions.

Mr Heer welcomed comments from Executives in relation to being influential with workforce, technology and systems.

Ms Oum was in agreement with showing ambition and leadership and asked Executives to reflect upon this.

Mr Heer advised that he would expect to see a Chief Executive overview report in future rather than a verbal update.

Resolution
The Board received and noted the verbal update.

161/18 Monthly Nursing and Midwifery Safer Staffing Report
Dr Dunderdale introduced the report which had been reviewed at the Quality, Patient Experience and Safety Committee, highlighting the following key points;

- The Nursing Workforce Transformation Programme was being implemented and a Nursing Quality Transformation Programme would follow.
- Quality was the main domain of both initiatives, incorporating the work of the Quality Academy, joining the workforce and quality aspects together.
- A more robust report would be reviewed at the next meeting.

Mr Dunn requested a focused cover report for board members who did not form part of the membership of the Quality, Patient Experience and Safety Committee. **KD**

Mr Heer gave thanks for the helpful report and welcomed the robust December report. Mr Heer queried the correlation between incidents and staffing numbers and how a conclusion was drawn. Dr Dunderdale replied that each incident had a Root Cause Analysis reporting conversation. There was an intention to run a specific quality review conversation to achieve detailed challenge with a focus on staffing and quality.

Ms Oum cautioned to balance priorities but not to compromise patient safety.

Dr Dunderdale informed that pieces of work were being bought together in the revised staffing report following the Quality Review meetings on a monthly basis.

Mr Heer queried what an enhanced experience to patients would look like.
Dr Dunderdale replied that further work was required in that area but the ambition would be to offer more than what was good enough and a strive for outstanding. A workshop was scheduled for the following week exploring what outstanding care looked like.

Ms Oum urged members to attend the upcoming Nursing strategy session.

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

162/18 CQC Preparedness Update

Dr Dunderdale introduced the report which outlined the key highlights during September;

- The PIR submission request had been received.
- Understanding the timeline. 9 weeks following the receipt of the PIR, the CQC hold a planning meeting which would then decide the format of their inspection which could be in the form of spot reviews, a full comprehensive visit of services or focused on specific areas. It was likely that an unannounced visit would take place between January and March 2019.
- Receipt of the PIR triggered the Well-Led review that would form part of the process.
- A number of Quality Assurance conversations had started in order to complete the PIR. There were 150 components in terms of narrative feedback, documents and policies.
- Monthly Engagement conversations were taking place. A visit of Medicines was taking place on 15th November where verbal feedback of the day would be expected.
- Areas of compliance had been discussed at the Quality, Patient Experience and Safety Committee.
- A Board self-assessment was undertaken on 23rd October with Executives which would feed in to the PCIP action plan.

Mr Dunn stated that he was of the impression that progress was more advanced.
Dr Dunderdale replied that the Trust was clear of the key priorities and had not wavered from those, though there needed to be additional focused effort, progress made was good overall.

Mr Dunn asked how engagement could be increased. Dr Dunderdale replied that CQC preparation meetings would

continue and workshops were being held with staff and a focus on CQC at the Trust Management Board.

Mr Gayle expressed concern that documentation quality had slipped including expiring policies and asked how that could be improved.
Ms Davies replied that Jackie White and Chris Rawlings were leading on a piece of work that encompasses national best practice.

Dr Dunderdale acknowledged that there were some improvements to be made with regard to bed side documentation. There were some areas of really good practice but others were still struggling. The key was identifying those areas and individuals and providing support.

Dr Lewis advised that there needed to be a resetting of expectations to address declining VTE performance, training and appraisals.

Ms Griffiths advised that there was a sophisticated approach to mandatory training though there were certain areas that were not engaged, it was not a trust wide issue. Further analysis to identify those areas had been completed.

Ms Oum summarised that there were concerns raised in relation to pace, staff engagement, documentation and its potential impact on patient care. Though significant progress had been made, there were areas requiring particular focus to achieve and sustain the standard of quality we require for our patients.

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

163/18 Safeguarding Adults Annual Report

Dr Dunderdale introduced the report which had been reviewed at the Quality and Safety Committee. Ms Diane Rhoden, Corporate Senior Nurse – Quality and Safeguarding attended the meeting to present the report;

- There had been a move from 1 to 3 levels of training. The target of 90% was not achieved within the timeframe, though it was now compliant.
- Prevent training target was also not achieved, though now it was now compliant.
- Main areas for concern related to pressure ulcers and discharge arrangements.
- There had been a decrease in the number of Deprivation of Liberty applications.

Ms Oum asked Ms Rhoden to articulate the difference between the way the Trust adult Safeguarding function worked with

partners compared to the arrangements for children.
Ms Rhoden replied that there was no adult MASH. Walsall wide had been focused on children.

Dr Dunderdale advised that the peer review undertaken by Enable East fed back how to apply guidance published during July and work was underway to implement.
A Senior Safeguarding Lead had been commissioned and had compiled a review identifying that fundamentally, the training providing is of a good standard, though further work was required to embed that training. A business case for a Head of Safeguarding was being drafted to present to Executives.

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

164/18 Safeguarding Children's Annual Report
Ms Rhoden highlighted the following key points;

- There had been a steep increase in referrals to the Multi Agency Safeguarding Hub.
- Mandatory training targets had not achieved by March 2018, though the Trust was now compliant.
- A business case was submitted requesting funding for 2 people within the MASH.
- Key priorities were training and working with multi agency partners.

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

165/18 Looked after Children's Annual Report
Ms Rhoden highlighted the following key points;

- High levels of Looked after Children into the service resulted in difficulties reaching the 80% performance target, though the Trust was now compliant.
- Challenges with the School Nursing service affected Review Health Assessments.
- Key priorities were securing investment for recruitment and continuing to work with partners.

Ms Oum informed that the Quality, Patient Experience and Safety Committee recommended approval of the 3 Annual Reports. All members approved the Annual Reports.

Mrs Baines asked for thanks and appreciation to be passed on to the teams who undertake a really difficult job, in addition to changes in legislation, requirements and the demand upon the service.

Mr Heer asked that in future, it would be helpful for key points of **JW**

DRAFT

the discussion held at the committee be documented and shared with non-members.

Resolution
The Board:
- **Received and noted the content of the report.**
- **Approved the Safeguarding Adults Annual Report.**
- **Approved the Safeguarding Children's Annual Report.**
- **Approved the Looked After Children's Annual Report.**

166/18 Winter Plan

Dr Dunderdale advised that the winter plan was being quality assured and final costings were being added along with understanding the quality and safety elements with the escalation policy. The Trust Management Board would be reviewing the plan on 6th November for final clinical oversight.
The winter plan assurance document had been submitted to NHSI the previous week. NHSI would be on site for a Progress Review Meeting on 13th November which would include a site walk around. The winter plan would be shared at an Extra-ordinary Private Trust Board on 26th November for final approval.

Resolution
The Board:
- **Received and noted the update.**
- **Noted the plan would be shared for approval at an Extra-ordinary Private Trust Board on 26th November.**

167/18 Guardian of Safe Working

Dr Lewis presented the Guardian of Safe Working Report which was a quarterly report and outlined safeguards with junior doctor working hours, escalation and work schedule reviews. Dr Lewis informed that the President of the Royal College of Physicians visited the Trust recently.

Mrs Baines queried whether the report extended to community. Dr Lewis replied that he would review the detail to check the relevancy of the community. **ML**

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

168/18 Integrated Performance Report

Quality and Safety Committee

Dr Dunderdale informed that there were no C. diff or MRSA cases reported during September.

Concern remained upon the increase in trend of falls and pressure ulcers resulting in an increase of patients who had

suffered severe harm.

The quality report continued to evolve and there would be further focus on infection control.

The Friends and Family Test had seen a positive impact through the ED department.

Partnerships
Mr Caldicott informed that focus remained on the frailty pathways in readiness for the winter period.

Ms Oum asked for commentary detailing the impacts and benefits.

Mr Caldicott informed that there was further information detailed page 9 of the report within the Rapid Response Team activity but further clarity could be provided at the next meeting.

POD
Ms Griffiths informed that mandatory training and PDR compliance had seen improvement over the last 6 months. Further action was planned to achieve further improvement on targets.

55% of the workforce Trust wide had had a flu vaccination.

Sickness and attendance was an area of concern. The approach was being reviewed and focusing upon staff wellbeing. Multidisciplinary workshops were starting the following week.

An equality, diversity and inclusion review categorised performance as a risk and further assurance was required for compliance.

Ms Griffiths reminded members that they had discussed developing a Board level pledge in line with the Trust values and advised the following;

"We, your Trust Board, pledge to demonstrate through our actions that we listen to and support people. We will ensure that the organisation treats people equally, fairly and inclusively, with zero-tolerance of bullying. We uphold and role-model the Trust values chosen by you."

The pledge would be circulated to members to reflect and comment upon at the next meeting.

A Freedom To Speak Up self-assessment was underway. A neighbouring Trust would visit and work with the Trust.

Ms Davies asked when it was likely that results would be seen in order to mitigate risk.

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Ms Griffiths replied that adjustments were being made in order to ensure compliance.

Professor Beale observed that the report did not detail retention.
Ms Griffiths responded that retention would form part of the NHSI pilot framework.

Performance, Finance & Investment Committee
Mr Caldicott advised that the financial position of the Trust was a deficit of £14.8m, resulting in a £4.7m variance to the plan. Root causes were being reviewed. In depth work and control metrics were in place for temporary workforce costs. A deep dive into medical establishments was underway inclusive of surgery and Women and Children's.

Temporary workforce was at its highest point of the year, practices needed to embed.

Productivity in Outpatients elective had struggled to achieve targets and was being reviewed weekly. Obstetric activity was below plan.

The Trust was off plan and behind on the recovery plan. A set of actions were in place.

Dr Dunderdale informed that Mr Beeken would lead a confirm and challenge meeting with each Executive on delivery of the financial recovery plan.

Mr Dunn stated that strong plans were in place but desperately required execution. There needed to be a clear result of trajectory for the year. Mr Dunn was concerned that CIPs were also under delivering.

Dr Lewis reminded of the need to maintain quality, performance and safety but it was a shared responsibility to ensure finances were on track and focusing on issues such as job planning.

Ms Winyard agreed that further work was required within Outpatients and Theatres, though improvements had been made to Theatre timetables which commenced in October creating seven extra sessions. All specialties had been asked to produce a rectification plan. Ms Winyard added that RTT was on track to deliver 90% during October.

Ms Oum informed that comprehensive plans were in place but the reputation of non-delivery needed to change.

Mr Gayle queried whether any lessons had been learnt from the previous year.
Ms Winyard replied that some initiatives were working. Actions from the previous year were being reviewed and would be incorporated in to the Winter Plan.

Ms Oum informed that a forecast decision would be taken at the December Trust Board meeting.

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

169/18 Quality, Patient Experience & Safety Committee

Prof Beale updated that recommendation had been made to exit the Lorenzo EPMA programme.

The breakdown of mammography had been reviewed and assurance obtained from teams that the issue had been effectively managed.

Ms Oum asked for thanks to be passed on to the teams involved in handling the equipment failure and looked forward to hearing a wider approach in terms of equipment breakdowns. **KD**

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

170/18 PFIC

Mr Dunn informed that focus of the committee remained on being clear of the next steps and actions being taken.

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

171/18 POD

Mr Gayle advised that there was nothing further to add to the update given within the Integrated Performance report.

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

172/18 Questions from the Public

There were no questions from the public.

173/18 Date of Next Meeting

The next meeting of the Trust Board held in public would be on Thursday 6th December 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

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
120/18 Pulse Check	Weekend visibility visits to ward and departments to be explored	Trust Secretary	31/12/18	Not started yet. Plan to review Board walks underway with new process to commence in February 2019.	
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	04/04/19	Will be built in once Walsall Together monitoring has started through the Partnership Board. Expected April 19	
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	04/04/19	Will be built in to phase 2 of the Walsall Together case.	
123/18 Risk Appetite	Statements needed to be further refined by Executive Leads prior to Board approval	Trust Secretary/ Director of Governance	6/12/18	On agenda	
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	01/11/18	Undertaken via QPES.	
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	01/11/18	Completed and statement included in SFIs which are on the agenda	

ENC 3

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
124/18 Board Assurance Framework and Corporate Risk Register	Agreed each committee would review their risks during October prior to Board review in December.	Trust Secretary / Director of Governance	6/12/18	Completed – all Committees have reviewed the BAF and an updated BAF is presented to the Board	
126/18 Strategy Committee Terms Of Reference	The Board noted the paper would be reviewed at a later date.	Director of Strategy / Director of Governance	5/12/18	Further work underway on development of TOR for this Committee	
147/18 Standing Financial Instructions	Further clarification on the rationale for raising the limits within the SFI and an update on implementation of the accountability framework	Director of Governance	01/11/18	Completed – considered by Audit Committee and SFIs included on the agenda.	
148/18 Terms of Reference	Review of Committee effectiveness to be completed in February 2019	Director of Governance	01/11/18	Committee effectiveness reviews have been scheduled in for February 2019 and Board for March 2019. No further action	
154/18 Patient Story	Patient story to be shared with Junior Doctors for learning purposes.	Quality, Patient Experience & Safety Committee			

ENC 3

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
160/18 Chief Executive's Report	A process was being explored in order to track actions in relation to national guidance	Director of Governance	30/11/18	Progressing – process identified and system being developed to track actions	
161/18 Monthly Nursing & Midwifery Safer Staffing Report	A focused cover report to be provided for board members who did not form part of the membership of the Quality, Patient & Experience Committee	Director of Nursing	06/12/18	Completed – covered on Board front sheet	
165/18 Looked after Children's Annual Report	Key points of discussion at committees to be documented and shared with non-members.	Trust Secretary	6/12/18	Information to be incorporated into highlight reports	
167/18 Guardian of Safe Working	Mr Lewis to review the detail to check the relevancy of the community	Medical Director	6/12/18		
169/18 Quality, Patient Experience & Safety Committee	A wider approach in terms of equipment breakdowns to be supplied.	Director of Nursing	6/12/18		

Key to RAG rating

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

PUBLIC TRUST BOARD ACTION SHEET

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

now progressing towards completion	

MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018			
Chair's Report			**AGENDA ITEM: 6, ENC 4**
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 ☒		

Caring for Walsall together

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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 and contributing to the development of the Nursing Strategy this month. This was a great event involving staff, patients and Board members discussing and designing the Strategy. There was a poignant presentation from Tommy Whitehall from NHSI. The presentation made it clear how good nursing can make life enhancing difference for patients and carers.

   As you will have seen in the press recently, we are just a few days away from patients being transferred into a new ICCU unit which is a culmination of many years of hard work and planning. I was pleased to participate in burying a time capsule outside the new Unit, containing items to provide future generations with a glimpse of life in 2018.

   The new unit will be an 18-bedded unit, which is an increase of five beds from the current provision. It is a prime development for the Trust that will bring significant improvements for the borough's sickest patients and their families.

2. **Improve our financial health through our robust improvement programme**
   Although not a member of the Board Committees, I occasionally attend the Committee meetings to get a sense of how they are running and this month attended the Performance, Finance and Investment Committee. There was great discussion and challenge on key issues such as temporary staffing spend in nursing and medical staff, the Financial Recovery plan progress, Cost Improvement plans and delivery of our constitutional performance standards.

3. **Develop the culture of the organisation to ensure mature decision making and clinical leadership**
   The full Board have commenced a leadership development programme focussing on team building and competencies to create a high performing team. We also continue to have our routine Board seminars and have recently been briefed on a range of key priorities including Sepsis, Infection Control, Safeguarding, Freedom to speak up, Use of Resources and Model Hospital.

   I was very pleased to attend the Engagents meeting recently; it was a pleasure to spend time with this group of staff who are so clearly committed to improving the culture in the organisation. There were clear messages given regarding people being able to challenge colleagues and peers on behaviours.

   I am delighted to welcome, Pam Bradbury and Liz England, as Non-Executive Director and Associate Non-Executive Director respectively, to the Trust Board. Pam is a nurse by background and Liz is a practicing GP. We welcome their clinical perspective and experience to the Board.

4. **Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts**
   I met with Jonathan Fellow, Independent Chair of the Black Country STP and discussed collaboration to benefit patients across the Black Country.
   I met with Harry Turner, Chair of Dudley and Walsall Mental Health Partnership NHS Trust.

Meetings attended / services visited
One to one meetings with Executive Directors
Appraisals with Non-Executive Directors
Board walk to ED and the Urgent Care Centre
Participation in the ASPIRE assessment centre pilot for aspiring executive directors

RECOMMENDATIONS
The Board are asked to note the report

Danielle Oum

December 2018

Appendix 1

Department visits

From staff working to safeguard children to the vital role played by the security team and the challenges across Theatres, and the Emergency Department – Walsall Healthcare NHS Trust Chair Danielle Oum has had a real insight into those working on the frontline.

Danielle has been spending time with teams across Walsall Manor Hospital and out in its community services, shadowing staff in a variety of settings.

She has visited Walsall Palliative Care Centre, talking to patients as well as colleagues, observed clinics being run in paediatric outpatients and pain management and caught up with the Learning Disability team. She has also spent time in Maternity and shadowed Finance and Library staff.

Danielle is keen to continue this and plans to join other teams over the coming weeks.

She explained: “I think it is really important to have a real sense of the challenges and opportunities that my healthcare colleagues are managing every day.

“I have been inspired, impressed and amazed and the one thing all teams have in common is their passion and commitment to care for and support our patients, enhancing their experience.

“Equally, I have been concerned at some of the difficulties faced by staff. In our Emergency Department it was fantastic to see the way staff are pulling together to provide the best care for patients in an inadequate physical environment, yet concerning to see a chaplain hurrying to be with an elderly End of Life patient in an ED cubicle; possibly one of the least suitable places to die.

“It was wonderful to spend time with the Theatres team and witness the high levels of commitment there but the staff shortages are apparent and it is clear that sustainable workforce models need to be built and implemented soon as we are over-reliant on agency staff and retired returnees.

“The Trust launched its new set of values in the summer, as chosen by staff, and I saw many examples of Respect, Compassion, Professionalism and Teamwork. But it’s important that we work together to embed those values at every level of our organisation and our Trust Board must lead by example.

“This experience has been an enlightening one and I want to make sure I spend time with many other teams in the near future to continue this insight.”

Danielle visited:

Walsall Palliative Care Centre

“I spent a lovely morning with patients and staff at the Palliative Care Centre. It was inspirational to see the positive and open culture fostered by the team and embraced by the patients. Thanks to Tracey Grinell for facilitating my visit.”

Lung Cancer

"It was impressive to see how Jo Knowles manages a range of priorities on limited resources and to hear her ideas for applying best practice from other Trusts for the benefit of Walsall. Thanks to Jo for taking the time to talk me through her work and I look forward to hearing how her ideas have progressed."

Older People's Mental Health

"I have had several opportunities to shadow members of this amazing team. Each time I have been impressed by their commitment to patient centred care. Thanks again to Debbie Shaw and the team - I look forward to being invited back."

Maternity

"It was fantastic to see the progress being made in Maternity and it was wonderful to meet so many passionate leaders focused on driving continuous improvement across this service. It was a pleasure to meet the wider team.

ED

"It's great the way staff are pulling together to provide the best care for patients in an inadequate physical environment, for example it was concerning to see a chaplain hurrying to be with an elderly End of Life patient in an ED cubicle, possibly one of the least suitable places to die. Thanks to Miss Ruchi Joshi for spending some of her valuable time with me."

Theatres

"It was wonderful to spend time with the team and witness the high levels of commitment but the staff shortages are apparent and it is clear that sustainable workforce models need to be built and implemented soon as we are over- reliant on agency and retired returnees. Thanks to Nike Akinwale for taking the time to show me round and introduce me to colleagues."

Safeguarding Children's Team

"I was bowled over by the passion and focus of this team but clearly the challenges of meeting MASH partnership commitments and supporting staff with advice and training are stretching the team's capacity to manage their clinical caseloads. Thanks to Liz Tandy for pulling together an informative visit."

Learning Disability Team

"Energy, drive and innovation were the defining characteristics this team. I was impressed by their effective use of limited resourced to support the Trust to be Learning Disability friendly and ensure this customer group receives care and communications in ways that are inclusive, informative and non-threatening. Thanks to Jennifer Robinson for making herself and colleagues available to brief me on their work."

Medicines

"I was interested to see the use of a mental health nurse as a charge nurse on Ward 2 and would like a return visit to see how the role is embedding and delivering impact. A really useful overview of the mental health role."

Paediatrics

“I was impressed by the care and professionalism of the outpatient service and the way that parents were given advice in a clear but non-patronising manner. Thanks to Hesham Abdalla for allowing me to sit in on his outpatient clinic.”

Security

“These colleagues were very welcoming and clearly work hard but I was struck by the lack of acknowledgement they receive from the Trust given they are such a vital part of the team. Thanks to William Powis for empowering his team to speak openly.”

Pain Management

“This team's work was fascinating and the link between physical and mental health was clear. I was struck by the potential for collaborative working with our colleagues at the Mental Health Trust as a means of improving service resilience. Thanks to Olamide Olukoga for allowing me to sit in on her outpatient clinic and introducing me to her colleague.”

Library & Knowledge services

“So much more than books, although they have quite a few of these. The breadth and depth of knowledge and support provided by the team to colleagues preparing for exams, conducting research or even reviewing policies and procedures was way beyond what I had assumed. This is a great resource. Thanks to Jacqui Watkeys and the team for enlightening me.”

Finance

“I was concerned to hear of the pressure faced by Finance colleagues from suppliers but also in the Trust. The whole organisation is operating in a challenging environment but we need to hold onto our values in our dealings with each other. Thanks to Trevor Baker for dropping everything to accommodate an unannounced visit.”

MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018			
Chief Executive's Report			**AGENDA ITEM: 7, ENC 5**
Report Author and Job Title:	Richard Beeken, Chief Executive Officer	**Responsible Director:**	Chief Executive Officer
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	The purpose of the reports is to keep the Board appraised of the high level, critical activities which I have been engaged in during the past month, with regard to the delivery of the four organisational priorities for 2018/19. The report also seeks to set out to the Board, the significant level of guidance, instruction and best practice adoption we received during November 2018 and assures the Board through an allocation to the relevant executive director. Given the significant challenges we face as we go into the last quarter of the year, on both quality assurance and financial delivery, I set out in this report the pragmatic prioritisation of the executive team's time as we enter that last quarter, recommending how we will re-prioritise our working weeks and focus on quality and financial delivery almost exclusively during that period.		
Recommendation	Members of the Trust Board are asked to: Note the report and discuss the recommendations.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF001 failure to delivery consistent standards of care to patients; BAF002 failure to achieve financial plans		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Chief Executive's report

1. PURPOSE OF REPORT

The purpose of the reports is to keep the Board appraised of the high level, critical activities which the organisation has been engaged in during the past month, with regard to the delivery of the four organisational priorities for 2018/19. The report also seeks to set out to the Board, the significant level of guidance, instruction and best practice adoption we received during August 2018 and assures the Board through an allocation to the relevant executive director.

2. BACKGROUND

The Trust has agreed four priorities for 2018/19. These will drive the bulk of our action as a wider leadership team and organisation:

- Continue our journey on patient safety and clinical quality through a comprehensive improvement programme
- Develop the culture of the organisation to ensure mature decision making and clinical leadership
- Improve our financial health through our robust improvement programme
- Develop the clinical service strategy focused on service integration in Walsall and in collaboration with other Trusts

3. DETAILS

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

The important work of the organisation, both to prepare for CQC re-inspection and to bed in the delivery of the "fundamentals of care" on an ongoing basis, continues. At present, from an executive perspective, we manage our mutual accountability on the delivery of the fundamentals of care, through the weekly steering group which I personally chair. My exec colleagues and I remain frustrated that whilst undeniable progress has been made recently on mandatory training, VTE assessment evidence, care of the deteriorating patient and most of the tracked measures of success in maternity services, we undermine that progress by not consistently managing delivery of good IPC practice in many areas, do not manage our physical environment as per agreed procedures and struggle to maintain documentation standards.

To tackle the above issues, our newly launched accountability framework, performance review meetings with Divisions and our weekly quality assurance

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Teamwork

meetings have refined and reduced membership to key accountable officers only. Our new Medical and Nursing Directors reinforce the expected standards with those accountable leaders, through their professional forums.

Board colleagues will recall that one of the key concerns raised with us by the Enable East inspection process was regarding our unclear and poorly managed bed capacity management process and associated escalation procedures. I am pleased to inform colleagues that some key changes have been made in the management team overseeing this on a daily basis. We have also revised and relaunched our escalation management procedures in tandem with our robust, week by week winter plan. These changes, operationally deployed, have led to far greater operational resilience. We delivered some of the best ED 4 hour performance in the region during October. November has seen very high attendance and admission levels, often exceeding not only our evidence based predictions for the month but also exceeding our predictions for the busiest month of January. On 27/11/18, we received a record number of ED attendances over a 24 hour period. Despite these challenges, our new approach and operational resilience has meant that we have not needed to deploy our winter escalation beds or areas. We will enter the predictably difficult December and January period in a stronger position than we have for some time.

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

The executive team are now regularly leading a weekly briefing session, open to all staff, entitled “Tuesday Topics”. The entire exec team participate, briefing colleagues on key matters regarding patient safety, financial recovery or operational pressure and mitigation, that are relevant to the past week and coming week. The sessions are held in the restaurant area and the exec team have agreed now to ensure the meeting is a “standing meeting” and takes place in the hospital atrium, to attract fuller participation.

Two positive signs of improved staff engagement at the Trust in recent times are the staff opinion survey response rate and the ‘flu vaccination rate for staff. Both are improved on where the Trust was at in the corresponding time last year. Of particular note is our ‘flu vaccination rate, which as of the week of 19th November, stood at 66%. The Trust was recognised as the most improved Trust in the country on this metric, having achieved 38% at the corresponding period, last year.

3.3 **Improve our financial health through our robust improvement programme**

In response to the Board's concern regarding the lack of traction on our financial recovery plan, I have personally chaired challenge meetings with Care Group leaders and corporate support services, on the key work streams of temporary workforce expenditure and operational productivity. Of particular ongoing concern has been the difficulty in getting agreed locum medical staff reductions enacted in the MLTC Division and the sickness rate increases in nursing, which have neutralised the progress made in control and reduction of bank and agency RGN and CSW deployment. The new nurse establishment output should now be seen in the production and lockdown of our December off duty rosters. The output of the Meridian Productivity review of medical establishments in MLTC should, as we enter the new year, clarify the long history of poor establishment control in both consultant, middle grade and junior medical staff.

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

Despite the challenges faced in pulling together the detailed activity baseline, developing the clinical model in sufficient detail with staff engagement and developing a governance and accountability proposal which suits all provider and commissioner partners, I have been delighted with the progress we have made on the development of the Walsall Together ICP business case. The challenges we have faced, however, do mean that the respective Boards, Governing Bodies and Cabinet, will now be formally reviewing the case in February 2019. We are breaking new ground in the development of this approach and our partners, KPMG, are confirming now that there is little evidence that can be learned from elsewhere regarding the formalisation of such partnerships, because Walsall is increasingly in the vanguard in this field.

4. RECOMMENDATIONS

Board members are asked to note the report and to also note the following statement regarding a refocusing of our priorities:

- We have made progress on a range of issues in 2018/19, most notably the building of an effective executive team, improved organisational culture, strategic direction, constitutional standards delivery and on quality assurance and governance. In essence, strong progress has been made on three of our four , balanced priorities for the year

- We have not yet consistently embedded productivity improvement in outpatients or theatres
- We have not yet got to grips with temporary staffing, although there is a clear and assertively managed approach underway with regards to the nursing workforce
- CIP delivery and expenditure management has not been sufficient to avoid a requirement to re-forecast, and the loss of PSF

Because of the above issues, the executive team have, with helpful prompting from the Chair and Deputy Chair, agreed a refocusing of our priorities for the remainder of the year. This will include:

- Ensuring that we have a safe winter, protecting patient safety and staff morale through a robust and clearly articulated winter plan and escalation arrangements. The oversight of this will be a collective task for the executive, not just for the COO
- Devoting additional time to supporting Division, Care Group and service leads on CQC inspection preparation and providing improved assurance on the delivery of the “fundamentals of care”
- Devoting additional time to the oversight of detailed recovery plans, by speciality on operational productivity and temporary workforce run rate

This is to be achieved through:

- A relaunch of the performance review process and new accountability framework
- A “meeting free” Friday culture with effect from 7/12/18 for all executives to up their visibility and face to face oversight of these issues
- Changes to the membership of the weekly quality assurance process, ensuring more transparent accountability for delivery by Care Group and Divisional officers

Richard Beeken
Chief Executive

NEW NATIONAL GUIDANCE, REPORTS AND CONSULTATIONS

The following guidance and policy actions, which have been received from the wider regulatory and policy system during November 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
	Regulatory approach to subsidiary companies NHSI have published an addendum to the transactions guidance to outline changes to the way subsidiaries are reported to and approved, following NHIS recent consultation . It clarifies the required approval process before Trusts can implement plans for subsidiaries; it does not affect your legal ability to develop such plans	**Information**	**Director of Finance & Performance**
	Board assessment framework for seven day hospital services In partnership with NHS England, NHSI are introducing a new way of measuring seven day hospital services for all providers of acute services, replacing the previous survey with a self-assessed board assurance framework (as announced in the 24 October provider bulletin). NHSI have published the new standard measurement and reporting template, alongside supporting national guidance and Q&As**.** The Trust will need to complete a trial run by February 2019, with full implementation by June 2019. Our regional teams will support you with this process.	**Information**	**Medical Director**
	Mental health and community services — new Model Hospital tools to help identify improvement opportunities The new Model Mental Health Services and the Model Community Health Services are tools have been developed by NHSI to help the Trust deliver the recommendations of Lord Carter's review into unwarranted variations in mental health and community health services, and identify opportunities for improvement. The Model Mental Health Services tool shows six service lines ranging from crisis response to	**Information**	**Director of Strategy & Improvemen t**

	rehabilitation and recovery. NHSI are also adding to their inpatient metrics on both tools.		
	Getting It Right First Time (GIRFT): oral and maxillofacial surgery report Improving the way oral and maxillofacial surgery is organised will improve patient experience and could help the NHS deliver up to £25 million in efficiency savings. The new oral and maxillofacial surgery report from the GIRFT programme includes 15 recommendations to help achieve this including developing hub and spoke networks and looking at why more simple surgery isn't being done outside of hospitals.	**Information**	**Medical Director**
	Preventing healthcare associated Gram-negative bacterial bloodstream infections NHSI have updated the tool that measures the impact of E. coli at trust and CCG level with 2017/18 data. The tool allows the Trust to measure the number of infections, length of time patients stay in hospital, how many deaths are associated with E. coli and the estimated financial cost incurred to the NHS. Trusts can also use it to demonstrate any improvements and reductions you have achieved	**Information**	**Director of Nursing**
	EU Settlement Scheme pilot Ahead of the launch of the EU Settlement Scheme pilot, find out more about what to do. It includes a briefing pack, email template for staff, and promotional poster.	**Information**	**Director of Strategy & Improvement**
	Well-led for the future board development workshops and 'King IV for Health and Social Care' Developed with input from NHS trust and foundation trust board members as part of the 'Well-led for the future' development programme, the King IV approach is designed to support NHS organisations to improve their governance arrangements and, as a result, deliver effectiveness and be able to evidence compliance with regulatory requirements. The final three sessions of the programme focus on understanding the key priorities and development needs of NHS board members, with a particular focus on the well-led framework.	**Information**	**Director of Governance**

	Campaign to encourage members of the public to volunteer in the NHS **Message to chief executives, chairs and directors of nursing: from Neil Churchill, Director Experience, Participation & Equalities, NHS England, and Ruth May, Executive Director of Nursing, NHS Improvement** NHSI wanted to bring to the Trust attention this letter from Sir Thomas Hughes-Hallett, the founder of Helpforce, regarding a joint campaign they will be running in December with the Daily Mail to encourage members of the public to volunteer in the NHS. Sir Thomas has written to both trusts and CCGs asking them to get involved in the initiative, highlighting the importance of volunteers to the NHS. This campaign will raise the profile of volunteering within the NHS to a large public audience and the benefits of volunteering to NHS staff and communities and NHSI hope the Trust will support the campaign by encouraging your organisation to get involved. Volunteering will be an important feature in the forthcoming NHS Long Term Plan which will recognise the importance of volunteers supporting community-based care and better health prevention and support.	**Information**	**Director of Strategy & Improvemen t**
	2017-18 reference costs published NHSI have now published the 2017-18 reference costs. These are the average unit cost to the NHS for providing defined services to NHS patients in England in a given financial year. They allow you to compare performance with others and identify opportunities to make improvements. This cost information is used nationally for decision-making and will be used in national metrics such as the Model Hospital and GIRFT . The 2017/18 reference cost collection was an important stage in the transition to patient-level costing, for information read our full guidance.	**Information**	**Director of Finance**
	Develop knowledge and skills in demand and capacity modeling Applications for the demand and capacity trainer programme in London and Bristol are now open. This free, accredited six-month programme is	**Information**	**Director of Finance**

	designed to develop organisations' internal knowledge and skills in demand and capacity modelling — a key component of a high performing organisation, resulting in reduced waiting times for patients. Graduates will be equipped to train others, develop demand and capacity plans, and spread knowledge more widely at a local level. The application deadline for cohort nine in the Midlands has also been extended to 25 November, and there will be one final cohort in the new year.		
	#iwill **Growing youth social action in health and social care** As part of the Daily Mail campaign to promote the contribution of volunteering in the NHS, the work of the #iwill campaign and their young volunteers will also be featured. The #iwill campaign, established in 2013 with cross-party support and led by HRH The Prince of Wales, is a coalition of over 900 cross-sector organisations aiming to ensure all young people are able to make a positive difference in their communities through activities such as volunteering, campaigning and fundraising. Such activity in the NHS can bring a wide range of benefits for both young people and their communities, including enhancing patient experience, improving the health and wellbeing of young people, and developing a new generation of health and care professionals. The campaign is working with NHS Improvement, NHS England, Pears Foundation and others to grow volunteering opportunities for young people in health and care. Learn more about the campaign, and support available for trusts interested in developing opportunities for young people.	**Information**	**Director of Strategy & Improvemen t**
	Patient Safety Alert: management of life threatening bleeds from arteriovenous fistulae and grafts A Patient Safety Alert has been issued around the management of life threatening bleeds (LTB) from arteriovenous fistulae and grafts in patients receiving haemodialysis. The alert signposts to resources produced jointly by the British Renal Society and the Vascular Access Society of	**Action**	**Director of Governance / Medical Director**

	Britain and Ireland to help you recognise the warning signs. Please ensure your local guidance incorporates the advice for the detection and management of LTB, and raises awareness of the resources.		
	Lessons learned from contract dispute resolution In partnership with NHS England, NHSI have outlined some lessons learned from recent experience of contract dispute resolution across the country, which includes 10 helpful hints for avoiding conflict.	**Information**	**Director of Finance & Performance**
	Resources supporting delayed transfers of care Evidence shows staying in hospital longer than needed can cause poor outcomes for patients. NHSI have developed five digital guides in partnership with NHS England and The Queen's Nursing Institute to support you to reduce the length of stay for inpatients when they are clinically fit to leave hospital.	**Information**	**COO**
	Guide to MP engagement for NHS providers Effective MP engagement is important for all NHS providers. Working on these relationships can change your MPs from vocal critics to critical friends, or even strong allies. To coincide with this year's UK Parliament Week , NHSI have produced a guide to MP engagement which has been shared with your communications teams (and is available to them on Comms Link to support you with your MP engagement.	**Information**	**Director of Strategy & Improvement**
	trusts accredited as Veteran Aware NHSI Veterans Covenant Hospital Alliance initiative has now accredited 25 NHS trusts across England, Scotland and Wales as 'Veteran Aware'. This mark of distinction means frontline staff have received training and education on the specific needs of veterans and can signpost them to local support services. To continue driving improvements in care for veterans, we're hoping to have 50 Veteran Aware trusts by the end of 2019.	**Information**	**Director of Strategy & Improvement**
	National Early Warning Score (NEWS2)	**Information**	**Director of**

	training platform updated The online NEWS2 training platform has recently been updated to include refreshed modules and access to the latest downloadable score cards and observation charts. The training remains free to NHS staff, with a new option for NHS organisations to embed the training in their own learning management systems.		**Nursing**
	Updated HM Treasury guidance on how to appraise and evaluate policies, projects and programmes The Green Book is guidance issued by HM Treasury on how to appraise policies, programmes and projects. It also provides guidance on the use of monitoring and evaluation techniques before, during and after implementation of projects and programmes. HM Treasury also publishes supplementary guidance to the Green Book, including two documents updated in October 2018: A Guide to Developing the Project Business Case and A Guide to Developing a Programme Business Case This guidance helps to deliver better business cases and outcomes with a practical step-by step-guide to the development of business cases.	**Information**	**Director of Strategy & Improvemen t**
	Support the Stop the Pressure campaign to help prevent pressure ulcers For International Stop Pressure Ulcers Day on Thursday 15 November, NHSI are launching a new awareness campaign around prevention — in line with the newly revised definition and measurement framework. To show your support, simply wear a red do on the day. Take the challenge to talk to anyone who ‘spots the dot’ about the steps we can all take to prevent pressure ulcers. You can wear a red dot or ‘wear and share one on your social media profile. Join the #StopThePressure conversation on Twitter	**Information**	**Director of Nursing**
	Have your say — online consultation on our guide to deploying nursing associates NHSI have drafted a new resource to support providers to safely and effectively deploy nursing associates into the healthcare workforce. It has been written with input from senior nurses,	**Information**	**Director of Nursing**

	clinicians, nursing organisations, workforce colleagues and regulatory and government organisations. NHSI would like to hear opinions from colleagues working across healthcare in England, patients, carers, service users and any other interested parties about whether you think it will be helpful in deploying nursing associates into the workforce.		
	Mandatory cost collection in 2019: what you need to know Next year will be the first year of a mandatory patient-level costing (PLICS) collection for designated acute providers and NHSI have now confirmed that where PLICS is collected from those trusts, NHSI will no longer be collecting reference cost information as well. Other non-acute providers that provide acute services (admitted patient care, outpatients and emergency) should continue to submit reference cost information. Read the full guidance.	**Information**	**Director of Finance**
	Pharmacy and medicines optimisation: a toolkit for winter 2018/19 NHS Improvement and NHS England have published a framework of good practice for pharmacy and medicines optimisation teams in readiness for managing winter pressures in the acute hospital sector and at the interface with the acute sector. It provides a toolkit for chief pharmacists and also a checklist for trust boards to assess readiness	**Information**	**Director of Nursing**
	Support to facilitate large-scale change NHS England has released new dates for its facilitating large scale change webinar series. Led by expert facilitators, this consists of six topic sessions in November and December 2018. Find out more and register . The team is also offering targeted large scale change support via face-to-face masterclasses . The masterclasses will take place in Leeds and London in February and March 2019. Express your interest by 5pm on Tuesday 20 November 2 018. If you have any questions about the series, please email england.si-events@nhs.net.	**Information**	**Director of Strategy & Improvement**

	Effective clinical governance for the medical profession The GMC has published a revised handbook for organisations that employ, contract or oversee the practice of doctors in the UK. It outlines the role of boards and governing bodies in ensuring effective clinical governance for doctors and how this can contribute to high quality patient care. It also provides clear advice about clinical governance processes for doctors including annual appraisal, managing concerns and pre-employment checks.	**Information**	**Director of Governance / Medical Director**
	Updated equally outstanding resources CQC has updated its equality and human rights good practice resource to include a new e-learning module, extra case studies from outstanding providers and an updated PDF version based on user feedback. These resources will help people working in health and social care to: • understand the different reasons why a focus on equality and human rights can improve care quality • to 'make the case' for equality and human rights in quality improvement work • learn from providers that have worked on equality and human rights to deliver outstanding care • reflect on the common success factors in outstanding providers using equality and human rights to improve care • think about how a focus on equality and human rights can help meet challenges in times of financial constraint	**Information**	**Director of People & Culture**
	Improving physical healthcare to reduce premature mortality in people with serious mental illness RCPsych has been commissioned to deliver two data collections to reflecting care delivered in different settings as part of the 2018-19 Commissioning for Quality and Innovation (CQUIN) scheme 'Improving physical healthcare to reduce premature mortality in people with severe mental illness'. The National Clinical Audit of Psychosis (NCAP) Early Intervention in Psychosis (EIP) audit will collect information on EIP settings against CQUIN metrics — including new indicators	**Information**	**Medical Director / Director of Governance**

	relating to weight gain and smoking cessation. Find out more about the audit, including the data collection, registration and submission timelines . A second bespoke audit assesses service performance in inpatient and community settings.		

MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018			
Monthly Nurse Staffing Report- October 2018 data			**AGENDA ITEM: 8, ENC 6**
Report Author and Job Title:	Gaynor Farmer Corporate Senior Nurse - Workforce	**Responsible Director:**	Dr Karen Dunderdale Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	This is a revised Nursing and Midwifery report. This will continue to be refined over the next couple of months to include further data, narrative and actions being taken as part of the Nursing Workforce Transformation Programme. It will be triangulated with data from the Nursing and Midwifery quality dashboard to ensure a holistic picture is presented for a wider understanding of impact around staffing levels and quality indicators. It will be aligned to the four programme workstreams and patient harm indictators. The average fill rate for registered nurses in October 2018 was 95.9% for day shifts and 98.2% for night shifts in comparison to September 2018 when it was 95.2% for days and 95.2% on nights. Going forwards this report will reflect reasons for temporary staffing fill, to indicate core business or other business, as a narrative for the positive fill rate as well as the negative fill rate. 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. CSW cover was less than 90% on wards 2, 9, 23, 18 (HDU) and 24/25 during the day and wards 18 and 24/25 during the night. These gaps were contributed to by an inability to fill Bank shifts but for some areas there was a risk assessment completed and temporary staffing were not sought due to work being able to be absorbed within the team. There were 2 falls that correlated with staffing incidents (Ward 15 and Ward 16 had one each) and the Corporate Lead Nurse for Quality has commenced safety huddles twice daily on Ward 15 and has a programme of roll out that includes Ward 16. There were 50 recorded incidents of red flags recorded through the staffing risk assessments within October. This is 3 less than last month.		

Recommendation	The Board is requested to review and note the content of the report.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Objective No 5: Establish a substantive workforce that reduces our expenditure on agency staff. Corporate Risk No 11: Failure to assure safe nurse staffing levels.	
Resource implications	Resources are needed from all teams to focus on efficient and safe scheduling and allocation of nursing staff and the prompt action to resolve shortfalls in staffing whenever possible to mitigate the risk to patient care and safety	
Legal and Equality and Diversity implications	None	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☒	

MONTHLY NURSE STAFFING REPORT

1. PURPOSE OF REPORT

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

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

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

2. SHIFT FILL RATES

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

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

The average fill rate for registered nurses in October 2018 was 97.30% for day shifts and 97.30% for night shifts in comparison to September 2018 when it was 95.2% for days and 95.2% on nights. Shift fill rates have increased this month for RNs on days and nights. The fill rate for Care Support Workers (CSW) increased in October 2018 to 94.6% on day shifts and to 99.2% on night shifts.

Of the 23 areas reported on during October 2018;

- No areas recorded less than 90% shift fill rate on days for RN
- On nights 1 area recorded less than 90% shift fill rate on nights for RN/RM
  This was Ward 18 (HDU).

The lower RN fill rate on Ward 18 (HDU) was due to Maternity leave no temporary staffing cover was required on nights due to ability to plan staffing against activity whilst still maintaining nationally recommended levels of staffing for this area.

CSW cover was less than 90% on wards 2, 9, 23, 18 (HDU) and 24/25 during the day and wards 18 and 24/25 during the night.

Ward 2 CSW fill was affected by requests for bank that were not filled .Ward 9 CSW under fill in the day was due to inability to fill shift requests however some days were a measured decision to not seek cover on late shifts due to patient acuity or activity that could be absorbed. The lower CSW fill rate on HDU was impacted by maternity leave. Some shifts did not require cover due to patient care levels. 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 impacted by maternity leave and these shifts could not be filled despite requests for temporary staffing cover though there is flexibility applied to share staff between this area and Delivery suite when appropriate.

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 October 2018. For nights there has been a consistent >90% fill rate on nights since January 2018. The fill rate for RNs on days increased this month after three months of decline.

Figure 1

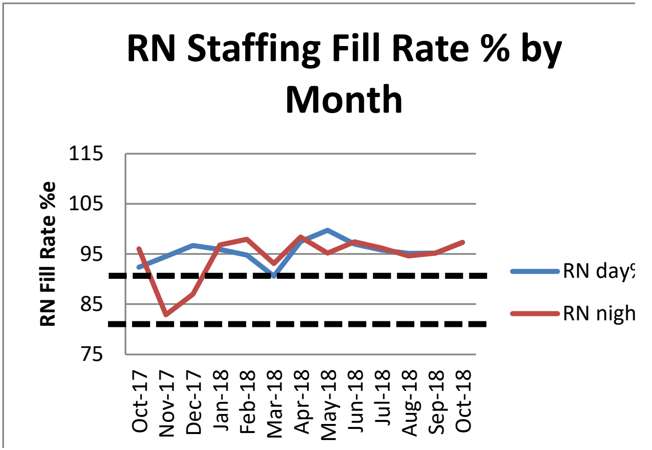


Figure 2

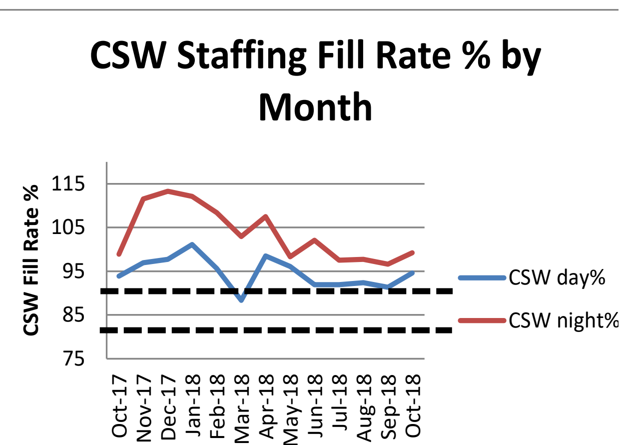


Figure 2 shows that the fill rate for CSWs on both days and nights has increased slightly though it is worth noting that substantive fill on the CSW shifts is at 73.74% for day and 64% for night meaning that there is a heavy reliance on temporary staffing to achieve these fill rates. Bank CSW recruitment processes are being revised to increase the amount of staff available to work bank and therefore reduce reliance on Agency.

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 staffing fill rates. These have been reviewed in relation to the quality and safety key performance indicators (KPI). These KPIs are shown below, (the KPIs for all wards are shown in Appendix 1):

Table 1

Ward	Hospital Acquired Pressure Ulcer	Falls	Serious Incidents	Complaints	FFT Score	Number of Staffing incidents	Any correlation between staffing incidents and KPI dates?
2	0	9	0	1	95.45%	8	Yes, 2 falls correlate with staffing incidents reported on the same date though do not cite a link
9	3	2	0	1	100%	2	No
18	0	0	0	0	100%	1	No
23	0	0	0	0	96.77%	1	No
24/25	0	0	0	0	90.32%	0	No

The incidence of pressure ulcers and falls can be influenced by the ward speciality and patient demographics e.g. a higher incidence of falls may be expected on an elderly care or rehabilitation clinical area; however, these can also correlate with staffing issues and shortages. There was no cited correlation between staffing incidents and Pressure Ulcer incidents for these wards during October 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 October are currently going through the RCA investigation process.

All the staffing related incidents reported on the Trust Safeguard incident reporting system for October 2018 were reviewed to identify any correlation with patient harms. In total there were 5 recorded staffing incidents where the date correlates with a patient fall during October 2018.

Table 2

Ward	Number of staffing related incidents	Level of Impact	Any correlation to other reported incidents?
Ward 1	2	Low harm	Yes, 1 fall correlates with the date of a reported staffing incident.
Ward 2	8	No/low harm	Yes, 2 falls correlate with the date of reported staffing incidents
Ward 15	1	Low harm	Yes, 1 fall correlates with the date of a reported staffing incident.
Ward 16	6	No/low harm	Yes, 1 fall correlates with the date of a reported staffing incident.

On review of the reported staffing incidents in October 18, the incident on Wards 15 and 16 state that staffing was low and that patients had a fall in that shift. Ward 1 and 2 incidents do not state a correlation between the events. Currently, the Corporate Senior Nurse for Quality is focussing on safety huddles on Ward 15 (twice daily) and Ward 16 are also in the schedule of work to do the same. The safety huddles focus on falls as well as other safety issues with a focus on rapid assessment and interventions to try and prevent safety issues from occurring.

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 recorded 50 red flag events in October 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.

The Director of 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.

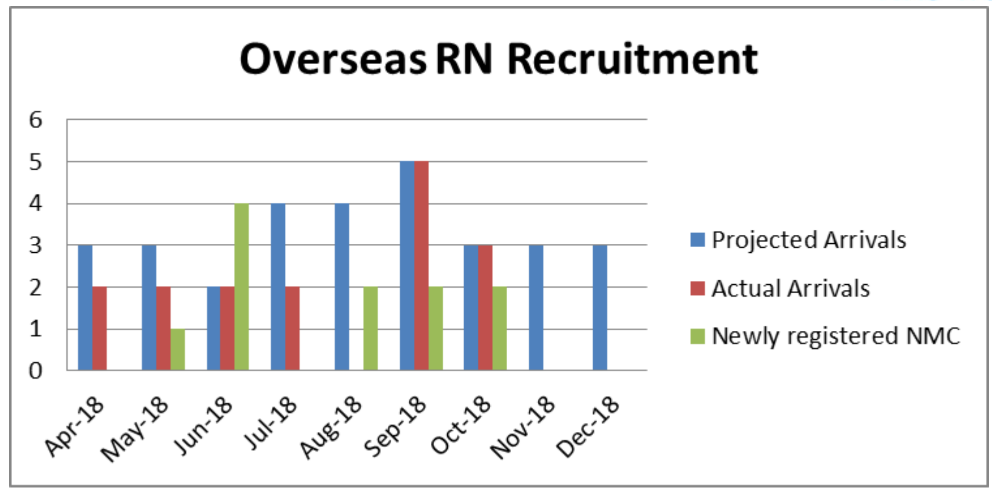
4.0 Update on Vacancies and Recruitment

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

Division	Vacancy
SURGERY	21.88 WTE
MLTC	44.90 WTE
WCCS	13.26 WTE

The current initiatives being undertaken in relation to RN recruitment:

- There is a rolling advert for Band 5 RN posts in the Medicine and Surgical Division on NHS jobs
- Regional RN recruitment event is planned by Corporate Nursing for 5th December 2018. The September event saw recruitment of 10 RN's.
- There is a planned integration of newly qualified Nurse Associates into the nursing workforce in Q4 of 2018-2019 which have now been modelled ready to be placed into establishment reviews
- The ongoing recruitment of overseas nurses will continue throughout 2018-2019. WHCT has overseas arrivals planned for the remainder of this financial year with an expected conversion to RN registered with the NMC within 6 months. The target for recruitment is 30WTE for this financial year. 16 have already arrived. 11 have now got NMC registration.



Student RNs are offered a conditional job offer upon commencement of placements with WHCT during their training. There were 23 newly qualified RNs and 8 RMs who commenced in post during September 2018. Retention of student nurses on qualifying as RN who have trained at WHCT is approximately 90%. The corporate nursing team have already commenced planning for the student RN's who will qualify in January 2019 and are working with Divisions to plan allocation of roles.

5.0 RECOMMENDATIONS

The Quality, Patient Experience & Safety Committee is requested to discuss the information contained in this report including:

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

6.0 CONCLUSIONS

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

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

7.0 APPENDICES

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

Appendix – Fill rates Nursing, Midwifery and Care staff

Oct-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 grade 3	Unstageable/or deep tissue injury	CDIFF	MRSA	NUMBER OF DAYS WHERE RED FLAGS OCCURRED	FORMAL COMPLAINTS	FFT(%)
Acute Surgical Unit		93.7%	102.8%	101.3%	98.4%	58.33%	70.07%	40.76%	45.36%	3.2	3.2	6.4	4	100.00%	3	0	0	0	0	0	4	0	100.00%
Paediatric Assessment Unit		98.0%	90.3%	100.0%	94.6%	99.02%	75.00%	96.77%	71.59%	49.2	65.9	115.1	0	N/A	0	0	0	0	0	0	0	0	N/A
Ward 01		94.1%	94.9%	97.8%	92.7%	76.57%	70.62%	60.44%	42.61%	2.2	2.8	5.1	2	78.79%	14	1	0	0	0	0	5	0	82.61%
Ward 02		92.0%	88.2%	97.8%	101.1%	87.15%	70.05%	69.23%	68.09%	2.3	2.6	4.8	8	82.35%	9	0	0	0	0	0	1	1	95.45%
Ward 03		105.3%	99.1%	101.6%	101.4%	91.30%	54.53%	60.31%	72.42%	1.8	2.8	4.5	1	91.18%	5	0	0	1	0	0	3	0	97.14%
Ward 04		98.8%	98.3%	100.0%	100.0%	91.80%	50.40%	72.58%	48.91%	2.6	3.4	6.0	1	96.15%	11	0	0	1	0	0	8	0	95.45%
Acute Medical Unit		98.9%	93.2%	97.2%	98.2%	87.40%	78.31%	71.09%	78.87%	4.3	4.5	8.8	1	90.00%	6	0	0	0	0	0	2	0	93.33%
Ward 07		98.0%	94.5%	98.9%	97.8%	96.71%	88.69%	97.83%	86.81%	3.7	3.6	7.3	0	91.30%	1	0	0	0	0	0	2	0	95.60%
Surgical Assessment Unit		97.8%	108.0%	-	-	75.27%	86.10%	n/a	n/a	53.7	29.6	83.3	0	100.00%	0	0	0	0	0	0	0	0	91.57%
Ward 09		92.3%	84.4%	98.9%	96.1%	71.33%	73.95%	66.30%	48.32%	2.8	3.2	6.0	2	92.31%	2	1	1	1	1	0	4	1	100.00%
Ward 14		93.3%	101.5%	100.0%	98.8%	41.92%	79.19%	34.92%	37.73%	2.5	3.1	5.6	0	N/A	14	0	0	0	0	0	2	0	93.62%
Ward 15		90.4%	90.6%	96.8%	100.0%	78.50%	76.37%	48.89%	89.16%	2.7	2.9	5.6	1	89.29%	3	0	0	0	0	0	7	1	100.00%
Ward 16		96.9%	97.1%	93.5%	148.4%	75.75%	64.43%	37.93%	47.83%	3.1	3.2	6.2	6	80.00%	4	1	0	0	0	0	5	2	89.74%
Ward 17		98.4%	99.9%	100.0%	112.7%	86.07%	87.48%	58.06%	72.50%	3.2	2.6	5.8	0	91.30%	1	0	0	0	0	0	2	0	88.33%
Ward 18		98.7%	77.9%	89.0%	58.1%	91.15%	97.93%	88.41%	66.67%	15.8	2.3	18.1	1	100.00%	0	0	0	0	0	0	0	0	100.00%
Ward 19		92.5%	-	93.0%	-	88.44%	n/a	87.36%	n/a	27.1	0.0	27.1	1	80.00%	0	0	0	0	0	0	0	0	100.00%
Ward 20A		96.7%	100.0%	95.2%	100.0%	82.26%	61.29%	61.02%	74.19%	3.8	2.4	6.2	0	100.00%	0	0	0	0	0	0	0	0	94.44%
Ward 20B/20C		97.2%	90.5%	98.9%	100.0%	83.26%	84.66%	65.22%	85.48%	3.6	3.0	6.6	4	70.00%	1	0	0	0	0	0	0	0	97.62%
Ward 21		100.8%	-	94.4%	-	100.00%	n/a	98.29%	n/a	6.2	0.0	6.2	1	100.00%	0	0	0	0	0	0	0	0	93.14%
Ward 23		116.5%	89.9%	100.4%	112.4%	100.00%	92.82%	91.06%	77.75%	4.0	2.7	6.8	1	100.00%	0	0	0	0	0	0	0	0	96.77%
Wards 24/25		105.0%	80.6%	98.5%	75.1%	96.56%	68.85%	89.57%	50.12%	4.0	2.2	6.2	0	100.00%	0	0	0	0	0	0	0	0	90.32%
Ward 28		100.0%	100.0%	100.0%	100.0%	94.71%	92.31%	90.20%	96.15%	13.8	1.7	15.4	2	100.00%	0	0	0	0	0	0	0	1	N/A
Ward 29		98.8%	106.3%	98.9%	110.6%	92.65%	79.76%	55.43%	87.51%	3.0	2.7	5.7	3	90.00%	10	0	0	0	0	0	5	1	96.43%
TOTAL FILL RATE		**97.30%**	**94.60%**	**97.30%**	**99.20%**	**83.98%**	**73.74%**	**71.56%**	**64.00%**														
		95.90%		**98.20%**																			

fill rate key

<81% - 90%>	(amber)
<80%	(red)
>115%	(blue)

<table>
<tr><td colspan="4">MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018</td></tr>
<tr><td colspan="3">CQC Preparedness Update</td><td>AGENDA ITEM: 9,
ENC 7</td></tr>
<tr><td>Report Author and Job Title:</td><td>Suzie Loader
Improvement Consultant</td><td>Responsible Director:</td><td>Richard Beeken
Chief Executive</td></tr>
<tr><td>Action Required</td><td colspan="3">Approve ☐ Discuss ☒ Inform ☒ Assure ☐</td></tr>
<tr><td>Executive Summary</td><td colspan="3">This paper aims to update the Board on the actions the trust has been taking over the past few months to improve the quality of care to patients, whilst simultaneously preparing the organization for the next CQC inspection.

The paper outlines the key issues for October 2018 as follows:

1. The Trust submitted 99% of the CQC Provider Information requested (PIR) by the deadline of 5pm on 18 October 2018, with the remaining pieces of information being submitted the following day.
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 later by the Well-Led and Use of Resources inspections.
3. The CQC have changed the way that they want to engage with the trust, preferring regular engagement visits to departments and quarterly engagement meetings. The first engagement visit was planned for the Medicine Division on the 15 November 2018. Feedback was largely very positive, however, anxiety was picked up around the new nursing templates
4. Improvements have been made to the PCIP, which is being supported by new business intelligence 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 for a 3rd month to 94.63%
b. Nurse staffing vacancies positively remain below the national average
c. Midwife to Birth ratio is excellent at 25:1 (nat. average 28:1)
d. Appraisal rates have dipped slightly to 88.91%
e. DNACPR MCA assessment has dipped slightly from 80% last month to 76%
f. Development of the Medical Records policy and SOP has been delayed – completion date now December 18
g. The number of outstanding SI actions has deteriorated in month in Surgery and WCSS
h. Mandatory training remains at 85.21%
i. Best practice moved from amber to red last month and remains red for compliance with NAPSIPS, CAS alerts & expired clinical guidelines</td></tr>
</table>

Caring for Walsall together

Value colleagues

	j. 95.4% of outpatient staff have completed competencies k. The number of out of date policies is significant. Policy update and review will be monitored tightly from now on l. 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 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 ☒	

Caring for Walsall together

CQC Preparedness Update: October 2018

Purpose

1. This report aims to update the Board on work being undertaken to improve the quality and safety of care delivered to patients, whilst simultaneously preparing the organisation for its next CQC inspection. It should be noted that all actions being taken are aimed at becoming embedded in everyday practice to facilitate continuous improvement.

Recommendations

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

The Report

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

CQC Inspection Preparation

4. The Trust submitted 99% of the CQC Provider Information requested (PIR) by the deadline of 5pm on 18 October 2018, with the remaining pieces of information being submitted the following day.

5. Because the trust has now 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 receipt date and from the information presented, together with other intelligence gathered (via CQC Insight etc.), will decide what the forth-coming inspection will look like. It could be either announced or unannounced and could be undertaken in one visit, or a series of shorter unannounced visits. Either way, the announced Use of Resources Inspection should follow a couple of weeks after the inspection has finished, followed by the Well-Led inspection.

6. The CQC visited the trust on the 15 November 2018, to carry out their first engagement session with the trust. They spoke to the Medical Division, held focus groups with staff and visited Ward 2 (elderly care) and the Frail Elderly Service (FES). Feedback received was positive; they said they could see a change in culture, team working and changes since the last inspection and met some proud staff. Staff talked about the support they received from staff and how approachable senior managers were (they gave an example of doctors being able to escalate issues from AMU to the Divisional Director). Staff were positive regarding planning being undertaken for winter and had clearly put a lot of work into the presentations they had given. The only issue they picked up was that staff seemed anxious regarding the new nursing templates; this was something they would be reviewing again during the inspection.

7. 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.

8. Examples of issues which have been highlighted for additional action during the last month include:
    a. PCIP governance
    b. Controlled drug management
    c. Evaluation of the trust-wide audit pilot
    d. Results of the documentation & DNACPR MCA audits
    e. PIR
    f. CQC readiness
    g. Feedback from the Enable East peer review

9. Sharing of best practice continues at each meeting, with departments presenting practice which could be adopted in some or all other departments across the organisation. Examples shared include:
    a. Pharmacy Patient Focus Group
    b. Demonstration of Power BI (to be used to present PCIP updates)

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

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

Board self-assessment against the Use of Resources Framework

12. The executive team's self-assessment against the new Use of Resources Framework (CQC, 2018) is nearing completion and specific actions identified. A board development session was held on the 15 November 2018 to discuss the assessment and a further board development session is planned for January 2019.

The Patient Care Improvement Programme (PCIP)

13. The PCIP continues to be 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), providing enhanced assurance. Work to 'theme' the issues and resulting actions continues, 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. To facilitate this work, a second 'Outcomes' workshop was carried out in October, to support staff in the development of their PCIPs in relation to any outstanding Key Performance Indicators (KPI's).

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

Issue	Improve / decline
VTE performance has dipped down to 94.63%	↓
Nurse staffing vacancies positively remain below the national average	
Midwife to Birth ratio is excellent at 25:1 (nat. average 28:1)	
Appraisal compliance has dipped slightly to 88.91%	↓
DNACPR & MCA compliance has dipped slightly from 80% to 76%	↓
Development of the Medical Records policy and SOP has been delayed – completion date now December 18	
Number of expired SI actions has deteriorated in month in Surgery and WCSS. This is being addressed via the safety huddles	↓
Mandatory training remains at 85.21%	
Best Practice has moved from amber to red, due to continued lack of compliance with NAPSIPS, CAS alerts & expired clinical guidelines	
95.4% of outpatient staff have completed competencies	
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.	

Appendices A - C summarise compliance against the Regulatory & Must Do actions.

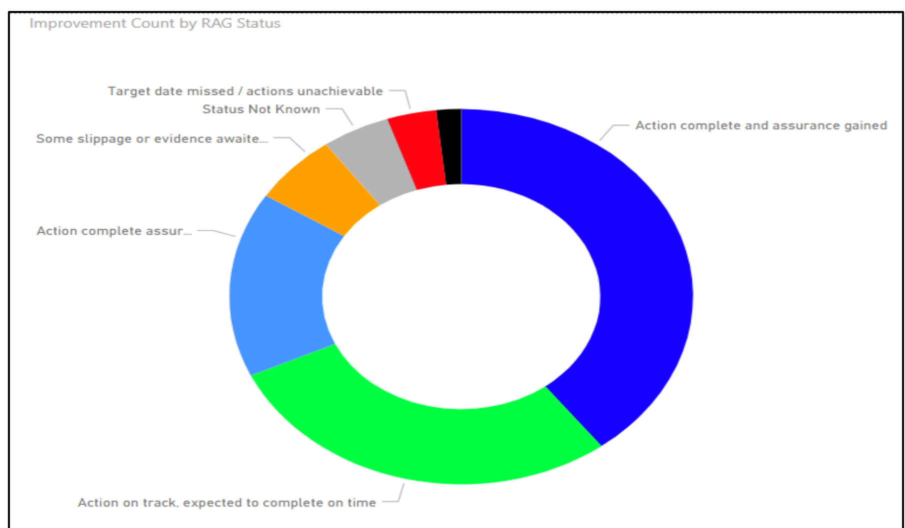
Progress with the PCIP actions

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

16. As the PCIP is being used as the one improvement plan for the Trust, it has started to capture actions from other sources in addition to the must/should do actions raised in the CQC inspection report. For this reason, the number of actions recorded has increased to 232 from 198 in October 2018. This will continue to evolve as the PCIP is extended to include care groups and corporate Directorates that are not identified as 'core services' by the CQC and also with 'corporate' or trust-wide actions being replicated in several care groups. Appendix D provides a histogram which shows the 'additional' actions now included and a small number of other actions which will be assigned a source.

17. The chart and table below outlines progress against the 232 actions identified within the overarching PCIP. It demonstrates that 39.7%% of actions noted in

the report have been completed and assurance gained via evidence provided; with a further 16.0% of actions completed but awaiting full assurance; 55.7% completed in total, a slight reduction from last month,. However there have been improvements in the other categories



RAG Status	Oct No.	Nov No.	Oct %	Nov No.
Action complete and assurance gained	90	92	45.5%	39.7%
Action complete assurance not or only partially gained	34	37	17.1%	16.0%
Action on track, expected to complete on time	41	66	20.7%	28.5%
Some slippage or evidence awaited, expected to complete on time	14	14	7.1%	6.0%
Status Not Known	11	11	5.6%	4.7%
Target date missed	8	8	4.0%	3.5%
Action start date not due	-	4		1.7%
Total	198	232	100.0%	100%

18. Appendix D provides further details in relation to compliance against the regulatory and must do actions. Areas of concern are highlighted in 8. above.

Conclusion

19. 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.

20. Work is on-going to enhance the quality of leadership within the organisation through the use of the well-led action plan and staff preparation for the forth-coming inspection. The aim of the actions outlined in this paper are designed to

become sustained and embedded in every day practice, to ensure that the organisation moves from ‘Requires Improvement’ to ‘Good’.

Appendices:

A: Progress Summary re Regulatory & Must Do Actions
B: Detailed update on Regulatory & Must Do Actions
C: C Section Rates – Maternity Services
D: PCIP Progress Report – Action Completion and Assurance

Appendix A

Summary update regarding progress against Regulatory Actions:

Regulatory Issue	Trust Target	Update (June '18)	Update (July 18)	Update (Aug. 18)	Update (Sep 18)	Update (Oct 18)
Thromboembolism assessments were not carried out for all patients at risk.	95% are assessed on admission by March 2018.	96% (run chart in ap. A)	95.57%	95.08%	94.38%	94.63%
There were **high levels of nursing staff vacancies** across acute services. This meant the provider was not providing sufficient numbers of suitably qualified staff to keep patients safe	Trust target is aligned to the National vacancy rate of 10.66%	8.73% (run chart in ap. A)	13.06%	8.78%	8.8%	8.01%
12 (2)(a) Not all staff were compliant or completed timely assessments for patients- in accordance with the **Mental Capacity Act 2005 or Deprivation of Liberty (DOL)**.	90% compliance with MCA training By March 2018 Compliance with MCA when completing DNA CPR decisions by March 2018.	55% (April 2018) 69% (June 2018)	98.54% 69% (June 2018)	98.4% training compliance 68% (August 2018)	98.496% training compliance 80%	97.6% Training compliance 75.71%
The **critical care environment** had only one isolation room. This provision was not meeting the needs of patients so was not sufficient to maintain safe management of infectious patients.	Revised SOP February 2018 New build October 2018.	SOP has been revised and audits undertaken to measure compliance. New build on target for December 2018 opening.			One incident in Sept. however SOP followed appropriately	No incidents reported in October

Regulatory Issue	Trust Target	Update (June '18)	Update (July 18)	Update (Aug. 18)	Update (Sep 18)	Update (Oct 18)
Staff were not up-to-date with **mandatory training**. There were a number of modules that had completion rates significantly lower than the trust's target.	90% compliance by 30th June 2018.	78.76% (Run chart ap. A)	83.6%	85.46%	85.21%	85.21%
Blind cords were not secured in all of the rooms at the child development centre	By March 2018. Risk assessment undertaken Permanent solution to be implemented. Audit of compliance.	All blind cords (including the main hall) have been adjusted to ensure a permanent solution to ensure that children cannot reach them.				
Safeguarding training completion rates were low for both medical and nursing staff. Not all staff were trained in level 3 safeguarding children, which is a requirement set by the Intercollegiate document (2014).	Achievement of targets for all levels of Children and Adult Safeguarding by end June 2018 Level 1=95% Level 2 & 3=85% PREVENT=85%	Training compliance figures in Appendix A	SG Paeds: L1: 99.26% L2: 84.52% L3: 92.24% SG Adults: L1: 99.92% L2: 87.04% L3: 89.64%	SG Paeds: L1: 98.67% L2: 85.37% L3: 92.08% SG Adults: L1: 99.83% L2: 89.53% L3: 87.89% MCA:98.49%	SG Paeds: L1 = 98.98% L2 = 85.67% L3 = 89.92% SG Adults L1 = 99.44% L2 = 90.52% L3 = 88.72% MCA: 98.49%	SG Paeds: L1 = 97.75% **L2 = 84.67%** L3 = 90.02% SG Adults L1 = 95.92% L2 = 91.85% L3 = 88.63% MCA: 97.6%
Staff were not consistently completing **patient records**. There were trust documentation that was	Secure accurate, complete contemporaneous records by ~~1st March 2018.~~ 90%	A new multiprofessional audit is in development	Medical Documentation Audit scheduled for 24.08.18 &	Audit conducted and results indicated approx. 30%	Very slight improvement from previous audit, but still	Not recorded centrally this month

Regulatory Issue	Trust Target	Update (June '18)	Update (July 18)	Update (Aug. 18)	Update (Sep 18)	Update (Oct 18)
not completed. Staff were not always on signing entries. There were a number of entries where there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times.	compliance against professional standards by December 2018 Develop a work stream plan to address the physical condition of the paper records by 31st March 2018	(completion 31.07.18) which will be piloted alongside the other fundamental standards peer review audits commencing 15.08.18	agreed that MD documentation audit to be piloted across the trust commencing 15.08.18	compliance. Each Division have individually agreed a plan to improve compliance by December 2018	more required	
Patients' records were taken home by the community children's nursing team when they were not returning to the office. We were not assured of the confidentiality or security of records for the	Confirm Trust strategy for EPR by 30th June 2018. 'Mobile' notes implemented across community	Total Mobile note system implemented	Total Mobile note system implemented	Total Mobile note system implemented	Total Mobile note system implemented	Total Mobile note system implemented

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

Summary update regarding progress against Must Do Actions:

Issue	Must	Trust Target	Update June '18	Update July '18	Update Aug '18	Update Sep '18	Update Oct '18
Action plans are monitored and managed for serious incidents	Must	Zero outstanding by January 2019	See appendix A	See appendix A	See appendix A	See appendix A	See appendix A
Lessons are disseminated effectively to enable staff learning from serious incidents, incidents and complaints.	Must	100% of staff interviewed can share one example of a lesson learnt and action taken	See appendix A	See appendix A	See appendix A	See appendix A	See appendix A
Patient medical notes are kept secure at all times	Must	90% compliance against the trust policy by January 2019	Policy is being develope d for implemen tation & audit	Policy is being developed for implementa tion & audit	Policy is being developed for implementa tion & audit	Policy is being developed for implementa tion (Oct. 18) & audit	Policy is being developed for implementa tion (Dec. 18) & audit
All staff are trained and competent when administering medications via syringe driver	Must	100% of relevant staff have undergone syringe driver equipment training 100% of relevant staff have undergone syringe driver competency training	80% complianc e (Alaris PCAM)	Figures not available	Population which requires training currently unknown, but numbers of staff trained known. Meeting to agree way forward established	See Appendix	First report is due in November
Staff follow best practice national guidance (NICE, CAS alerts, Royal College Guidance, local clinical guidelines etc.)	Must	Zero CAS alerts outstanding	2 CAS Alerts outstandi ng:	See Appendix A	See Appendix A	See Appendix A CAS alerts	See Appendix A

Issue	Must	Trust Target	Update June '18	Update July '18	Update Aug '18	Update Sep '18	Update Oct '18
		100% Technology Appraisals, assessment & implementation within 90 days Zero Clinical Guidelines out of date by xxxx	Review of clinical guidelines			outstanding; NAPSIPS outstanding and 89 out of date clinical guidelines	
The service uses an acuity tool to evidence safe staffing (nursing & midwifery)	Must	100%	SNCT & midwife: birth ratio in place	SNCT & midwife:birth ratio in place 1:28	SNCT & midwife:birth ratio in place 1:25	SNCT & midwife:birth ratio in place 1:27.3	SNCT & midwife:birth ratio in place 1:25.1
All staff receive an appraisal in line with local policy	Must	90%	83.41%	87.56%	90.04%	89.73%	88.91%
COMMUNITY FOR CHILDREN & YOUNG PEOPLE: Continue to follow standard operating procedures with medicines in special schools	Must	100%	100%	100%	100%	100%	100%
MATERNITY: Risks are explained when consenting women for procedures	Must	100%	Consent audit undertaken 2017. Re-audit required	Re-audit being undertaken in August 2018	Achieved, CQC inspection report August 2018	August 2018 audit results demonstrate areas of improvement needed	August 2018 audit results demonstrate areas of improvement needed
ED: completes the action plan completed following the CQC inspection carried out in September 2015	Must	100%	Currently reviewing compliance	2 actions outstanding and being implemented	2 actions outstanding and being implemented	1 action remains - appraisals	1 action remains - appraisals
SAFEGUARDING: adults and	Must	100%	Revised	Adult Policy	Adult Policy	Adult Policy	Adult Policy

Issue	Must	Trust Target	Update June '18	Update July '18	Update Aug '18	Update Sep '18	Update Oct '18
Safeguarding children policies are up to date and include relevant references to external guidance			Adult policy by 31.07.18 Revised Children's Policy TBC	completed. Revised Children's Policy TBC	completed. Revised Children's Policy TBC	completed. Revised Children's Policy is now out to consultation	completed. Revised Children's Policy is nearing approval
CRITICAL CARE: All staff working within the outreach team are competent to do so	Must	100% by 01.01.2019		Monthly trajectory to be established	August – 50% Trajectories Sept – 60% Oct – 80% Nov – 100%	September trajectory achieved Sept – 60% Oct – 80% Nov – 100%	
OUTPATIENTS: All staff have the required competencies to effectively care for patients, and evidence of competence is documented.	Must	90%	90%	90%	90%	90%	95.4%
OUTPATIENTS: All outpatient clinics are suitable for the purpose for which they are being used (This relates specifically to the Fracture Clinic)	Must	100%		See appendix A for actions taken. Once evidence received can be altered to blue	See appendix A for actions taken. Once evidence received can be altered to blue	See appendix A for actions taken. Once evidence received can be altered to blue	See appendix A for actions taken. Once evidence received can be altered to blue

Appendix B

Update on Regulatory & MUST DO Actions (August 2018)

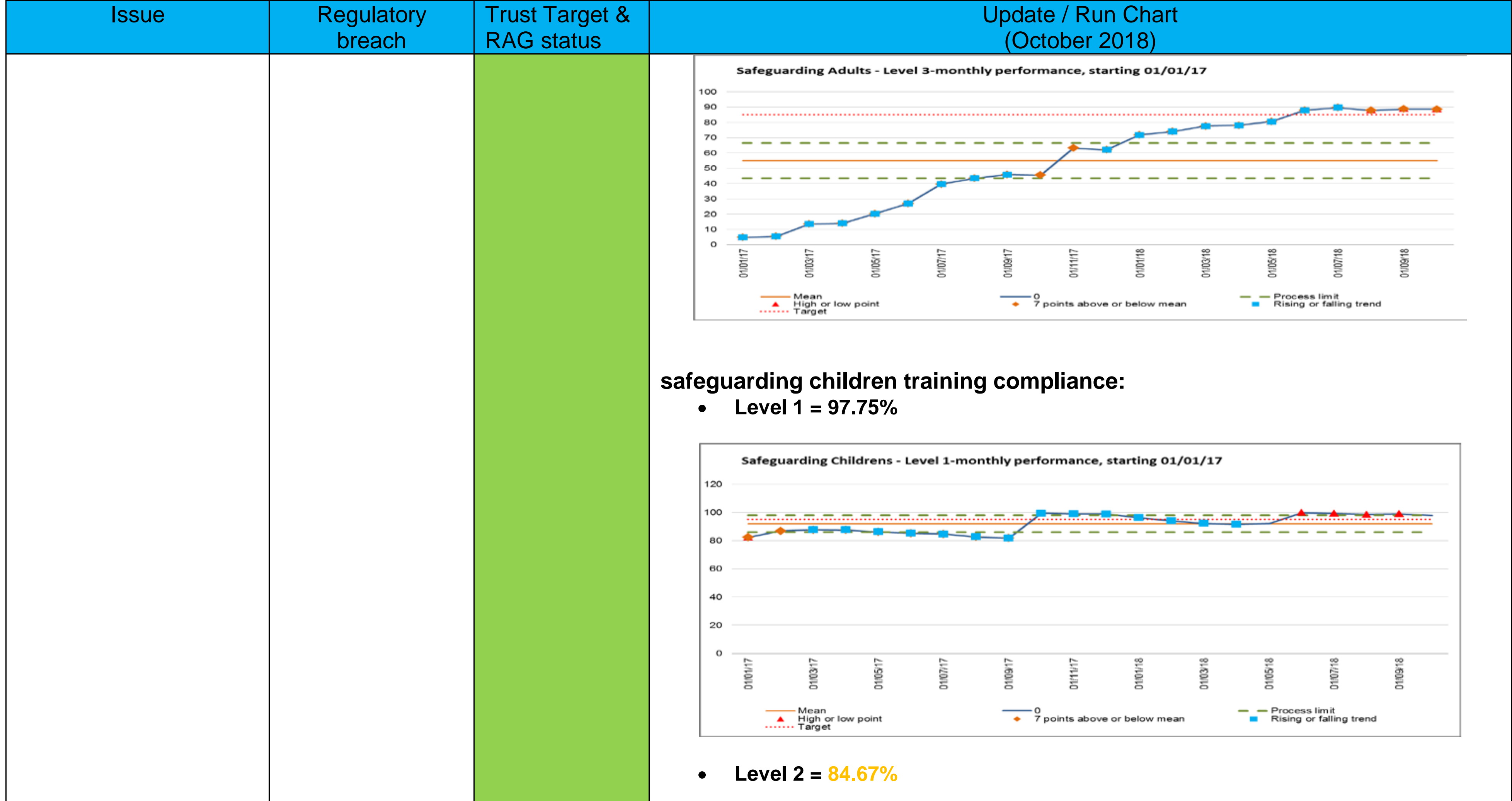
REGULATORY ACTION UPDATE:

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (October 2018)
Thromboembolism assessments were not carried out for all patients at risk.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	95% are assessed on admission March 2018.	**October performance = 94.63%** VTE Risk Assessment - monthly performance, starting 01/08/16 120% 100% 80% 60% 40% 20% 0% 01/08/16 01/10/16 01/12/16 01/02/17 01/04/17 01/06/17 01/08/17 01/10/17 01/12/17 01/02/18 01/04/18 01/06/18 01/08/18 01/10/18 Measure Mean Process limit High or low point

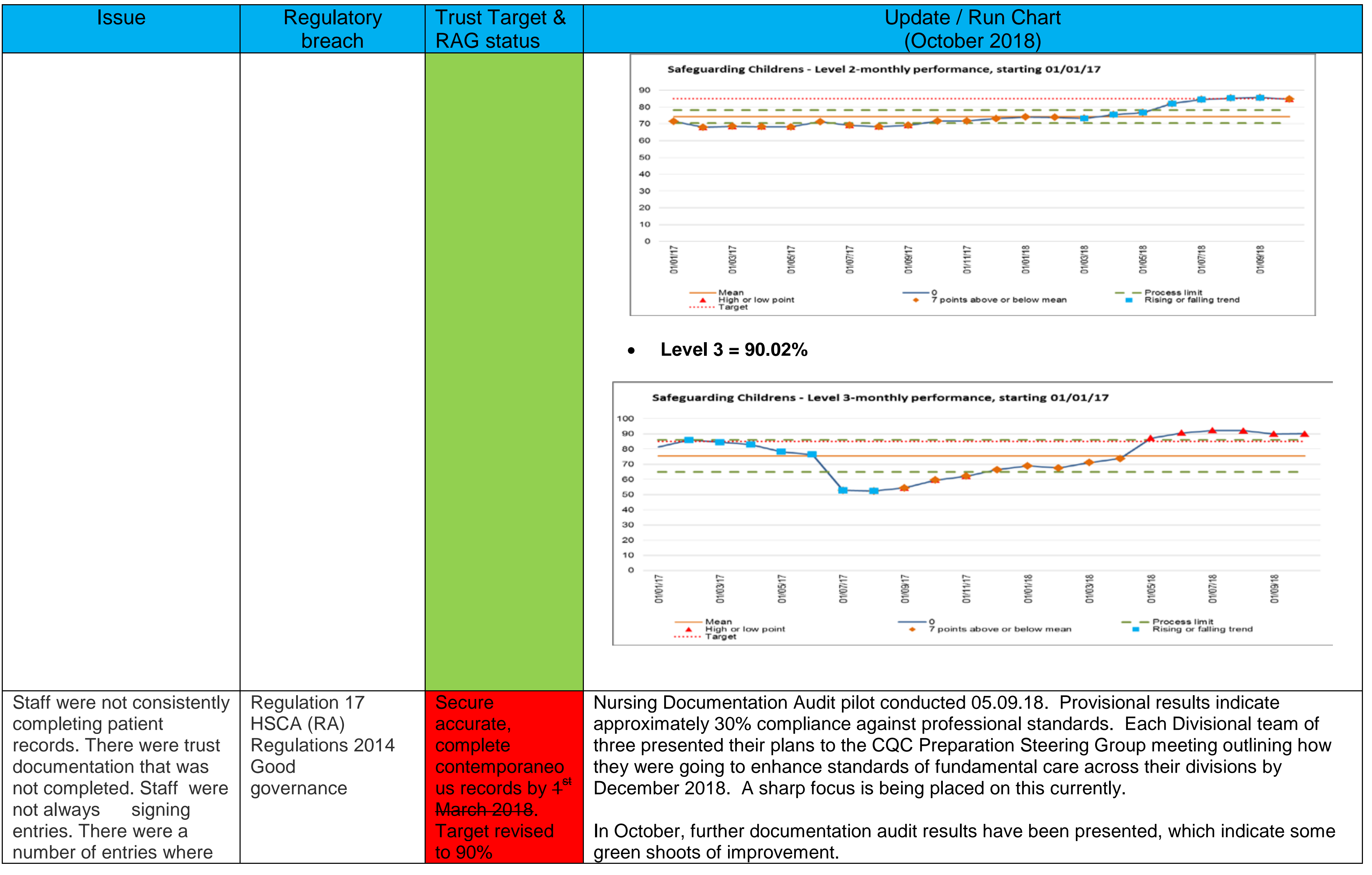
Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (October 2018)
There were high levels of nursing staff vacancies across acute services. This meant the provider was not providing sufficient numbers of suitably qualified staff to keep patients safe	Regulation 18 HSCA (RA) Regulations 2014 Staffing	Trust target is aligned to the National vacancy rate of 10.66%	**Nurse Staffing = 8.01%** **Midwifery Staffing / Birth Ratio 1:27.3 (September 2018):**
12 (2)(a) Not all staff were compliant or completed timely assessments for patients- in accordance with the Mental Capacity Act 2005 or Deprivation of Liberty (DOL).	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	90% compliance with MCA training By March 2018 Compliance with MCA when completing DNA CPR decisions by March 2018.	**MCA Training compliance = 97.6% (98.49% in September)** **Compliance with completion of part 2 of the DNACPR form in relation to MCA = 75.7%, a decrease of 3.7% from last month's compliance (41 audited)**

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (October 2018)
The critical care environment had only one isolation room. This provision was not meeting the needs of patients so was not sufficient to maintain safe management of infectious patients.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	Revised SOP February 2018 New build October 2018.	SOP has been revised and audits to be undertaken to measure compliance to the SOP. This is included in the Infection Control - Isolation Policy Page 12. New build on target for December 2018 opening.
Staff were not up-to-date with mandatory training. There were a number of modules that had completion rates significantly lower than the trust's target.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	90% compliance by 30th June 2018.	**September achievement; 85.21%** Mandatory Training Compliance-monthly performance, starting 01/01/17 Mean 0
Blind cords were not secured in all of the rooms at the child development center	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	By March 2018. Risk assessment Permanent solution to be	All blind cords (including the main hall) have been adjusted to ensure a permanent solution to ensure that children cannot reach them. Audit of compliance was completed 16th May 2018.

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (October 2018)
		implemented. Audit of compliance.	
Safeguarding training completion rates were low for both medical and nursing staff. Not all staff were trained in level 3 safeguarding children, which is a requirement Set by the Intercollegiate document (2014).	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment	Achievement of targets for all levels of Children and Adult Safeguarding by end June 2018 Level 1=95% Level 2 & 3=85% PREVENT=85%	**Safeguarding adults training compliance:** • **Level 1 = 95.92%** • **Level 2 = 91.85%** • **Level 3 = 88.63%**



Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (October 2018)
			safeguarding children training compliance: • **Level 1 = 97.75%** • **Level 2 = 84.67%**

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (October 2018)
			 • **Level 3 = 90.02%**
Staff were not consistently completing patient records. There were trust documentation that was not completed. Staff were not always signing entries. There were a number of entries where	Regulation 17 HSCA (RA) Regulations 2014 Good governance	Secure accurate, complete contemporaneous records by ~~1st March 2018~~. Target revised to 90%	Nursing Documentation Audit pilot conducted 05.09.18. Provisional results indicate approximately 30% compliance against professional standards. Each Divisional team of three presented their plans to the CQC Preparation Steering Group meeting outlining how they were going to enhance standards of fundamental care across their divisions by December 2018. A sharp focus is being placed on this currently. In October, further documentation audit results have been presented, which indicate some green shoots of improvement.

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (October 2018)
there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times.		compliance by end of December 2018 (quality of records) & 90% compliance by January 2019 (security of records). Develop a work stream plan to address the physical condition of the paper records by 31st March 2018 Confirm Trust strategy for EPR by 30th June 2018.	In addition, the agenda's for the Care Group & Divisional Quality & Safety meetings are being reviewed to ensure that they are standardised and cover fundamental standards of care. No update for November, as the wards are doing their own snap shot audits and these are not being collated centrally. In addition the Matrons and Divisional Directors of Nursing are undertaking quality assurance walk about's to ensure standards are maintained on a daily basis. Each Ward/Department has had a lead consultant identified to help enhance multi-professional team working. The Lead Consultants met with the Senior Ward Sisters, the Medical Director, Deputy Director of Nursing and Improvement Consultant to talk through these new roles and how they wanted to implement them. They will continue to meet on a quarterly basis from now on to monitor progress and share best practice.
Patients' records were taken home by the community children's nursing team when they were not returning to the office. We were not assured of the confidentiality or security of records			Total Mobile note system implemented

MUST DO ACTION UPDATE:

<table>
<tr><th>Issue</th><th>Must</th><th>Trust Target & RAG status</th><th>Update / SPC Chart</th></tr>
<tr>
<td>Action plans are monitored and managed for serious incidents</td>
<td>Must</td>
<td>Zero outstanding by January 2019</td>
<td>
The number of outstanding SI actions are reported to the Risk Management Committee and Quality & Safety Committee in the SI report which shows:

the number of SI investigation action plans with open actions in any given month
the number of SI action plans with one or more actions open beyond their target date.

<table>
<tr><th rowspan="2">Division</th><th colspan="10">SI’s with actions outstanding past completion date</th></tr>
<tr><th>Oct 2018</th><th>Sept 2018</th><th>Aug 2018</th><th>July 2018</th><th>Jun 2018</th><th>May 2018</th><th>Apr 2018</th><th>Mar 2018</th><th>Feb 2018</th><th>Jan 2018</th></tr>
<tr><td>WCCSS</td><td>7 (8 open actions)</td><td>6 (7 open actions)</td><td>5 (6 open actions)</td><td>9</td><td>8</td><td>8</td><td>6</td><td>7</td><td>6</td><td>7</td></tr>
<tr><td>Surgery</td><td>1 (3 open actions)</td><td>0</td><td>1 (5 open actions)</td><td>1</td><td>1</td><td>2</td><td>2</td><td>1</td><td>1</td><td>6</td></tr>
<tr><td>MLTC</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>3</td><td>5</td><td>3</td><td>1</td><td>0</td></tr>
<tr><td>Total SI’s</td><td>9</td><td>6</td><td>6</td><td>10</td><td>9</td><td>13</td><td>13</td><td>11</td><td>8</td><td>13</td></tr>
</table>
The position has deteriorated in month in Surgery and WCSS. This will be followed up with the Divisions at their safety huddles
</td>
</tr>
<tr>
<td>Lessons are disseminated effectively to enable staff learning from serious incidents, incidents and complaints.</td>
<td>Must</td>
<td>100% of staff interviewed can share one example of a lesson learnt and action taken</td>
<td>
Lessons learnt are disseminated via:

Email automatically sent via Safeguard to the reporter when an incident is closed by the responsible manager
Sharing the SI investigation report with the staff involved
Weekly Divisional Safety Huddles
Safety huddles at department level have started
Risk Roadshows
‘Incidents at a glance’ one page summaries describing the incident, lessons learned - discussed at Care Groups as part of their quality meeting agenda and in MLTC are added it the ward display boards at the entrance to the ward.
Weekly ward based drop in sessions to share learning from incidents and risks and to answer staff questions
Lessons learned bulletin

</td>
</tr>
</table>

Issue	Must	Trust Target & RAG status	Update / SPC Chart
			• Care Groups quality/audit meeting • Specialty Governance meetings – i.e. General surgery, TACC. • Workshops covering professional responsibilities and human factors - we share learning relating to specific incidents, complaints, claims, coroners and/ or audits from that department so that staff at the frontline understand the learning. • Social media feedback has started – Twitter / Yammer with development of a blog / vlog planned • Twice yearly Patient Safety Kitchen Table events in line with the national Sign up to Safety agenda. **Feedback following an incident is also covered in Clinical Update training** There needs to be an increased emphasis and expectation for Line Managers to own and disseminate feedback to their teams/staff and not rely on the Governance teams to do so. **Measures**: • The number of staff contacted through the Risk Roadshows • Attendance at Care Group governance meetings each month. • Participants in workshops in ESR • ***Peer review questionnaire for staff to capture the number of staff interviewed who can share an example of a lesson learnt and action taken***
Patient medical notes are kept secure at all times	Must	90% compliance by Jan 19	• Policy being reviewed (Now December 2018) • Checklist being developed for ward / departments to use to check compliance • Peer reviews on-going, with results to be monitored by care group / divisional governance meetings and CQC preparation steering group
All staff are trained and competent when administering medications via syringe driver (McKinley T34)	Must	100% of relevant staff undergone syringe driver equipment training 100% of relevant staff have undergone competency training	Training for T34 McKinley Syringe Pumps, the following actions have been progressed: The ESR Team have cleansed the current database to remove all staff that have been trained but no longer employed by the organisation and the first report is due on 23rd November. This will identify where gaps in training exist and need to be targeted with EBME. The report will track percentage compliance and an initial target of 80% for compliance with training is being considered. Competency will then be addressed.
Staff follow best practice national guidance (NICE, CAS alerts, Royal College	Must	Zero CAS alerts outstanding 100% NICE Technology	There are 2 **CAS Alerts** outstanding: • **NATSIPPS** (aiming for closure in October 2018) – Divisional and Care Group action required to complete the roll out and ensure there are cycles of continuous improvement through audit. Divisional Medical Directors asked to ensure this happens. • **Luer lock connectors** (aiming for closure January 2019) - The trust continues in phase 2 for

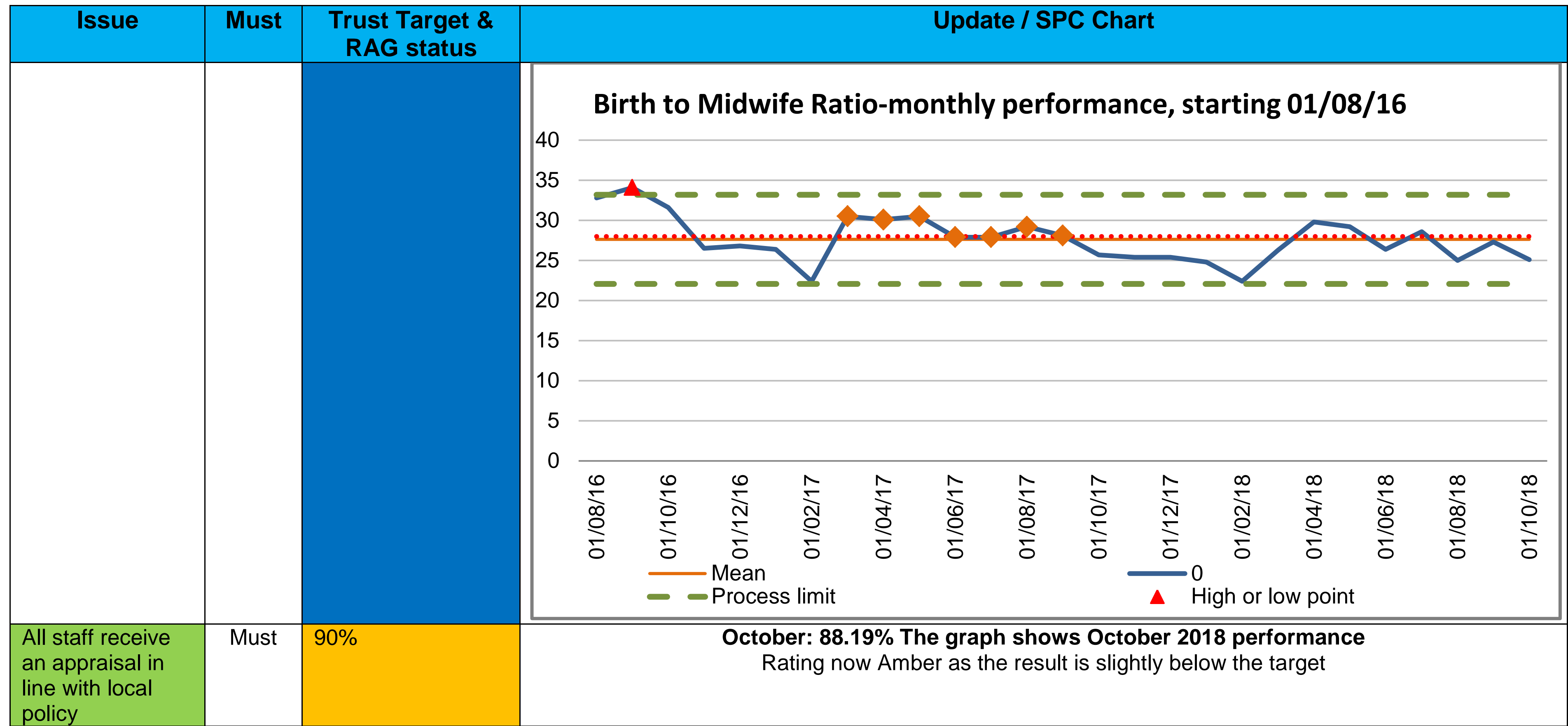
<table>
<tr><th>Issue</th><th>Must</th><th>Trust Target & RAG status</th><th>Update / SPC Chart</th></tr>
<tr><td>Guidelines, local clinical guidelines etc. etc.</td><td></td><td>Appraisals, assessment & implementation within 90 days

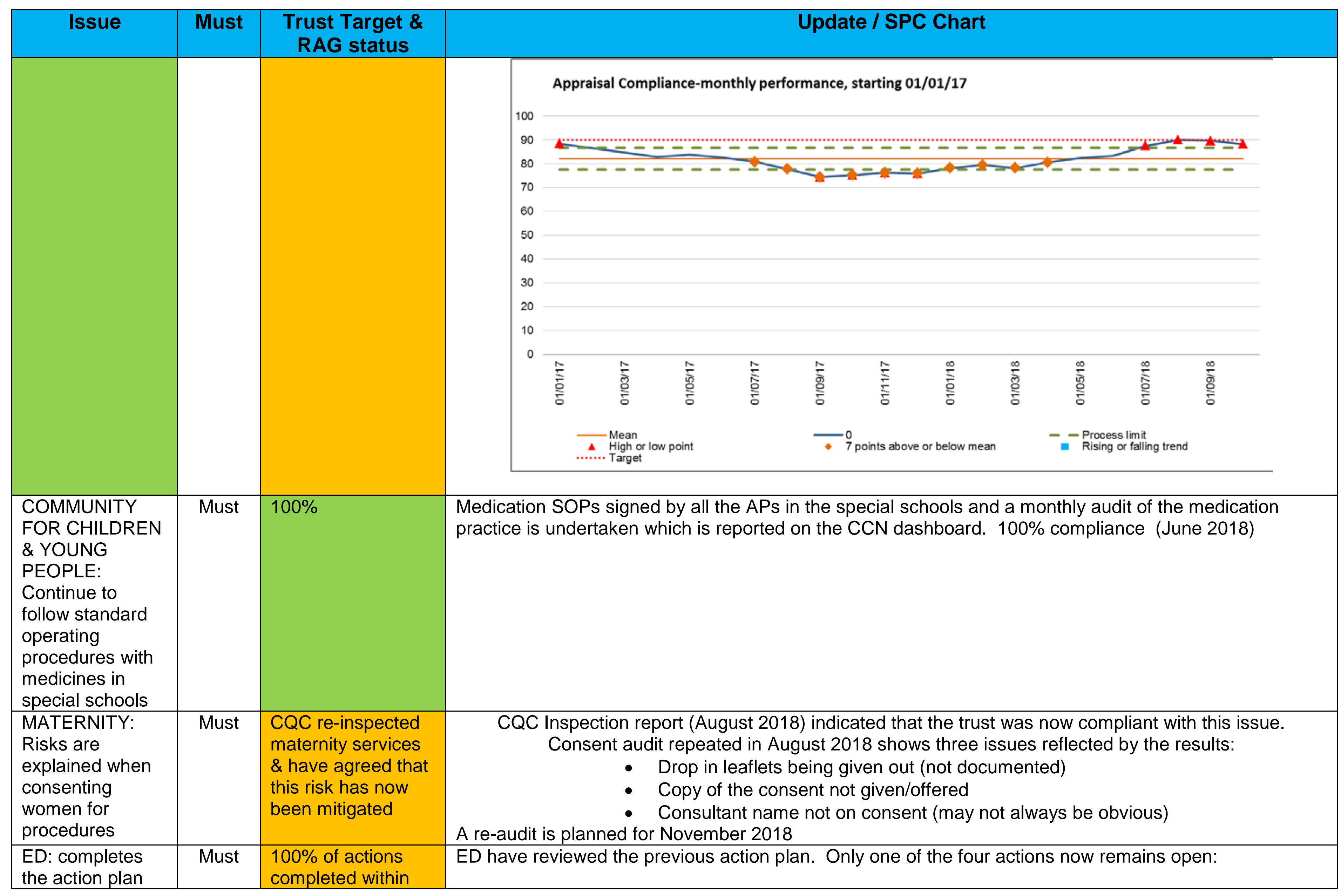
95% Clinical Guidelines in date by March 2019</td><td>connectors and there is no date or progress on what was last reported. There is a risk assessment to mitigate this and an audit has been conducted to test the risk compliance

NICE Compliance – Technology Appraisals
▪ 2018 April – September– 100% of TAs were received and reviewed in year

Clinical Guidelines have recently been reviewed, with the current position below:
<table>
<tr><th>Date</th><th>Type</th><th>Number of documents</th><th>In date</th><th>Due</th><th>Expired</th><th>No information</th></tr>
<tr><td>September 2018</td><td>Guideline</td><td>287</td><td>114</td><td>34</td><td>78</td><td>61</td></tr>
<tr><td>October 15th 2018</td><td>Guideline</td><td>281</td><td>120</td><td>23</td><td>89</td><td>49</td></tr>
<tr><td>November</td><td>Guideline</td><td>278</td><td>133</td><td>23</td><td>80</td><td>42</td></tr>
</table>

A small improvement is seen and additional resource is being provided to understand the documents for which there is ‘no information’ and to work on the expired guidelines to increase the pace of improvement.</td></tr>
<tr><td>The service uses an acuity tool to evidence safe staffing (nursing & midwifery)</td><td>Must</td><td>100%</td><td>SNCT & midwife: birth ratio in place 1:25.1 for October 18</td></tr>
</table>

Issue	Must	Trust Target & RAG status	Update / SPC Chart
			
All staff receive an appraisal in line with local policy	Must	90%	**October: 88.19% The graph shows October 2018 performance** Rating now Amber as the result is slightly below the target

Issue	Must	Trust Target & RAG status	Update / SPC Chart
			
COMMUNITY FOR CHILDREN & YOUNG PEOPLE: Continue to follow standard operating procedures with medicines in special schools	Must	100%	Medication SOPs signed by all the APs in the special schools and a monthly audit of the medication practice is undertaken which is reported on the CCN dashboard. 100% compliance (June 2018)
MATERNITY: Risks are explained when consenting women for procedures	Must	CQC re-inspected maternity services & have agreed that this risk has now been mitigated	CQC Inspection report (August 2018) indicated that the trust was now compliant with this issue. Consent audit repeated in August 2018 shows three issues reflected by the results: • Drop in leaflets being given out (not documented) • Copy of the consent not given/offered • Consultant name not on consent (may not always be obvious) A re-audit is planned for November 2018
ED: completes the action plan	Must	100% of actions completed within	ED have reviewed the previous action plan. Only one of the four actions now remains open:

Issue	Must	Trust Target & RAG status	Update / SPC Chart
completed following the CQC inspection carried out in September 2015		specified timeframes with desired outcomes achieved	• improving staff appraisal rates; - currently 87% • ensuring staff could be identified easily by patients and visitors; Completed ○ The ID badges were related to particular roles so for examples we now have high visibility arm bands for Ambulance handover nurse and similar for our RATs team. ○ The medics were all provided with new Medic In Charge badges which are in use… • management of equipment (2015) – closed in 2016 • stock in the resuscitation area. (2015) – closed in 2016
SAFEGUARDING: adults and Safeguarding children policies are up to date and include relevant references to external guidance	Must	100%	Revised Adult Policy to be ratified by 31.07.18 (September update: policy to be ratified by Nursing & Midwifery Advisory Forum on the 20 September 2018, and to Quality & Safety Committee in October 2018) Revised Children's Policy due for review at NMAF on 15th November with approval to follow at the TMB
CRITICAL CARE: All staff working within the outreach team are competent to do so	Must	100% by 01.01.2019	Monthly trajectory as follows: September 60%, October 80% and November 100%. October performance = 80% - on trajectory
OUTPATIENTS: All staff have the required competencies to effectively care for patients, and evidence of competence is documented.	Must	90%	90% of staff have achieved the required competencies October = 95.4%
OUTPATIENTS: All outpatient clinics are suitable for the	Must	100% of actions completed within the specified timeframes with	1. OPD TOT to assess waiting area and corridor area in fracture clinic for accessibility for patients in wheelchairs or those that require the use of a walking aid. SR Allport has completed the audit OPD have also enlisted a seating company to design a bespoke seating solution. An order will now be raised.

Issue	Must	Trust Target & RAG status	Update / SPC Chart
purpose for which they are being used		desired outcomes achieved	2. Areas de-cluttered and maintained. 3. Risk assessment is now completed and has been added to the risk register. 4. In fracture clinic, cubicles where patients were treated had a curtain to maintain patient's privacy and dignity. However, consultations with patients could be heard within the department due to the confined spaces within fracture clinic and the lack of a wall between the corridor and treatment area. Sound proof curtains are not available. "Curtain Conversations" are being implemented as per hyperlink https://www.uclh.nhs.uk/News/Pages/Itscurtainconfidential.aspx and have devised the Confidential Conversation Poster attached to use in cubicle area. 5. Within fracture clinic, patients of all ages waited within the same space. The children's waiting area has now been opened to address the issue of adults seated in the same space as children.

Appendix C

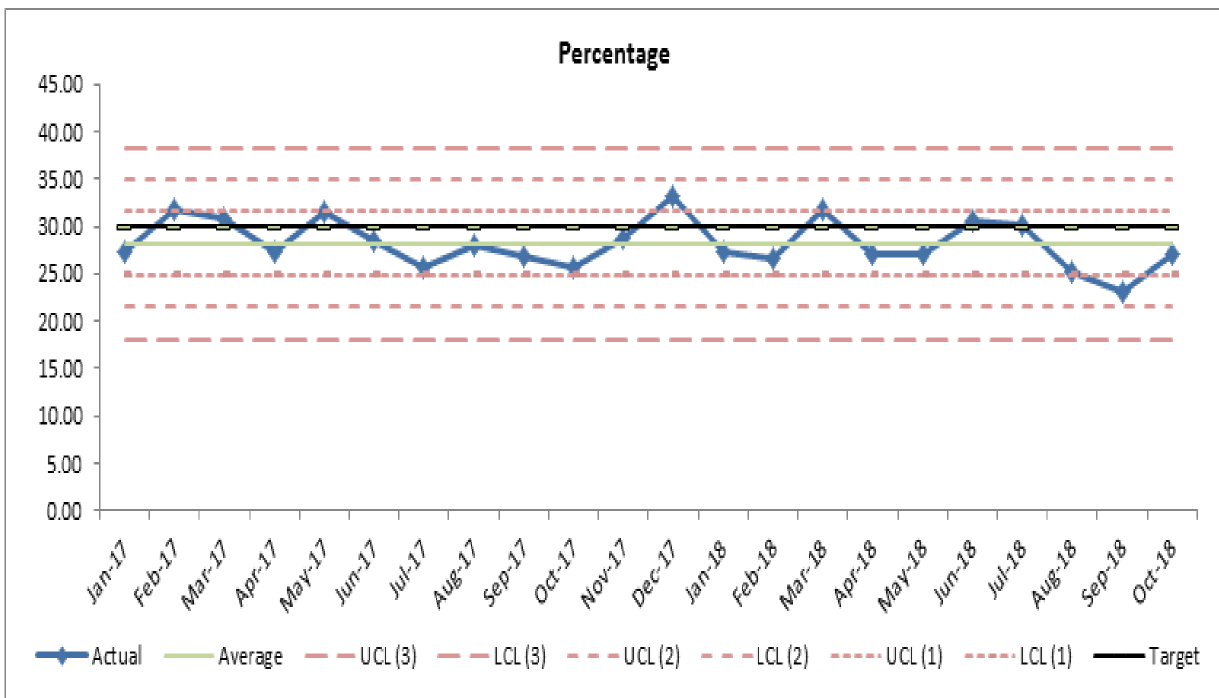
C Section Rates – Maternity Services

Introduction

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

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

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



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

Appendix D

PCIP Progress Report – Action Completion and Assurance

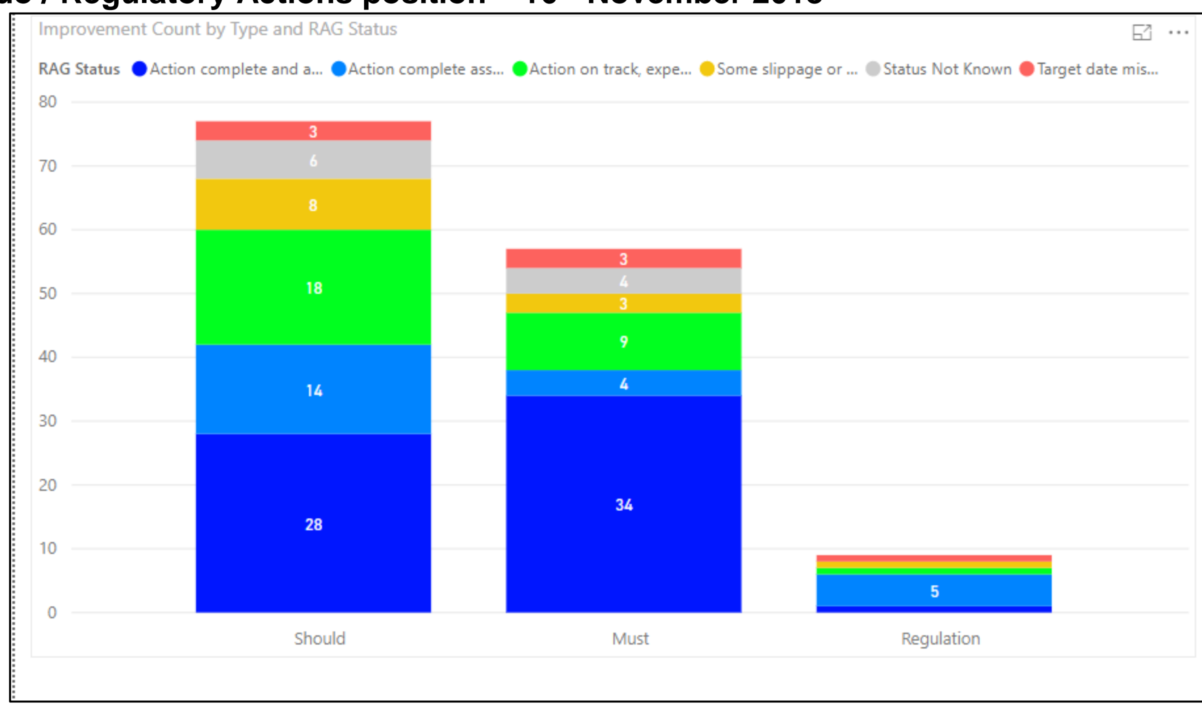
a) The overall PCIP position – 16th November 2018

RAG Status	Additional	Must	Not Known	Regulation	Should	Tota
Action complete and assurance gained	21	34	8	1	28	**92**
Action complete assurance not or only partially gained	3	4	11	5	14	**37**
Action on track, expected to complete on time	34	9	4	1	18	**66**
Action start date not due	4					**4**
Some slippage or evidence awaited, expected to complete on time	2	3		1	8	**14**
Status Not Known	1	4			6	**11**
Target date missed / actions unachievable	1	3		1	3	**8**
Total	**66**	**57**	**23**	**9**	**77**	**232**

RAG Status	%GT Improvement Count
Action complete and assurance gained	39.66%
Action complete assurance not or only partially gained	15.95%
Action on track, expected to complete on time	28.45%
Action start date not due	1.72%
Some slippage or evidence awaited, expected to complete on time	6.03%
Status Not Known	4.74%
Target date missed / actions unachievable	3.45%
Total	**100.00%**

Compliance with KPI Measure - RAG	Improvement Count
Fully Compliant	41
Non Compliance	13
Partially Compliant	32
Status Not Known	146
Total	**232**

b) The Must do / Should do / Regulatory Actions position – 16th November 2018



RAG Status	Must	Regulation	Should	Total
Action complete and assurance gained	34	1	28	**63**
Action complete assurance not or only partially gained	4	5	14	**23**
Action on track, expected to complete on time	9	1	18	**28**
Some slippage or evidence awaited, expected to complete on time	3	1	8	**12**
Status Not Known	4		6	**10**
Target date missed / actions unachievable	3	1	3	**7**
Total	**57**	**9**	**77**	**143**

MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018			
Establishment Reviews – Skill Mix			**AGENDA ITEM: 10, ENC 8**
Report Author and Job Title:	Angie Davies Associate Director of Nursing	**Responsible Director:**	Dr Karen Dunderdale Director of Nursing
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The second phase of the in-patient ward areas establishment reviews has looked at the skill mix of each area. It was clear that a number of areas needed a dedicated role to lead and manage the shift, as well as provide a deputising supportive role to the ward manager role. This will be the role of the band 6 Deputy Manager / Shift Coordinator. The quality and performance demand and issues in the inpatient areas requires a strengthened senior clinical nursing presence, who can lead the shift and provide a senior level of decision making. The band 6 shift coordinator role will provide this, hence the inclusion of a shift coordinator in each area. This is a strong clinical leadership model and reflects best practice as a workforce model. The skill mix review also included consideration of the new role of Nursing Associate (NA) where possible and all twenty trainee NA's due to qualify in January 2019 have been placed in a substantive area and will be included in the ward establishment and identified in the band 5 position on the rosters. As registered accountable practitioners they provide a workforce solution to the nursing workforce vacancy issue. A number of staff at band 6, band 3 and band 2 may require an adjustment to band or clinical area and this will be managed with due process as required in the near future.		

Recommendation	Members of the Trust Board are asked to: • note the actions and the progress being made against the establishment reviews • approve the skill mix position of the Establishment reviews.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline		
Resource implications		
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 ☒	

Establishment Reviews – Phase 2 Skill Mix

1. PURPOSE OF REPORT

The purpose of the report is to update the Trust Board on the skill mix element of the in-patient ward establishment reviews.

This report provides the skill mix position of each area and reflects the skill mix from band 2 to band 7.

The Trust Board is asked to note the skill mix review and recommendations and approve this as part of the ongoing in patient ward review establishments.

2. BACKGROUND

The Director of Nursing has been reviewing the nursing team establishments of all in-patient wards. This review is being conducted over two phases. Phase one determined the required number of staff to deliver care safely according to the applied establishment model. Phase two has looked at the skill mix of the required staff numbers.

This involved understanding what skill mix currently exists for each area and why that mix of bands and roles were needed, to support the positioning of the proposed skill mix and how that should look when aligned to the establishment figures.

3. DETAILS

All inpatient ward areas have been reviewed to determine the establishment for that area. Establishment numbers have been previously discussed and approved by Trust Board.

The current phase of the establishment reviews is to ensure there is sufficient and adequate skill mix to deliver care safely and that a quality service model delivery is upheld. The skill mix model is looking at a Band 7 Ward Manager, Band 6 Deputy Ward Manager / Shift Coordinator; Band 5 staff nurses; Band 4 Nursing Associates; Band 2 Clinical Support Workers.

It was clear that a number of areas needed a dedicated role to lead and manage the shift, as well as provide a deputising supportive role to the ward manager role. This will be the role of the band 6 Deputy Manager / Shift Coordinator. The current job description of the band 6 will be developed to support this role and responsibilities. The quality and performance demand and issues in the inpatient areas requires a strengthened senior clinical nursing presence, who can lead the shift and provide a

senior level of decision making. The band 6 shift coordinator role will provide this, hence the inclusion of a shift coordinator in each area. This is a strong clinical leadership model and reflects best practice as a workforce model.

There will be an adjustment to both Registered Nurses (RN) and CSW establishments across the areas, and the vacancy position will be readjusted to accommodate this change. There is no intention to terminate any individual employment; if staff are affected and need to be relocated this will be managed through due process. The adjusted establishments will start from the 3rd December rosters.

The next clinical areas to be reviewed will include paediatric wards and the Emergency Department. This review process will be conducted over two phases using the establishment review model applied to the initial areas as previously described for the Board.

4. RECOMMENDATIONS

The Trust Board is asked to note the report, and to approve the skill mix of the new ward establishments.

APPENDICES
Attached – Appendix 1, Skill Mix.

Appendix 1 – Skill Mix

PROPOSED ESTABLISHMENTS

Data Entry

	beds	8a Manager Time	7 Manager Time	8a	7	6	5	4	Registered Clinical Time	Registered Bank Cover	TOTAL Registered	3	2	1	Unreg nursing	Unreg Bank Cover	Total Unreg Nursing	total nursing Time
Ward_AMU	42		1.00		1.00	4.34	31.54	1.00	37.88	1.28	40.16		25.25		25.25	0.86	26.11	66.27
Ward_29	26		1.00			2.52	13.16	2.00	17.68	0.60	19.28		12.63		12.63	0.43	13.05	32.33
Ward_15	28		1.00			2.52	13.16	2.00	17.68	0.60	19.28		15.15		15.15	0.51	15.66	34.94
Ward_16	25		1.00			2.52	10.63	2.00	15.15	0.51	16.66		15.15		15.15	0.51	15.66	32.33
Ward_17	25		1.00			2.52	13.16	2.00	17.68	0.60	19.28		12.63		12.63	0.43	13.05	32.33
Ward_7	23		1.00			7.56	12.64		20.20	0.68	21.89		12.63		12.63	0.43	13.05	34.94
Ward_1	34		1.00			2.52	20.21		22.73	0.77	24.50		17.68		17.68	0.60	18.28	42.77
Ward_2	34		1.00			2.52	18.21	2.00	22.73	0.77	24.50		17.68		17.68	0.60	18.28	42.77
Ward_3	34		1.00			2.52	11.63	1.00	15.15	0.51	16.66		20.20		20.20	0.68	20.89	37.55
Ward_4	18		1.00			2.52	10.11		12.63	0.43	14.05		10.10		10.10	0.34	10.44	24.50
Ward_ASU	40		1.00		1.00	5.06	27.29	2.00	35.35	1.20	37.55		20.20		20.20	0.68	20.89	58.44
Ward_20b	24		1.00			2.52	10.91	1.00	14.43	0.49	15.92		12.63		12.63	0.43	13.05	28.97
Ward_8SAU	9		1.00			1.91	3.80		5.71	0.19	6.90		2.85		2.85	0.10	2.95	9.85
Ward_9	26		1.00			2.52	15.16		17.68	0.60	19.28		15.15		15.15	0.51	15.66	34.94
Ward_20a	16		1.00			1.80	10.83		12.63	0.43	14.05		7.58		7.58	0.26	7.83	21.89
Ward_1819	16		1.00		1.00	10.10	45.45		56.55	1.88	59.44		5.05		5.05	0.17	5.22	64.66
Ward_23	19		1.00			1.00	11.53		12.53	0.42	13.96		7.58		7.58	0.26	7.83	21.79
	439		**17.00**		**3.00**	**56.97**	**279.40**	**15.00**	**354.37**	**11.98**	**383.34**		**230.12**		**230.12**	**7.80**	**237.92**	**621.27**

BUDGETED ESTABLISHMENT

	beds	8a Manager Time	7 Manager Time	8a	7	6	5	4	Registered Clinical Time	Registered Bank Cover	TOTAL Registered	3	2	1	Unreg nursing	Unreg Bank Cover	Total Unreg Nursing	total nursing Time
Ward_AMU	42		2.00			13.92	22.50		36.42		38.42	3.50	33.30		36.80		36.80	75.22
Ward_29	26		1.00			6.00	11.58		17.58		18.58		15.58		15.58		15.58	34.16
Ward_15	28		1.00			3.00	15.18		18.18		19.18	3.87	10.71		14.58		14.58	33.76
Ward_16	25		1.00			4.00	13.68		17.68	0.50	19.18		13.71		13.71	1.00	14.71	33.89
Ward_17	25		1.00			3.92	14.07		17.99		18.99	1.00	10.99		11.99		11.99	30.98
Ward_7	23		1.00			7.18	11.58		18.76		19.76		18.92		18.92		18.92	38.68
Ward_1	34		1.00			4.00	16.58		20.58		21.58	2.20	14.98		17.18		17.18	38.76
Ward_2	34		1.00			3.00	17.78		20.78		21.78	0.80	16.38		17.18		17.18	38.96
Ward_3	34	1.00				3.00	11.08		14.08		15.08		19.68		19.68		19.68	34.76
Ward_4	18		1.00			1.00	11.99		12.99		13.99		10.39		10.39		10.39	24.38
Ward_ASU	40		2.00			6.00	25.57		31.57		33.57	2.00	23.94		25.94		25.94	59.51
Ward_20b	24		1.00			2.00	16.18		18.18		19.18		14.87		14.87		14.87	34.05
Ward_8SAU	9		1.00			2.00	4.52		6.52		7.52		3.76		3.76		3.76	11.28
Ward_9	26		1.00			2.00	16.18		18.18		19.18		16.05		16.05		16.05	35.23
Ward_20a	16		1.00			1.00	11.66		12.66		13.66		8.12		8.12		8.12	21.78
Ward_1819	16		2.00			13.81	45.57		59.38		61.38		5.58		5.58		5.58	66.96
Ward_23	19		1.00			1.00	12.43		13.43		14.43		7.60		7.60		7.60	22.03
	439	**1.00**	**19.00**			**76.83**	**278.13**		**354.96**	**0.50**	**375.46**	**13.37**	**244.56**		**257.93**	**1.00**	**258.93**	**634.39**

MOVEMENT BUDGET VS PROPOSED

	beds	8a Manager Time	7 Manager Time	8a	7	6	5	4	Registered Clinical Time	Registered Bank Cover	TOTAL Registered	3	2	1	Unreg nursing	Unreg Bank Cover	Total Unreg Nursing	total nursing Time
Ward_AMU	42		(1.00)		1.00	(9.58)	9.04	1.00	1.46	1.28	1.74	(3.50)	(8.05)		(11.55)	0.86	(10.69)	(8.95)
Ward_29	26					(3.48)	1.58	2.00	0.10	0.60	0.70		(2.95)		(2.95)	0.43	(2.53)	(1.83)
Ward_15	28					(0.48)	(2.02)	2.00	(0.50)	0.60	0.10	(3.87)	4.44		0.57	0.51	1.08	1.18
Ward_16	25					(1.48)	(3.05)	2.00	(2.53)	0.01	(2.52)		1.44		1.44	(0.49)	0.95	(1.56)
Ward_17	25					(1.40)	(0.91)	2.00	(0.31)	0.60	0.29	(1.00)	1.64		0.64	0.43	1.06	1.35
Ward_7	23					0.38	1.06		1.44	0.68	2.13		(6.29)		(6.29)	0.43	(5.87)	(3.74)
Ward_1	34					(1.48)	3.63		2.15	0.77	2.92	(2.20)	2.70		0.50	0.60	1.10	4.01
Ward_2	34					(0.48)	0.43	2.00	1.95	0.77	2.72	(0.80)	1.30		0.50	0.60	1.10	3.81
Ward_3	34	(1.00)	1.00			(0.48)	0.55	1.00	1.07	0.51	1.58		0.52		0.52	0.68	1.21	2.79
Ward_4	18					1.52	(1.88)		(0.36)	0.43	0.06		(0.29)		(0.29)	0.34	0.05	0.12
Ward_ASU	40		(1.00)		1.00	(0.94)	1.72	2.00	3.78	1.20	3.98	(2.00)	(3.74)		(5.74)	0.68	(5.05)	(1.07)
Ward_20b	24					0.52	(5.27)	1.00	(3.75)	0.49	(3.26)		(2.24)		(2.24)	0.43	(1.82)	(5.08)
Ward_8SAU	9					(0.09)	(0.72)		(0.81)	0.19	(0.62)		(0.91)		(0.91)	0.10	(0.81)	(1.43)
Ward_9	26					0.52	(1.02)		(0.50)	0.60	0.10		(0.90)		(0.90)	0.51	(0.39)	(0.29)
Ward_20a	16					0.80	(0.83)		(0.03)	0.43	0.39		(0.54)		(0.54)	0.26	(0.29)	0.11
Ward_1819	16		(1.00)		1.00	(3.71)	(0.12)		(2.83)	1.88	(1.94)		(0.53)		(0.53)	0.17	(0.36)	(2.30)
Ward_23	19						(0.90)		(0.90)	0.42	(0.47)		(0.02)		(0.02)	0.26	0.23	(0.24)
	439	**(1.00)**	**(2.00)**		**3.00**	**(19.86)**	**1.27**	**15.00**	**(0.59)**	**11.48**	**7.88**	**(13.37)**	**(14.44)**		**(27.81)**	**6.80**	**(21.01)**	**(13.12)**

NURSING ESTABLISHMENT SUMMARY

		Establishment		Bank (sickness)		TOTAL		Jul-18		Impact of New Rotas	
								Bud WT	BUDGET	WTE	COST
Ward_AMU	WARD 5/6 - AMU	64.13	2,367,800	2.14	64,747	66.27	2,432,547	77.22	2,666,473	(10.95)	(233,926)
Ward_29	WARD 29	31.30	1,038,100	1.03	30,846	32.33	1,068,946	34.16	1,090,504	(1.83)	(21,558)
Ward_15	WARD 15 - KESTREL	33.83	1,128,500	1.11	32,739	34.94	1,161,239	35.76	1,187,715	(0.82)	(26,476)
Ward_16	WARD 16 - JAY	31.30	989,000	1.03	29,684	32.33	1,018,684	35.89	1,079,840	(3.56)	(61,156)
Ward_17	WARD 17 - RCU	31.30	1,057,500	1.03	30,846	32.33	1,088,346	30.98	1,088,920	1.35	(574)
Ward_7	WARD 7 - OSPREY	33.83	1,201,600	1.11	33,901	34.94	1,235,501	38.68	1,280,757	(3.74)	(45,256)
Ward_1	WARD 3 - POPLAR	41.40	1,462,700	1.37	40,741	42.77	1,503,441	38.76	1,318,078	4.01	185,363
Ward_2	WARD 4 - BEECH	41.40	1,457,200	1.37	40,741	42.77	1,497,941	40.96	1,325,954	1.81	171,987
Ward_3	SWIFT DISCHARGE SUITE	36.35	1,242,600	1.20	33,469	37.55	1,276,069	34.76	1,306,865	2.79	(30,796)
Ward_4	WARD 1 - STROKE	23.73	838,600	0.77	22,844	24.50	861,444	26.38	818,208	(1.88)	43,236
		-	-	-	-	0.00	0	-	-	0.00	0
Ward_ASU	ACUTE SURGICAL UNIT	56.55	1,966,600	1.88	57,907	58.44	2,024,507	60.51	2,074,559	(2.07)	(50,052)
Ward_20b	Ward 20 B	28.06	939,000	0.92	26,919	28.97	965,919	35.05	1,167,155	(6.08)	(201,236)
Ward_8SAU	Ward 8 - SAU	9.56	362,200	0.29	9,046	9.85	371,246	11.28	405,953	(1.43)	(34,707)
Ward_9	WARD 9	33.83	1,207,700	1.11	32,739	34.94	1,240,439	39.23	1,256,796	(4.29)	(16,357)
Ward_20a	WARD 20 A	21.20	751,300	0.68	20,951	21.89	772,251	22.78	763,214	(0.89)	9,037
Ward_1819	HIGH DEPENDENCY UNIT	62.60	2,713,200	2.05	87,788	64.66	2,800,988	66.96	2,975,469	(2.30)	(174,481)
		-	-	-	-	0.00	0	-	-	0.00	0
		-	-	-	-	0.00	0	-	-	0.00	0
Ward_23	WARD 23	21.11	773,900	0.68	20,837	21.79	794,737	22.03	795,494	(0.24)	(757)
		601.48	**21,497,500**	**19.78**	**616,744**	**621.27**	**22,114,244**	**651.39**	**22,601,954**	**(30.12)**	**(487,710)**
Bank/Virtual team/Pay Awards										-	
TOTAL		**601.48**	**21,497,500**	**19.78**	**616,744**	**621.27**	**22,114,244**	**651.39**	**22,601,954**	**(30.12)**	**(487,710)**

MEETING OF THE PUBLIC TRUST BOARD – THURSDAY 6th DECEMBER			
Freedom to Speak Up Guardians Report			**AGENDA ITEM: 11, ENC 9**
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 update report provides information to the Board on the actions in progress on the Trust approach to Freedom to Speak up: 1. Quarterly reporting to National Guardians Office. 2. An update on the Freedom to Speak Up Guardians and Board work on completing the NHS Improvement Self-Assessment Tool for Freedom to Speak up. 3. An update on the reporting system for raising freedom to speak up concerns. 4. Arrangements for regular executive and non-executive meetings with the FTSU Guardians. 5. The process for escalating Trust risks related to the approach to Freedom to Speak Up.		
Recommendation	Members of the Trust Board are asked to note the content of the report for information and to note that a further report to Trust Board from the Freedom to Speak up Guardians is scheduled for January 2019.		
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 not any additional resource implications associated with this report. The ongoing provision for Freedom to Speak Up Guardians and associated budget is part of the budget setting provision for the 2019-2020 financial year.	
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 ☒	

Background

The Sir Robert Francis report, **Freedom to Speak Up; an Independent review into creating an open and honest reporting culture in the NHS (2015)**, provided key principles for NHS Trusts to implement, including the following:

1. Creating a culture of safety
2. Creating an organisation that welcomes concerns being raised
3. Developing a culture that is free from Bullying
4. Creating an organisation with visible leadership that values staff
5. Creating the role of Freedom to Speak Guardian

The Trust has worked on the key principles and has three freedom to speak up guardians in post.

Update on Action on Freedom to Speak Up

This update report provides information to the Board on the actions in progress on the Trust approach to Freedom to Speak up:

1. The Trust return for Freedom to Speak Up concerns during Q2 has been submitted and received by the National Guardians Office. The process is in place to validate the data submitted at each quarter and the detail of this is considered every quarter at the People and Organisation Development Committee.

2. The Freedom to Speak Up Guardians took part in a facilitated session following Trust Board Developments session in November 2018 and have used the NHS Improvement self-review tool for NHS Trusts to complete a rating of the Trust's current position relating to Freedom to Speak up. This is attached for the information of Trust Board. The supporting action plan is currently being completed

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for review at People and OD Committee during December 2018. This will be part of the annual report to Trust Board in January 2019.

3. The specification for working on the Safeguard system has been provided and work has been initiated to provide an area within the Safeguard system for use by the Freedom to Speak up Guardians for recording concerns raised. This will ensure the governance processes adopted are robust, confidential and allow timely feedback to individuals raising concerns whilst ensuring the data and reporting can be used to provide trend data over time.

4. Regular meetings take place with the FTSU Guardians, non-executive and executive sponsors and chief executive officer. Quarterly meetings are scheduled from December 2019 with the FTSU Guardians, Chief Executive Officer and Non-executive Director.

5. The management of Trust risks related to the Trust approach to Freedom to Speak Up and progress and controls are contained within the Board Assurance Framework, these are regularly reviewed at the People and Organisation Development Committee with escalation to Trust Board.

Next Steps and Recommendations

1. The Trust Board is asked to note the actions taken
2. The Trust Board is asked to receive a further annual report from the FTSU Guardians in January 2019.

Walsall Healthcare NHS
NHS Trust

Safe, high quality care

Care at home

Partners

Value colleagues

Resources

Respect
Compassion
Professionalism
Teamwork

<table>
<tr><td colspan="4">MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018</td></tr>
<tr><td colspan="3">Trust Board Pledge</td><td>AGENDA ITEM: 12, ENC 10</td></tr>
<tr><td>Report Author and Job Title:</td><td>Catherine Griffiths, Director of People and Culture</td><td>Responsible Director:</td><td>Catherine Griffiths, Director of People and Culture</td></tr>
<tr><td>Action Required</td><td colspan="3">Approve ☒ Discuss ☒ Inform ☐ Assure ☐</td></tr>
<tr><td>Executive Summary</td><td colspan="3">The NHS nationally and Walsall Healthcare Trust are working to reduce bullying and harassment within the workplace and to improve colleague experience. A 'Collective Call to Action' has been issued to NHS Trusts by the Social Partnership Forum and requires Trusts to work with trades unions to reduce bullying and harassment.

The pledge below has been devised in order to provide a clear statement of intent from the Trust Board and to support the Trust values and behaviours within the workplace.
"We, your Trust Board, pledge to demonstrate through our actions that we listen to and support people. We will ensure that the organisation treats people equally, fairly and inclusively, with zero-tolerance of bullying. We uphold and role-model the Trust values chosen by you."</td></tr>
<tr><td>Recommendation</td><td colspan="3">Members of the Trust Board are asked to note progress on the work developed by the internal steering group and the action plan which supports the national Collective Call to Action.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="3">The national draft survey results 2017 contain areas for improvement relating to organisational culture, these are also contained as the BAF. This work described seeks to take action to mitigate those risks.</td></tr>
<tr><td>Resource implications</td><td colspan="3">There are no resource implications associated with this report.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="3">The NHS national staff survey 2017 indicates a differential experience for staff and actions to address this is contained within an action plan approved at POD during April 2018.</td></tr>
<tr><td rowspan="2">Strategic Objectives</td><td>Safe, high quality care ☒</td><td colspan="2">Care at home ☐</td></tr>
<tr><td>Partners ☐</td><td colspan="2">Value colleagues ☒</td></tr>
</table>

Respect Compassion Professionalism Teamwork

	Resources ☐	

Tackling Bullying in the NHS - A Collective Call to Action. March 2018

Background

The Social Partnership Forum, at the request of the Department of Health and in partnership with trades unions, has issued a 'Collective Call to Action' on bullying and harassment in the NHS. The 'Collective Call to Action' (see Appendix 2) asks NHS trusts to:

- *"achieve the overarching leadership and cultural change to tackle bullying*
- *support staff to respectfully challenge problem behaviours*
- *publish their plans and progress so staff, patients and the public can hold them to account*

Identify the nature and extent of bullying in our organisation

Summary of Thematic Analysis of Survey and Consultation Findings 2014-2016

The staff surveys indicate that over a quarter of colleagues have experienced bullying, of whom only 4 out of 10 report it. Over 1 in 10 experience discrimination and 1 in 30 experience violence from colleagues. Walsall Healthcare is slightly worse than the national average for all these issues, however many colleagues continue to report good experiences at work, with almost half recommending it as a place to work.

Talk to our staff about it, listening to and learning from their experiences

The trust's Engagement Lead conducted 19 focus groups involving colleagues from all divisions in the organisation. From this he compiled a detailed report and had 'some professional, frank, honest and direct conversations with Trust Executives and senior leaders to ensure that they are fully informed as to what you, its workforce, have to say about what it is really like to work around here', including toxic and bullying behaviour.

The Organisational Development Practitioner undertook a survey of some staff groups and the findings echoed the national staff survey and the focus group findings.

Set a baseline and goal for improvement

The Engagement Lead is working with all colleagues to develop a set of new values and a behaviour framework. This will form the baseline for expected behaviour.

Implement an action plan – and publish it

Completed

- Leadership development programmes for executive, very senior and senior leaders, delivered by Ashridge Business School and The King's Fund, to develop compassionate and systems leadership
- Appointment of Freedom to Speak Up Guardians

- ‘Value Colleagues’ campaign to embed activity to promote what colleagues can expect from each other and managers by way of respectful behaviours through the Leadership Charter
- Recruitment of Workplace Support Advisers to provide support, information and signposting
- Review of relevant policies and procedures
- How to Have a Great Meeting guide has been advertised in Daily Dose newsletter and on Yammer, and circulated to all divisional teams of three and PAs.

Planned

See Appendix 1 for Action Plan

Proposed

The CEO and staff side to sign the SPF Collective Call to Action and publish the same, with support from the communications team. Message and format to be agreed between CEO and Engagement Lead. This is to take place once staff side is confident sufficient impact on bullying has been made.

Evaluating our progress

Evaluation of the impact of the Call to Action will occur via the Staff Survey and Friends and Family Test reports in 2019, and will be apparent in both the statistics and narrative. Staff side reports will also contribute to evaluation. It is possible that reported incidents and HR casework will reflect the impact – potentially rising along with awareness and then reducing as new behaviours are adopted. Catherine Griffiths is exploring how to effectively analyse all sources of data to elicit themes, issues and locations of concern or improvement.

Collective Call to Action to Tackle Bullying in the NHS

Walsall Healthcare Trust Action Plan – March 2018 onwards

Social Partnership Forum - A Collective Call to Action					
No.	**Action**	**Who**	**Timescale**	**Notes**	**Progress/Mitigation**
1	Identify the nature and extent of bullying in our organisation	OD team	Summer 2017	Completed via analysis of NHS Staff Survey and Pulse Check Survey from 2012-2016; HR data; staff side data	Completed
2	Talk to our staff about it, listening to and learning from their experiences	OD team Engagement lead	Summer 2017	Completed via focus groups and online survey of a sample of clinical and non-clinical staff groups	Completed
3	Set a baseline goal for improvement	OD team Engagement lead	February 2018	Focus group feedback	Completed
4	Implement an action plan	Steering group	Spring 2018	SEE BELOW	Completed
5	Evaluate our progress	OD team	Winter 2018	Staff survey; F&F Test; HR casework; JNCC	
6	Signing the Call to Action Sending updates to SPF	CEO and staff side OD team, Comms	Spring 2018	Comms	Launch completed Signing to occurred when impact measured

ACTION PLAN		**Aim:** Shared trust wide values, expectations of behaviour, actual behaviour and accountability			
Ref	**Action**	**Who**	**Timescale**	**Notes**	**Progress/Mitigation**
A. Develop and communicate values					
A.i	Co-develop values with colleagues	Staff side, OD and Engagement Lead with Engagents	Jan-Mar 2018	Focus group feedback (See also SJ Action Plan)	Completed
A.ii	Board to support embedding values	Director of OD/HR	April 2018	(See also SJ Action Plan)	Pledge planned for 3 September
A.iii	Communication plan	OD and comms team	June 2018	CEO/board and staff side to be visible part of this. Values will be launched at the annual Leadership Conference	SJ and HR/OD staff delivering events during autumn 2018
A.iv	Implement and embed	Board and VSM	September 2018 and onwards		SJ and HR/OD staff delivering events during autumn 2018
B. Develop and communicate expectations					
B.i	Co-develop expectations with colleagues via Behavioural Framework	Staff side, OD and Engagement Lead with Engagents	Summer onwards 2018	(See also SJ Action Plan – BF has been launched. A programme of engagement events is underway, and some issues are being raised as part of this process)	SJ and HR/OD staff delivering events during autumn 2018
B.ii	Board to agree and support expectations	Director of OD/HR	April 2018	Use new Behavioural Framework. (See also SJ Action Plan)	Pledge planned for 3 September
B.iii	Communication plan • In parallel with values/BF • To follow policy review by HR • Leaflet on definitions?	OD and comms team	April 2018	Tagline: ‘It’s About Respect and Dignity’. CEO/board and staff side to be visible part of this. Roadshow launch; posters; ESR Icon; newsletters; slot	TF from Comms to draft a plan for 26.11.18 – link to launch of new policy

	See UHB version • Focus on positives of dignity and respect			on induction. Utilise old 'Respect' video.	
B.iv	Implement and embed	Board and VSM; staff side	April 2018	Appraisals; Meeting etiquette (see below)	Completed
C. Behaviour					
C.i	Challenge How to Have a Great Meeting guidance	All colleagues, especially leaders; staff side	Summer 2018	Meeting etiquette (See 'How to have a great meeting') already issued to divisional PAs, chairs, posters in rooms, Daily Dose, intranet	Completed
C.ii	Challenge and Model Email etiquette and social media	All colleagues, especially leaders; staff side	Autumn/winter 2018	Reiterate existing guidance on use of social media, email etiquette – and reporting of concerns/incidents	KS to write email etiquette HR to advise and Comms to promote
C.iii	Model Literature and communications	All leaders, especially board and VSM; staff side, Comms	Summer 2018	(See also SJ Action Plan)	Completed
C.iv	Learning Induction and updates	Learning and Development Team	Autumn 2018	Empathy with others Calling out bullying behaviour BP to discuss L&D Team re: 2-6 admin programme, separate course and inclusion in existing programmes	Pilot awareness session to be delivered by BP in Pharmacy (discussed at EDIC also) Values events
D. Accountability					

D.i	Challenge Highlight errors	All colleagues, especially leaders; staff side	Summer 2018 onwards	(See also SJ Action Plan)	Ongoing
D.ii	Model	All leaders, especially board and VSM; staff side	Autumn 2018 onwards	Colleagues talking about 'it feels different here now'; visible examples (See also SJ Action Plan)	Pledge planned
D.iii	Report	HR; staff side	Autumn 2018 onwards		Policy review by HR ops
D.iv	Action and remedy Proactive management and staff Add to JD/PS and appraisals	HR; staff side	Autumn 2018 onwards	Mediation WPSAs Revised HR helpline	Policy review by HR ops
D.v	Communication of action	OD and Comms			See B.iii
E. Reward					
E.i	Communicate benefits of valuing each other	OD and Comms			See B.iii
E.ii	Praise / affirm Thank you cards for model behaviours Colleague of the month who picks the next CotM Divisional newsletter / In the Loop LfE to have more reminders for completion	All leaders Care groups Divisions / Simon J		Via Learning from Excellence reporting Recognition has already made a difference in maternity (See also SJ Action Plan) Values added to awards scheme and recognition cards.	Completed
E.iii	Awards	Board and VSM		Revise award schemes to align with new values and expected behaviours. Values added to awards scheme and recognition	Completed

				cards.	
E.iv	Treats	Board and VSM		Away days? (See also SJ Action Plan)	

Performance Report

November 2018

(October 2018 Results)

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

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Quality, Patient Experience and Safety Committee

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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 MRSA reported in October 2018
- **Falls** – the ratio of falls per 1000 bed days reduced to 4.60 which is the lowest since June 2018
- **VTE** – the VTE risk assessments are improving, reporting 94.6% in October

Key Areas of Concern

- **Infection control –** There was 1 reported case of hospital acquired C Diff in October. This case was deemed unavoidable with antibiotics implicated but used appropriately
- **Pressure Ulcers-** The overall number of hospital acquired pressure ulcers in the hospital continues to increase along with the severity of the pressure damage. This is an on-going concern.

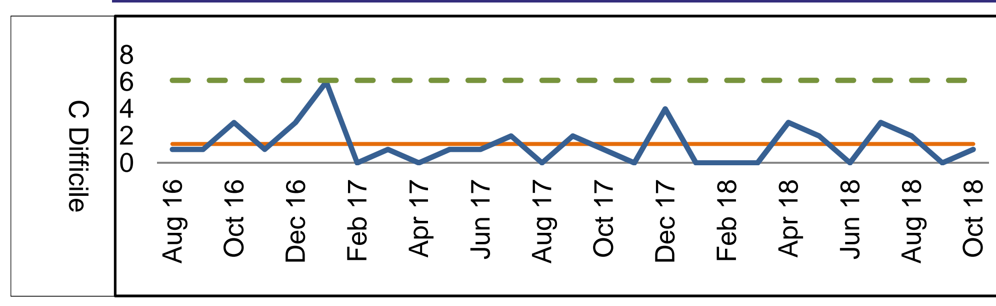
Key Actions Taken

- A deeper analysis of falls, pressure ulcers and infection control was provided in the Quality Report along with initiatives to reduce these. The Director of Nursing remains concerned at the numbers of falls and pressure ulcers and a continued focus will remain on these areas.

Key Focus for Next Committee

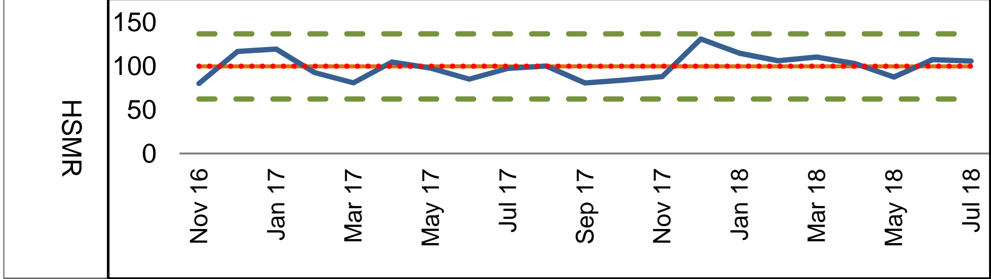
- Infection Control as part of Quality report
- Continued focus on falls and pressure ulcers

Quality, Patient Experience and Safety Committee



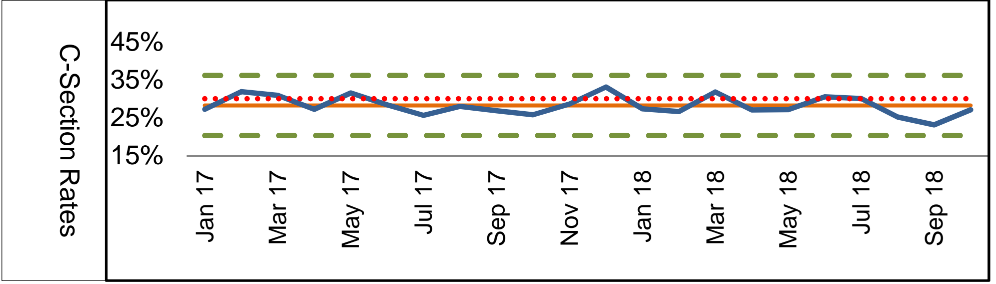
Narrative (supplied by Director of Nursing)

There was 1 toxin positive case attributed to the acute hospital. The RCA carried out on the October case found this was unavoidable and antibiotics were prescribed in line with current policy.



HSMR (supplied by Medical Director)

Medical Examiner appointed but not currently fulfilling the role. New mortality leads appointed for each Care Group to review deaths. A review of all deaths related to fluid/electrolyte balance for 2017/18 was undertaken. Expected deaths in 12 months exceeded expected deaths. 24 Cases reviewed 7 cases had existing DNACPR and further 17 had DNACPR enacted during the admission. There were no preventable deaths identified. 33% of cases were recoded. Medical Director is reviewing the processes regarding mortality reviews



Narrative (supplied by Director of Nursing)

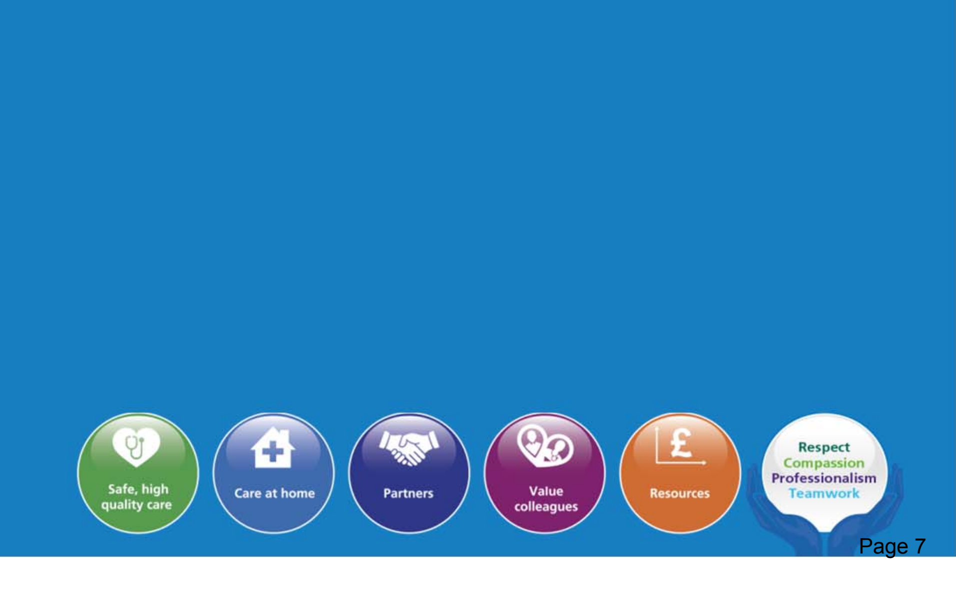
C – Section rates show monthly variation. The overall rate for 2018/19 remains below target at 23.1%. The following actions remain in place in relation to C Section monitoring

- 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 than quarterly). Actions entered on to action log as required. Learning points cascaded.

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE 2018-2019

		May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no..	HSMR (HED)	87.65	107.55	105.76					100.00		N
no..	SHMI (HED)								100.00		BP
no	Clostridium Difficile - No. of cases	2	0	3	2	0	1	11	17	11	N
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired Avoidable per 1,000 beddays (current two months figs are unvalidated)	0.90	0.67	1.00	0.45	0.60	0.28				L
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired Avoidable per 10,000 CCG Population (current two months figs are unvalidated)	0.07	0.00	0.03	0.10	0.03	0.00				L
no..	Falls - Rate per 1000 Beddays	5.62	3.57	5.09	6.94	6.21	4.60		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	0	0	2	1	3	0	9	0	8	BP
%..	VTE Risk Assessment	96.28%	96.50%	95.57%	95.08%	94.38%	94.63%	95.53%	95.00%	88.49%	N
no..	Midwife to Birth Ratio	1:29.2	1:26.2	1:28.6	1:25.0	1:27.3	1:25.1		1:28	1:26.3	N
%..	C-Section Rates	27.12%	30.53%	30.03%	25.17%	23.10%	27.08%	27.18%	30.00%		BP
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	11.07%	10.12%	9.94%	10.64%	10.93%		10.65%	10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	92.29%	90.83%	85.48%	87.24%	82.74%	83.47%	86.36%	100.00%	89.33%	N/L
%..	Compliance with MCA 2 Stage Tracking	81.00%	69.00%	69.00%	68.00%	80.00%	72.00%		100.00%		BP
%..	Friends and Family Test - Inpatient (% Recommended)	95.00%	97.00%	94.00%	95.00%	96.00%	95.00%		96.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	98.29%	98.22%	98.75%	98.29%	97.78%	96.48%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	77.51%	84.47%	89.59%	90.42%	90.38%	88.99%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	93.69%	99.84%	99.92%	99.83%	99.44%	95.92%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	80.32%	83.77%	87.04%	89.53%	90.52%	91.85%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	80.41%	87.98%	89.64%	87.89%	88.72%	88.63%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	92.38%	99.77%	99.26%	98.67%	98.98%	97.75%		95.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	76.93%	88.58%	93.69%	85.37%	85.67%	84.67%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	88.58%	90.62%	92.24%	92.08%	89.92%	90.02%		85.00%		L

Integration



Integration – Highlight Page

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

Key Areas of Success

The two vacancies in Rapid Response have been recruited too, one is already in post with the other due to start on the 17th Dec this increases the skill mix as ANP roles have now been introduced into the team structure.

The GP Led MDT's are progressing very well with more practices joining, there are now 14 practices participating covering 32% of the population list size. A locality based MDT is due to be piloted in one locality as soon as approval is agreed by the CCG with the GP Leadership, this would see multiple practices participating in four locality MDT's on a regular basis rather than multiple MDT's across the borough that are proving difficult to accommodate by all participating organisations.

Key Areas of Concern

A couple of Practices withdrew from the MDT's due to poor response from the Adult Social Care Service

We have cumulatively seen a decrease in readmissions within 30 days of discharge and length of stay when comparing Q2 with previous 2 quarters, this will be monitored to see whether it is a continuing trend.

Key Actions Taken

Discussions have taken place with the Adult Social Care service to resolve issues regarding practices withdrawing, this was due to staff shortages within one of the place based team which has now been addressed.

MDT Coordinator actively recruiting GP Practices to the MDT's

Discussions taken with Younger Adult Mental Health team to address concerns seen within the MDT's and improve engagement.

Key Focus

Review the proposal for the Locality MDT's prior to pilot going live.

Review Stroke services data and validate in preparation for adding to the dashboards.

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.

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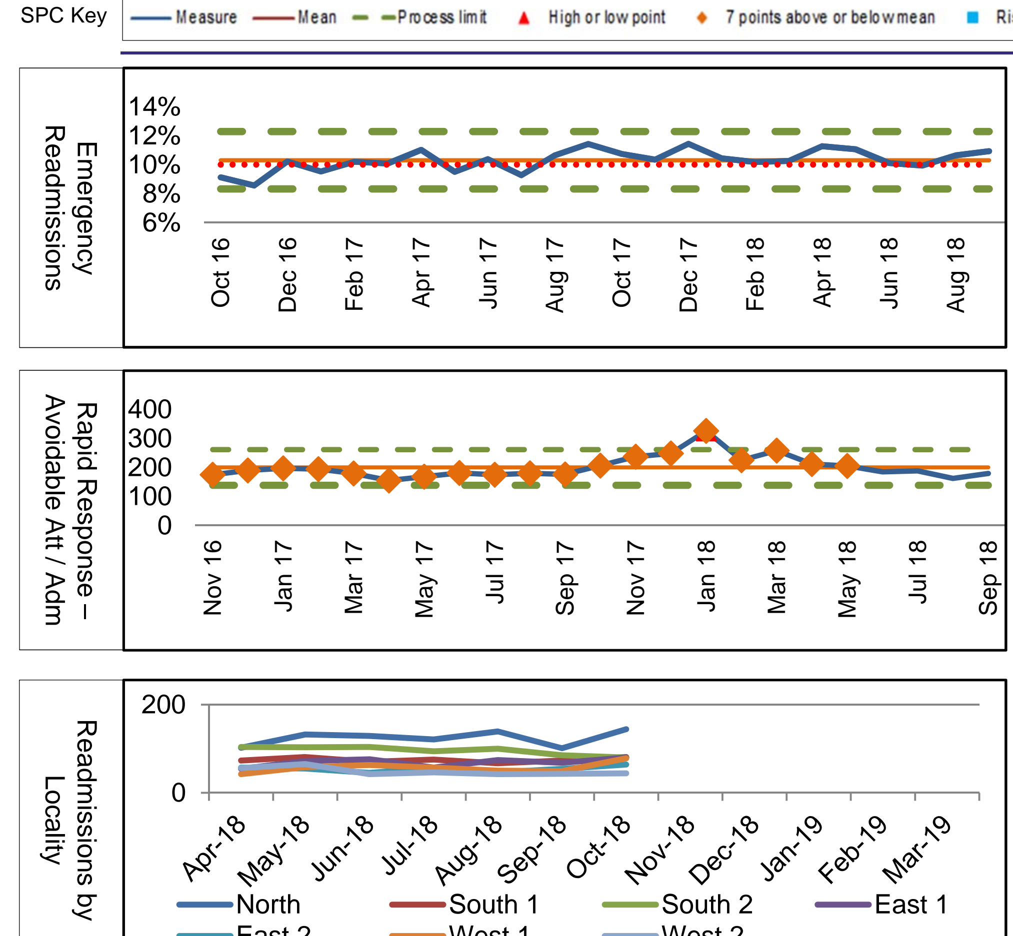
Integration



Narrative (supplied by Director of Strategy & Improvement)

The teams continue to maintain a similar pattern to last year and are operating very close to the target of 10%. Additional specialisms are now being added to the teams, Continence specialists were added in Q1 and COPD specialists are now being added although there has been some issues due to slow recruitment.

The rapid response team is now under new management and being aligned with the Integrated Care Service. The reporting data is being reviewed and the team are working with the QI team to carry out some demand and capacity modelling.

This chart shows the number of emergency readmissions within 30 days of discharge by locality. The highest readmitting locality continues to be the North. There is a trial taking place in the North Locality to split the team as they have the largest population to cover

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INTEGRATION
2018-2019

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-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%	10.93%		10.65%	10.00%		L
no	Rapid Response Team - Total Referrals (one month in arrears)	222	219	195	195	174	195	203				L
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission (one month in arrears)	212	205	185	188	162	179	177				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%	6.86%	7.30%	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	42				L
no	Average Number of Medically Fit Patients - Trust	49	42	39	36	42	48	39				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	40.35				L
no	Nursing Contacts per Locality - Total	18066	19325	18527	19796	19807	18387	19649	133502			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	1.89				L
no	No. of patients on stroke pathway in partnership with Wolverhampton - new metric under development											L

People and Organisation Development Committee

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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. Flu – multi disciplinary team (including staff side) are meeting every week to identify and mitigate any risks to delivering the campaign, the group are working effectively together support the health and wellbeing of staff through the up take of the vaccine within the Trust. The Trust was named as the most improved Trust for flu vaccine uptake nationally based on October figures. https://www.nhsemployers.org/news/2018/11/october-flu-figures-show-6000-more-staff-get-their-flu-jab
2. The Nursing workforce transformation programme is in place, led by Director of Nursing, PODC and JNCC. They were updated during November.

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. Multi-disciplinary Health and Wellbeing Workshops have been held across the Trust in partnership with Staff-side to identify ways of improving staff health and wellbeing and attendance, with a view to implementing new processes and policy framework by end of Q3.
2. Set of core people management metrics designed and reviewed at PODC.
3. On-going requirements for Staff Engagement Lead, proposal in place and view on long term approach being developed.
4. Board assurance framework in place categorising key People and OD risks, received and approved by PODC. Corporate risk register updated and HR Governance meeting established.
5. FTSU workshop and self assessment completed with external support, quarterly reporting to National Guardian Office in place Q2.
6. Equality Objectives reviewed by PODC.

Key Focus for Next Committee

1. EPR - Implications of electronic patient record
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

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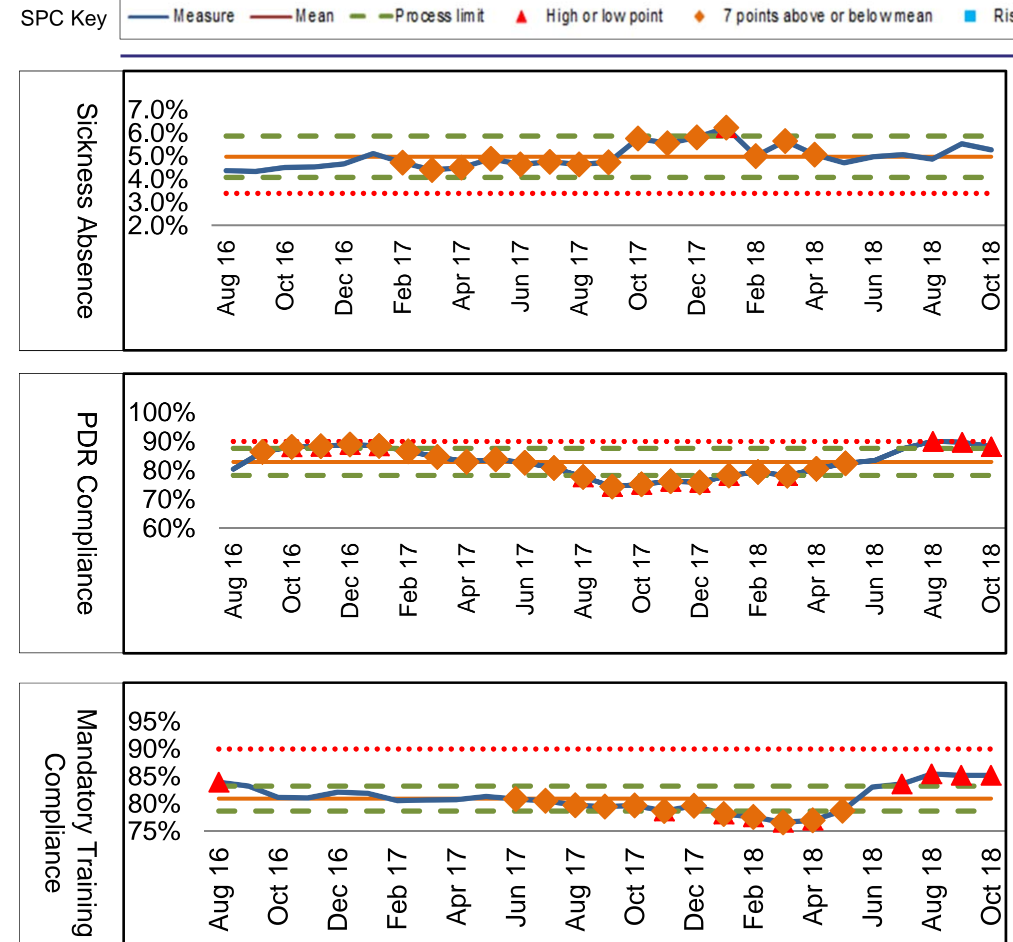
People and Organisation Development Committee



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. The Trust performance on sickness absence benchmarks at 4th worst nationally on Model Hospital. A series of Trust wide workshops are underway with a focus on how to improve attendance.

PDR appraisal completion rates remain rated amber. The appraisal policy is currently being reviewed and will be updated to include talent management and succession planning. The data on ESR is being reviewed with the Divisions to ensure all data is accurate and up-to-date.

Mandatory training compliance levels remain amber rated. Compliance remains below trust target, so analysis continues in order to support targeted improvement action. In addition, the data on ESR is being reviewed with the Divisions to ensure all activity is fully captured.

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PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 2018-2019

		May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Mandatory Training Compliance	78.76%	83.06%	83.63%	85.46%	85.21%	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	4.71%	4.97%	5.06%	4.87%	5.53%	5.27%	5.04%	3.39%	5.30%	L
%..	PDRs	82.42%	83.41%	87.56%	90.04%	89.73%	88.19%	88.19%	90.00%	78.17%	L
.	Staff Referral to Occupational Health - new metric under development										
	RESOURCES										
no	Staff in post (Budgeted Establishment FTE)	4114	4125	4121	4123	4121	4039	4039			L
%..	Turnover	9.92%	10.33%	9.20%	10.42%	10.94%	14.03%	14.03%	10.00%	9.13%	L
.	Time to Recruit - new metric under development										

Performance, Finance and Investment Committee

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Performance, Finance and Investment Committee – Highlight Page

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

Key Areas of Success

- Attaining national performance standards against Cancer and 6 week diagnostic targets
- Integrated Critical Care Unit (ICCU) now completed
- Maternity Theatre and Neo-Natal Unit construction commenced and on trajectory

Key Areas of Concern

- Attainment of the Emergency Department (ED) four hour constitutional standard
- High levels for medically fit for discharge patients currently occupying bed capacity
- Temporary workforce costs continue at higher than planned levels
- Productivity within theatres and outpatients requires improvement to deliver targeted levels of income projections in year
- Cost Improvement Programme (CIP) behind plan and phased into the latter half of the financial year

Key Actions Taken

- Patient flow changes deployed within the Trust to support enhanced ED performance have commenced to reduce elderly admissions and Winter Plan actions have been reviewed by members
- Forecast outturn reviewed by members, recommendations to be discussed at Private Trust Board

Key Focus for Next Committee

- Continued focus on performance against constitutional standards, focus on ED 4 hour performance
- Run rate reductions delivery month on month in accordance with the planned deficit for the Trust, focus placed upon;
  - Increased productivity within outpatients and theatres
  - Reductions in expenditure on temporary workforce (Nursing and Medical staffing)
- Forward trajectories for monthly income and expenditure contained within the agreed Financial Plan (analysed for Cost Improvement and Run Rate improvement) monitored through;
  - Weekly Performance meetings
  - Performance & Finance Executive
  - Performance, Finance & Information Committee (PFIC)

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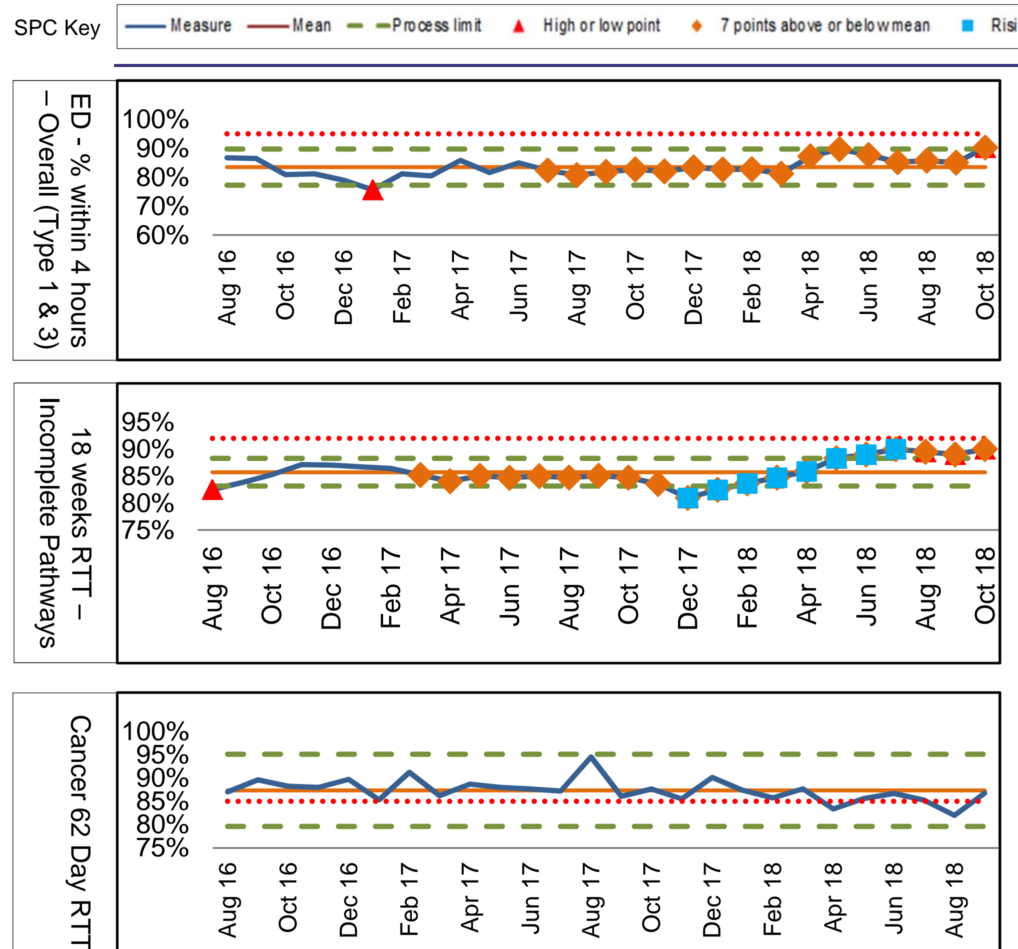
Performance, Finance and Investment Committee



Narrative (supplied by Chief Operating Officer)

Performance delivered 90.24% against a trajectory of 90%. Emergency activity in Walsall continued to be challenging with high attendances above plan for example; over 90 ambulances on 15 days of the month. October also saw daily admissions to the hospital increase to 98 compared to 89 in September. Highest number of patients were discharged between 08.00-18.00 at 79.81% and over 50% of discharges were transferred to the discharge lounge before midday.

RTT has sustained its improvements and achieved 90.01% in October. The number of patient pathways has increased to 14748. The focus continues on RTT improvement and performance, there were no 52 week breaches in September. There are 17 patients waiting over 40 weeks which has reduced from 37 waiting in September. Planning has commenced in relation to performance over the winter period.

Confirmed Cancer performance for September shows achievement of all cancer measures

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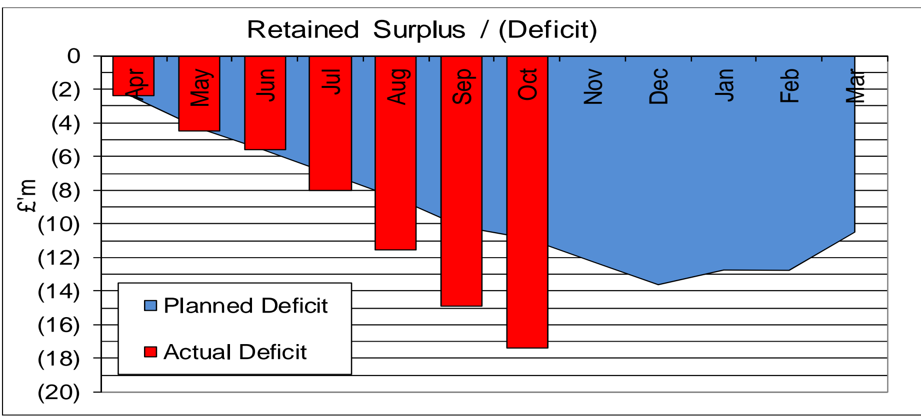
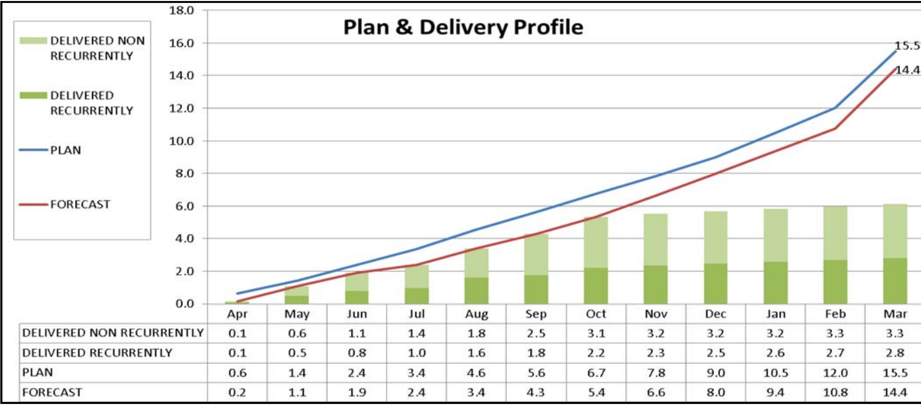
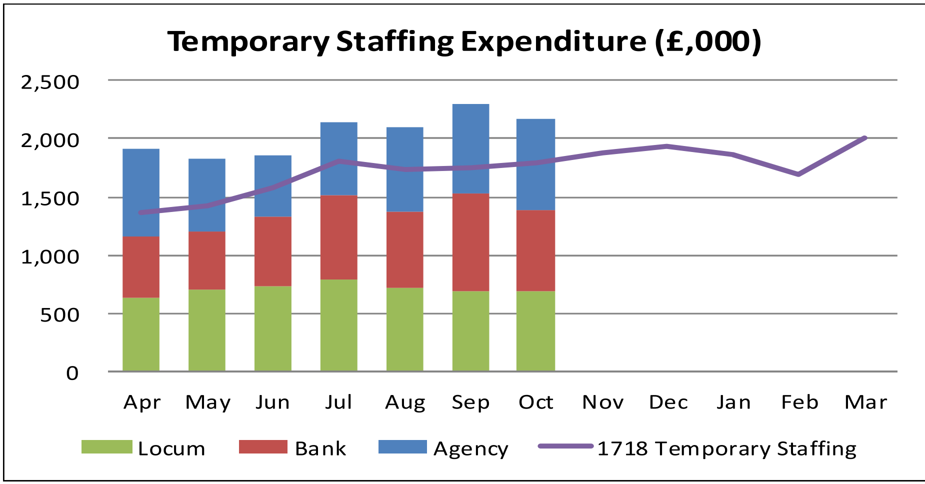
Financial Performance to October 2018 (Month 7)





	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	3.1	3.2	3.2	3.2	3.3	3.3
DELIVERED RECURRENTLY	0.1	0.5	0.8	1.0	1.6	1.8	2.2	2.3	2.5	2.6	2.7	2.8
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	8.0	9.4	10.8	14.4



Financial Performance

- The total financial position for the Trust at M7 is a deficit of £17.4m, resulting in a £6.6m adverse variance to plan .
- The position includes £1.7m of lost PSF (which is recovered in part if the Trust attains plan at the end of quarter 3) reflected in the Income section opposite as the variance shown against DoH and Social Care.
- Contracted income shows an unfavourable variance to plan of £1m, the main area of under-performance occurring in Maternity and Adult/Neonatal Critical care and outpatients.
- Expenditure is overspent £4.0m YTD. The main area of overspending is pay (£3.5m) due to temporary staffing costs in Medical and Nursing. The overspending on non-pay largely relates to non delivery of CIP.

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding is £1.1m.
- The Trust's agreed borrowing for 2018/19 is £10.6m, reflecting the deficit plan. The increasing adverse deficit to plan is placing greater pressure on cash flow and therefore borrowing requirements.

Capital

- The year to date capital expenditure is £6.9m, with the main spends relating to ICCU (£3.3m), Estates Lifecycle (£0.6m), Maternity (£2.1m) and Medical Equipment (£0.3m).

Financial Performance - Period ended 31st October 2018

Description	Annual Budget	Budget to Date	Actual to Date		Variance
	£'000	£'000	£'000		£'000
Income					
CCGs	198,839	115,512	114,514		(998)
NHS England	19,214	11,082	10,555		(526)
Local Authorities	9,600	5,602	5,741		139
DoH and Social Care	7,725	3,844	2,130		(1,714)
NHS Trusts	830	480	700		220
Non NHS Clinical Revenue (RTA Etc)	4,229	2,599	2,754		155
Education and Training Income	7,222	4,356	4,372		16
Other Operating Income (Incl Non Rec)	4,880	3,076	3,284		208
Total Income	**252,539**	**146,550**	**144,050**		**(2,500)**
Expenditure					
Employee Benefits Expense	(175,358)	(101,611)	(105,156)		(3,545)
Drug Expense	(12,938)	(10,782)	(10,716)		65
Clinical Supplies	(17,772)	(10,873)	(11,288)		(414)
Non Clinical Supplies	(15,936)	(9,612)	(9,891)		(280)
PFI Operating Expenses	(5,073)	(2,973)	(3,120)		(147)
Other Operating Expense	(20,687)	(12,230)	(11,950)		280
Sub - Total Operating Expenses	**(247,765)**	**(148,081)**	**(152,122)**		**(4,040)**
Earnings before Interest & Depreciation	**4,774**	**(1,531)**	**(8,072)**		**(6,540)**
Interest expense on Working Capital	51	30	30		1
Interest Expense on Loans and leases	(8,895)	(5,537)	(5,864)		(326)
Depreciation and Amortisation	(6,560)	(3,827)	(3,550)		277
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(15,405)**	**(9,335)**	**(9,383)**		**(49)**
Total Expenses	**(263,170)**	**(157,416)**	**(161,505)**		**(4,089)**
RETAINED SURPLUS/(DEFICIT)	**(10,631)**	**(10,866)**	**(17,455)**		**(6,589)**
Adjustment for Gains on Donated Assets			45		45
Adjusted Financial Performance (Control Total)	**(10,631)**	**(10,866)**	**(17,410)**		**(6,544)**

Use of Resources Ratings (M7)

Finance and use of resources rating	03AUDITPY	03PLANYTD	03ACTYTD	03PLANCY	03FOTCY
i	Audited PY 31/03/2018 Year ending Number	Plan 31/10/2018 YTD Number	Actual 30/10/2018 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 October 2018	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	(11,621)
Depreciation and Amortisation	3,550
Donated Assets Received credited to revenue but non-cash	(85)
(Increase)/Decrease in Trade and Other Receivables	614
Increase/(Decrease) in Trade and Other Payables	(1,192)
Increase/(Decrease) in Stock	136
Interest Paid	(5,864)
Net Cash Inflow/(Outflow) from Operating Activities	**(14,462)**
Cash Flows from Investing Activities	
Interest received	**30**
(Payments) for Property, Plant and Equipment	**(7,430)**
Net Cash Inflow/(Outflow)from Investing Activities	**(7,400)**
Net Cash Inflow/(Outflow) before Financing	**(21,862)**
Cash Flows from Financing Activities	20,668
Net Increase/(Decrease) in Cash	**(1,194)**
Cash at the Beginning of the Year 2017/18	2,277
Cash at the End of the September	**1,083**

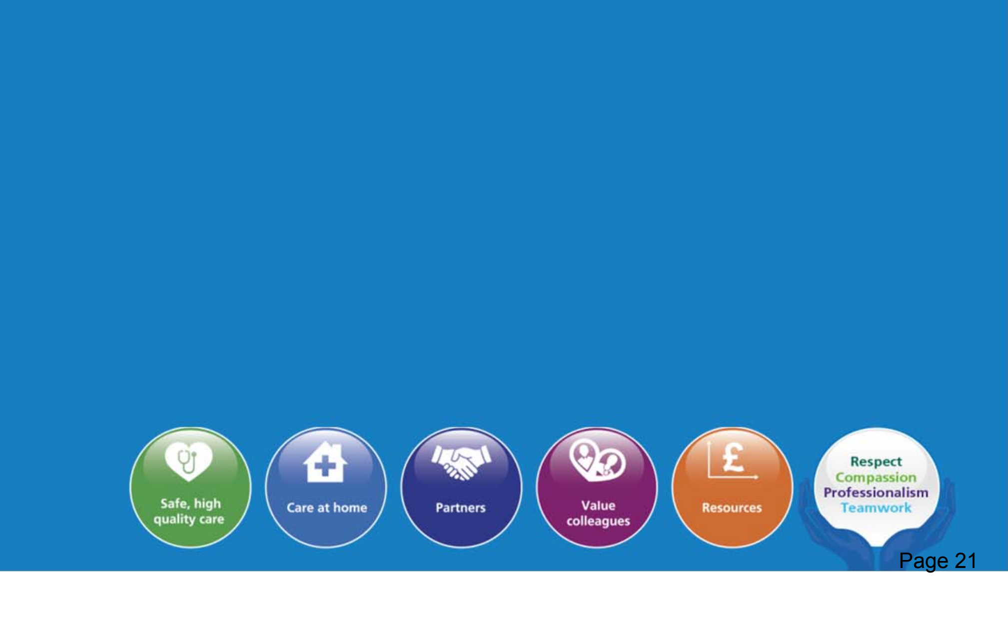
STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending October 2018	Balance as at 31/03/18	Balance as at 31/10/18	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Total Non-Current Assets	**140,656**	**144,663**	**4,007**
Current Assets			
Receivables & pre-payments less than one Year	17,214	16,224	(990)
Cash (Citi and Other)	2,277	1,083	(1,194)
Inventories	2,277	2,141	(136)
Total Current Assets	**21,768**	**19,448**	**(2,320)**
Current Liabilities			
NHS & Trade Payables less than one year	(30,702)	(29,176)	1,526
Payables less than one year	-	-	-
Borrowings less than one year	(60,740)	(6,883)	53,857
Provisions less than one year	(432)	(432)	-
Total Current Liabilities	**(91,874)**	**(36,491)**	**55,383**
Net Current Assets less Liabilities	**(70,106)**	**(17,043)**	**53,063**
Non-current liabilities			
Borrowings greater than one year	(127,859)	(199,216)	(71,357)
Total Assets less Total Liabilities	**(57,309)**	**(71,596)**	**(14,287)**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	58,318	61,486	3,168
Revaluation	16,023	16,023	-
Income and Expenditure	(131,650)	(131,650)	-
In Year Income & Expenditure	-	(17,455)	(17,455)
Total TAXPAYERS' EQUITY	**(57,309)**	**(71,596)**	**(14,287)**

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-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)	89.70%	87.73%	85.21%	85.74%	85.04%	90.24%	87.31%	95.00%	82.67%	N
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	80.65%	76.24%	71.95%	71.68%	71.86%	77.57%	75.87%	85.00%	65.80%	BP
no	Ambulance Handover - No. of Handovers completed over 60mins	5	0	7	4	13	3	33	0	236	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	93.98%	96.08%	97.64%	95.04%	93.56%	90.96%	94.29%	93.00%	95.45%	N
%..	Cancer - 62 day referral to treatment of all cancers	85.58%	86.67%	85.23%	81.97%	86.73%	86.05%	85.18%	85.00%	88.05%	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	88.33%	89.00%	90.01%	89.51%	89.02%	90.01%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	0	0	0	0	0	0	0	0		N
%..	Diagnostic Waits - % waiting under 6 weeks	99.57%	99.79%	99.75%	99.61%	99.83%	99.71%	99.60%	99.00%	99.06%	N
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission (one month in arrears)	205	185	188	162	179	177				L
no	No. of Open Contract Performance Notices	7	8	7	7	7	8		0	7	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	7.68%	7.12%	7.46%	7.58%	7.59%	6.86%	7.30%	7.00%	6.76%	BP
	RESOURCES										
%..	Outpatient DNA Rate (Hospital and Community)	11.03%	10.59%	10.45%	10.59%	10.27%	9.88%	10.48%	8.00%	12.16%	L
%..	Theatre Utilisation - Touch Time Utilisation (%)	83.76%	82.63%	84.44%	81.50%	79.79%	92.29%	83.58%	75.00%		L
%..	Delayed transfers of care (one month in arrears)	4.74%	3.74%	3.65%	4.07%	3.95%		3.84%	2.50%	2.56%	L
no	Average Number of Medically Fit Patients	87	85	88	92	107	104		80		L
no..	Average LoS for Medically Fit Patients (from point they become Medically Fit)	10.57	8	9	8	9	11		5		L
£	Surplus or Deficit (year to date) (000's)	-£4,509	-£5,616	-£8,012	-£11,496	-£14,888	-£17,455	-£17,455		-£23,267	L
£	Variance from plan (year to date) (000's)	-£186	-£18	-£553	-£3,038	-£4,711	-£6,589	-£6,589		-£2,511	L
£	CIP Plan (YTD) (000s)	£1,612	£2,268	£3,182	£4,554	£5,620	£6,747	£6,747			L
£	CIP Delivery (YTD) (000s)	£1,080	£1,919	£2,391	£3,405	£4,158	£5,351	£5,351			L
£	Temporary Workforce Plan (YTD) (000s)	£2,784	£4,246	£5,935	£7,502	£9,156	£10,836	£10,836			L
£	Temporary Workforce Delivery (YTD) (000s)	£3,743	£5,594	£7,733	£9,836	£12,140	£14,301	£14,301			L
£	Capital Spend Plan (YTD) (000s)	£2,129	£3,183	£4,105	£5,027	£5,842	£6,287	£6,287			L
£	Capital Spend Delivery (YTD) (000s)	£1,077	£2,542	£3,946	£5,487	£6,391	£6,890	£6,890			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

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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

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MEETING OF THE TRUST BOARD – Thursday 6th December 2018			
Final Winter Plan			**AGENDA ITEM: 14, ENC 12**
Report Author and Job Title:	Anna Winyard, Divisional Director of Operations, Surgery	**Responsible Director:**	Philip Thomas-Hands, Chief Operating Officer
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The purpose of this Winter Plan is to provide a collective overview of initiatives that will support operational resilience with the Trust, particularly the acute site, during the winter period (1st November 2018 to 31 March 2019). The Winter Plan is fully operational within the Trust and has been discussed and challenged within Performance Finance and Investment Committee and Quality Patient Experience and Safety Committee. Verbal assurances will be given at Board.		
Recommendation	Members of the Trust Board are asked to: • Approve the Winter Plan		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This paper aims to mitigate the Risk Register Risk in relation to Constitutional Standards.		
Resource implications	Resource implications are outlined in the financial modelling attached to the winter plan.		
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 ☒		

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ARRANGEMENTS FOR WINTER 2018/19

Active Period
1st November 2018 to
31st March 2019

Version 3

Executive Lead

Chief Operating Officer

Walsall Healthcare NHS Trust+

Trust Headquarters | Moat Road | Walsall | West Midlands | WS2 9PS

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1.0 Context

2.0 Aims and introduction

3.0 Key pressures

4.0 Initiatives Planned for Winter

5.0 Risk management

6.0 Clinical operating principles and standards

7.0 Governance arrangements

8.0 Winter reporting through UNIFY2

9.0 Winter Actions 2018/19

10.0 Conclusion

APP 1 Expected Inpatient Demand

1.0 Context

1.1 Walsall's health economy has experienced operational challenges in recent years; with key drivers being an increase in demand for urgent care services in primary and secondary care and challenges in patient flow through and out of hospital into stretched health and social care community services

1.2 More specifically the Trust has seen:

- an increase in attendances and admissions from Walsall and further afield
- Increased admissions from Walsall as a result of a combination of increased acuity / complexity of patients presenting at A&E as a result of improved primary care/community services.
- Challenges in discharging patients with more complex needs from hospital to home or more appropriate environments caused by:
  - Increasing volumes
  - Changes in complexity of the long-term needs for some patients
  - Increased patient and carer expectations
  - Market limitations in the provision of social care both residential and home care and pressures on social care funding.
- Historical hospital discharge planning processes, which have been reviewed, improved in particularly with local stakeholders.
- Increased numbers of older people with mental health needs and/or challenging behaviours that are not always well served by current models of care.

1.3 Although the Trust approaches the 2018/19 winter period in a challenged position, throughout the year it has been working with the local health and care economy to respond to lessons learned from previous years to produce a "system-wide" approach to the challenges that winter will inevitably bring, with built in oversight and flexibility.

2.0 Aim and introduction

2.1 The purpose of this Winter Plan is to provide a collective overview of initiatives that will support operational resilience with the Trust, particularly the acute site, during the winter period (1st November 2018 to 31 March 2019).

2.2 This document sets out:

- key pressures expected to arise during winter
- initiatives planned for Winter 2018/19
- measures for managing extra capacity.

2.3 This document should be read in conjunction with the following plans and arrangements:

- Walsall A&E Delivery Board Demand and Capacity plan
- Escalation policy – Full Hospital Protocol (2016)
- Major Incident Plan (May 2016)
- Local business continuity arrangements
- Walsall Escalation Policy.

3.0 Key pressures

3.1 The key pressures to the Trust posed by the winter season include:

- Winter medical presentations have a tendency to be of a more complex/ dependant case mix leading to an increase in length of stay and a subsequent reduction in capacity
- The increase in demand leads to reductions in timely discharge of patients due to increased demand from the hospital Trust and primary care for capacity in community / social care
- Increased demand for acute services due to higher levels of infection and/or ill-health within the community
- Seasonal increase in demand for non-medicine specialties such as orthopaedics and paediatrics
- Significant peaks of bed closures due to sustained infection (e.g. Norovirus) outbreaks
- Increase in medical outliers, cancelled operations and ambulance handover delays
- Pressure on adult and paediatric critical capacity across the network
- Unplanned absence of staff due to seasonal illnesses e.g. flu like symptoms and winter vomiting (Norovirus)
- Adverse weather resulting in difficulty in discharging patients and affecting staff getting to and from work.

3.2 In managing these pressures Walsall Healthcare NHS Trust's overriding objectives are to maintain:

- **patient safety:** safe, high quality services for patients including effective management of infection
- **patient experience:** ensuring patients are seen in the right place and right time, and maintaining privacy and dignity.

This will be measured through key quality performance including Emergency Department standards:

- 4 hour standard,
- ambulance turnaround times,
- triage and time to treatment times in ED,
- time to theatre for Trauma patients,
- Length of stay in hospital,
- overarching waiting time's standards for patients with suspected cancer
- 18 week referral to treatment waits.

4.0 Initiatives Planned for Winter

4.1.1 In preparation for our 2018/19 winter plan we have built on lessons learned from across the whole health and care economy of the Borough and beyond to produce a week by week calendar of anticipated demand and resource capacity.

4.1.2 The work with our partners under the Walsall Together banner, has focussed on ensuring that whenever it is safe to do so, patients are cared for at or near their home with an integrated approach from health and social care. From here we have taken steps to improve pathways between secondary, community and primary care. In addition we have improved our community capacity through the implementation of mobile technology and the integration of health and social care community services into 7 locality teams across the borough, providing MDT care and reducing duplication of resources. Additional provision has been made for community in-reach to the hospital from both nursing and therapies. We have also secured STP funding to provide additional care and support to vulnerable elderly residents of nursing homes.

4.1.3 In our acute setting the ambulatory care service has been extended to 7 days per week, and the discharge lounge is available five days a week; and a winter ward is identified and available for opening in January 2019.

4.1.4 We have transferred senior management expertise from our acute site into the community integrated care service to help improve transfers of care.

4.1.5 As stated above, a thorough analysis of historical data has been used to develop a week by week review and forecast of demand and resource capacity for the winter season. This has been undertaken and the information used to triangulate the levels of staff and other resources required, and to understand the risks that need to be mitigated.

4.2 The winter calendar plan is underpinned by a thorough, week-by-week analysis of historical data relating to demand and capacity and learning from previous winter periods, covering November to February/March. Combined with other data and business intelligence available to us we have been able to produce a forecast of anticipated demand for acute services, which has been overlaid with trends in staffing levels, the assumed outcomes from service improvement initiatives and a focus on resources to deliver care at home.

4.3 From this level of research, we have been able to triangulate our staffing requirements on a weekly basis; revise our escalation triggers aligned to winter demand; and improve our monitoring, escalation/de-escalation triggers and processes.

4.4 The information has been shared with our operational teams to understand and mitigate associated risks; and with our external partners, to understand where any additional pressures or support might be. From their feedback the week by week plan clearly highlights when and where we expect pressures to arise and how the system will best respond - always with a primary focus on patient safety. Risk management and oversight arrangements have been put in place, including formalised steps to opening up or closing down additional capacity. This has been done so that each step becomes a planned, rather than an adhoc event, and that the actions can be tracked and so provide an understanding of progress against the plan.

4.5 We have revised our escalation and de-escalation processes and are using the experience of an external expert to oversee our winter preparations and plan implementation.

4.6 The final output is a well thought-through demand and capacity plan for the coming months, with formal oversight and regular review to facilitate flexibility. Appendix 1 provides a summary of this information.

5.0 Risk management

5.1 The Walsall A&E Delivery Board has in place a set of overarching operational recovery/improvement activities that reflect the priorities of the local health economy demand and capacity plan agreed in spring 2018.

5.2 In addition to the above preparations have included identification and development of mitigation measures to ensure all services are well coordinated, responsive and resilient. Measures taken to manage key risks are set out in the tables below.

Risk	Mitigation Actions	Risk Owner(s)
- Lack of capacity to cope with increased demand	- Improved patient flow management from October 2018 through obligatory use of SAFER principles to reduce LOS and create capacity to meet demand.	Divisional Directors – MLTC, Surgery
	- Targeted resources at key points of the winter to create capacity needed - Review of capacity management processes and escalation triggers to identify if and where capacity needed in advance.	Divisional Directors – MLTC, Surgery

Risk	Mitigation Actions	Risk Owner(s)
- Patients remaining in hospital who no longer require acute care	- Daily escalation of individual cases at bed meetings so targeted actions taken.	Director Ops Medicine
	- Hospital MSFD & >21/7: Weekly review of stranded patients to review ward processes and set discharge dates with stakeholders, escalating where appropriate to remove blockages	Director of Ops Medicine / Director of Ops Surgery / Services Director Community/ICS
	- *ICS MSFD & > 6/52 community stay:* Weekly Complex Discharge Meetings to set discharge dates with stakeholders, escalating where appropriate to remove blockages	Services Director Community / ICS

Risk	Mitigation Actions	Risk Owner(s)
- Emergency Department attendances exceed plan	- Use of Walsall Healthcare NHS Trust Escalation Policy	Chief Operating Officer
	- Escalation to CCG	COO/ Director on Call
	- Increasing capacity for admission alternatives through FES, Rapid Response Team, ICS, Trigger points for increased bed and/ or expertise capacity	Divisional Director – MLTC
	- Implement communications strategy	Head of Communications

Risk	Mitigation Actions	Risk Owner(s)
- Loss of elective capacity	- Capacity planning to match peak periods, for example substitution of inpatient operating with day cases - Ensuring prioritisation of cancer and urgent patients - Ensure operating resilience; if necessary using contingencies in the independent sector	Divisional Director of Operations – Surgery
	- Reduction of elective activity over the acute winter period (January)	Divisional Director of Operations – Surgery
	- Increase day case capacity	Divisional Director of Operations – Surgery

Risk	Mitigation Actions	Risk Owner(s)
- Loss of capacity for prolonged periods due to adverse weather, staff absence, infectious outbreak	- Implement Walsall Healthcare NHS Trust Full Escalation Policy (2016)	Chief Operating Officer
	- Implement local business continuity arrangements	Divisional Director of Nursing
	- Activate infection control measures	Head of Infection Control
	- Implement communications strategy	Head of Communications

Risk	Mitigation Actions	Risk Owner(s)
- Lack of uptake for seasonal flu vaccination	- Proactive management of data and responsive increase in communication with support from Clinical Directors and Head of Nursing	Director of Human Resources

6.0 Clinical operating principles and standards

6.1 This section sets out a series of key principles and standards, applicable to all areas, to assist patient flow whilst maintaining service quality and patient experience. These are in line with recommendations made by amongst others, the Emergency Care Intensive Support Team/national best practice.

6.2 The Accident and Emergency Dept should primarily be accessed for serious and life threatening conditions and therefore all patients will spend as little time as possible within the A&E Department and in any event will not spend more than 4-hours waiting wherever possible.

6.3 All patients will undergo triage within 15 minutes of attending A&E.

6.4 All patients in A&E requiring assessment or admission will be 'pulled' into the appropriate short stay areas or speciality bed within the 4-hour waiting time, and will be assessed where required by an appropriate decision maker working to a service agreed care pathway.

6.5 Regalement will be offered where appropriate to allow considered decisions about long-term care.

6.6 Any proposed change to the EDD will only be agreed by the consultant in charge of the patients care (regardless of reason for change).

6.7 All specialities will review all emergency patients daily – 7 days a week – and continue a multi professional board/ward round approach to be completed each morning based on clinical need with a follow up board round in the afternoon.

6.8 All specialities will support the use of criteria led discharge with appropriate documentation in the notes. This is particularly critical at weekends and will be monitored by the site team for Executive review.

6.9 All patients will be discharged via the Discharge Lounge 5 days per week.

6.10 As many patients as possible agreed for discharge at the Board / Ward Round will be discharged before 12:00 hrs (as appropriate) using the Discharge Lounge.

6.11 Specialities will provide appropriate in reach to admission areas to:

a. Provide specialist support in inpatient management

b. Ensure appropriate patients are identified and rapidly moved to speciality wards

c. Discharge/early supported discharge is expedited by specialist opinion/community management

7.0 Governance arrangements

7.1 Three governance mechanisms exist that ensure our clinical operating principles and standards are maintained, and quality as well as patient safety standards are not compromised throughout the winter period. Each of these mechanisms is well established and embedded within the operational arrangements of the Trust. The governance mechanisms for winter preparedness and response are:

i. Ward Audits
   - Weekly every Thursday

ii. Quality and safety structures

iii. Audit of response to ED and AMU by specialties

iv. Daily audits of ward patient profile and SAFER processes

7.2 Internal governance of the implementation of arrangements for winter is through the Trust Management Board. The Board will receive reports on:

a. proposed plans for winter
b. monitoring the monthly feedback on progress against the plan
c. risk mitigations put in place
d. Overall performance against standards.

7.3 In terms of the partnership governance arrangements for the wider economy, formal reporting will be via the Urgent Care Delivery Board.

7.4 Detailed operational monitoring of the plan will be undertaken at:

a. three times daily bed capacity meetings
b. weekly Operations Group
c. monthly Trust Management via summary reports

7.5 The focus of discussion at each of the above meeting will be the development of actions and plans to recover the expected trajectory and Trust position.

7.6 A full table of forums with responsibility for monitoring performance and compliance throughout winter are set out below. However, the Department of Health is still to clarify how winter reporting will be managed. Daily winter situation reports (SITREPs) will be

submitted through the UNIFY2 system (and further details regarding UNIFY2 reporting are set out in section 8.0).

Quality and safety assurance forums

MEETINGS	FREQUENCY	TERMS OF REFERENCE	MEMBERSHIP
Quality and Safety Committee	Monthly	Board sub-committee overview/scrutiny	Non-Executive & Executive Directors
Trust Management Board	Monthly	Executive oversight and delivery responsibility for all quality and safety activity within the Trust	Executive Directors, Divisional & Corporate Teams
Trust Clinical Senate	Monthly	Review overall performance and update reports on winter, quality and safety	Executive Directors • Divisional Directors • Clinical Directors / Directors of Nursing / Operations
Divisional Quality Team	Monthly	Reviews quality and safety issues escalated from Care Group Quality Teams and escalates to Quality and Safety Committee as appropriate	Director of Nursing / Director of Operations • Matrons • Clinical Directors / care Group Managers
Care Group Quality Team	Monthly	Reviews quality and safety issues and escalates to Divisional Quality Team Safety Committee as appropriate	Clinical Directors • Matrons • Doctors • Nurses • Allied Health Professionals • Care Group Manager
Capacity Meetings	3 times a day	Ascertain bed capacity, manage breaches	Per Escalation Policy
Complex discharge escalation	Weekly	Analysis of each individual patient who is clinically stable, out of area, in need of complex packages, or for whom the discharge package needs escalation	Interim Services Director (community) • Discharge Co-ordinators ICS Rep • Ward Managers

8.0 Winter SITREP Reporting through UNIFY2

8.1 Early reporting of data that indicates emerging problems is seen as a key element in the effective management of winter. Trusts are required to use UNIFY2 for reporting local winter pressures. Clarity regarding SITREPs contents will follow in due course, however, current expectations are:

- temporary A&E closures;
- A&E diverts;
- ambulance handover delays over 30 minutes;
- trolley-waits of over 12 hours;
- cancelled elective operations;
- urgent operations cancelled in the previous 24 hours and those operations cancelled for the second or subsequent time in the previous 24 hours;
- availability of critical care, paediatric intensive care and neonatal intensive care beds;
- non clinical critical care transfers out of an approved group and within approved critical care transfer group (including paediatric and neonatal);
- Bed stock numbers (including escalation, numbers closed, those unavailable due to delayed transfers of care etc.);
- details of actions being taken if trust has considers that it has experienced serious operational problems.

9.0 2018/19 Winter Actions

Highlighted below are priority actions linked to the Walsall A&E Delivery Board winter plan shown at section

Area	Description	Who	When
Enhanced Community Nursing Rapid Response Team by November 2018	The established multidisciplinary team (managing critical, sub-acutely ill patients who require quick, intensive, interventions to avoid a hospital admission and expediting hospital discharge by supporting step down from an acute bed) has been enhanced by: 1. The implementation of mobile technology releasing resources by re-allocation within the Rapid Response team. 2. The funding of senior community nurse support to support Residential homes as a source of hospital attendance from STP in monies in November 2018 3. Increased GP support to the Rapid Response Team OOH 4. Enhancing skill mix through recruitment of additional ANP posts Plan is to support 260 referrals in December (195 in September)	K Geffen M Dodd	15/11/18
Enhanced community matron in-reach from October 2018	• Community therapy and nursing support to Manor Hospital at weekends ('Team in a Jeep') to run during October and early November, with a view to evaluating the model mid-November • Community matrons covering their admitted caseload at the Manor (this service is to operate on a 7/7 basis) • Community therapy weekly patient review for MSFD Wards (3 & 14) • Community therapy in weekly MDT on trauma ward to reduce LOS and increase referrals to ICT beds • Community therapy support to Ward 4 and Ward 14 patients	K Geffen M Dodd	15/11/18
Early Senior Assessment in ED	On arrival in ED, patients will be first seen by a senior doctor and nurse to ensure rapid, senior, effective assessment and treatment planning. This will reduce time for diagnostics, referral and discharge when	N Rashid	November 2018

Area	Description	Who	When
	appropriate. This scheme requires space in ED to operate consistently (see below).		
Expansion of ED facilities to reduce waiting times	To convert a standby viewing room in the ED dept. into a see and treat facility in the evenings To convert the empty HDU facility into a flexible facility from December 24th as part of NHSI capital scheme	N Rashid	November 2018
Increased Medical Staffing in ED	Extra A&E consultant on weekends Extra middle grade shift in A&E (6pm-2am) 7/7	N Rashid	November 2018
Acute Physicians In ED to reduce medicine admissions	From September 2018 acute physicians have been targeted to work in ED at the identified high demand periods: Sunday afternoons, Monday evenings and Tuesday evenings to review medical patients, discharging with appropriate arrangements to reduce admissions. This should be increased to 7 days during the January 2019 period and a winter bid will be ready for submission.	A Townsend	Mid November
Medical Staffing - weekends	Extra juniors to support Saturday morning ward rounds	N Rashid	November 2018
Seasonal Flu Campaign to reduce staff sickness during winter	Roll out of the occupation health service annual flu programme for 2018/19, ensuring a robust plan is in place so that all front line staff offered the seasonal flu vaccine. The vaccination target is 100%. For community staff, the actions are as above. We also are exploring use of PGD's to increase supporting community caseload vaccination and we have a contingency plan for community nursing teams to support any flu outbreaks within private nursing and residential homes	Debbie Glasgow Occupational Health Manager	January 2019
Flexing elective sessions	Reducing planned elective sessions and providing increased emergency surgery sessions and increased consultant input to the wards from last week in December and in January 2018. Additional Trauma and General Surgery Consultant to ensure responsive decision making.	A Winyard	23/12/18
5 day Frail Elderly	Frail Elderly Service to ED, with extended	A Townsend	01/10/18

Area	Description	Who	When
Service established from October 2018	multi-disciplinary support in an extend assessment facility to release ED capacity in the day and reduce re-admissions of this patient category during the winter. Consultant physician and ACPs in post.		
7 day Ambulatory Service	Providing a 7 day ambulatory service to ED for medical patients to prevent bed based admissions and telephone access to GPs	Dr Saim	01/10/18
Senior Nurse On-Site Cover	Senior nurse on site till 9pm bringing additional challenge and robustness to decisions around staffing in particular. They will advise on incidents, complaints etc. and carry fire bleep. Consideration is being given to swap this funding into the Site Nursing team out of hours to focus senior nurse cover into operational areas in the winter period.	K Dunderdale	01/10/18
Infection Control Procedures	Implementation of the Norovirus outbreak arrangements including issuing pack for wards and departments to include: – Identification of designated ward to receive suspected Norovirus patients and commencement of ring-fenced side-room – Assess need to ring fence and manage areas for direct admissions of potential Norovirus cases – Admission criteria to Norovirus side rooms / ward – Symptom checklist for medical staff – Patient and staff information during outbreak – Outbreak monitoring chart – Ward closure signs – Enhanced microbiology diagnostic cover in an outbreak An machine with extra capacity for rapid sample analysis will be in place by November 2018	K Dunderdale	Mid November
Infection Control Procedures	Provision of algorithm for Ward closure and ward reopening based on national guidance for management of Norovirus outbreaks including escalation	K Dunderdale	Mid November
Focused MSFD initiatives in 2018 to release capacity in accordance with demand analysis	To co-ordinate community and ICS services across the hospital and community pathways to reduce MFFD numbers by targeted initiatives in advance of hospital high demand forecasts: Late October, late November and December 2018.	Lloyd Broderick Kelly Geffen	22/10/18

Area	Description	Who	When
	Non-recurrent funding has been provided for 2 extra therapists into community teams. STP funding has secured extra social work support. Proposed trajectory is to reduce MSFD within the Manor to 80 during November and 60 by December 24th, while also reducing the numbers of patients over 42 days in community ICS services		
Offering UCC slots after midnight to ED streamers and triage (November 2018)	Slots for category 4 and 5 patients after midnight to be provided in UCC from November 2018 to release ED capacity and reduce waiting times	Andy Rust/Miss Joshi	November 2018
Increase extra bed capacity	NHSI capital funding has been secured to establish 5 new beds onto ward 29 by 24th December, increasing core bed base for the peak of winter. From late December 2018 a full ward is ready to be opened recognising the increased LOS at this time and the need to focus MFFD patients that accumulate, in this period, away from acute hospital beds	A Townsend	09/12/18
Annual Leave Management	Divisional Teams to micro manage annual leave over the Christmas and early January period to ensure effective service provision at peak demand times e.g. w/b 17th December to w/b 17th January 2019	Divisional Directors	December 2018
Pharmacy	Pharmacy to later in the day at busy weekends in December 18 and January 19. Discussions are underway to move pharmacy hours to support expected high demand - A Pharmacist visits the Discharge Lounge and facilitates medicine requests liaising with the ward based pharmacy teams and the Dispensary (Monday to Friday) . - EDS for the Discharge Lounge are fast tracked and nursing staff collect from the ward collect room when the nurse sees it completed on the prescription tracking system without having to make ‘phone calls. - A Pharmacist on Ward 10 for FES patients and supports timely decisions about medicines (Monday to Friday)	G Fletcher	December 2018

Area	Description	Who	When
	- Collect status (level) that the Hospital is at from bed bureau each morning and share extra capacity areas with the ward based teams at 9am (Monday to Friday) - Collect the list of patients for discharges from Bed Bureau between 12 midday and 12.30 and disseminate to the ward based teams to ensure medicines are prepared, in advance where we can if the EDS still needs the prescriber to complete (Monday to Friday) - Use Pharmhub who are across the main road to the Hospital to process dosette trays for the same day when prescriptions are ready before midday with a turnaround of 2 hours. If there is an urgent dosette to be done just after midday, we can request and check if Pharmhub can turnaround the dosette for us if they have all the medicines in stock (Monday to Friday). - On weekdays and at weekends we have a Pharmacist with a dispenser on Bleep 7111 to support discharges up to 6.30pm.		
Paediatrics	- A second Paediatric Consultant has been identified - a secondary consultant of the week to provide more senior decision makers on PAU and the ward over the winter period. This Doctor also works 11am – 7pm thus providing further twilight hours coverage - Improved communication with A&E and in December also have a consultant starting who will sit over both Paediatrics and ED in order to improve flow between the two departments - Increase the number of rapid assessment clinics run over the winter period so patients as appropriate can be seen in an outpatient setting rather than in PAU - Undertake work to formalise the	D Bernard	December 2018

Area	Description	Who	When
	process of Reg's/ Acute care consultants who are resident overnight being able to discharge as appropriate overnight / first thing in the morning. We have also put a step into the ward round to ensure the sick children and the quick discharges are seen fast to expedite early discharge from the ward in the morning. - Work with the CCN team to ensure appropriate and increased use of the hospital at home service to take children quicker form the wards. We have also made contact with support service such as pharmacy about ensure appropriate support throughout the winter period.		
Therapies	- Implementation of the enhanced 6-day discharge model with additional cover on Sunday - Dec 22nd- Jan 7th : outpatient clinics cancelled during this period to provide additional All other areas will operate business as usual.	D Bernard	December 2018

9.1 Opening of additional capacity in accordance with demand modelling.

Opening additional capacity, over and above the planned opening of a winter ward, will only be undertaken with prior approval of the Chief Operating Officer or Director On-Call. Care will be taken to ensure all patients meet appropriate criteria for admittance to additional capacity areas and consideration given to the maintenance of good care provision

Area	Description	When	Net impact on Beds	Cumulative impact on beds
Ward 23	• Additional 5 beds for female surgical patients	15/11/18-01/03/31	+5	+5
Ward 29 upgrade of bays • Impact on W29	• Ambulatory, 3 bays and s/rooms will operate from W29 • Discharge Lounge will move to ward ASU • 12 x IP beds to be re-	12/11/18		

Area	Description	When	Net impact on Beds	Cumulative impact on beds
	provided on W3 and 12 IP on ward 10 – FES/MSFD			
Completion of W29 works	• W29 full operational	08/12/18	+12	+17
New Critical Care facility • Impact on FES & Discharge Lounge	• Relocate FES & Discharge Lounge to old ITU • Open additional beds on 15 – for MSFD	08/12/18	+15	+32
New Critical Care facility • Impact on ED	• Create A&E Assessment Facility in HDU	20/12/18		
Winter Ward	• Acuity on Ward 3 changed to deal with acutely ill patients	08/12/18 11/02/2019		
Additional Surge Capacity	• Stroke Unit will have General Medicine patients and go from 18 to 26 beds every weekend	Flex	+8	+40
CIU & Endoscopy • Weekend capacity	• CIU x 5: Saturday - Tuesday • Endoscopy x 6: Sunday - Monday	Flex	+11	+51
ASU x 12 beds	• First line escalation beds for Medicine & Surgery	Flex	+12	+63
Relocation of Stroke Ward	• Stroke ward to move to Hollybank (18 stroke beds) • Reduces scope for use of extra beds for Gen Med	01/01/19		

Additional beds on wards:

The full hospital protocol (June 2016) provides for an additional bed to be placed on wards in situations where the Trust would otherwise be at Level 4 escalation.

The above will be kept under constant review in terms of capacity demand. Opening of additional capacity beds will not be taken as a last minute decision, but reviewed formally by capacity team and site manager throughout the day and night. The Divisional Director for MLTC or Surgery will approve the plan to open such areas following agreement with senior medical, nursing & managerial colleagues. Priority shall be given to closing these areas the following operational day.

Risks & Issues Log

Risk	Description	Mitigation
Funding not confirmed for schemes	• Acute Physicians In ED to reduce medicine admissions (extension to 7/7) • Extended hours for Ambulatory service • Additional social workers & community beds • Extended pharmacy services	• Agreement at TMB of which schemes to be undertaken 'at risk'
Infection control – outbreaks & ward closures	• Closures of wards leading to delays with patient flow	• Ensure adequate supplies of FFP3 masks, escalation & management protocols agreed and circulated
MSFD numbers not reducing	• Availability of care home beds for D2A patients • Availability of care agencies for DH2A packages • Throughput of social workers • Numbers of hospital-based MSFD as half of total • Out of Area MSFDs (Sandwell., South Staffs, Birmingham)	Agree use of £1.4m allocated to councils to reduce MSFD – Additional community social workers, OTs, Physios – Commission Dudley & Walsall MHT to provide beds for EMI patients awaiting care home placement – Commission additional ward-based therapy to reduce delays for therapy intervention 7/7 and prevent patient deconditioning – Commission beds at Hollybank post stroke ward move Revised ward processes
Demand profile changes	• Increased admissions / reduced discharges linked to change in acuity	• Extra winter ward will have to be opened before 1st January / closed after 31st January • Use of escalation protocols and SOP for opening further capacity beds
Ward upgrade on W29 not started / completed on schedule	• Work extends beyond the 9th December completion date	• Continue with W29 in-patients relocated onto modular block
Risk	• **Description**	• **Mitigation**
Unable to staff areas	• Delays in opening facilities	• Confirm dates for opening extra beds

Stroke Ward does not move to Hollybank	• Delays to throughput of stroke patients will continue	• Continue with stroke ward on modular block
Patient equipment linked to opening extra beds • Identified shortfalls in ward equipment (beds, lockers, tables, chairs)	• Will mean that any extra beds opened will not have adequate furniture	• Use of kit from empty maternity ward • Sign off contingency call off order to rent extra beds

10: Conclusion

Our primary focus is the safety of all patients in our care, and secondary, that we deliver the right care in the most appropriate setting.

Governance around the plan will need to be effective to ensure the plan is properly implemented, and that escalations and more especially de-escalations are appropriately applied.

We are confident that the measures taken in preparation of the winter plan, based on the assumptions shown, are robust and fit for purpose.

Appendix 1

Expected Inpatient Demand

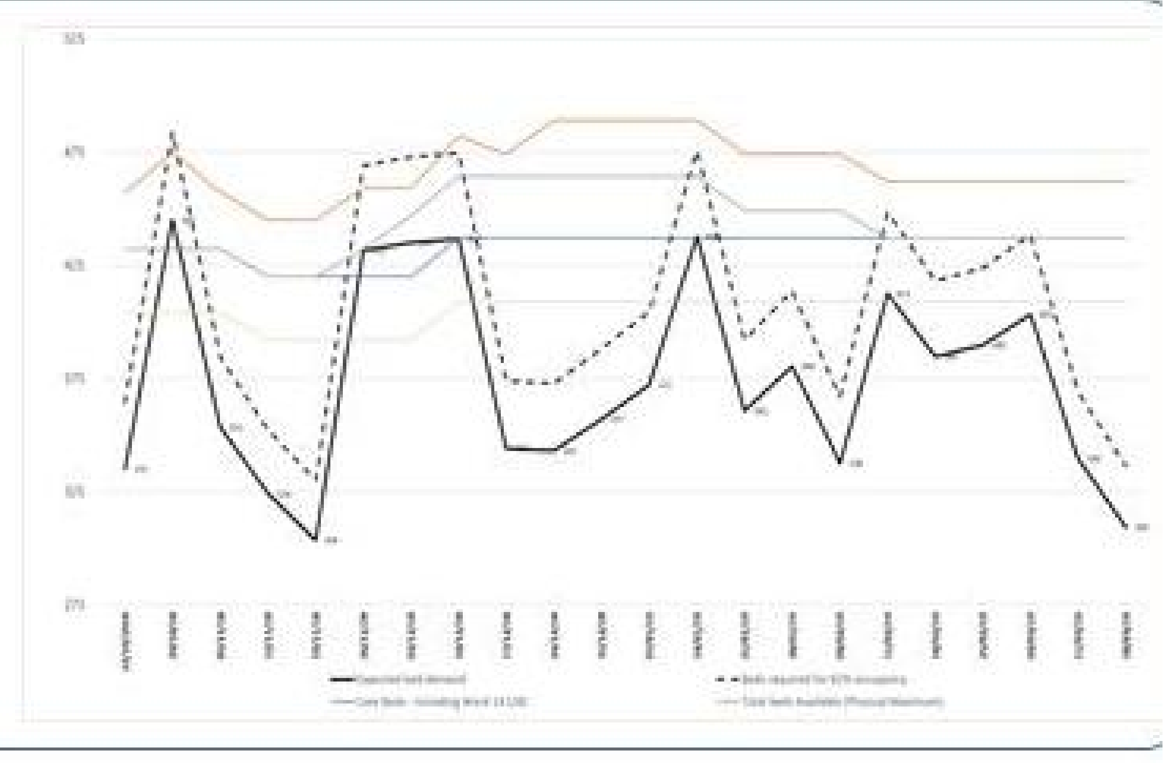
Expected Demand
This graph shows the proposed escalation model to deal with the expected increase in bed demand over the winter period.

The demand (black line) is modelled on 2017/18 with a reduction based on improvements documented and presented at A&E board in the autumn of 2018. The black dotted line indicates the bed capacity required to operate at 92% bed occupancy.

The orange line shows the maximum available physical bed capacity we can access at any given week based on the way we use our proposed winter ward (Ward 10) and agreed surge capacity.

The intention is to enter Ward 10 in 2 stages. 1 adding 2 extra bays of capacity then moving into a further 2 bays at the point that RES could move into ICU (along with Discharge Lounge)

Our forecast shows that we could reasonably expect to exit Ward 10 on or around 11th February.



MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018			
Black Country STP – Memorandum of Understanding			AGENDA ITEM: 15, ENC 13
Report Author and Job Title:	Richard Beeken, Chief Executive	**Responsible Director:**	Chief Executive
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	NHS Shared Planning Guidance for 2016/17 – 2020/21 asked every local health and care system to come together to create its own Sustainability and Transformation Plan (STP) for accelerating the implementation of the Five Year Forward View (FYFV). The subsequent 2017 delivery plan, Next Steps on the Five Year Forward View, set out national priorities for implementation and clarified the developing role of STPs. The STP members have agreed to work together to enable transformative change and the implementation of the FYFV vision of better health and wellbeing, improved quality of care, and more sustainable services. The Objective of this MoU is to provide a mechanism for securing the Parties' agreement and commitment to sustained engagement with, and delivery of, STP plans in order to realise a transformed model of care across The Black Country and West Birmingham. It is our understanding that all member organisations have now agreed to sign this MoU. Walsall Healthcare NHS Trust is one of the last organisations to take it through their Board cycle.		
Recommendation	Members of the Trust Board are asked to approve the signing of the Black Country STP MoU by Walsall Healthcare NHS Trust.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no immediate or direct risk implications associated with this report.		
Resource implications	There are potential resource implications for WHT with respect to the wider STP programme governance arrangements and the "fair shares basis" expectation of contribution to the running costs thereof. This is not expected to be an issue for any member organisation until 2019/20.		

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 ☒	

The Black Country and West Birmingham Sustainability & Transformation Partnership

Memorandum of Understanding

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1. Parties

1.1 The parties to the Partnership are the following NHS organisations and Local Authorities, where their governing bodies authorize the signing of this Memorandum of Understanding (MoU):

- Black Country Partnership NHS Foundation Trust
- Dudley Metropolitan Borough Council
- Dudley Group NHS Foundation Trust
- Dudley and Walsall Mental Health Partnership NHS Trust
- NHS Dudley Clinical Commissioning Group
- Sandwell Metropolitan Borough Council
- Birmingham City Council
- Birmingham Community Healthcare NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- NHS Sandwell & West Birmingham Clinical Commissioning Group
- Walsall Metropolitan Borough Council
- Walsall Healthcare NHS Trust
- NHS Walsall Clinical Commissioning Group
- Wolverhampton City Council
- Royal Wolverhampton NHS Trust
- NHS Wolverhampton Clinical Commissioning Group
- West Midlands Ambulance Service NHS Foundation Trust
- NHS England (Specialised Commissioning).

1.2 Organisations listed above that do not sign this MoU but wish to contribute to Partnership discussions will be welcomed as Associate Members. Partnership Board Terms of Reference also allow for wider system partners to be included in Partnership discussions.

1.3 The Partnership recognizes that there are other system partners, not listed above (e.g. Primary Care, Third Sector organisations), and it affirms its intention to work for the benefit of the whole system not simply that of Partner and Associate members. The Terms of Reference for the Partnership Board sets out how wider partners will be engaged, including the patient voice.

1.4 In the event that any of the above organisations is party to a merger or is subject to acquisition, or that a new provider is formed or contracted to provide services within the footprint (e.g. an accountable care organisation), the Partnership Board shall determine whether any additional organisations should be invited to sign this MoU as Partners.

2. Background

2.1 NHS Shared Planning Guidance for 2016/17 – 2020/21 asked every local health and care system to come together to create its own Sustainability and Transformation Plan (STP) for accelerating the implementation of the Five Year Forward View (FYFV). The subsequent 2017 delivery plan, Next Steps on the Five Year Forward View, set out national priorities for implementation and clarified the developing role of STPs.

2.2 The Black Country and West Birmingham footprint was identified as one of the STP footprint areas in which people and organisations would work together to develop robust plans to transform the way that health and care is planned and delivered for the footprint population. The Black Country and West Birmingham partnership represents many different constituent interests (including registered population, resident populations, and populations utilising services and/or working within the geographical area) and that this may change over time. Subject to agreement by the STP Board, to allow new members or associate members representing neighbouring population interests to be included within the arrangement.

2.3 The Parties have agreed to work together to enable transformative change and the implementation of the FYFV vision of better health and wellbeing, improved quality of care, and more sustainable services.

2.4 The Parties have collaborated in the development of draft proposals (as set out in Schedule 1) and recognise they need now to develop and implement more detailed plans in key areas.

3. Objective and Intent

3.1 The Objective of this MoU is to provide a mechanism for securing the Parties' agreement and commitment to sustained engagement with, and delivery of, STP plans in order to realise a transformed model of care across The Black Country and West Birmingham.

3.2 The intent of this agreement is to bind the parties to the common purpose of delivering a clinically, socially and financially sustainable health and care system that will improve the health and wellbeing of the population and address inequalities. This requires the Parties to recognise the scale of change required and that its impact may be differential on the Parties. The Partnering Statement is included within Schedule 4.

4. Obligations

4.1 The Parties agree to work collectively to establish the detailed plans and organisational impacts that will achieve the Objectives and Intent. These will incorporate finance, activity and workforce as a minimum, and will be set out in an annual system plan in a format to be agreed.

4.2 The Parties agree that they will comply with the annual system plans that move the system incrementally towards the Objectives and Intent, and that they will actively contribute to reporting performance and progress against the plan both within the Partnership and, through the Partnership, to Regulators.

5. Benefits

5.1 The Parties shall realise the benefits of working collectively by receiving system and regulator support to manage in-year and longer term risks as a whole system, supported by the Parties individually and collectively to the extent that no organisation is deemed to fail individually. Regulator interventions will be aligned to this benefit in order that all parts of the system can release maximum resources to delivery of the intent.

6. Leadership

6.1 The partners will appoint an Independent Chair. The independent chair will serve for a period of 2 years unless the contract of employment is legally terminated.

6.2 The partners will also appoint an STP Lead.

6.3 The STP Lead's role and remit are set out in Schedule 2.

6.4 The designated STP Lead may change from time to time in accordance with such process as may be agreed by the Partnership in consultation with Regulators.

7. Duration of the MoU

7.1 This MoU will take effect for each party on the date it is signed by that party, following a formal resolution by its governing body.

7.2 The Parties expect the initial duration of the MoU to be for the period of 2017-2021, as a minimum, or otherwise until its termination in accordance with Clause 15.

The MOU will be reviewed annually by the partnership to ensure it remains fit for purpose.

8. Agreed principles

8.1 The Parties have agreed to work together in a constructive and open manner in accordance with the agreed principles for ways of working and the culture set out in Schedule 3 to achieve the Objective and Intent.

9. Effect of the MoU

9.1 This MoU does not and is not intended to give rise to legally binding commitments between the Parties.

9.2 The MoU does not and is not intended to affect each Party's individual accountability as an independent organisation.

9.3 Despite the lack of legal obligation imposed by this MoU, the Parties:

- have given proper consideration to the terms set out in this MoU; and
- agree to act in good faith to meet the requirements of the MoU.

10. Governance

10.1 The Parties have agreed to establish the Partnership to co-ordinate achievement of the Objective and Intent.

10.2 The Parties have agreed Terms of Reference for the Partnership Board in the form set out in Schedule 4. Terms of Reference describe arrangements for aligned decision making of the Parties which they agree is necessary to achieve the Objective and Intent.

10.3 Each Party will nominate a representative to the Partnership Board and notify the STP Lead of the name of that representative and the name of a deputy who is authorised to attend in her/his place.

10.4 The Parties agree that the Partnership Board will be responsible for co-ordinating the arrangements set out in this MoU and providing overview and drive for the STP.

10.5 The Partnership Board will meet at least monthly or as otherwise may be required to meet the requirements of the STP.

10.6 The Partnership Board does not have any authority to make binding decisions

on behalf of the Parties. Collective decisions made by the Partnership require ratification by each Party's unitary Board or equivalent.

11. Subsidiarity

11.1 The Parties acknowledge the importance of subsidiarity in terms of The Black Country and West Birmingham's distinct communities.

11.2 The Parties agree that, where appropriate, decisions should be made as close as possible to the people affected by them.

12. Risk management and assurance

12.1 The Parties will develop and maintain a risk register for the STP.

12.2 NHS Commissioners will confirm risk sharing agreements in the light of this MoU.

13. Resources

13.1 The Parties have agreed to commit their own resources to achieve the Objective in accordance with the arrangements set out in Schedule 5.

13.2 Parties also expect that resources currently held by NHS Regulators will also be committed to the work of the STP.

13.3 The STP has an existing Partnership Agreement with The Strategy Unit to provide strategic support and advice, and data and evidence analysis.

13.4 The Parties have further agreed the arrangements set out in Schedule 6 for engaging any additional external resource and advice.

14. Openness and transparency

14.1 The Parties agree that they will work openly and transparently with each other and with other stakeholders, including non-executive directors, governors and elected members of the Parties and other local health and care organisations.

14.2 The Partnership Board will receive plans that demonstrate each Party's compliance with their duties of public involvement to the extent that these

may impact on any other party to this agreement, or be enhanced by the involvement of one or more of the Parties. If there is any ambiguity as to whether the Partnership may require these plans then this should be discussed with the STP Lead.

15. Termination

15.1 Any Party may withdraw from this agreement at any time, following a formal resolution by its governing body, duly notified to the STP Lead who will promptly communicate this notice to other Parties.

15.2 In making such a resolution, the withdrawing Party recognises that it will cease to benefit from any collective agreement or treatment established whilst acting under the agreement, and that it will lose the ability to play a part in Partnership decision-making.

15.3 This agreement is intended to endure for the lifespan of the STP but this collective commitment will be reviewed at least annually to ensure that it remains fit for purpose and meets the needs of the Parties. The Parties will agree whether to extend and/or amend this arrangement according to prevailing circumstances.

16. Dispute resolution

16.1 The Parties will attempt to resolve any dispute between them in respect of this MoU by negotiation in good faith.

16.2 Where Parties are unable to reach agreement, proposals for dispute resolution will be set out by the STP Lead according to the circumstances of the dispute, such that any mediation/arbitration is conducted by one or more of the Parties neutral to the dispute. This may require recourse to external expertise (procured in accordance with Schedule 6) or to intervention by NHS Regulators.

17. General provisions

The Parties agree that this MoU may be varied only with the written agreement of all the Parties.

Signed by the duly authorised representatives of the parties on the dates set out below.

Partner Organisation	Role of Signatory	Signature	Date of Signature
Black Country Partnership NHS Foundation Trust			
Dudley Metropolitan Borough Council			
Dudley Group NHS Foundation Trust			
Dudley and Walsall Mental Health Partnership NHS Trust			
NHS Dudley Clinical Commissioning Group			
Sandwell Metropolitan Borough Council			
Birmingham City Council			
Birmingham Community Healthcare NHS Foundation Trust			
Sandwell and West Birmingham Hospitals NHS Trust			
NHS Sandwell & West Birmingham Clinical Commissioning Group			
Walsall Metropolitan Borough Council			

Partner Organisation	Role of Signatory	Signature	Date of Signature
Walsall Healthcare NHS Trust			
NHS Walsall Clinical Commissioning Group			
Wolverhampton City Council			
Royal Wolverhampton NHS Trust			
NHS Wolverhampton Clinical Commissioning Group			
West Midlands Ambulance Service NHS Foundation Trust			
NHS England – Specialised Commissioning			

[MoU adapted with permission from a template developed for the Devon Success Regime by Hempsons]

Schedule One – Latest STP Submission

Schedule Two – Role and Remit of STP Lead

1 Introduction

The Black Country and West Birmingham STP provides an important opportunity to redefine the future of health and social care locally. There is a collective responsibility to transform care and build delivery and confidence through collaborative effort so that local populations experience services that are of outstanding quality, and are both financially and clinically sustainable.

STP Partner organisations, informed by national guidance, have identified the appointment of an STP Lead as an essential role in supporting the achievement of this goal.

2 What behaviours will the STP Lead need to demonstrate?

The STP Lead (like any leader across the footprint) will need to prioritise and advocate for the needs of The Black Country and West Birmingham population over and above the interests of individual partner organisations. The STP Lead will need to be:

- Organisationally neutral, system leadership focused
- Open, frank and constructive, building good relationships with colleagues and between colleagues
- Engaging of all stakeholders, partners and the public to build a momentum for constructive challenge, constructive dialogue, engagement and consultation
- Committed to build on the positive experiences and services across the patch while pursuing the adoption of best practice and outcomes for all to meet the scale of the challenge faced
- Act and be regarded as fair, balanced and inclusive
- Be an honest broker and mandated by colleague Chief Executives to support and constructively challenge other leaders and Boards to reframe their leadership style and language if necessary to secure agreed STP goals
- Able to explore, through openness and transparency, areas of conflicting views or perceived vested interests of any of the parties.
- Appreciate and integrate the differing requirements, governance and accountabilities involved, supporting all Partners to secure the best outcomes for the STP population while respecting the extant statutory roles of each

organisation

- Demonstrate courage, energy and upmost integrity.

3 What are the requirements of the STP Lead?

This role will require an individual who has the confidence and, therefore, the mandate of existing leaders in the STP, and who possesses the following attributes:

- An experienced and successful executive leader
- Detailed understanding of the regulatory arena and the complexity of health and social care provision
- A wide range of experience working with Boards, and interacting with system partners at local, regional and national levels
- Able to be an efficient, effective, person-centred and future-focused coach of very senior individuals
- Track record of succeeding in a highly challenging environment where tenacity, resilience and humility have been key ingredients for success.
- Able to rapidly secure the confidence of regulatory bodies - credibly balancing the best efforts of local Partners whilst also harnessing external capacity (including relevant resource within Regulators) to drive a new and fully integrated way of working.
- Visible to stakeholders to secure their engagement and confidence to offer and participate in solutions for future models of care
- Able to facilitate and resolve potential material issues of difference in terms of governance and pace of delivery
- A confident public and media spokesperson
- Fluent in the new models of care, national developments, integrated care and the potential for devolution deals across a wide and dispersed geographical patch
- Demonstrable experience of managing local delivery and change under intense national political and media interest.

4 What is the role of the STP Lead?

- To lead Partners in developing and delivering an overall system plan, and in

working towards an acceptable mechanism for managing a single financial control total. This plan will be a compelling platform from which to transform health and care services at pace and scale, securing sustainability within an ambitious timescale.

- To design, lead and drive the overall STP programme. This would include working with all stakeholders and NHS bodies to maximise the potential to deliver excellence, improved health and well-being for populations and communities and integrated and improved care for people.

- To ensure that, where any major service change is proposed, relevant Partners undertake an exemplary approach to engagement and consultation, and that proposals are developed in line with national guidance around the 'five tests' and informed by the Clinical Assurance Framework developed by the West Midlands Clinical Senate.

- To be the lead officer and main point of contact in the footprint for NHS Regulators, and to be the focus of liaison with neighbouring (and national) STPs, working to ensure the appropriate alignment of plans

- To secure from Partners the resources required to develop and deliver the system plan, including the secondment (full or partial) of Partner organisation staff to fulfil STP roles.

- To administer and deploy all STP resources, internally or externally acquired, and to be accountable to Partners for the resource expended.

- To ensure that, although the STP currently has no stand-alone statutory basis, sufficient commitment to, and confidence in, the STP and its leadership is established so as to support the robust and timely delivery of transformation plans. This will include assisting the Partnership to articulate its role on which the collective support is made as being separate from the individual statutory roles and requirements of each organisation represented. As the STP evolves, and subsequent guidance and advice is received, the STP Lead should bring forward proposals for developing the mechanisms for governance and for potential changes to organisational form.

Schedule Three – Agreed Principles

1. **Partnership Working Agreement**

The Partnership has been established to oversee delivery of the Sustainability and Transformation Plan (STP). This group comprises STP Partner organisations, with associate and other relevant local organisations in attendance at meetings of the Partnership Board.

The following framework sets out the principles that shape how the Partnership shall conduct itself, and agreement to these principles is a pre-requisite to membership of Partnership for organisations that are signatories to the MoU. Other organisations attending the Partnership Board will also be asked to reflect the values set out below.

This agreement is open to statutory bodies responsible for commissioning and/or delivering health and social care services within the defined STP footprint. The organisations eligible for membership, subject to signing up to this agreement, are set out in Appendix 1.

In order that the system may performance manage itself to achieve its objectives, there is a requirement for organisations to give Board/Governing body approval for their organisations to be collectively supported to deliver and to be held to account for that delivery by the system governance arrangements. Whilst their agreement cannot be legally enforced, commitment to this level of mutual accountability is essential, particularly in advance of any challenging circumstances arising.

In order to minimise external intervention, there is considerable advantage to the system of sign-up by regulators to a system-wide plan and accountability arrangements, so that they can have confidence in the system delivering without their intervention. It is therefore proposed that regulators are similarly requested to sign up to a similar commitment.

The organisations therefore agree by their signature to this MoU to the following Partnership Statement:

> *The Partners in The Black Country and West Birmingham STP agree that there is considerable benefit to joint working arrangements that put our patients and service users at the heart of everything we do.*
>
> *We accept that the sustainability challenge is of a scale that will require significant change in order for these to be addressed.*
>
> *Some of the changes may require any of our organisations to enact developments that, whilst demonstrably improving delivery across the*

system, may be suboptimal to a member's organisation. We commit to making such changes where these deliver the STP overall objective of sustainability of the system in the knowledge that none of our organisations will be able to achieve optimal outcomes for patients, service users, carers and families unless the whole system is enabled to function optimally.

We agree to provide the appropriate attendance to support the membership of Partnership, to hold each other to account to deliver our elements of the system plan, and to support and accept support from our fellow Partners to achieve our objectives.

We agree that this function shall be exercised both collectively and by the appointed STP Lead.

2. Partnership Values

The Sustainability and Transformation Plan relationship will be based on:

- Securing beneficial impact for the population of the footprint, and for others accessing footprint services
- Collaborative Leadership & Decision Making
- An inclusive process across the NHS and Local Government
- Engaging clinicians, practitioners, and staff delivering NHS funded care
- Equality of status between all Partner organisations (subject to the respecting of each organisation's differential rights and responsibilities as determined by statute)
- Mutual respect and trust
- Open and transparent communications
- Co-operation and consultation
- A commitment to being positive and constructive
- A willingness to work with and learn from others
- A shared commitment to providing effective and efficient services to the population of The Black Country and West Birmingham
- A shared commitment to deliver parity between mental and physical health care

- A desire to make the best use of resources across the NHS and local government.

3. Partnership Outcomes

- Service delivery will be quality and outcomes focused, prioritising patient/user care and experience by working towards an improvement in health and well-being and a reduction in health inequality.

- The work of the STP needs to be led by health and care clinicians and other professionals, focused on the development of a strategy that targets material improvements in areas of care highlighted in the STP's draft proposals and in NHSE's 2017-21 delivery plan.

- Partner organisations share a common vision and values, whilst understanding the scope of their individual obligations to ensure commissioning ambitions, service delivery and intentions of each of the organisation are accounted for.

- The Model of Care within our system will be transformed to achieve sustainable health and care systems within The Black Country and West Birmingham, mindful also of the impact of plans on neighbouring systems.

- Developing high quality and efficient place-based systems of care will be a prime focus of our work programme. We recognise that the definition of 'place' will differ between services. For the majority of services, 'place' may equate to our four Local Authority areas (each with its own subsidiary 'places' – neighbourhoods/localities of c.30,000-50,000 population) but, for more specialist services, 'place' may be the whole footprint (or even multiple STP footprints) where there is evidence that providing services to larger populations supports the delivery of safe, effective and sustainable care.

- Primary Care provision will play a key role in the design and delivery of the emergent new models of care, and mechanisms to secure the involvement of non- statutory body providers must be developed.

- Our plan will deliver financial and performance improvement from year one.

- Partners recognise that achieving financial sustainability for health and care services in the long term may differentially impact individual STP organisations. Where this results in short term financial pressures for one or more individual organisations, Partners will work together transparently to support the identification and/or implementation of local actions that mitigate short term pressures and that avoid, where possible, the emergence of unsustainable and unplanned long term pressures.

The STP recognizes, however, that it has no direct control over Partner finances but will simply facilitate collaboration between Partners to create whole-system benefit.

4. Partnership Behaviours

- We agree to work collaboratively at pace to successfully develop and deliver a system plan for the STP

- We will identify where it is mutually beneficial to share information to advance an evidenced individual and/or system benefit, and to do so on the basis that the information requested is reasonable for the purpose only, and not excessive. Where information is shared, it is agreed that it will be used for the stated purpose only

- We will demonstrate, through our positive and proactive and inclusive manner, a willingness to make the Partnership succeed

- We will communicate openly about major concerns, issues or opportunities

- We will demonstrate transparent communications in terms of delivery of STP plans and notification of any quality or financial organisational concerns, including mitigation planning

- We will share information , experience and resource, to work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost

- We will adhere to statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, data protection and freedom of information

- We will act in a timely manner, developing robust plans that take full account of governance, assurance, procurement and democratic accountability processes, and will seek to respond promptly to requests for information from such processes

- We will learn from the best practice of Partner organisations and will seek to develop as a Partnership to achieve the full potential of the relationship

- We will work collaboratively on all aspects of our work, seeking to release resource to focus on transformation and adopting an approach based on doing things once together (i.e. one plan for everything we do – trusting others to act on our behalf and on behalf of the system)

- We will publish operational plans and performance data including waiting times, sharing strategic plans, headline contract values and CIP plans

- We agree that challenge will be required in the system and parties will on occasion take different views. All parties agree that where possible we will aim to resolve issues of difference between organisations professionally and privately

- We agree not to take pre-emptive public action on any matter that may result in a public disagreement between Partners

- We agree that the right thing to do is to take costs out of system and therefore we will not engage in activities that primarily aim to transfer deficits

- We will require programme leads to be responsible for assuring and mitigating the commercial conflict of involvement in the wider redesign programmes

- We will develop our workforce to enable people to deliver the objectives requested of them from the STP

- We agree to cascade within our own organisations these values, behaviours and work programmes, leading by example

- We agree to challenge one another in an open and measured manner when there are matters on which we disagree

- To ensure the robust and timely delivery of agreed STP plans, Partners agree to the use of peer review processes within the STP, providing mutual assurance about the effective contribution of each Partner. These processes will adopt an 'open book' approach with confidentiality safeguards where the information to be shared is commercially sensitive.

Appendix 1: Eligible Partnership Organisations

- Black Country Partnership NHS Foundation Trust
- Dudley Metropolitan Borough Council
- Dudley Group NHS Foundation Trust
- Dudley and Walsall Mental Health Partnership NHS Trust
- NHS Dudley Clinical Commissioning Group
- Sandwell Metropolitan Borough Council
- Birmingham City Council
- Birmingham Community Healthcare NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- NHS Sandwell & West Birmingham Clinical Commissioning Group
- Walsall Metropolitan Borough Council
- Walsall Healthcare NHS Trust
- NHS Walsall Clinical Commissioning Group
- Wolverhampton City Council
- Royal Wolverhampton NHS Trust
- NHS Wolverhampton Clinical Commissioning Group
- West Midlands Ambulance Service NHS Foundation Trust
- NHS England (Specialised Commissioning).

Schedule Four – Black Country and West Birmingham Partnership Board Terms of Reference

1. Introduction

The Partnership is established in accordance with "Next Steps on the NHS Five Year Forward View" and the MoU between the Partners of The Black Country and West Birmingham STP. These terms of reference set out the membership, remit, duties and responsibilities of the Partnership. The Partnership will review its terms of reference annually.

2. Role:

The purpose of the Partnership is to bring together the statutory providers and commissioners of health and care services in The Black Country and West Birmingham to oversee the development and delivery of plans that will keep people healthier for longer and integrate services around the patients who need them most. To enable this, the Partnership recognizes the need to proactively engage with other significant elements within the local health and social care system, including through their attendance at Partnership Board meetings.

The objectives of the Partnership Board are to:

- Plan services across The Black Country and West Birmingham that are safer and more effective because they link together hospitals so that staff and expertise are shared between them
- Engage front-line clinicians in all settings to drive the real changes to the way care is delivered
- Determine the priorities of the Partnership
- Ensure alignment with Operating Plans
- Ensure that the findings from JSNA inform Partnership plans and strategic objectives
- Identify and ensure the delivery of strategic redesign work streams
- Ensure that Partners fulfil their statutory requirement to consult and engage with patients, public and stakeholders with regard to strategic and local commissioning plans and service changes
- Ensure that the equality and diversity implications of commissioning services and clinical/professional developments are properly considered and acted upon
- Monitor and review commissioning strategies, joint working arrangement, plans and

redesign work streams and their respective implementation.

3. **Membership:**

The voting members of the Partnership shall be the nominated single representatives of each Partner organisation that is a signatory to this MoU. Additionally, voting rights shall also apply to the STP Lead, the STP Professional Chair and the lay member/non-executive director nominated by the Chairs of NHS provider Trusts with Partner status.

The Partnership Board may agree that non-voting members may be in attendance at its meetings to contribute to its discussions where relevant and appropriate. In particular, the Partnership Board will, as a priority, identify how Primary Care should be represented (e.g. via established Federations of a certain scale or via LMC or RCGP representation). In addition, single representatives of NHSE/NHSI (in their regulatory capacity), Healthwatch, the voluntary sector, the Leadership Centre and The Strategy Unit will normally be in attendance.

Those leadings aspects of the Partnership's work will be invited to attend as required by the STP Lead.

Meetings of the Partnership Board will not normally take place in public since responsibility for engaging with the public and providing opportunities for questions to be raised remains with the Boards of statutory NHS partners and through existing Local Authority mechanisms.

4. **Quorum:**

The quorum for Partnership Board meetings shall be at least one third of the eligible membership including the following:

- Either the STP Lead or the Professional Chair
- At least one representative from each of the stakeholder groups
    - NHS provider Trusts (acute, community or mental health)
    - Local Authorities
    - NHS Clinical Commissioning Groups
- At least one representative from each of the four Black Country areas (who may be coterminous with the above representatives).

Where members are unable to attend a meeting they must arrange for their named and duly authorised representative to attend in their place.

If a member should be required to leave prior to the conclusion of the meeting, the Chair should confirm whether the meeting is still quorate. If the meeting is no longer quorate, it may continue but any decisions would have to be ratified at the next meeting or, where the Chair judges this would cause undue delay, by email.

Partnership Board decisions may be effected via email – either in the case of inquoracy or other urgent circumstance (at the discretion of the Chair) provided that:

- The Chair sets out the rationale for acting outside of an ordinary meeting;
- Those Partners participating in the email exchange and consenting to the decision would constitute a quorum for a physical meeting;
- The decision is reported to the next meeting and its ratification is minuted; and
- Email responses by Partners are copied to all members of the Partnership Board and form part of the papers for the next meeting of the Partnership.

5. Conflicts of Interest

The Partnership shall establish a register of interests for both voting and associate members.

At the beginning of each meeting, the Chair will ask all Partners and other attendees to declare if they have any conflicts of interest in any matters to be discussed. The Chair will determine how any declared conflicts will be managed during the meeting.

6. Voting:

It is desirable that Partnership Board decisions are made on the basis of a consensus amongst all Partner organisations present at the meeting.

Where it is evident to the Chair that such a consensus does not exist then decisions shall be taken on the basis of a simple majority (indicated by a show of hands). The rationale of those opposing the decision shall be recorded in the minutes.

Where a lack of consensus may adversely impact the delivery of STP plan (or in other cases at the discretion of the STP Lead), the dispute resolution approach set out in the MoU shall be invoked by the STP Lead.

Partnership decisions constitute the consensus or majority view of Partners in relation to the matter in question. They do not and cannot bind the action of Partner organisations' existing governance mechanisms.

In the case of a Local Authority that is a signatory to the MoU, the Partnership recognises

that there may be occasions on which voting on a Partnership decision may be in conflict with an Authority's statutory rights and responsibilities (for example, in relation to public consultation and the right of referral to the Secretary of State). Local Authority Partners shall have the right to determine when such circumstances exist and, in such circumstances, to exempt themselves from a Partnership decision.

7. **Chair:**

The STP Independent Chair shall Chair the Partnership meetings. Where the Chair is not available the STP lead will chair the meetings.

8. **Secretary:**

A named individual will be responsible for supporting the Chair in the management of the Board's business and will be responsible for:

- Preparation of the agenda in conjunction with the Chair
- Circulating the agenda and papers to Partners in advance of the meeting at least 5 working days in advance;
- Minuting the proceedings and resolutions of all meetings of the Partnership Board, including recording the names of those present and in attendance, and details of any conflicts and how they were managed;
- Circulating draft minutes to all members of the Partnership Board within 5 working days;
- Keeping a record of matters arising and issues to be carried forward; and
- Advising the Board on pertinent areas.

9. **Frequency and notice of meetings:**

Partnership Board meetings will normally take place monthly.

No unscheduled or rescheduled meetings will take place without members having at least one week's notice of the date. The agenda and supporting papers will (save in exceptional circumstances) be circulated to all members at least three working days before the date of the meeting.

10. **Partnership Infrastructure:**

In order both to develop plans for consideration and approval by the Partnership Board and to oversee the

implementation of plans agreed by the Partnership, an appropriate infrastructure needs to be established and resourced. That infrastructure shall be directed by the STP Lead and shall be accountable to the Partnership Board.

The Partnership infrastructure is formed of care-focused programmes and function-based Working Groups (see diagram below). The driving force for Partnership Board proposals should be the work of the professionally-led, care-focused Workstreams but those proposals, as they emerge, will need to be reviewed from the perspective of the function-based Working Groups. This is intended to ensure that, by the time proposals are considered by the Partnership Board, they have been well tested. The STP Lead may also draw on additional mechanisms, internal or external to the STP, to assess the appropriateness and robustness of emerging proposals.

The STP Partnership Board shall from time to time, agree a set of work programmes, projects and workstreams that will comprise the work of the STP.

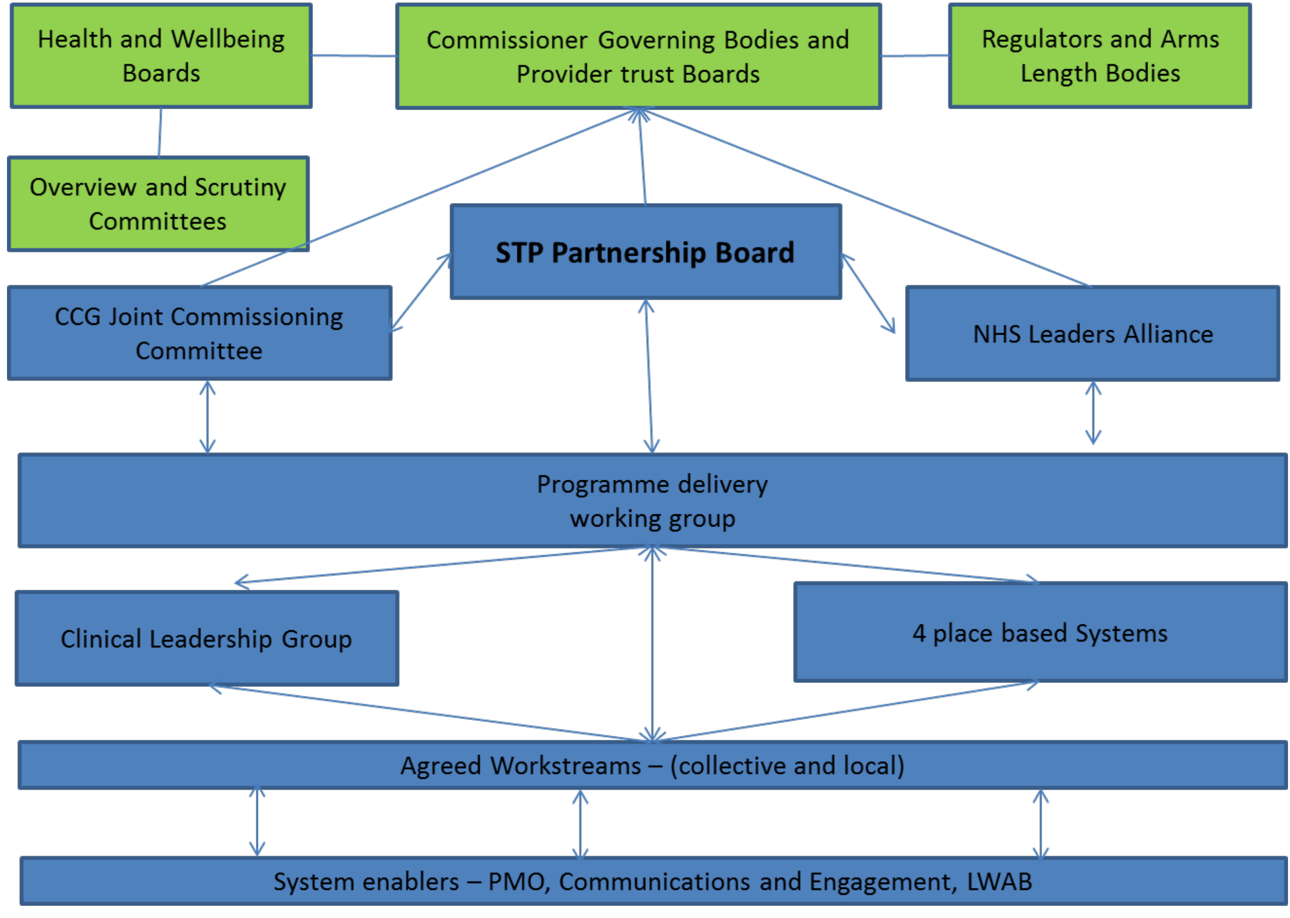
Each work programme, project and workstream shall have a project mandate and project brief which will be signed off by the programme delivery working group with performance, progress and risks and issues reported and mitigated monthly. A summary report will be presented to the STP Partnership Board. Areas off track will be escalated for discussion and intervention by the STP Partnership Board.

For agreed proposals which have been approved by the Partnership Board, delivery will be coordinated by the relevant Work programme lead, working closely with the affected system Partners. Progress will be reported to and monitored by the programme delivery working group

The role and remit of these groups is summarised below. All programmes / projects and workstreams are responsible for drafting their own detailed mandate, brief and terms of reference (a standard framework will be provided) which will need approval and sign off by the Partnership Board.

Once proposals are approved by the Partnership Board, delivery is to be coordinated by the relevant Workstream, working closely with the affected system Partners.

The Black Country and West Birmingham STP Governance



The role and remit of these groups is summarised below. Groups are responsible for drafting their own detailed terms of reference for approval by the Partnership Board.

Partners recognize that accountability for place-based work sits with local governance mechanisms. Each Partner comes to the Partnership with multiple existing commitments to other bodies and needs to be conscious of this in Partnership discussions.

a) The role of the Programme Delivery Working Group is to:

i) Ensure that for every programme/work stream approved by the STP Partnership Board there is a defined programme/project plan supports timely delivery of the specific programme and the delivery of the Five Year Forward View priorities and support the achievement of improved health and wellbeing, better outcomes and experience of care for patients, and the financial sustainability of the STP.

ii) Oversee the delivery of proposals approved by the Partnership Board and all relevant Partners/external authorities.

iii) Develop systems for monitoring key performance indicators across the STP, as agreed by the Partnership or as otherwise required by regulators, including but not limited to A&E, RTT and Cancer performance. The Group will provide leadership, strategic advice and guidance.

iv) Make regular reports to the Partnership on performance related issues, including regular analysis of activity to plan, providing corrective actions, short-term improvements against quality and performance standards and mitigation where necessary.

v) Develop and monitor a programme plan for the work of the Partnership, ensuring that the activities of Workstreams and Working Groups are well aligned.

vi) Advise the partnership on progress against the plan, highlighting exceptions and proposing mitigation (in collaboration with the relevant Workstream).

vii) Develop and manage a risk register for the Partnership's activities.

viii) The executive lead of the Performance and Delivery Group will act as Portfolio Director for the STP.

b) **Clinical Leadership Group (CLG)**

The role of the CLG is to provide clinical leadership to the Partnership, ensuring that it develops robust proposals that are safe and effective, that align with the evidence base

and that are clinically sustainable. The CLG's work will also inform the work of the CCGs' joint committee - the Black Country and West Birmingham Commissioning Board. Specifically, CLG will:

a. Identify priority areas for the STP to consider;

b. Identify and support a network of clinical champions to provide senior clinical advice to STP Workstreams in developing models of care or other interventions impacting clinical services;

c. Provide assurance about the proposals developed by Workstreams, including advising on the need for external review of proposals. As part of this, CLG will be guided by, and promote the use by Workstreams, of the Clinical Assurance Framework developed by the West Midlands Clinical Senate;

d. Ensure that clinical colleagues across The Black Country and West Birmingham (and, where relevant, in wider networks) are kept informed about the work and are engaged in that work as appropriate; and

e. Work with clinical colleagues to support the implementation of STP plans following all necessary approvals.

c) **STP Core Team**

The co-ordination of STP activities is the responsibility of the STP Lead supported by a Core Team formed of the Portfolio Director, PMO staff and programme / project management leads from the Transformation Works treams.

d) **Workforce Group**

The role of the Workforce Group is to:

a. Assure the quality and sustainability of the future workforce implicit or explicit in Workstream proposals.

b. Ensure that Partner organisations are aware of the workforce matters that may have an impact on them, and organisational actions required.

c. Make proposals about the more efficient use of the workforce and/or the training and recruitment needs of the STP.

d. Liaise with educational providers (Health Education England, Universities, Colleges, Schools, Leadership Academy, etc.), regionally and nationally, to influence supply of future workforce capability/skills.

e. Identify and manage workforce related risks.

The Group will liaise closely with the Local Workforce Action Board (LWAB) that has two areas of responsibility detailed within the terms of reference:

a) Supporting STPs across broad range of workforce and HR related activity
b) Local delivery of HEE mandate and strategic priorities affecting STPs

The LWAB role is to:

- Agree the workforce work programme to support STPs
- Oversee implementation of the work programme
- Engage with local and national stakeholders to co-ordinate inputs from both HEE and other STP member organisations.

The LWABs will develop 4 key products as part of the Sustainability and Transformation plan/partnership, these are:

- A comprehensive baseline of the NHS and care workforce within the STP footprint and an overarching assessment of the key issues that the relevant labour markets(s) present. This will describe the workforce case for change.
- A scenario based, high level workforce strategy that sets out the workforce implications of the STP's ambitions in terms of workforce type, numbers and skills, including leadership development
- A workforce transformation plan focused on what is needed to deliver the service ambitions set out in the STP.
- An action plan that proposes the necessary investment in workforce required to support STP delivery, identifying sources of funds to enable its implementation.

e) **Finance Group**

The role of the Finance Working Group is to:

a. Provide leadership, strategic advice and guidance for the financial delivery of the Sustainability Transformational Plan (STP). This will include the provision of

director level advice and support to the programme.

b. Ensure that the strategy is fully costed, that its impact on the wider health and social care system is modelled and understood and that it meets the requirements to deliver a financially sustainable health system. This will be set out in a Strategic Financial Framework (StFF).

c. Provide assurance about the financial sustainability of proposals developed by the Workstreams.

d. Manage the financial resources committed to the programme by Partners, including the procurement of external advice and support.

f) **Organisational Development Group**

The role of the Organisational Development Group is to support the development of the Partnership and its ways of collaborating.

g) **Communications & Engagement Group [?]**

The role of the Communications & Engagement Group is to:

a. Ensure that Partner activities are coordinated and aligned in relation to the work of the STP, and that Partners discharge their statutory duties in relation to STP proposals;

b. Advise the Partnership Board and its Workstreams on communication and engagement matters including in relation to media management and public consultation requirements.

h) **Equality & Diversity Group**

The role of the Equality & Diversity Group is to ensure that equality & diversity considerations are included in the development of STP plans, and to facilitate collaboration between Partners, where appropriate, in the discharge of their statutory duties in relation to STP proposals.

Schedule Five – Resourcing [review with Helen]

It is expected that delivery of the STP objectives is seen as the core business of each member organisation, and each will therefore commit in-kind resources to deliver of the STP objectives without recourse for additional resource to the system.

For the Partnership's initial phase, key personnel have been identified as indicated in Section Ten of Schedule Four, above. This includes both the senior leaders sponsoring a Workstream and management personnel who are dedicating an agreed element of their working time to the STP. It is expected that these persons will serve on an in-kind basis pending a review of resourcing in April 2018.

The Partnership Board may, from time to time, agree that system objectives cannot be delivered as described above, and that some additional resourcing is required to be deployed for system benefit. In such circumstances Partner organisations are expected to contribute in a way that is considered fair and proportionate. This will be agreed on a case by case basis as need arises.

Schedule Six – Engaging external resources

Circumstances may arise from time to time whereby the system requires expert external advice or services that are either not available to be sourced from a partner member, or are required for purposes of independence.

Such resources will only be commissioned by agreement of the Partnership Board or by the STP Lead or other officer duly delegated to commission such advice or services.

Where this is the case, to provide the necessary assurances to member organisations regarding value for money and probity, proper procurement process will be followed as set out in the SFIs and SOs of the organisation most appropriate to commission the advice or services.

Schedule Seven – Risk Register

To Be Developed..

Schedule Eight – STP Programme Plan

This is the road map and delivery plans for priority work programmes.

MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018			
Partnership Update November 2018			**AGENDA ITEM: 16, ENC 14**
Report Author and Job Title:	Daren Fradgley Director of Strategy and Improvement	**Responsible Director:**	Daren Fradgley Director of Strategy and Improvement
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	This paper updates Board Members on the key partnership working undertaken this month. This includes the following • Primary care MDT's • Estates Challenges • Walsall Together Digital Strategy • Intermediate Care Service		
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 ☒		

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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. PRIMARY CARE MDT'S

The locality teams are continuing to build positive relationships with Primary Care to enable the MDT meetings to take place. In the last few weeks another 4 practices have come online with monthly MDT's and to date, a further practice is planned to start in December 18. The table below shows the trend over the last few months.

Covered by GP Led MDT's				
	Aug	Sep	Oct	Trend
% Total Practices covered	12%	17%	23%	
% Population covered	13%	16%	25%	

As part of this programme of work, the newly appointed MDT coordinator is now building a series of outcome metrics for the complex cases that are being discussed in these MDT's to demonstrate how effect they are.

Conversations have now started with partners to understand what the next steps are for the smaller practices who will not be able to join the MDT's regularly. Equally this is an important piece of diagnostic work for the Walsall Together Partnership as it is widely accepted that not all practices can have a bespoke MDT each month – this is manly due to the amount of resources required does match the capacity of the teams.

2.1 ESTATE CHALLENGES

A piece of work has been commissioned by the provider board to understand the colocation issues that are a result of our estate capacity issues. This work has been focusing on how the partnership can get a dedicated team site in each of the four localities. In summary, this work has highlighted that options exist to reconfigure some of the teams to achieve co location in the North and West Localities. Action is now being taken to enable this. The East locality has a variety of options, most of which are more complex and involve multiple site moves, some of which are not currently in use. This will be explored over the next few months with a firm plan being developed for the end of Q4 2018/19. The final locality, however, is much more complex and no firm options are currently available. The provider board has asked for the partners to reach out through their networks to provide feedback in January of potential next steps.

In support of this work, the combined local authority through a regional piece of work are looking to establish transformation projects for the future based on the principle of one public sector estate where possible. To compliment this, the Walsall Together Partnership have requested that a model locality hub with options for a public facing services is designed and scoped out. This will be complete in preparation for any national funding that is expected in 2019/20.

2.2 WALSALL TOGETHER DIGITAL STRATEGY

As part of the Walsall Together planning work it has become very clear that one of the key enablers and more importantly, barriers at the current time is the lack of a single care record. This has been highlighted at every clinical workshop and in most of the current project teams supporting the Walsall Together work.

It is clear that this strategy not only needs to look at how the partnership deploys a single care record but more importantly how it is accessed and stored within the associated systems. The output of this work will be present in the WT final business case and is complemented by the current EPR review process that the Trust is undertaking.

3. INTERMEDIATE CARE SERVICE

The Performance, Finance and Investment Committee this month heard from the Intermediate Care Leadership how the average length of stay for patients requiring supportive discharge is falling month on month. Whilst this is a successful measure in its own right, the total number of patients waiting for discharges from the Trust has risen slightly too circa 100.

The committee heard that additional actions need to be taken both within the pathways for the winter months of January to March and also the way in which the Trust Therapy Services work within these pathways. A joint leadership post in this service is proving difficult to resolve at the minute but actions are now being taken to move this forward.

Finally, the committee heard that the next steps for this service will be collective understanding of the consequence of service reconfigurations across the system. This will clearly be a key domain for the Walsall Together Board as the wider system thinking and effects mature.

4. RECOMMENDATION

Board members are asked to NOTE the information within this report

Daren Fradgley
Director of Strategy & Improvement
28th November 2018

MEETING OF THE PUBLIC TRUST BOARD – 6 December 2018			
Risk Appetite			**AGENDA ITEM: 17, ENC 15**
Report Author and Job Title:	Jackie White Interim Trust Secretary	**Responsible Director:**	Jenna Davies Director of Governance
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The UK Corporate Governance Code states that 'the Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives'. Risk Appetite is defined as 'the amount of risk the organisation is prepared to accept, tolerate, or be exposed to at any point in time.' It allows the Board to take considered risks and to seek assurance that risks of any grade in areas of low tolerance are being managed, rather than focussing predominately on high rated risks. The Board has previously considered and provided feedback on the statements as part of the Board development session and at the Trust Board meeting held on 6 September 2018. The feedback from these sessions has been incorporated into the enclosed report and proposed statements. In addition each of the Board sub committees have considered and recommended approval by the Board of their risk appetite.		
Recommendation	Members of the Trust Board are asked to: 1. Approve the Risk Appetite Statements		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.		
Resource implications	There are no resource implications associated with this report.		

Legal and Equality and Diversity implications	To ensure the Trust complies with recommended good governance practice.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

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RISK APPETITE

1. PURPOSE OF REPORT

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

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

2. BACKGROUND

The Board has previously considered and provided feedback on the statements as part of the Board development session and at the Trust Board meeting held on 6 September 2018.

The Board requested that each of its sub committees reviewed the suggested risk appetite statements and made a recommendation back to Board once considered.

3. DETAILS

Risk Appetite is defined as ‘the amount of risk the organisation is prepared to accept, tolerate, or be exposed to at any point in time.’ It allows the board to take considered risks and to seek assurance that risks of any grade in areas of low tolerance are being managed, rather than focussing predominately on high rated risks.

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

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

The methodology for developing the Trust’s risk appetite statements has been comprehensive. A Board Development session on risk appetite was held during the summer. At the development session the Board agreed that we would develop risk appetite statements for each one of our organisational priorities, instead of a high level overarching statement. The draft statements were developed at the session and further

challenge and exploration of each statement has taken place at each of the Board Sub Committees. The appended statements have been agreed through each of the Board Committees.

As part of the process for developing the risk appetite statements, the Board has considered the value of having an overarching risk appetite statement. We have agreed that given the Trust current position with the financial and quality challenges that an overarching statement would dilute the importance of these issues and manging the risks associated

Whilst the recommendation is for the Board to agree the risk appetite statement it is important to note that the risk appetite statements may change as a result of changes in the strategy and operating environment and it is recommended that when developing the strategy, the board agree their appetite or tolerance for individual key risks.

4. RECOMMENDATIONS

Members of the Trust Board are asked to:

1. Approve the Risk Appetite Statements
2. Approve the overall risk appetite statement

APPENDICES

Risk appetite statements

Provide Safe, high quality care across all our services	Continue our journey on patient safety and clinical quality through a comprehensive improvement programme	The Trust is committed to delivering high quality services provided to patients and we will seek to implement a low appetite for taking risks that will compromise quality, patient safety or affect the experience of our service users
Use resources well to ensure we are sustainable	Improve our financial health through our robust improvement programme	The Trust is prepared to accept a moderate risk appetite on finance where this would impact on patient safety. The Trust will accept a low appetite for enhancing quality or patient safety beyond safe levels to the detriment of its financial stability. The Trust will ensure all decisions taken are aligned to our principle of ensuring good use of resources.
Work closely with partners in Walsall and surrounding areas Care at home	Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts	The Board is prepared to accept a high risk appetite on the development of integrated pathways across partner organisations to deliver sustainability. It has a moderate risk appetite on development of technology driven improvements and on sustainability to deliver the Trust vision.
Value our colleagues so they recommend us as a place to work	Develop the culture of the organisation to ensure mature decision making and clinical leadership	The Trust aspires to having a zero risk appetite for any behaviours or actions that damage or compromise our Trust values. Specifically working to reduce the current areas of risk such as bullying and harassment, improving inclusion, staff engagement and experience and confidence to speak up. The Trust aims to reduce the current levels of risk to patient and staff experience by reducing the resourcing risks in the Trust and risks to staff health and wellbeing. To foster a healthy organisational culture where Colleagues feel valued and recommend us as a place to work and a place for treatment. The Trust will have a moderate risk appetite for risks associated with building new workforce models for future

		service sustainability reasons.

MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018			
Board Assurance and Corporate Risk Register Report			**AGENDA ITEM: 18,** **ENC 16**
Report Author and Job Title:	Jackie White, Interim Trust Secretary	**Responsible Director:**	Jenna Davies, Director of Governance
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	The Board Assurance Framework (BAF) has been updated in line with the 2018/19 annual objectives. This paper provides a summary of the developments aligned to the Trust's strategic objectives There are currently 11 BAF and 19 Corporate level risks recorded onto the Safeguard risk management system. There has been no change in the risk score of the strategic risks since the previous report. A comprehensive review of the Corporate Risk Register was undertaken during Quarter 2 and this report is reflective of that status. A robust monitoring and improvement programme will commence during Q3 to ensure the Trust Board receives the appropriate oversight and assurance on a quarterly basis. Each of the BAF risks have been reviewed in detail at each of the Board Sub-committees. The overall BAF and the CRR have been added to the reading room for reference.		
Recommendation	Members of the Trust Board are asked to approve the new BAF and note the Corporate Risk Register progress and development.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risk implications are identified within the document.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper."		

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

Board Assurance Framework 2018/19 and Corporate Risk Register

1. PURPOSE OF REPORT

The purpose of the report is to present the current Board Assurance Framework and provide details of the Corporate Risk register in relation to progress of risks and associated actions.

2. BACKGROUND

The Board Assurance Framework (BAF) forms the strategic risk register of this organisation. Strategic risks are recorded on the corporate risk register and managed in the same way as other risks, but are raised and accepted by the Trust Board to determine adequacy of assurance and controls measures to effectively minimise these risks to acceptable levels.

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

Members should note that the BAF has been input onto the Trusts risk management system SAFEGUARD and therefore the format of the report will appear different to previous reports. As this is the first time the risk management system has been used there has been some technical difficulties in aligning the correct fields and the Risk Manager has been working with the provider in order to rectify these issues. Unfortunately some of these technical difficulties still appear in the report on this occasion but will be rectified by the next report.

3. DETAILS

3.1 Board Assurance Framework (BAF)

The attached Board Assurance Framework is presented to show the breadth of risk identified together with the current mitigations and sources of assurance. Further to this, it describes the actions being taken to reduce these risks to the delivery of our Strategy.

There are currently 11 strategic risks included within the BAF, of which 2 risks have a score > 15.

- *BAF006 - Effective resourcing - If the trust does not have a robust plan in place for recruitment and retention then there will be staff shortages (Score 20)*
- *BAF002 Failure to achieve financial plans as agreed by the Board and communicated to NHSI (Score 15)*

One new risk has been added since the last report – *BAF011 - IM&T systems do not meet the requirements of the organisation. This has been graded as 12*.

The Safeguard risk management system was updated in October 2018 to include the BAF risks and will be effectively monitored and updated as appropriate. The progress and movement of Corporate and BAF risks will be detailed in future reports.

The Executive Lead for each BAF risk has reviewed the controls and reported assurances, however there have been no new BAF risks added to the register or movement in risk scores since the last report.

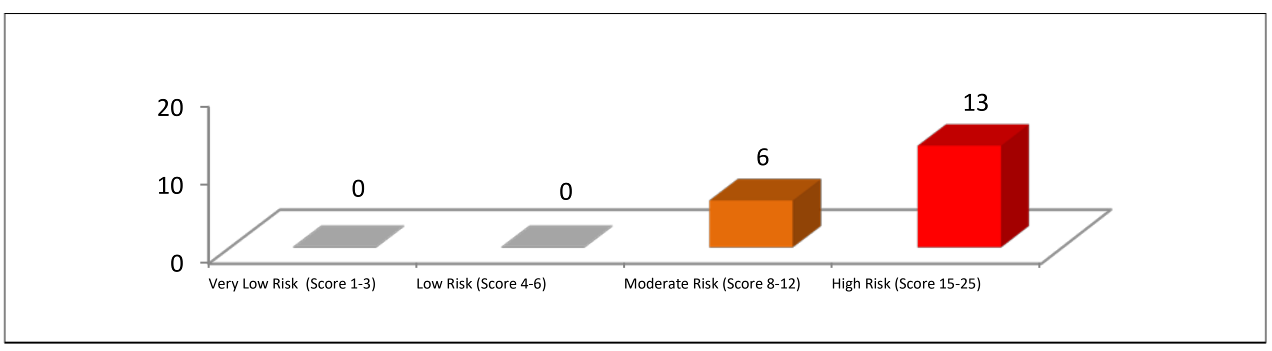
A dashboard is shown on the front of the Board Assurance Framework (Appendix 1) illustrating the current status of each risk with subsequent summaries for the individual risks detailing the assurance and controls in place.

A robust monitoring and improvement programme will commence during Q3 to ensure the Trust Board receives the appropriate oversight and assurance on a quarterly basis. In the interim reporting periods, it is proposed that the establishment and re-focus of a Risk Management forum will oversee the Corporate and BAF level risks with particular focus on sources of assurance and mitigation.

3.2 <u>Corporate Risk Register</u>

A comprehensive review of the Corporate Risk Register was undertaken during Quarter 2 and this report is reflective of that status. It was identified that a total of 16 risks should be de-escalated for lower tier level management.

There are currently 19 accepted risks on the Corporate Risk Register and the risk profile is shown below.



3.3 New Risks added to the Corporate Risk Register

Risk No.	Risk Description	Risk Score
1524	Failure to comply with professional standards of clinical record keeping which may impact on quality of care and patient safety	16
1572	Failure to adequately assess and record VTE assessments impacting on the Trust compliance with national standards	12
1573	The Trust is currently has in terms of procedural documents. There is limited corporate oversight, and quality assurance.	12
316	The Trust sets compliance rates for mandatory training at 90%. Historically this target has been inconsistently met impacting on compliance rates and staff learning	12

3.4 Reporting and assurance

The Corporate Risk Register and BAF reports will be presented to the Board on a quarterly basis to provide assurance and mitigation and the identification of emergent risks when appropriate.

Following the recent Internal Audit report, recommendations and actions have been agreed and will be progressed to ensure there is a much more robust approach to risk management, underpinned by the implementation of risk reporting to all governance committees across the organisation and enhanced training provision.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note and accept the Corporate and BAF risks and their respective progress.

The complete Corporate Risk Register and BAF have been made available within the reading room.

MEETING OF THE TRUST BOARD – Thursday 6th December 2018			
Update to the Standing Financial Instructions and Scheme of Delegation			AGENDA ITEM: 19, ENC 17
Report Author and Job Title:	Jackie White Interim Trust Secretary Jenna Davies Director of Governance	**Responsible Director:**	Jenna Davies Director of Governance / Russell Caldicott Director of Finance & Performance
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The Trust is required to review its Standing Financial Instructions (SFIs) on an annual basis to ensure it continues to adhere to best practice guidelines and takes account of any recently issued guidance or documentation. A detailed review has been completed and a summary of the changes are listed in the attached report. The changes have been approved by the Audit Committee and are recommended for approval by the Trust Board.		
Recommendation	Members of the Trust Board are asked to approve the amendments to the Standing Financial Instructions following recommendation from the Audit Committee.		
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 (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Update to the Standing Financial Instructions and Scheme of Delegation

1. PURPOSE OF REPORT

The purpose of the report is to provide the Trust Board with a summary of the changes which have been identified as part of a detailed review of the SFIs which has been carried out during the financial year of 2018/19.

The proposed changes to SFIs are summarised in the sections below. An updated version of SFIs has been uploaded to the Reading Room.

2. BACKGROUND

The Trust is required to review its Standing Financial Instructions (SFIs) annually. The Board's Standing Financial Instructions (SFIs) and Scheme of Delegation were last reviewed, updated and approved by the Board in February 2016.

A full review of the SFIs has now been completed and the proposed changes to SFIs were considered and approved by the Audit Committee at their meeting on 12 November 2018.

The main changes are summarised in the sections below. An updated version of SFIs has been uploaded to the Reading Room.

3. DETAILS

3.1 General

General updates to legislation, policy changes, page numbering and job titles and roles have been made throughout the document.

3.2 Standing Orders – Section B

Section 3 – Agenda and supporting papers

"Working days" has been inserted into the agenda and supporting papers section to strengthen this section.

Section 4 – Appointment of Committees and Sub Committees

This section has been re-written to separate out statutory and mandatory committees' duties and non-mandatory committees.

Section 5 – Arrangements for the exercise of Trust functions by delegation

New paragraph inserted at 5.7 to allow urgent decision making processes (as requested by the Chair of PFIC)

Section 7 – Duties and obligations of Board members / Directors and Senior Managers under these Standing Orders

References to Fit and Proper Persons added.

3.3 Section C – Reservation and delegation of Powers

Decisions reserved to the Board - New section added - Health & Safety including approval of the Trusts Health & Safety Policy and receipt of the Annual Health & Safety report

Decisions / Duties delegated by the Board to Committees - SFI 20.1.2 – deleted the description and duties of non-mandatory committees – PFIC, Q&S, POD as these are described in the SFIs.

Scheme of Delegation from Standing Financial Instructions - amended section 21.2.7 – amended to refer to financial and estates guidance rather than specific reference to codes.

Scheme of Delegation from Standing Financial Instructions - 33.2 - Board – Risk pooling schemes - additional text added to strength this duty.

3.4 Section D – Standing Financial Instructions

Foreword removed.

Section 11 Audit – The Bribery Act 2010 and appropriate legislative text has been added into this section and clarity of roles and responsibilities with regard to the Chief Executive, Local Security Management Specialist and Director to undertake the role of the Security Management Director has been identified.

Section 17 – Tendering and Contracting – insert The Bribery Act 2012 and subsequent legislative text

Section 17 – 17.6.3 – Opening tenders and Register of tenders – section amended with changes to roles and responsibilities and changes to recording of tenders received.

Section 20 – Terms of Service, Allowances and payment of members of the Trust Board and Executive Committee and Employees – paragraph changed slightly to reflect the terms of reference for Remuneration and Nominations Committee.

Section 30 – Acceptance of Gifts by Staff and link to standards of business conduct and bribery act – the majority of this section has been deleted and staff are referred to the appropriate policy.

4. RECOMMENDATIONS

It is recommended from the Audit Committee that the Trust Board approve the changes set out above.

APPENDICES
None

MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018			
Fit and Proper Person Policy		**AGENDA ITEM: 20** **ENC 18**	
Report Author and Job Title:	Jenna Davies, Director of Governance	**Responsible Director:**	Jenna Davies, Director of Governance
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The Trust initially approved the Fit and Proper Person Policy in response to the requirements placed on NHS providers, following the introduction of the Care Quality Commission's regulatory standards for the Fit and Proper Person Requirements of directors to ensure compliance with regulation. The Policy has been reviewed in line with the Trust's Policy for the Development and Review of Policies, which requires policies are reviewed every 3 years. The Policy has been updated with the following changes • New Director Appointments procedure has been added to the policy. This will add clarity around the role of the Trust and NHSi when appointing new Non-Executive Director Colleagues • The new Director Appointment procedure also references a new values based assessment, which is in line with the Trust's new values. • Changes to the responsible Director have also been made. The Director of Governance will now be responsible for supporting the Chair of the Trust to discharge her duties under the Fit and Proper person regulations. All Board members have been consulted as part of the review and changes made accordingly.		
Recommendation	Members of the Board are recommended to discuss the content of the report and raise any questions in relation to the assurance provided.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	None		

Resource implications	There are no resource implications raised within the report.	
Legal and Equality and Diversity implications	None	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☒	

Document Title	
Fit and Proper Persons Requirement Policy	
Document Description	
Document Type	Policy
Service Application	Directors Interim appointments to the Board Designated director equivalent roles appointed from time to timed
Version Draft	1.0
Lead Author(s)	
Name	Job Title
Jenna Davies	Director of Governance

Change History		
Version	Date	Comments
1.0	24/09/2015	First Version/New Policy

Links with External Standards	
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and Proper Persons Test	
Key Dates	**DATE**
Ratification Date	
Review Date	

Executive Summary Sheet		
Document Title:	Fit and Proper Persons Requirement Policy	
Please Tick (☑) as appropriate	This is a new document within the Trust	
	This is a revised Document within the Trust	Yes

What is the purpose of this document?

To set out how the Trust will meet its regulatory requirements to ensure that all Directors and people 'performing the functions of, or functions equivalent or similar to the functions of, such a director' are, and continue to be, fit and proper persons to carry out their roles.

What key Issues does this document explore?

Appropriate systems and processes to ensure compliance with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Fit and Proper Persons provisions.

Who is this document aimed at?

All directors and people performing the functions of or functions equivalent or similar to the functions of a director:

Directors (Executive and Non-executive)
Interim appointments to the above roles
Designated Director equivalent roles appointed from time to time

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

Recruitment and Selection Policy
Employment Checks Policy
Disciplinary policy
Raising Concerns at Work (Whistleblowing) Policy

How and when will this document be reviewed?

September 2021.

CONTRIBUTION LIST

Key individuals involved in developing the document

Name	Designation

Linda Storey	Interim Trust Secretary
Mark Sinclair	Director of Organisational Development & Human Resources
Michala Dytor	Head of Human Resources Operations

Circulated to the following for consultation

Name/Committee/Group/	Date
People and Organisational Development Committee	17th September 2015
Board Nominations and Remuneration Committee	24th September 2015

Version Control Summary

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

When a document is reviewed the changes should using the tracking tool in order to clearly show areas of change for the consultation process.

Version	Date	Comments on Changes	Author
1.0	24/09/2015	New Policy	Linda Storey, Interim Trust Secretary

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1. INTRODUCTION

1.1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations") introduced a 'fit and proper person requirement'.(FPPR) The regulation applies to all Very Senior Managers (VSMs), the Trust Chairman and Non-Executive Directors [referred to hereinafter as directors]. The regulations apply regardless of contract status, whether the post is an associate position and irrespective of voting rights.

1.2 The Regulations came into force for NHS bodies, on 27 November 2014 and all care providers from 1st April 2015. Compliance with the FPPR is monitored and enforced by the Care Quality Commission (CQC) as part of the inspection regime, using specific lines of enquiry and prompts for the domains of 'safe' and 'well-led' to ensure compliance.

1.3 It is the overall responsibility of the Board of Directors of the Trust to ensure that it complies with the Regulations by not having an unfit director in place. It is the ultimate responsibility of the Trust Chair to discharge the requirement placed on the Trust to ensure that all Directors meet the fitness test and do not meet any unfit criteria.

1.4 It is the responsibility of NHS Improvement to ensure that the Non-executive Directors including the Chair meet the criteria and the Trust will contact the NHS Improvement requesting confirmation that the criteria has been met upon appointment of new Non-executive Directors..

1.5 This document outlines the Trust's commitment to ensuring that all persons appointed as directors satisfy the requirements of the regulation. The individual does not have to be an employee of the Trust to fall within the scope of this policy.

2. SCOPE

2.1 The Trust must demonstrate that it has appropriate systems and processes in place to ensure that all new appointees to, and holders of Director posts including interims, are, and continue to be, fit and proper persons.

2.2 The policy covers individuals employed or engaged in both substantive and interim capacities for the above posts.

3. STATEMENT OF INTENT

3.1 The policy objectives are:

- To define the standards for determining the fitness and propriety of individuals on appointment and on an ongoing basis (Appendix 1).
- To satisfy external regulators how the Trust is complying with the Regulations (See Appendix 2).
- To define the individuals and/or roles to which this policy applies.

- To describe the procedural steps in relation to this policy (Appendix 2).

- To outline the evidence required to demonstrate compliance with statutory obligations (Appendix 1).

4. GENERAL PRINCIPLE

4.1 What is a 'Fit and Proper Person?' – The Regulations

The Regulations place a duty on providers not to appoint a person or allow a person to continue to be a Director unless they pass the FPPR by:

- being of good character;

- having the qualifications, competence, skills and experience which are necessary for the relevant office or position or work for which they are employed;

- being able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

- having not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

- ensuring none of the grounds of unfitness set out in Part 1 of Schedule 4 apply, as specified below in section 4.2 of this policy:

- In addition the Director must supply information as set out in Schedule 3 of the Regulations and as set out below:

    - Proof of identify including a recent photograph.

    - Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997, a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request).

    - Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of the Act together with, where applicable, suitability information relating to children or vulnerable adults.

    - Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to health or social care, or children or vulnerable adults.

- Where a person has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why employment in that position ended.

- In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.

- A full employment history, together with a satisfactory written explanation of any gaps in employment.

- Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.

For the purposes of the Schedule:

'The appointed day' means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force.

'Satisfactory' means satisfactory in the opinion of the Commission.

'Suitability of information relating to children and vulnerable adults' means information specific in sections 113BA and 113BB respectively of the Police Act 1997.

4.2 Good Character and Unfit Person Tests

The purpose of the FPPR is to ensure that appropriate systems and processes are in place to ensure that all new and existing Directors are, and continue to be of good character and that no Director meets any of the unfitness criteria set out in Schedule 4 of the Regulations. This is defined in two parts: unfit persons test (Part 1, Schedule 4) and good character (Part 2, Schedule 4).

Under Part 1, Schedule 4, a Director will be deemed unfit and prevented from holding the post and/or office of a Director if:

- The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.

- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

- The person has made a composition arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.

- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Under Schedule 4, Part 2, a Director will fail the 'good character' test if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and

- Have been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

4.3 Organisational Culture: The Nolan Principles

The CQC requires Directors to set the tone and culture of the Trust so that it leads to staff adopting a caring and compassionate attitude. It is important therefore that in making appointments Directors take account of the values of the Trust and the extent to which candidates provide a good fit with those values. This policy therefore incorporates the Nolan Principles. Directors are required to promote and support these principles by leadership and example. (See Appendix 3: List of Nolan Principles).

5. PROCEDURE

5.1 New Director Appointments

5.1.1 The job description should refer to the requirement to comply with the Fit and Proper Persons requirement. This should also be included within the advert and person specification.

5.1.2 Where specific qualifications are required for a role, these must be clearly defined in the person specification and the Trust must verify the validity of qualifications as part of the pre-employment checks.

5.1.3 The recruitment process should include a values-based assessment, as this will help form the assessment as to whether candidates are of good character.

5.1.4 The interview process should include some specific questions designed to test the compliance with the key components of the Regulation.

5.1.5 'Good character' and fitness to practice should also be assessed through the pre-employment checks process in line with NHS standards. Some of these checks are undertaken by NHS Improvement and some checks by the Trust. These are set out below:

NHS Improvement (for Non Executive Directors)

- A company Director search – for any self-employed candidates etc
- Disqualified Director search
- Insolvency/Bankruptcy search
- Background checks
- Qualification checks - where applicable i.e. financial qualifications where a financial qualification is required
- 2 references for each newly appointed Non-executive

Trust (for Executive and Associate Non- Executive Directors)

- Proof of identity i.e. driving licence or passport
- DBS check
- Fit and proper person declaration forms
- Occupational Health clearance
- Detailed references to cover as a minimum the preceding 3 years, one of which must be from the most recent employer
- A full employment history (with satisfactory explanation for any employment gaps)
- Driving licence check (via Licence Bureau
- A company Director search – for any self-employed candidates etc
- Disqualified Director search
- Insolvency/Bankruptcy search
- Background checks
- Qualification checks - where applicable i.e. financial qualifications where a financial qualification is required

5.1.2 All Directors must comply with the conditions of their offer of employment/engagement as detailed in Appendices 1-3 prior to confirmation of appointment. All relevant checks will be carried out prior to final checking and an unconditional offer being made. All conditional offers will be conditional on meeting the statutory requirements.

5.1.3 A failure or refusal by a candidate for appointment to comply with any of the procedures set out in this policy will immediately disqualify that person from the proposed appointment.

5.1.4 The Director of People and Culture will notify any prospective candidate for appointment as Director soon as practicable if that person is determined to be ineligible under this policy and he shall withdraw any conditional offer of employment or engagement.

5.2 Existing Directors

5.2.1 The Trust will issue Directors with a Fit and Proper Person Test Self-declaration and Checklist Form on an annual basis as set out in Appendix 1 and the Director of Governance shall ensure that they are completed.

5.2.2 If a concern regarding an individual is brought to the attention of the Trust, an investigation will be carried out by an appropriate person/body dependent on the particular circumstances.

Where an individual's fitness to carry out their role is being investigated appropriate interim measures may be required. This may mean that an individual's duties need to be temporarily varied or closely supervised, and in some cases exclusion from duty may be warranted.

The Trust reserves the right to withhold pay at any stage during the period of exclusion if it believes that the individual is unreasonably delaying the investigation process or is in breach of the terms of the exclusion.

For individuals employed on contracts for service, the contract may be suspended, without payment of fees whilst the investigation takes place.

Where it is considered appropriate, the investigation in the case of employed Directors will follow the principles set out in the Trust's disciplinary policy.

5.3 Evidence

The CQC requires certain information to be available as evidence in respect of Directors employed or appointed by the Trust. The information required is set out in Schedule 3 of the Regulations and section 4.1 of this policy. A Fit and Proper Person Test Self-declaration and Checklist relating to this information (Appendix 1) will be completed for each Director and placed on their personal file. An annual self-declaration is required for each Director which will also be placed on the personal file (Appendix 1).

5.4 Confidentiality

All information provided by a person in accordance with this policy will be kept confidential in accordance with the Trust's confidentiality policy. However, a person seeking to demonstrate that they are a 'fit and proper person' in accordance with this policy consents to the Trust disclosing to the regulators, to the extent that it is necessary any personal information and confidential information for the purpose of undertaking the checks required by this policy and for the related purposes of this policy.

6. ROLES AND RESPONSIBILITIES

6.1 Chair

The Chair has overall responsibility for compliance with FPPR and will be required to confirm to the CQC that:

- The fitness of all Directors has been assessed in line with the Regulations; and
- Declare to the CQC in writing that they are satisfied that all Directors within the scope of FPPR have undertaken the necessary checks and meet the FPPR and are thus fit and proper individuals for their role.

6.2 Trust Board

The Trust Board is responsible for upholding compliance with this Policy.

6.3 Board Nominations and Remuneration Committee

- Review this policy to ensure it is fit for purpose.
- Receive an annual report on the application of FPPR to ensure ongoing compliance.

6.4 NHS Improvement

NHS Improvement has responsibility for undertaking checks for Non-executive directors of the Trust.

6.5 Director of Governance

The Director of Governance:

- To act as the liaison officer between NHS Improvement and the Trust in respect of the appointment process for the Chairman and Non-Executive Directors (including Associate Non-Executive Directors).
- To oversee all appointment checks for Directors and ensure the results are recorded and evidenced within an individual's file. Where checks have not been undertaken by NHS Improvement, require assurance that these checks are undertaken by Human Resources.
- To undertake an annual refresh of suitability (as outlined in Appendix B) for all Directors. This includes requesting that an annual declaration of suitability is completed by all directors annually. This should be requested in November of each year in order that the assurance of compliance can be given to the Board of Directors [the Board] each February.

To ensure that the Register of Interests is maintained and that arrangements are in place for all directors to make declarations when required.

6.6 Human Resources

The Human Resources department will

- Ensure that all pre and post-employment checks are undertaken in line with the regulation and NHS Employment Check standards for all directors and ensure the results are recorded and evidenced within an individual's file.
- Undertake an annual refresh of suitability for all directors on request from the

Director of Governance.

- Ensure that all checks are complete prior to the commencement of employment

6.6 Affected Individuals

Directors who fall within the policy are responsible for:

- The provision of their consent to the checks described in Appendix 1 upon request for the purposes of this policy.
- The signing of the self-declaration form that they are a fit and proper person on appointment, which is to be completed on an annual basis.
- The provision of evidence of their qualifications, experience and identity documents on appointment or upon request.
- The identification of any issues which may affect their ability to meet the statutory requirements on appointment and on an ongoing basis, which must be brought to the immediate attention of the Chief Executive and/or the Chairman.

6.7 Procurement

- To ensure all agencies/candidate providers understand their responsibilities and comply with the requirements of this policy. This should be evidenced through suitable contract documentation to ensure the position is clear

6.8 Agency Providers

- To ensure the necessary checks that are outlined in this policy have been undertaken for any interim staff supplied to the Trust and make those checks available as and when requested.

7. AUDIT/MONITORING ARRANGEMENTS

Compliance with this policy will be upheld and regularly monitored by the Trust Board.

Oversight and overall monitoring of the policy will be led by the Director of Governance, and an audit of the annual check of the FPPR signed self-declarations shall also take place.

8. TRAINING

The policy will be promoted via the Trust intranet for staff and through induction for new Directors.

9. DEFINITIONS

CQC = Care Quality Commission
NED = Non-executive Director
FPPR = Fit and Proper Person Requirement

10. REFERENCES

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Fit and Proper Persons Test

11. RELATED POLICIES

Recruitment and Selection Policy
Employment Checks Policy
Disciplinary policy
Raising Concerns at Work (Whistleblowing) Policy

12. APPENDICES

Appendix 1: Fit and Proper Person Test - Self-Declaration Form and Checklist
Appendix 2: Fit and Proper Person Test - Procedural Steps
Appendix 3: Principles of Conduct in Public Life: Nolan Principles

APPENDIX 1

Fit and Proper Person Test - Self-Declaration Form and Checklist

Actions: To be completed upon recruitment and thereafter annually by directors and director-equivalents

Human Resources to complete the evidence checklist set out in this self-declaration form

"FIT AND PROPER PERSON TEST"

SELF-DECLARATION FORM AND EVIDENCE CHECKLIST

It is a condition of your employment/office, as well as a CQC requirement, that those holding director and director-equivalent ("Director") posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's provider licence and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 ("the Regulated Activities Regulations").

This self-declaration requires you to provide a response against set criteria. The criteria fall into four distinct categories and assess "fitness" giving consideration to:

- Good character and the unfit person test
- Qualifications, Competence, Skills and Experience
- Health
- Serious misconduct or mismanagement in carrying out a regulated activity

You are therefore required to provide a response against each of the set criteria within 14 days of being sent this self-declaration form and, should you answer yes to any given criteria, **a full response must be given** using the spaces provided or, alternatively, by attaching a separate document.

The information that you provide in this declaration form will be processed in accordance with the Data Protection Act 1998. It will be used for the purpose of determining that you are a "Fit and Proper Person" in line with Regulated Activities Regulations and CQC requirements and a copy will be stored on your personal file.

The questions which appear in the table below must be answered upon appointment and on a yearly basis, save that DBS checks are carried out at three yearly intervals following appointment.

1. Good Character and Unfit Person Test

No.	Criteria	For completion by Director	For completion by HR
1.	Have you completed an Enhanced DBS check with Barred List information in the previous 3 years? Are you included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained in Scotland or Northern Ireland?		Recruitment Office to attach a log of when check undertaken. [NB – DBS checks are undertaken for eligible post-holders only and where required must be obtained upon appointment and at three yearly intervals. HR to confirm to the director whether a DBS check is required, and whether it is standard or enhanced]
2.	Have you been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence?		Any convictions? Y/N
3.	Are you a disqualified director?		Attach search of disqualified directors register Is it clear?
4.	Have you been involved in a Parliamentary and Health Service Ombudsman investigation or report? If the answer is yes, please attach a copy of the report.		Attach website search Is it clear?
5.	Are you an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged?		Attach bankruptcy check Is it clear?
6.	Are you the subject of a bankruptcy restrictions order, an interim bankruptcy restrictions order, or an order to like effect in Scotland or Northern Ireland?		

No.	Criteria	For completion by Director	For completion by HR
7.	Are you a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986?		Attach insolvency check Is it clear?
8.	Are you a person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it?		
9.	As a skilled professional do you hold registration/membership of the relevant statutory or professional body? If so which body?		Attach search of professional register
10.	Do you/have you had any limitations on this registration/membership or has your fitness to practice ever been subject to investigation?		Are there any conditions on registration or membership?
11.	Have you been erased, removed or struck-off a register of professionals maintained by a regulator of health care of social work professionals?		
12.	Are you prohibited from holding the position you hold, or from carrying out the regulated activity, by or under any enactment?		

Additional information from Director:
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2. Qualifications, Competence, Skills and Experience

No.	Criteria	For completion by Director	For completion by HR
1.	Do you have the necessary qualifications, competence, skills and experience to perform your role?		
2.	Have you provided documentary evidence of your qualifications?		Check original certificates and attach copies confirming checked against originals
3.	If applicable, are you registered with the relevant professional regulator?		
4.	Have you provided a copy of your up-to-date CV which sets out your full employment history, including a written explanation for any employment gaps?		Check copy CV and attach [this will be obtained upon appointment]
5.	Do you consider that you share the values of the organisation and have a caring and compassionate nature?		
6.	Do you have access to appropriate ongoing development and support? Have you had an appraisal?		Attach completed appraisal document

Additional information from Director:

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3. Health

No	Criteria	For completion by Director	For completion by HR
1.	Do you have a health condition or disability that requires adjustments in the workplace to enable you to undertake your role, or requires restrictions to your role? If so, please provide details below.		Attach Occupational Health Clearance and details of any adjustments

Additional information from Director:

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4. Serious Misconduct or Mismanagement

No	Criteria	For completion by Director	For completion by HR
1.	Have you been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity in the UK, or an equivalent service overseas? Please provide details below or attach a separate document detailing any serious misconduct or mismanagement issues.		Ensure that reference request template covers off this question
2.	Have you or any of your previous employers had any notable issues highlighted as a result of CQC inspections? Please provide any further information below.		

Additional information from Director:

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5. Further Information CQC has Right to Require

No	Criteria	For completion by Director	For completion by HR
1.	Have you provided two forms of photographic personal identification and one document confirming your address, or one form of photographic personal identification and two documents confirming your address?		Check documents and attach upon appointment
2.	Have you provided proof of your right to work in the United Kingdom?		Check documents and attach upon appointment

Additional information from Director:

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Declaration

I declare that I have provided truthful and complete answers and explanations to the questions set out above. I confirm that I comply with the requirements set out in the Regulated Activities Regulations (as amended from time to time) and CQC guidance/information (as amended from time to time) regarding the Fit and Proper Persons test, and that I am a Fit and Proper Person to carry out my role at the organisation. I understand that the provision of any false or misleading information may lead to the offer of my employment or engagement being withdrawn or my employment or engagement being terminated, without further notice to me. I confirm my continuing obligation to inform the organisation of any circumstances which may affect my status as a Fit and Proper Person or any other grounds which impact upon my employment or engagement.

Name: ________________________________ Signed: ______________________________

Position: ______________________________ Date: _______________________________

Please return this completed form by [ ] to [ ].

I confirm that this Fit and Proper Persons self-declaration form for directors and the evidence checklist has been completed

Name: ________________________________ Signed: ______________________________

Position: **Director of Organisational Development and Human Resources**
Date: ____________________________________

Appendix 2

FIT AND PROPER PERSON TEST - PROCEDURAL STEPS

Clauses and Declarations

1. FPPR clause to be inserted in contracts of employment and interim contracts for service.

   "It is a condition of your continuing employment that you remain a fit and proper person as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the guidance issued by Monitor and the Care Quality Commission as amended from time to time'.

2. FPPR self-declaration to be signed upon appointment and annually.

Process Steps – Upon Appointment

1. All initial checks undertaken by the Recruitment Office.

2. Directors asked to sign the employment contract with the FPPR clause and self-declaration.

3. The supplying company signs the contract for service that incorporates the FPPR clause; the actual individual being supplied signs the self-declaration at Appendix 1.

4. The FPPR checklist (Appendix 1) is maintained/ticked for each individual, which the Director of Organisational Development & Human Resources signs when all checks have been made to their satisfaction (the Chief Executive does this for the Director of Organisational Development & Human Resources).

5. The Director of Organisational Development & Human Resources will consider gaps in employment etc. In general, the reason for leaving a previous position that had direct involvement with children or vulnerable adults will be verified.

6. Completed FPPR processes for Directors will be reported to the Board Nominations and Remuneration Committee .

7. Completed FPPR processes for NEDs is undertaken by the Trust Development Authority and reported to the Board Nominations and Remuneration Committee .

8. Any concerns or unacceptably incomplete data for NEDS will be discussed by the Chair with the Trust Development Authority and the outcome reported to the Board Nominations and Remuneration Committee . In the case of the Chair, the Chief Executive will undertake the discussion with the Trust Development Authority and the outcome will be reported to the Board Nominations and Remuneration Committee .

9. Any concerns or unacceptably incomplete data for other Directors not referred to in paragraph 8 above will be discussed with the Chief Executive (Chair in the case of the Chief Executive). The Director of Organisational Development & Human Resources or the Chief Executive will make a recommendation as to next steps and where this is the case, it will be reported to the Board Nominations and

Remuneration Committee for information.

In the case of a candidate for a director appointment if the recommendation is still to support the appointment of the individual, this must be referred to the Board Nominations and Remuneration Committee for the final decision.

Annual Checks

1. Annual checks will be completed during January each year, co-ordinated by the Director of Organisational Development and Human Resources.

2. Individuals (employees, contractors and NEDs) will be required to sign the FPPR self-declaration.

3. The FPPR checklist is maintained/ticked for each Director, which the Director of Organisational Development and Human Resources signs when all checks have been made to their satisfaction. The Chief Executive does this for the Director of Human Resources and Personal Development.

4. Completed annual FPPR checks will be reported to the Board Nominations and Remuneration Committee (usually in March).

5. Any concerns about Directors, will be discussed with the Chief Executive or Chair, as appropriate and referred to the Board Nominations and Remuneration Committee for a decision about next steps. The Board Nominations and Remuneration Committee will consider what employment processes need to be followed if any.

Appendix 3

Principles of Conduct in Public Life

The Nolan Committee was established in 1994 to examine concerns about standards of conduct of all holders of public office, including arrangements relating to financial and commercial activities, and make recommendations as to any changes in arrangements which might be required to ensure the highest standards of propriety in public life. The Committee published 'Seven Principles of Public Life' (in Ministerial Code 2010, Annex A) to apply to all those operating in public service sector.

These principles should be adopted by all working within the NHS and are:

Selflessness: Holders of public office should act solely in terms of the public interest. They should not dos so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity: In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness: Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership: Holders of public office should promote and support these principles by leadership and example.

MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018			
Quality, Patient Experience & Safety Committee Highlight Report			**AGENDA ITEM: 21, ENC 19**
Report Author and Job Title:	Dr Karen Dunderdale, Director of Nursing	**Responsible Director:**	Danielle Oum, Chair & 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 29 November 2018. Key items discussed at the meeting were: • Quality report – Pressure ulcers and falls • VTE achievement to date • Hand Hygiene compliance • Winter plan • WMQRS reports on deteriorating patient review and Children's Critical Care review • Clinical risks of the follow up back log The meeting was quorate and chaired by Danielle Oum, Chair & 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 ☐		

Caring for Walsall together

Partners

Quality, Patient Experience & 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 29 November 2018 together with the confirmed minutes of the meeting held on 25 October 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 29 November 2018:

<u>Quality report</u>

There was a detailed discussion in relation to quality report and specifically pressure ulcers and falls. The Director of Nursing discussed the link between these quality indicators and staffing levels on the wards along with initiatives being undertaken to reduce the incidents.

The committee discussed its concerns about the unacceptable levels of compliance with hand hygiene particularly in the medical staff. The Director of Nursing and Medical Director are working together to agree a zero tolerance approach to this issue.

<u>Winter Plan</u>

The Committee received a detailed report on the winter plan and reviewed the quality implications of the plan and the maintenance of patient safety during times of escalation and surge.

4. RECOMMENDATIONS

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

Caring for Walsall together

Walsall Healthcare NHS
NHS Trust

Safe, high quality care

Care at home

Partners

Value colleagues

Resources

Respect
Compassion
Professionalism
Teamwork

MEETING OF THE PUBLIC TRUST BOARD – THURSDAY 6th DECEMBER			
People and Organisational Development Committee Highlight Report			**AGENDA ITEM: 23, ENC 20**
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. Board Assurance Framework and Update on Risks:
   The Board Assurance Framework was reviewed and the Committee discussed the key risks and the annual cycle of business aimed at providing assurance that the key risks are being mitigated effectively. The Committee noted that the BAF requires further update to include metrics and scheduled completion dates for all planned control mechanisms.

2. Workforce Performance Data & Metrics:
   The Committee received and considered a report on the proposed set of standard Trust wide metrics and noted that these show the Trust position and the position for each Directorate to ensure consistency. The Committee noted that these metrics

will feature within the Trust Accountability Framework with a particular focus on current levels of sickness absence, turnover, PDR compliance, Mandatory training compliance. The standard metric set and the six key indicators were approved by the Committee, with an amendment to show data on long-term and short-term absence as a ratio rather than a percentage.

3. Progress on Actions to minimise agency use within the Nursing Workforce:
   The Committee received and noted an update report on the Nursing Workforce Transformation Programme, which outlined the Trust wide actions being taken to ensure effective utilisation of the nursing workforce. The Committee noted that the skill mix and establishment review work had been completed and noted the update on improving the control mechanisms in place for use of temporary and agency workforce. The Committee noted the progress made on scoping and specifying requirements for a replacement rostering system able to support the resourcing requirements of the nursing workforce.

4. Briefing on Medical Workforce Productivity Programme – Terms of Reference:
   The Committee noted the terms of reference set for a review of medical workforce productivity programme with input from Meridian Resourcing and agreed to have further updates on medical workforce productivity.

5. People Strategy 2016 – 2020 Review:
   The Committee noted the Trust People Strategy for 2016 – 2020 has been reviewed and received a report on the status of each of the critical outcomes. It was noted by the Committee that the strategic imperatives for the Trust are very different now and that a much broader system wide approach is required to align with the priorities of Walsall Together and the changing workforce and service requirements. The Committee agreed that the People Strategy requires update and that this will mean an approach that fully engages all stakeholders. The Committee noted that the outstanding actions within the current strategy would be the workforce focus until April 2019, also target date for launch the new joint strategy on workforce for Walsall Together.

6. Strategic Approach to Equalities Update and Equality Objectives:
   The Committee noted a report detailing progress on the development of a Trust Strategy on Equality, Diversity and Inclusion and plans to set the strategic approach over a three year period 2019 to 2021. The Committee considered equality objectives proposed and approved these with the proviso that each aspirational statement on equality is reframed as a SMART objective and is supported by an action plan to ensure the outcomes are achieved within the timescale identified.

7. Quarterly Academy Update Report:
   The Committee received and noted a report on the Quality Academy which provided an update on the number of staff trained in QI approaches (653 during 2018/2019 to date) as well as an update on the Quality Service Improvement and Redesign (QSIR) programme and noted that 5 Trust staff are now accredited trainers for the

delivery of QSIR training across the Trust. The Committee noted the QI branding and noted that the QI strategy is being updated and received an update on the Quality Improvement Office support.

8. Sustainability Reviews:
   The Committee received an update on the work on the service sustainability reviews and noted that many of these have flagged up the need for workforce and HR support. The Committee noted the key importance of the Operational Plan in setting the baseline for an approach to workforce planning and the requirement for looking at the use of national and local pilots for new roles in order to build a sustainable workforce for the future.

9. Medical Workforce Education and Engagement:
   The Committee received the report and noted the key issues for the medical workforce on education and engagement. The Committee noted that work is taking place relating to the quality of training, pastoral support, support for doctors in difficulty, appraisal process and the Fatigue and Facilities Charter and noted that there are some gaps in current provision and governance. The Committee resolved to receive a further update regarding these matters at least on a quarterly basis.

10. Use of Resources People – Model Hospital and Well Led Framework:
   The Committee received a presentation providing detail on performance against the use of resources for people indicators from the Model Hospital Portal, the particular focus was on the Trust performance relating to sickness absence and Committee noted the work taking place on workplace wellbeing aimed at improving attendance. The Committee received and discussed the Trust Well-led action plan and noted the scheduled work plan and resolved to receive reports and plans related to these outcomes as required at Committee meetings.

11. Influenza Situation Report.
   The Committee noted the situation report and the first due date for national submission, and noted that the percentage uptake for front-line healthcare staff had improved compared to this point last year.

4. RECOMMENDATIONS

The recommendation to Board is to note the content of the report for information.

APPENDICES
People and Organisational Development Committee Minutes (15.10.2018)

MEETING OF THE PUBLIC TRUST BOARD – Thursday 6th December 2018			
Audit Committee Highlight Report			AGENDA ITEM: 24, ENC 21
Report Author and Job Title:	Jenna Davies, Director of Governance	**Responsible Director:**	Sukhbinder Heer, Non-Executive Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The Audit Committee met on 12th November. The Committee welcomed Grant Thornton has the new Internal Auditors from the 31st October 2018. The Committee thanked West Midland Ambulance Service NHS Foundation Trust (WMAS) for their time with the Trust. The Committee received a revised internal audit plan from Grant Thornton and were assured of the plan, however asked for two additional audits including a review of the Financial Recovery plan together with a follow up audit of risk management. The risk Management Audit was presented together with an action plan. Assurance had been given as actions were being progressed. A re-audit was suggested. A review of the Standing Financial Instructions, standing orders, and scheme of delegation had been completed. The Committee approved the revised documents however the Committee agreed not to change delegated limits due to the Trusts financial position. Conflicts of Interest policy was approved, and the committee agreed that the register of interests would be monitored on a quarterly basis		
Recommendation	Members of the Board are recommended to discuss the content of the report and raise any questions in relation to the assurance provided.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	None		
Resource implications	There are no resource implications raised within the report.		

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Respect Compassion Professionalism Teamwork

Legal and Equality and Diversity implications	All NHS organisations are required to have an Audit Committee that that reports to its governing body (Trust Board for Walsall Healthcare NHS Trust). The formal requirements to have an Audit Committee are set out for non-NHS Trusts in the NHS Improvement Code of Conduct and Accountability.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☒	