Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 7 FEBRUARY 2019 AT 14:00
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
1.	Patients, Carer and Staff Story	Learning	Director of Nursing	Verbal
CHAIR'S BUSINESS				
2.	Apologies for Absence	Information	Chair	Verbal
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1
4.	Minutes of the Board Meeting Held on 6 December 2018	Approval	Chair	ENC 2
5.	Matters Arising and Action Sheet	Review	Chair	ENC 3
6.	Chair's Report	Information	Chair	ENC 4
7.	Chief Executive's Report	Information	Chief Executive	ENC 5
SAFE HIGH QUALITY CARE				
8.	Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Director of Nursing	ENC 6
9.	Improvement Update	Information	Chief Executive	ENC 7
10.	Learning from Deaths (Mortality) report	Receive	Medical Director	ENC 8
11.	Nursing Strategy	Approval	Director of Nursing	ENC 9
12.	Board Assurance framework for seven day hospital services	Approval	Medical Director	ENC 10
VALUE COLLEAGUES				
13.	Freedom to Speak Up Guardians Report (Whistleblowing)	Discussion	Freedom to Speak up Guardians	ENC 11
14.	Guardian of safe working	Receive	Guardian of Safe Working	ENC 12
BREAK – TEA/COFFEE PROVIDED				

ITEM		PURPOSE	BOARD LEAD	FORMAT
RESOURCES				
15.	Performance Report	Discussion	Director of Finance & Performance	ENC 13
PARTNERS				
16.	Operational Planning and Contracting 2019 / 20	Information	Director of Strategy & Improvement	ENC 14
17.	Partnership Update	Information	Director of Strategy & Improvement	ENC 15
GOVERNANCE AND COMPLIANCE				
18.	BAF and Risk Register update	Information	Director of Governance	ENC 16
19.	Use of the Seal	Information	Director of Governance	ENC 17
20.	Quality, Patient Experience and Safety Committee Highlight Report	Information	Committee Chair	ENC 18
21.	Performance, Finance & Investment Committee Highlight Report	Information	Committee Chair	ENC 19
22.	POD Highlight Report	Information	Committee Chair	ENC 20
23.	Audit Committee Highlight Report	Information	Committee Chair	ENC 21
24.	**QUESTIONS FROM THE PUBLIC**			
25.	**DATE OF NEXT MEETING** Public meeting on **Thursday 7 March 2019** at 16:00 at the Manor Learning and Conference Centre, Manor Hospital			
26.	**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 7th February 2019			
Declarations of Interest			**AGENDA ITEM: 3**
Report Author and Job Title:	Jackie White Interim Trust Secretary	**Responsible Director:**	Danielle Oum
Action Required	Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	The report presents a Register of Directors' interests to reflect the interests of the Trust Board members. The register is available to the public and to the Trust's internal and external auditors, and is published on the Trust's website to ensure both transparency and also compliance with the Information Commissioner's Office Publication Scheme.		
Recommendation	Members of the Trust Board are asked to: Note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Register of Directors Interests at January 2019

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
Mr John Dunn	Non-executive Director	No Interests to declare.
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).
		Partner - Unicorn Ascension Fund (Venture Capital)
Mr Philip Gayle	Non-executive Director	Chief Executive Newservol (charitable organisation – services to mental health provision).
Mrs Anne Baines	Non-executive Director	Director/Consultant at Middlefield Two Ltd Associate Consultant at Provex Solutions Ltd Clinical Strategy Lead – Worcester Acute Hospitals NHS Trust
Ms Pamela Bradbury	Non-executive Director	Chair of Healthwatch Dudley Consultant with Health Education England People Champion – NHS Leadership Academy Partner is an Independent Clinical Lead with Sandwell and West Birmingham Clinical Commissioning Group
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)
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
Dr Elizabeth England	Associate Non-executive Director	Clinician – Laurie Pike Health Centre, Modality Clinician – Lilley Road Medical Centre, GP at Hand

		Mental Health & Learning Disability Clinical Lead, SWB CCG Clinical Director – Mindsafe Mental Health Clinical Lead – RCGP
Mr Richard Beeken	Chief Executive	Spouse, Fiona Beeken is a Midwifery Lecturer at Wolverhampton University. Director – Watery Bank Barns Ltd.
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
Dr Matthew Lewis	Medical Director	Spouse, Dr Anne Lewis, is a partner in general practice at the Oaks Medical, Great Barr
		Director of Dr MJV Lewis Private Practice Ltd.
Dr Karen Dunderdale	Director of Nursing	No Interests to declare.
Ms Jenna Davies	Director of Governance	No Interests to declare.
Ms Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy ltd Chartered Institute of Personnel (CIPD)
Ms Margaret Barnaby	Interim Chief Operating Officer	Director of Ltd Company as a Management Consultant Husband has properties

Report Author: Jackie White, Interim Trust Secretary
Date of report: January 2019

RECOMMENDATIONS

The Board are asked to note the report

Walsall Healthcare NHS
NHS Trust

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 6TH DECEMBER 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 P Gayle	Non-Executive Director
Mr R Beeken	Chief Executive
Dr K Dunderdale	Director of Nursing/Deputy Chief Executive
Dr M Lewis	Medical Director
Mr R Caldicott	Director of Finance
Mrs M Barnaby	Interim Chief Operating Officer

In Attendance:

Mrs A Baines	Associate Non-Executive Director
Mr A Yates	Associate Non-Executive Director
Ms P Furnival	Associate Non-Executive Director
Mr D Fradgley	Director of Strategy & Improvement
Ms J Davies	Director of Governance
Ms C Griffiths	Director of People & Culture
Mrs J White	Trust Secretary
Miss J Wells	Senior Executive PA (Minutes)

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

174/18 Patient Story

Ms Louise Mabley, Lead for Patient Experience introduced an audio clip of patients sharing their experience with services provided by the Trust and reflections to the patient's experiences by staff.

Ms Oum summarised that the clips identified some positive feedback and praised staff involved in their care. Ms Oum also noted the negative feedback regarding junior doctors and wait time in ED and pharmacy.

Dr Lewis stated it was helpful to hear the voice of patients, acknowledging that there appeared to have been some unnecessary delays and stressed the importance of acting upon patient concerns.

Dr Dunderdale highlighted that patients had described compassionate care throughout their care however there

appeared to be inconsistencies from patient to patient.

Ms Oum asked all to reflect upon the feedback and to consider the points raised.

Ms Furnival added that there had been improvements with 4 hour wait times and ambulance handovers with ED was the proxy of the system.

Mr Fradgley advised that there were opportunities to be explored with communications around waiting times and the reason for the length of wait. Members noted that the Communications team had been working with the ED team in order to make improvements. Mr Fradgley added that the ED environment was also an issue. Some interim steps had been taken in respect of a refurbishment programme.

Mr Fradgley further added that the Trust maintained a good relationship with West Midlands Ambulance Service and were reviewing admission avoidance collaboratively. The ED handover times were amongst the best within the region.

Ms Oum asked Dr Lewis and Dr Dunderdale to review the points highlighted by patients and to seek assurance that they were being dealt with. **Dr Lewis/Dr Dunderdale**

175/18 Apologies for Absence

Apologies were noted from Mr S Heer, Non-Executive Director.

Ms Oum informed that Ms P Bradbury would be joining the Trust as a Non-Executive Director and Dr E England would be joining the Trust as an Associate Non-Executive Director during December.

A formal welcome to the Trust was made to Ms M Barnaby, Interim Chief Operating Officer.

Ms Oum welcomed Caroline Bell and Amanda Heggarty from the CQC who were observing the meeting.

176/18 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.

177/18 Minutes of the Board Meeting Held in Public on 1st November 2018

The Board approved the minutes of the meeting held on the 1st November 2018 as an accurate record.

Dr Dunderdale advised members that item 161/18 – Nursing and Midwifery Safer Staffing Report would be reviewed at the next Quality, Patient Experience and Safety Committee in January and Trust Board in February.

178/18 Matters Arising and Action Sheet

The Board reviewed the action sheet.

Mr Beeken advised that Terms of Reference had been drafted and agreed by the Chair for the Strategy Committee but asked for views whether they would be required given that the Walsall Together Partnership Board would become a sub-committee during April 2019. All agreed that the action could be removed.

Ms Davies informed members that from February 2019 the Board format would be changing and that the day would include a Board Development session, Board Walk and NED meeting prior to a public and private Board meeting.

Mr Lewis would discuss patient stories at the Junior Doctor's forum to ensure that stories were being shared and reviewed. **Dr Lewis**

Resolution

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

179/18 Chair's Report

Ms Oum presented the report which was taken as read.
An appendix was included detailing visits undertaken by the Chair which was included in the Daily Dose communication for staff.

Resolution

The Board received and noted the Chair's report.

180/18 Chief Executive's Report

Mr Beeken reported that there had been remarkable progress in patient flow processes made during October and November. 4 hour performance had also improvement against national standards. Mr Beeken added that though attendance and admissions exceeded winter plan predictions during November, no extra capacity had been opened, as planned. Mr Beeken thanked all colleagues who contributed to this work.

Members noted that nationally, the Trust was the most improved Trust with flu vaccination uptake. The uptake of staff was currently 72%, compared to 38% the previous year. Mr Beeken thanked colleagues for their efforts in encouraging staff to partake.

Mr Beeken advised that the Business Case for Walsall Together would come to Board and Cabinet in February 2019.

Finally, Mr Beeken added that the Trust continued to struggle with temporary staffing numbers and productivity but that Dr Dunderdale and Dr Lewis continued to progress these workstreams. The Executive team had reprioritised time to ensure visibility and presence in clinical areas and had relaunched the accountability review process.

Resolution
The Board received and noted the verbal update.

181/18 Monthly Nursing and Midwifery Safer Staffing Report

Dr Dunderdale introduced the report, highlighting that 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. CSW cover was less than 90% on 6 wards during the day and 3 wards 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 50 recorded incidents of red flags recorded through the staffing risk assessments within October. This is 3 less than last month

Ms Oum recognised the mark of progress and welcomed the collaborative work between the Director of Nursing and the Director of Finance.

Mrs Baines queried the timescale of availability for the dashboard. Dr Dunderdale replied that the dashboard had been populated for the first time during November and metrics would be reviewed later in the month. Work was underway with Mr Fradgley to develop a business intelligence system and an overview would be considered at the Quality, Patient Experience and Safety Committee in December.

Mr Beeken queried whether there was any benchmarking data available with regard to red flags. Dr Dunderdale replied that she had started having conversations regionally with the Directors of Nursing and nationally the data would be picked up through model hospital. Ms Oum asked for timescales involved and Dr Dunderdale responded that national benchmarking model hospital data would be reviewed at the February Trust Board meeting.

Finally Dr Dunderale advised that she was developing a business case for moving to a different rostering system which would progress to the Performance, Finance and Investment Committee for review during March 2019.

Resolution
The Board:

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

182/18 CQC Preparedness Update

Mr Beeken introduced the report which outlined the key highlights;

- Work was continuing to improve the format and content of the Patient Improvement Plan.
- Good progress was being made in terms of mandatory training.
- VTE performance was struggling, though November did achieve 95% for the first time in three months.
- It had been identified that there was a significant number of out of date polices and guidelines and as a result, Ms Davies had implemented a project plan to address this risk.

Mr Dunn questioned how many outdated policies there were and how they would be prioritised. Ms Davies replied that each Executive Director had taken responsibility for their area. Clinical policies were prioritised. There remained 36 policies out of date.

Mr Gayle queried whether the policies had been equality impact assessed. Ms Davies replied that policies had been assessed and the Equality and Diversity Lead was assisting with the process going forward.

Mr Yates referenced the good progress made with mandatory training but noted it had appeared to have levelled out, querying if there was a plan in place. Ms Griffiths replied that areas of compliance were being reviewed, ensuring that all training was properly recorded. Assurance would be given at the next Trust Board meeting.

Resolution

The Board received and noted the content of the report.

183/18 Nurse Staffing Establishment Review

Dr Dunderdale informed members that this was the second phase of the in-patient ward areas establishment reviews which has focused on the skill mix of each area.

Members noted that 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.

Dr Dunderdale further advised that a skill mix review was taking place within ED with Paediatrics, community and maternity taking place over the coming months.

Ms Oum noted that rigor and inclusiveness was in a significantly improved position but asked for consideration to be given to culture, custom and practice.

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

184/18 Freedom to Speak Up Guardians Report

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

- The People and Organisational Development Committee would review the Freedom to speak up annual report and self-assessment prior to review at the next Trust Board meeting.
- A single point of reporting was being sourced through Safeguard.
- There had been an increase in the number of enquires to the team.
- Regular meetings with Non-Executive Directors and Executives took place. Ms Griffiths also met with the team fortnightly.

Ms Oum informed that Mrs Baines had been nominated as the Non-Executive Director Lead in order to provide support to the team.

Mr Beeken praised the work of the Guardians as individuals and as a collective.

Ms Oum asked what the process was of giving feedback to colleagues. Ms Griffiths replied that there was a feedback process in place which was currently being built in to Safeguard.

Resolution

The Board received and noted the content of the report.

185/18 Pledge

Ms Griffiths presented the Trust Pledge and asked for formal adoption by the Trust Board.

Ms Oum welcomed the pledge which demonstrated that the Trust was listening to staff requirements.

All board members endorsed the pledge.

Ms Oum expressed thanks to staff for developing the Trust values.

Resolution

The Board:

- **Received and noted the content of the report.**
- **Formally adopted the Trust Pledge.**

186/18 Performance Report

Quality and Safety Committee

Dr Dunderdale informed that there were no episodes of MRSA reported in October, however there was a hospital acquired MRSA reported in November. Dr Dunderdale chaired the review meeting held earlier in the week which concluded that the incident was unavoidable. The Quality, Patient Experience and Safety Committee would review the findings in detail. **QPES**

Members noted that there was 1 reported case of C-diff during October and a reduced number of falls.

Mrs Barnaby queried whether the incidents of pressure ulcers were linked to nutrition. Dr Dunderdale replied that there was a nutritional implication and a review was underway to explore this in more detail.

Mr Gayle asked whether there would be a campaign implemented to reduce pressure ulcers and Dr Dunderdale replied that one had recently taken place within the Trust.

Mrs Baines noted that there was little improvement on electronic discharge summaries. Dr Dunderdale responded that discussions had started in relation to this area of work. Mr Beeken informed that though patient flow had improved, there was often still a ward-round approach. Improvements would likely be seen if electronic discharge summaries were completed in real time. Dr Lewis advised that he would raise the issue at the Junior Doctors Forum. **Dr Lewis**

Partnerships

Mr Fradgley informed that Rapid Response had additional capacity ready for winter.

A number of work steams were underway in terms of GP led MDT's and engagement through 4 new locality leads.

Intermediate care service pathways data was included within the report.

Ms Oum observed disparity in admissions by locality and queried what could be done differently. Mr Fradgley replied that the teams were looking at complex cases and readmissions, targeting more respiratory support within the north and the west areas. Frailty support was required within the east and south. Teams were now becoming self-diagnostic in terms of the case load and were calling for changes in the model. There appeared to be a drug and alcohol problem within the north resulting in conversations now taking place with mental health in order to provide support.

POD
Ms Griffiths referenced the mandatory training figures which had already been discussed.

Sickness figures were concerning. Health and Wellbeing workshops had been created in an effort to manage sickness.

Performance, Finance & Investment Committee
Mr Caldicott reported a £17m deficit.

Members noted that there would be a more in-depth discussion regarding the financial position at the Private Board.

RTT has sustained its improvements and achieved 90.01% in October.
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.

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

187/18 Winter Plan
Mr Beeken informed that the winter plan had been enacted which had been developed in conjunction with partners and stakeholders and was evidence based. NHSI and the CCG had scrutinised the plan which received good feedback. The Quality, Patient Experience and Safety Committee and the Performance, Finance and Investment Committee had reviewed the plan. Mr Dunn, Mr Beeken and Operational Leads had completed a walk through.

Ms Oum advised that the Quality, Patient Experience and Safety Committee were assured that patient safety was going to be

maintained.

Mr Dunn informed that a rigorous review of the plan had taken place. The importance was getting the right people with the right skills in place and ensuring lessons had been learnt. The plan fully met the need requirement and thanked those involved in its creation.

Ms Oum asked that actions in relation to quality and safety were shared with board members. Dr Dunderdale informed that the intention was to share the plan with the CQC following approval from the Board.

The Winter Plan was approved.

Resolution
The Board:

- **Received and noted the content of the plan.**
- **Approved the Winter Plan.**

188/18 The Black Country and Birmingham STP MOU

Mr Beeken presented the Memorandum of understanding which was, in essence a partnership agreement. Members noted that every local health and care system have come together to create its own Sustainability and Transformation Plan (STP) for accelerating the implementation of the Five Year Forward View (FYFV).

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.

Mrs Baines asked how an STP Professional Chair was appointed. Mr Beeken replied that the Professional Chair was the chair of the Clinical Reference Group

Mr Dunn asked for clarity in relation to any legal significance members needed to be aware of. Ms Davies responded to highlight the legal basis of the MOU.

The Board agreed to adopting the principles of the STP MoU, recognising that collaboration on its clinical strategy was one of the organisation's key priorities for the year. It was recognised that the MoU was incomplete and as a result, the Board agreed to defer full and formal sign off until the revised and final MoU was available in the new calendar year.

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

189/18 Partnership Update

Mr Fradgley advised that he had attended a meeting with the local housing group the previous day and they were keen to attend and present to a future board meeting.

Mr Fradgley advised that 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.

KPMG were providing support with digital strategy and its inclusion in the Walsall Together business case.

Ms Furnival reiterated the need to understand where the concerns were. An example was given where, on average, patients would wait up to 13 days for therapy intervention. A best practice model needed to be endorsed but would require a risk appetite.

Ms Oum confirmed the perusal of the approach but the board would require further information of the requirements. Dr Dunderdale and Dr Lewis to provide support.

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

190/18 Risk Appetite

Ms Davies updated the Board had 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.

Members noted that each of the Board sub committees have considered and recommended approval by the Board of their risk appetite.
There were two changes within the statements since the board reports were issued:

- Improvement of financial health – low impact.
- Culture – low impact.

Mr Beeken queried whether in future, there should be a differential between the pillars of quality and patient safety. Mr Dunn supported the approach.

All recognised and agreed the accurate reflection of the risk appetite.

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

191/18 Board Assurance Framework & Risk Register

Ms Davies advised that a process for BAF risks and Risk Register

risks had been developed. Each risk was aligned to a committee for detailed review.

The risk management strategy required revision and would include risk tolerance. The risk management policy also required further development.

Members noted that 2 BAF risks had elevated to a score of 15. 1 new risk had been added in terms of IT support. 4 new risks had been added to the Corporate Risk Register.

Mr Yates welcomed the risk framework for review on a quarterly basis.

Mrs Baines asked that the full BAF be visible in public papers in future.

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

192/18

Review of the Standing Orders, Standing Financial Instructions and Scheme of Delegation
Ms Davies informed that the Standing Financial Instructions had been reviewed in line with good practice and key changes were made in relation to updated legislation, bribery and urgent decision making processes. The Audit Committee had reviewed the changes and were recommending approval by the Board.

All were in agreement and approved the process.

Resolution:
The Board:

- **Received and noted the content of the report.**
- **Approved the revised process.**

193/18

Fit and proper
Ms Davies referred members to her report which set out a revision to the Trust policy on Fit and Proper Person. Members noted that the Policy had been reviewed and changes made to align fit and proper checks to national best practice. This included a more comprehensive process and assurance around the checks that had been completed.

The process was approved.

Resolution:
The Board:

- **Received and noted the content of the report.**
- **Approved the reviewed process.**

194/18

Quality and Safety
Dr Dunderdale informed that there were no further items to add to

the previous update given during the performance report agenda item. The Winter plan had also been discussed under that agenda item.

Ms Oum reminded that patient experience would form a stronger feature. Dr Dunderdale responded that the process around the use of patient stories and patient voice was being reviewed.

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

195/18 Performance, Finance and Investment Committee
Mr Caldicott stated that the committee received a presentation from the Outpatients workstream which included discussion around seeing patients earlier and patient flow.

The ICCU had opened. The Maternity Neonatal build was proceeding at pace.

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

196/18 People and Organisational Development Committee
Mr Gayle advised that he was happy with the refreshed terms of reference and the annual cycle of business.

Health and wellbeing sessions were taking place, sending a clear message to staff about how much they were valued and that the Trust were taking forward different initiatives.

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

197/18 Audit committee
Ms Davies advised that the Internal Audit Plan had been revised. The Chair would meet with the new auditors and would share the plan following that meeting.

Good, strong debate took place in relation to the risk management audit. It was suggested that the Trust undertook a re-audit by the end of the year.

The conflicts of interest policy had been reviewed and updated to reflect national best practice and would continue to be reviewed on a quarterly basis.

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

198/18 Reflections of the meeting
Mr Yates observed the way the meeting started set the tone. The patient voices raised the profile of the Trust's work. There was healthy debate around a number of issues with clear challenges

as expected.

Mr Gayle observed a very positive meeting and welcomed Dr Dunderdale's report on staffing establishment and working in partnership with Mr Caldicott was reassuring.

Mr Beeken informed that good consideration had been given to quality and safety and not totally focused on money.

Ms Oum reiterated the commitment to the principals of the STP. The Board had given formal endorsement of the winter plan and signed off the skill mix review which was also an important piece of work.

199/18 Questions from the Public

Mr Cliff Lemord, Joint staff side lead joined the Board members. Mr Lemord commented that the Patient Experience item was interesting but some of the themes were well known. Mr Lemord was pleased that the Board has signed up to the Pledge and would like to see the progress made. He advised that the impact of the Skill Mix was unknown and would like a further detailed discussion to take place at JNCC.

200/18 Date of Next Meeting

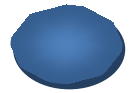
The next meeting of the Trust Board held in public would be on Thursday 7th February 2019 at 2:00p.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

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

ENC 3

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
154/18 Patient Story	Patient story to be shared with Junior Doctors for learning purposes.	Quality, Patient Experience & Safety Committee		Mr Lewis would discuss at the Junior Doctors Forum in December.	
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	Manual process in place with an electronic system being developed through Safeguard which should be in place by the end of February. Actions in relation to national guidance will be feedback through the Trusts governance structures	
167/18 Guardian of Safe Working	Mr Lewis to review the detail to check the relevancy of the community	Medical Director	6/12/18	Mr Lewis confirmed that the community were included and relevant.	

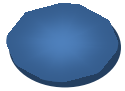
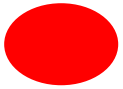
ENC 3

Walsall Healthcare NHS
NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
169/18 Quality, Patient Experience & Safety Committee	A wider approach in terms of equipment breakdowns to be supplied.	Director of Nursing	6/12/18	Report on the Equipment Replacement Programme being presented to QPES in January	
147/18 Patient Story	Dr Lewis and Dr Dunderdale to review the points highlighted by patients and to seek assurance that they were being dealt with.	Medical Director & Director of Nursing	07/02/19	Completed as part of director walk about and continued reviews.	
186/18 Performance Report	The Quality, Patient Experience and Safety Committee would review the findings of a hospital acquired MRSA reported in November.	Director of Nursing	07/02/19	This was discussed and actions noted at the January meeting of QPES	

Key to RAG rating

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

MEETING OF THE PUBLIC TRUST BOARD – Thursday 7th February 2019			
Chair's Report			**AGENDA ITEM: 6**
Report Author and Job Title:	Danielle Oum, Chair	**Responsible Director:**	Danielle Oum, Chair
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The report contains information that the Chair wants to bring to the Board's attention and includes a summary of the meetings attended and activity undertaken by the chair since the last Board meeting. In keeping with the Trust's refocusing on core fundamentals, this report has been restructured to fit with the organisational priority objectives for the coming year. With regard to the priorities 3 and 4, I have embarked on a programme of engagement with colleagues and stakeholders to communicate our organisational focus as well as gather perspectives and triangulate information to contribute to Board assurance.		
Recommendation	Members of the Trust Board are asked to: Note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Walsall Healthcare NHS
NHS Trust

Chair's Update

PRIORITY OBJECTIVES FOR 2018/19

1. **Continue our journey on patient safety and clinical quality through a comprehensive improvement programme**
   Accompanied by the Deputy Director of Nursing, I joined a Ward Review on ward 9, Trauma and Orthopaedics. The Ward Review process is reviewing quality indicators such as pressure ulcers, hand hygiene and cleanliness.

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 the financial recovery plan, theatres workstream and agency staffing.

3. **Develop the culture of the organisation to ensure mature decision making and clinical leadership**
   I had pleasure in attending a review of the Stepping Up programme and receiving feedback from attendees who had benefitted from their participation. Quarterly meetings would be held to provide support and receive progress updates.

   I was an interview panel member for the Consultant Cardiologist vacancy.

4. **Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts**
   I attended a Board Development session which focused on the Walsall Together Business Case.

   Together with the Chief Executive, I attended a Walsall Together CEO & Chairs meeting to discuss our journey to integrated health and care and key issues prior to the full business case being discussed at Cabinet

   I joined a stakeholder event for the recruitment of a Chair in Common for the Black Country Partnership NHS FT and Dudley and Walsall Mental Health Partnership NHS Trust.

Meetings attended / services visited
One to one meetings with Executive Directors
Mentoring a Community Palliative Care Nurse
Dermatology
EBME Department
Board Development session focused on CQC Use of Resources
Offsted briefing to staff

RECOMMENDATIONS
The Board are asked to note the report

Danielle Oum, February 2019

MEETING OF THE PUBLIC TRUST BOARD – Thursday 07 February 2019			
Chief Executive's Report			**AGENDA ITEM: 7**
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 report is to keep the Board appraised of the high level, critical activities which I have been engaged in during the past month against the four organisational priorities for 2018/19. I also set out to the Board my reflections as Accountable Officer with regard to the coming financial year and the important shift in approach we need to take to deliver on our long term strategic objectives and vision, linked to the NHS Long Term Plan. The report also seeks to set out to the Board, the significant level of guidance, instruction and best practice adoption we received during December 2018 and January 2019 and assures the Board through an allocation to the relevant executive director.		
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 deliver consistent standards of care to patients' across the Trust results in poor patient outcomes and incidents of avoidable harm. BAF002 Failure to achieve financial plans as agreed by the Board and communicated to NHSI BAF003 If the Trust does not agree a suitable alliance approach with the Local Health Economy partners it will be able to deliver a sustainable integrated care model. BAF004 Failure to progress the delivery of the Walsall Integrated model for health and social care. BAF005 The lack of leadership capability and capacity could lead to insufficient key performance improvement and the Trusts ability to be a high performing organisation.		
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 report 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 contains my reflections as Accountable Officer with regard to the coming financial year and the important shift in approach we need to take to deliver on our long term strategic objectives and vision.

The report also sets 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

Urgent care pressures are a dominating concern during the winter months and the NHS as a whole is much more conscious of how ED overcrowding and poor patient flow has a material impact on safety and experience for patients and their carers. The Trust as a whole, from our community services, to our intermediate care partnership with Walsall Council, to our acute hospital colleagues, have been intensively managing the Christmas and New Year period, to try to mitigate those quality risks at all times. Overall, the holiday period this year has been more successful and resilient than last year because:

- Our 4 hour performance is 4% better than this period last year, despite a significant 4.8% increase in ED attendances beyond our plan

- Our utilisation of winter plan contingency beds has been successfully deployed and we have virtually eradicated the practice of placing temporary extra capacity on our inpatient wards
- The deployment of the old HDU area for use by ED has created, at no increased cost, additional ED capacity to ensure ambulance turnaround times remain some of the best in the region
- We have never escalated to EMS level 4 (highest level of business continuity risk) whereas other Trusts in the region have done so, on occasion
- The above has been delivered at a proportionately lower cost from a nursing perspective than last year and with no changes to safety incidents or staffing incidents on the wards
- The CQC appreciative enquiry visit to ED in early January was very positive and they appeared impressed with the service improvement focus of the leadership team in the service

Our plans for urgent care as we move into the new financial year are extensive and will be teased out further by the COO during the Performance Report agenda item for the Board. It is clear that further improvements can be made with site management process and discipline, ward based MDT best practice, transformation of the therapies model for discharge leading the list of future developments.

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

We have been hugely encouraged to have confirmed that over 1000 colleagues have gone through our Trust Values sessions, following which people essentially "graduate" in the values and behaviours framework and how to deploy it. We expect to see, as a result of this work as well as our wider staff engagement, continued improvements to staff opinion of the Trust as a place to work. Early indications of this evidence are really encouraging and we are confident this will be demonstrated in the result of the national staff survey, due shortly.

Following a lot of the heavy lifting on the fundamentals of staff engagement, we should now be turning our attention to the wider structure, skills and professional development of our leaders. By tackling this in a systematic way, we will stand a greater chance of moving from "requires improvement" to "good" and beyond and deliver a wider and ambitious integrated improvement programme. We are starting this process with planning the following actions:

- Defining roles and responsibilities of our "Teams of Three" and using our new accountability framework to provide teams with greater clarity on expectations. This will be led by the Interim COO with assistance from the DPC, MD and DoN
- Using the West Midlands Leadership Academy to undertake a personal leadership development assessment for all our key clinical and general management leaders
- Introducing a development programme for our Clinical Directors, sponsored by the MD
- Introducing values based appraisal skills and associated first line manager training in values based leadership
- Introducing a development programme for general managers on the fundamentals of their role, most notably service planning, capacity planning and productivity, sponsored by the CEO and COO
- Standardising the governance processes and decision making processes within our leadership structure in clinical services, ensuring a clearer line of sight and better delegation, between Board and Care Groups

On an unrelated matter, I was proud to have represented the Trust at the annual service to celebrate the life and work of Sister Dorothy Pattinson. "Sister Dora" played a pivotal role in the provision of healthcare for the people of Walsall and the event was appropriately defined as being not just a celebration of Sister Dora's contribution but also a celebration of the NHS and healthcare free at the point of delivery. We must cherish what we have in the UK and our strategic work, as well as our work on professional development and service improvement, are all aimed at ensuring our sustainability, protecting that right to access such services for the long term.

3.3. Improve our financial health through our robust improvement programme

We have now received our control total offer from NHSI for the new financial year. PFIC will consider our proposed response to this before consideration by the Board in more depth. A key precondition to any receipt of PSF or FRF monies next year is exiting the financial year at a run rate acceptable to both us as a Board and to NHSI. The key financial recovery plan scheme which puts this at risk remains, in my view, Theatres productivity. The executive team, through the Interim COO, is taking its responsibility regarding Theatres recovery plan very

seriously and actions regarding management and leadership in this critical area are now being worked through.

I am pleased that our temporary nursing workforce costs are now at a lower level than last year. We haven't used agency CSW since October 2018. This is a significant and symbolic achievement because the introduction of risk assessment and tight management controls, together with a considered winter plan, has delivered this, rather than a risky reduction in fill rates or core establishments. Next year, we must continue to roll out the systematic changes within the nursing workforce transformation programme and in addition, consider how we, in partnership with other Trusts across the STP, can move safely to a "no agency" culture through the establishment of a Black Country nursing bank.

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

Now the NHS Long term Plan (LTP) has been published, it is important that the Board consider every key strategic decision it takes, against the principles and expectations of that national plan.

With regard to Walsall Together (our Integrated Care Partnership – ICP), the Board is in the process of considering the final drafts of that business case. We have long been confident that the intentions, operating model and strategic changes of Walsall Together, were consistent with the NHS Five Year Forward View. Our cross referencing of our intentions to the LTP, leaves partner organisations content that similar congruence is achieved. For example:

- Developing community services in a "locality" footprint of 30-50000 population, consistent with primary care at scale, through new primary care networks
- Reduction of avoidable demand and associated premium costs
- Shift of resources and attention to the prevention of chronic illness/long term conditions
- Relatively higher mental health service investment and focus to that in secondary physical health care

It is critically important for the Board to note and understand another subtlety within both the LTP and the subsequent policy steer from NHSI and NHSE surrounding its implementation. NHSE/I are unequivocal in their view that the delivery and assurance vehicle for the LTP will be STPs. STPs (ours being the Black Country footprint) have to become accredited "Integrated Care Systems"

(ICS) by 2021. So, although we are putting a huge amount of leadership effort into developing transformation of care in Walsall ("place" level), the NHS has a view that equal, if not more effort needs to be given by individually governed NHS providers and commissioners into the ICS agenda. That agenda involves:

- Collaboratively delivering improvements in urgent, elective and cancer care and not assuming that those improvements will be solely achieved at place level
- Repatriation of specialised commissioning activity from Birmingham to the sub-regional centre at RWT
- Integrating service provision in both mental health and secondary acute care, by service, across the Black Country when sustainability problems or service resilience are chronically challenged
- Consideration, where appropriate, of hospital "chain" arrangements where that governance vehicle is considered to be able to accelerate the change expected above

It is clear to me that as a Trust, in 2019/20, we will need to commit similar programme management and leadership time and resources into the ICS horizontal integration agenda, as we have done and will do, with the place based care agenda. Failure to do so could lead us exposed to direction from above, which would not necessarily be in the best interests of the population we serve.

4. RECOMMENDATIONS

Board members are asked to note the report and discuss the implications of my interpretations of both national policy and our strategic intentions, for our future delivery programmes and Board agendas.

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 December and January 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
	Help us improve our Freedom to Speak Up guidance for boards In May 2018 NHSI issued the Freedom to Speak Up guidance and self-assessment toolkit and committed to refining it a year later based on organisation's experiences of using it. NHSI would like to hear the Trusts thoughts on the guidance, which sections proved helpful and which didn't, and whether the toolkit helped us complete a thorough review. NHSI will use our feedback to refresh the guidance, which will be published in the spring. The survey closes on Friday 1 February	**Information**	**Director of People & Culture**
	Creating a just culture In partnership with the Department of Health and Social Care, and as part of NHSI's wider consultation Developing a patient safety strategy for the NHS, NHSI would like Trusts and frontline staff to share their views on how NHSI can create a just culture. A just culture is where staff involved in safety incidents are confident they will be treated in a consistent, constructive and fair way and not unfairly blamed. This is a chance for the Trust to have direct input through the Talk Health and Care online community. NHSI would like to hear from as many people as possible, so please encourage your staff to participate.	**Information**	**Director of Governance**
	Resource pack to support the early adoption of the National Early Warning Score (NEWS2) The deadline for adopting NEWS2 in acute hospitals is Sunday 31 March 2019. To support this, NHSI have published a NEWS2 resource pack — developed with clinical input and in partnership with NHS England, Health Education England and the Royal College of Physicians.	**Action**	**Medical Director / Director of Governance**

	The resource pack includes tools and resources to support Trusts to plan and implement NEWS2 and contains examples of how other organisations are implementing it across the country		
	Hand hygiene and infection control — share your views **Have your say on national hand hygiene policy** Hand hygiene is a key component of standard infection control precautions and remains a priority in tackling healthcare-associated infections. NHSIs national infection prevention and control policy and guidance consensus group has been developing the content of a national hand hygiene policy for England. NHSI are keen to have feedback on this policy from as many frontline NHS staff as possible, so please share this survey and tell us what you think Friday 1 February	**Information**	**Director of Nursing**
	Data from the corporate services 2017/18 benchmarking return now on the Model Hospital Log on to the Model Hospital to find updated corporate services metrics in the finance, governance and risk, HR, information management and technology, payroll, and procurement functions. Trusts can also view 2017/18 corporate services report and the new corporate services opportunity page.	**Information**	**Director of Finance**
	NHS England ***Medicine supply update*** Dr Keith Ridge, Chief Pharmaceutical Officer at NHS England, sent a letter last week to trust pharmacy teams and GPs explaining the steps that have been taken to maintain medicines supply in the event of a 'no-deal' Brexit.	**Information**	**Medical Director**
	NHS shared planning guidance The full NHS shared planning guidance for 2019/20 was published last week. 2019/20 Operational Planning and Contracting guidance sets out the trust financial regime for 2019/20, alongside the service deliverables including those arising from year one of the NHS Long Term Plan. The technical guidance for NHS planning	**Information**	**Director of Strategy**

	2019/20 includes guidance for operational plans in Annex CThe supplementary finance, activity and workforce planning templates and guidance are also now available on the trust portal and on NHSIs website.		
	Review of the patient safety collaborative programme In 2018 NHSI commissioned a review of the operational delivery and impact of the patient safety collaborative programme. This report gives its findings and recommendations to strengthen the programme, including greater collective focus on priority workstreams and delivery of the forthcoming patient safety strategy.	**Information**	**Director of Governance**
	Improvement resource to support the deployment of nursing associates The first nursing associates enter the register this month. To help organisations who have included, or are considering including, this new role as part of their workforce, NHSI have published a deployment resource building on the Nursing and Midwifery Council's standards of proficiency. This resource outlines recommended procedures on governance, leadership and reporting to assist Trusts to deploy nursing associates into clinical teams safely and effectively.	**Information**	**Director of Nursing / Director of People & Culture**
	NHS England **Clinical guidance for use in major incidents** NHS England's clinical guidelines for use in major incidents and mass casualty have been developed following challenging incidents — such as blast injury, penetrating injury and the use of chemical agents, which are unlike those seen in day-to-day practice. This guidance includes best practice in the clinical management of such incidents. Medical and nursing directors, please share this with frontline staff.	**Information**	**COO**
	NHS Digital **Summary Hospital Mortality Indicator (SHMI) review** NHS Digital is leading an ongoing review of the SHMI to evaluate the potential short and long-	**Information**	**Medical Director**

	term changes to improve the indicator. User feedback, especially from medical directors and mortality and quality leads, is invaluable to this process. Medical directors —have any questions or comments on the presentational or methodological changes proposed, please send them to clinical.indicators@nhs.net by Monday 4 February and include 'SHMI review' in the subject line.		
	Patient Safety Alert: Risk of harm from inappropriate placement of pulse oximeter probes An alert has been issued highlighting the risk of harm from inappropriate placement of pulse oximeter probes. Measurement of oxygen saturation, using a pulse oximeter probe, is routinely undertaken as part of patients' vital signs during diagnosis and ongoing monitoring. Adult oximeters are designed to attach to specific parts of the body, such as the finger or an ear, but are not interchangeable between these sites, and probes for babies and children need to be selected according to the patient's weight. Inappropriate placement of oximeters can lead to inaccurate readings putting the patient at risk of harm. If the Trust uses oxygen saturation probes as part of routine or emergency monitoring of patients, please develop an action plan to reduce the risk of their inappropriate placement, as highlighted in the alert.	**Action**	**Director of Governance**
	Quality accounts 2018/19 requirements All providers are required to publish a quality account by 30 June each year. NHSI have now published requirements for 2018/19, which include new considerations for disclosures on seven day hospital services and arrangements for staff who speak up. Please ensure governance team is aware of these requirements	**Action**	**Director of Governance**
	Upcoming changes to the venous thromboembolism (VTE) data collection In April 2018 NICE updated their Venous thromboembolism (VTE) risk assessment guidance (NG89). One of the main changes was	**Action**	**Medical Director**

	that patients aged 16 and 17 years old should be risk assessed. The guidance previously only referred to patients over the age of 18. From April 2019 NHSI will be bringing our VTE data collection in line with this change and the NHS Standard Contract will also be updated. The current VTE Data Collection guidance will be replaced by new guidance in March. Trusts will need to start collecting the data from April 2019 with the first submission of data including the new criteria for Q1 2019/20 in July 2019, so Trusts may need to make adjustments to T systems to take account of this change. Data for Q4 2018/19 submitted in April 2019 should be collected using the old criteria for patients aged 18+ only.		
	NHS England **New guidance on instant messaging for the NHS** New guidance has been published by NHS England, NHS Digital, Public Health England, and the Department of Health and Social Care to help NHS organisations and staff to make a judgement on how and when to use instant messaging safely in acute clinical settings, taking in to account data sharing and data privacy rules. The NHS has not endorsed any particular instant messaging tools; instead, the guidance sets out what information governance issues need to be considered and what standards need to be met. Please share this guidance with IG leads and department heads to communicate the guidance to clinicians.	**Information**	**Director of Strategy & Improvement**
	NHS Supply Chain **VAT registration changes for NHS Supply Chain** NHSI notified Trusts by email on Tuesday 11 December that from 1 April 2019, the entity responsible for managing NHS Supply Chain procurement will be Supply Chain Coordination Limited (SCCL), an entity VAT registered independently of the NHS, and therefore existing outside the English NHS divisional VAT registration. Directors of finance — to help NHS Supply Chain understand the impact of these changes	**Action**	**Director of Finance**

	on back office and procurement systems and processes, please ask relevant finance or procurement representative to complete this short survey by Thursday 31 January.		
	A national patient safety strategy is being developed alongside the NHS Long Term Plan and will be relevant to all parts of the NHS. NHSI are running a consultation until Friday 15 February, and would like to hear what Trusts think to make sure the strategy works for both patients and staff. Find out more and share your views.	**Action**	**Director of Governance**
	New outpatients diagnostic dashboard Our outpatients diagnostic dashboard provides analysis and benchmarking of outpatient activity across 112 trusts nationwide. All trusts can now access the dashboard and view high-level trust analysis. If your trust is participating in our outpatient improvement programme and you've submitted data, you can benchmark your trust against selected peers across three domains (productivity, capacity release and digital improvement opportunities) to help identify potential outpatient efficiency and productivity improvements.	**Information**	**COO**
	Patient Safety Alert — Safer temporary identification criteria for unknown or unidentified patients Patient Safety Alert resources have been issued to help organisations ensure a safer system for the temporary identification of unidentified or unknown patients. Emergency departments often care for patients unable or unwilling to give their identity — including people who are unconscious or who have a critical illness, people with delirium, people with a mental health condition, and people affected by drink or drugs. Several unidentified patients may arrive together after an accident, or in mass casualty situations.	**Action**	**Director of Governance**
	NHS England **New mental health support for mothers** A new set of mental health leaflets offer support for mothers, their families, and the teams that care for them. The eight leaflets cover a broad	**Information**	**COO**

	range of topics including postnatal depression, postpartum psychosis and perinatal OCD, and the use of lithium and antipsychotics in pregnancy and breastfeeding. They offer advice and signposts to promote better understanding and support people in making decisions about perinatal mental health issues. The leaflets have been written jointly by perinatal psychiatrists, women with lived experience of perinatal mental illness, and their partners. They have been delivered in partnership by RCPsych, NHS England and Health Education England. Please ensure your maternity and mental health teams are aware of these leaflets.		
	NHS Employers **New resources to improve doctors' experience of rotations** NHS Employers has launched a range of web-based resources to help Trusts improve the rotational experience for doctors in training. The resources are developed following a pilot study by 12 NHS organisations who tested six principles designed to streamline the rotational experience. The resources include an interactive readiness assessment tool that helps establish the Trust position against the six principles, highlight actions to be taken and directs them to relevant resources.	**Information**	**Medical Director / Director of People & Culture**
	Apply for a share of £78 million national funding to support the increased use of electronic prescribing and medicines administration (ePMA) Last week, the Department of Health and Social Care announced the first 13 trusts who will receive a share of £78 million national funding to support the implementation of electronic prescribing and medicines administration (ePMA). The money will accelerate the introduction of these systems to provide safer, better quality patient care. NHSI are now looking for more trusts to bid for funding by 31 January 2019. Please speak with your chief pharmacist who can apply through the Hospital Pharmacy and Medicines Optimisation collaboration hub.	**Action**	**Director of Strategy / Medical Director**

	Nursing and Midwifery Council (NMC) **Change to English language requirements for nurses and midwives gets green light** Proposals to change the requirements for overseas nurses and midwives taking the International English Language Test System (IELTS) have been approved by the NMC. Following the change, nurses and midwives will still be required to achieve a minimum overall level of 7 in the test. HoNHSIver, a level 6.5 in writing will be accepted alongside a level 7 in reading, listening and speaking. NMC is not currently changing the requirements for the Occupational English Test, but will keep this under review. NMC will be monitoring the impact of this change carefully and will be doing some more engagement and research on how they test for language competence in the future starting early next year.	**Information**	**Director of Nursing / Director of People & Culture**
	NHS Employers **Implementing the 'SAS charter'** NHS Employers has produced a suite of new resources to support employers with implementing the charter for specialty and associate specialist doctors (SAS). The checklist, monitoring tool and evaluation toolkit can help gauge current progress in clinical departments, identify areas for improvement and offer further support. The charter was launched in 2014 to assist employers and SAS doctors in working together. It sets out what employers can expect from SAS doctors, and also ensures clinicians are properly supported in the workplace and get the recognition they deserve.	**Information**	**Medical Director / Director of People & Culture**

MEETING OF THE PUBLIC TRUST BOARD - 7TH FEBRUARY 2019			
Monthly Nurse Staffing Report – December 2018 Data			**AGENDA ITEM: 8**
Report Author and Job Title:	Angie Davies Associate Director of Nursing - Workforce	**Responsible Director:**	Dr Karen Dunderdale Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	December was a challenging month for securing temporary staffing due to an increase in annual leave uptake amongst bank staff and agency staff. This along with unprecedented activity (Level 4, internal gold command) resulted in an in-house escalation rate for bank staff approved at Director level, to support staffing levels for identified shifts when needed which helped to secure temporary staffing for the most vulnerable shifts. Despite this we maintained our overall position of shift fill rate around the 95% fill rate, and temporary staffing spend and usage remains lower than at this time last year. All of the new establishments have been run on the December rota and the quality indicators demonstrate that staffing levels have not had a detrimental effect on patient harm. Leadership and management development for ward managers has started and will be undertaken over the coming year, with a clear expectation around objective setting and application of learning into practice.		
Recommendation	The Trust Board is requested to note the contents of the report and make recommendations as needed.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Corporate Risk No 211: Failure to recruit to the nursing body of the organisation leaves a deficit in nursing provision.		
Resource implications	None		
Legal and Equality and Diversity implications	None		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

MONTHLY NURSE STAFFING AND WORKFORCE REPORT

1. PURPOSE OF REPORT

This is the monthly report to the Trust 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 all settings and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care.

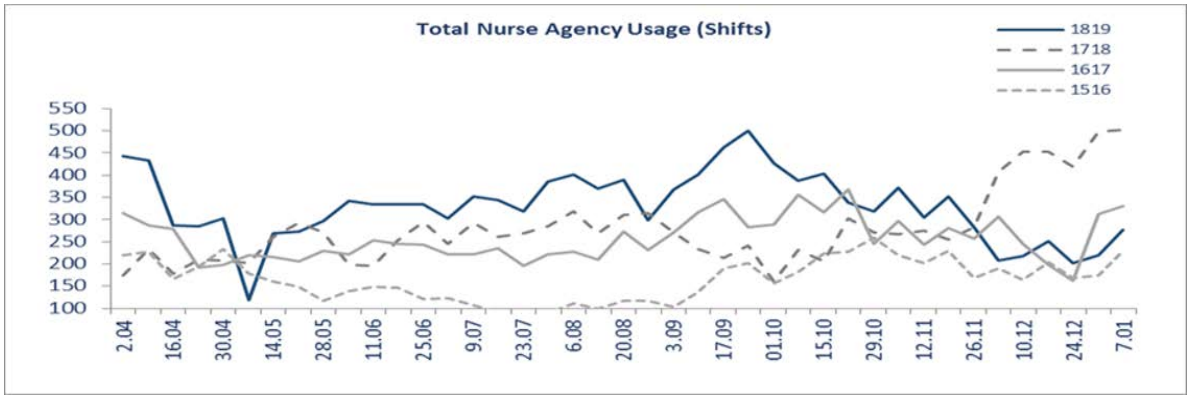
Progress is reported against the four key workstreams in the nursing workforce transformation programme – Temporary Staffing; Rostering; Workforce Development; Establishments.

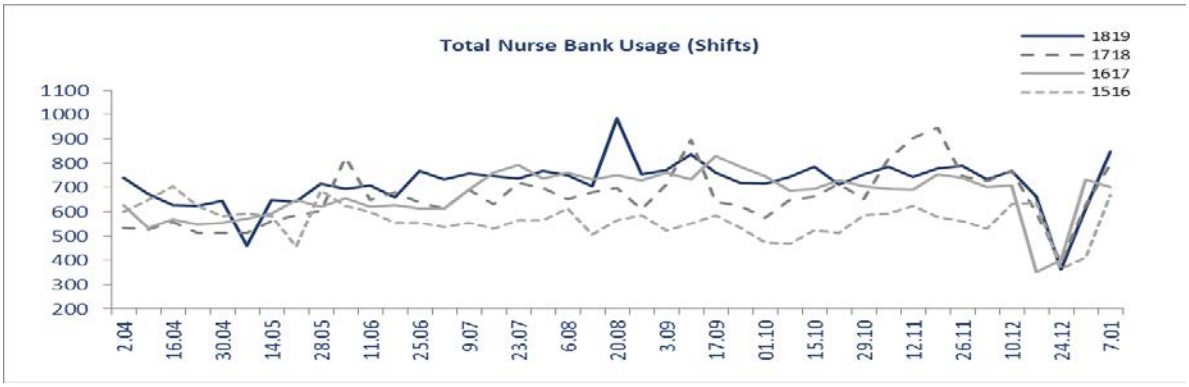
2. PROGRESS UPDATE

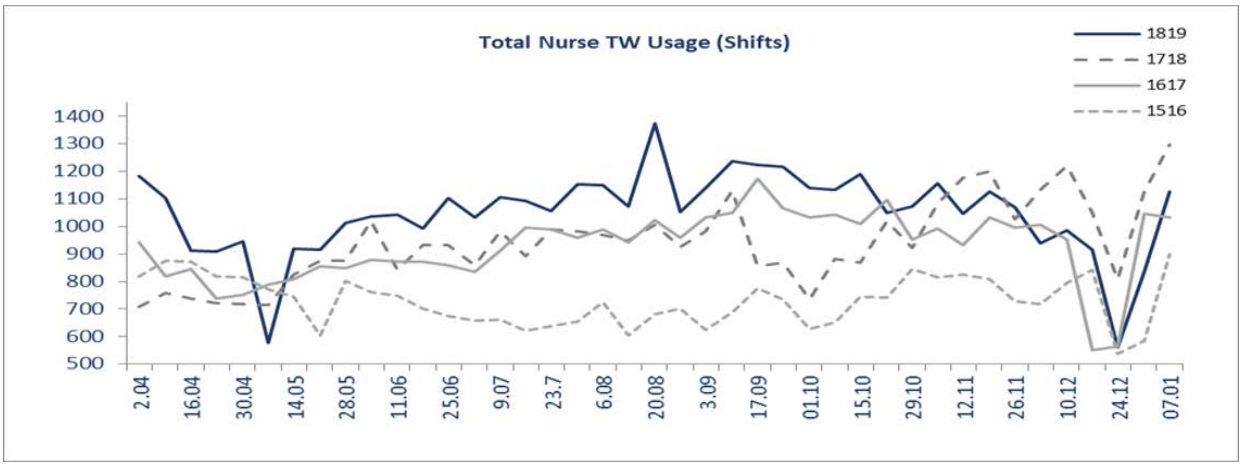
2.1 Temporary Staffing

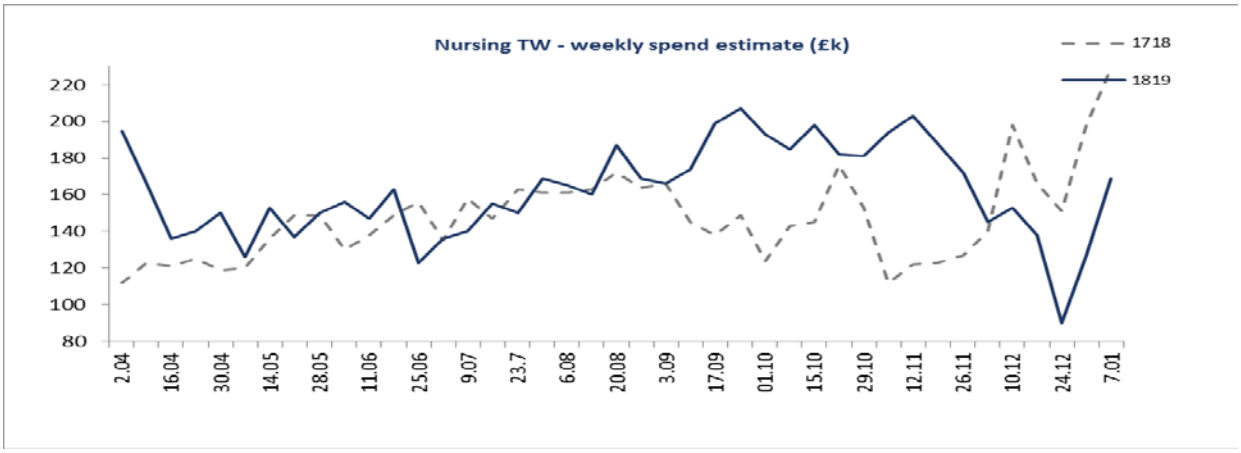
Nurse Agency total usage reduced during December 2018 (following the general reduction trend seen since mid September) and remains lower than the same period in 2017. Bank usage also reduced during December and is slightly higher than the same period in 2017.

Christmas and New Year rosters were monitored weekly from mid November to the festive period, so actions could be taken in a timely manner to secure appropriate cover as required. Daily staffing meetings occurred twice daily, 'red and amber' shifts were opened to temporary staffing at seven days in advance instead of the usual five days to secure shift cover. Christmas week was difficult to secure temporary staffing, due to annual leave uptake across the bank and agencies. Bank and Agency use and spend overall during December remains lower than for the same period for last year.





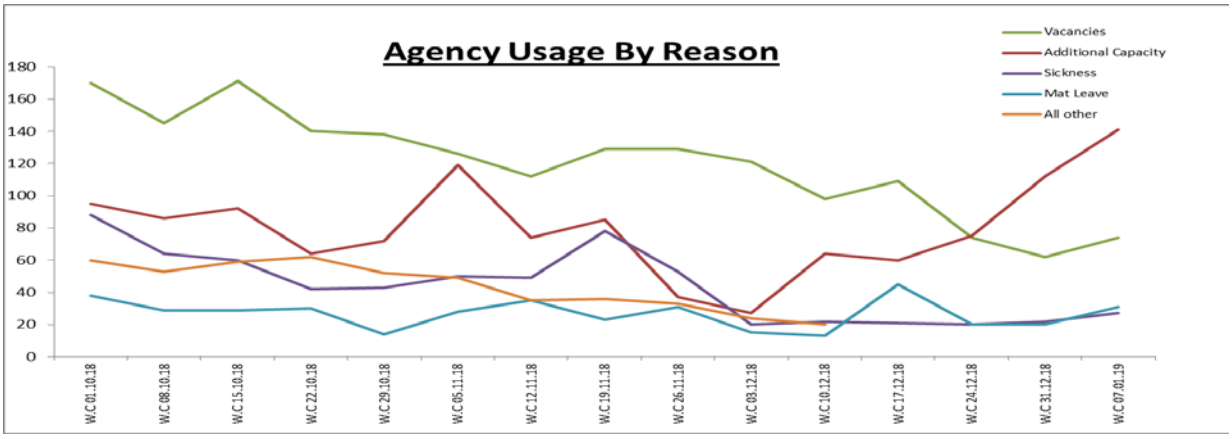




The top four reasons for temporary staffing usage during December 2018 were:-

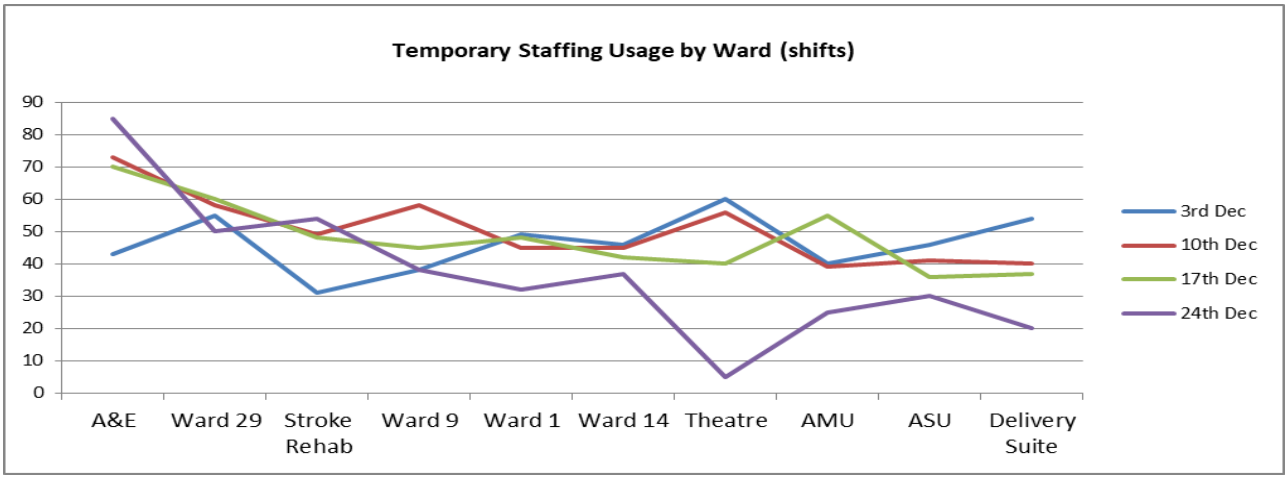
- Vacancy
- Additional capacity
- Sickness
- Maternity leave

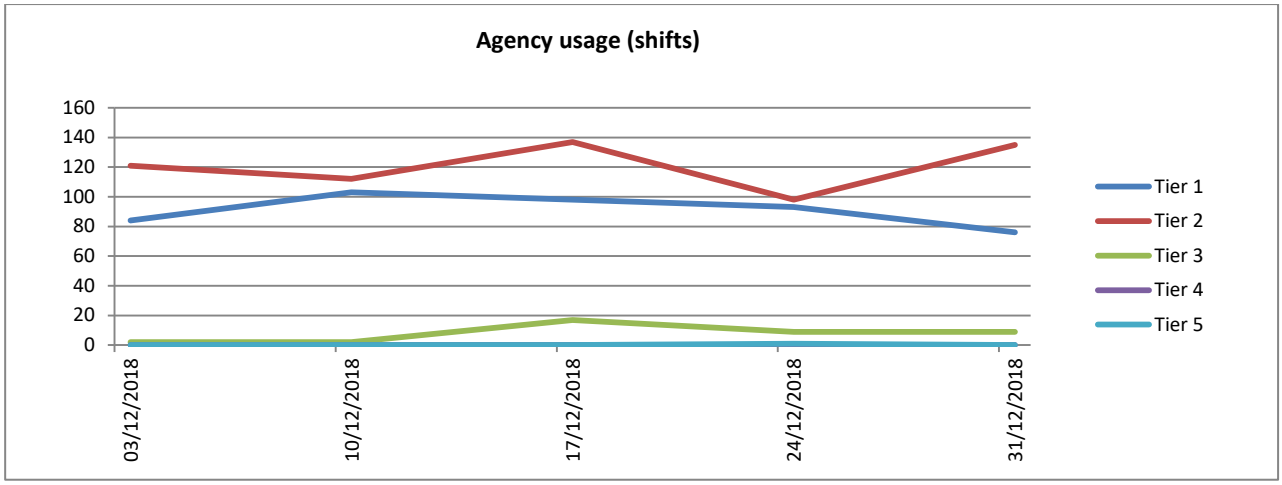
This is a consistent picture with weekly fluctuations to bookings requested for additional capacity bed opening and short term sickness. Temporary staffing requests due to vacancy has declined steadily since October as newly recruited staff have started in post. Temporary staffing requests due to maternity leave remains fairly constant month on month and an organisational solution for this may need to be considered to support a more sustainable temporary staffing arrangement.



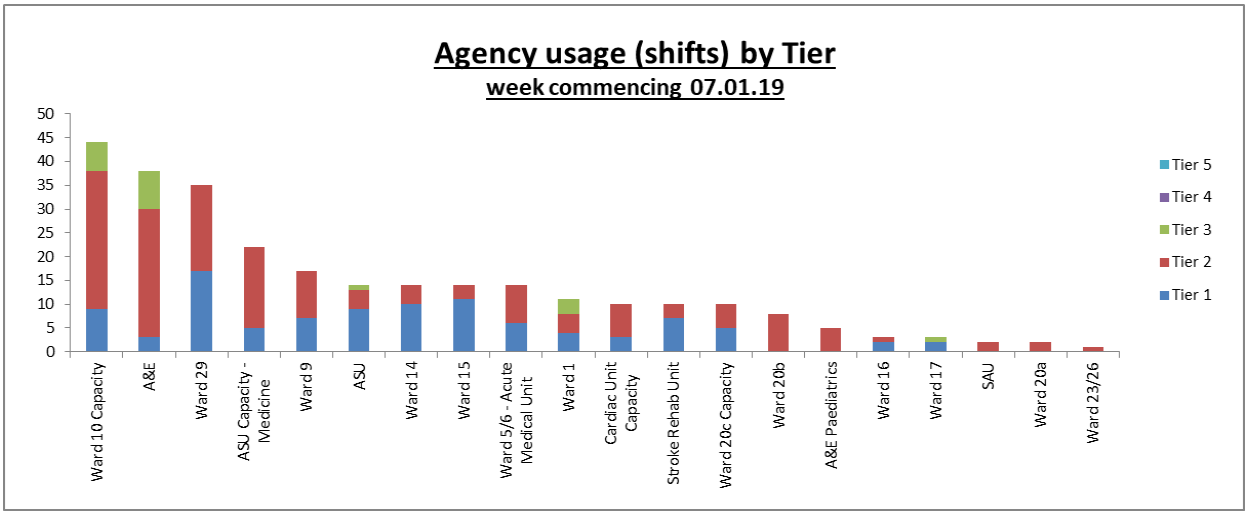
Week	Additional Capacity	Vacancies	Sickness	Mat Leave	All other
W.C 03.12.18	27	121	20	15	24
W.C 10.12.18	64	98	22	13	20
W.C 17.12.18	60	109	21	45	17
W.C 24.12.18	75	74	20	20	12

The ward areas with the highest volume of temporary staffing usage during December are captured below and this fits with the reasons for temporary staffing requests around the opening of additional beds, spikes in short term sickness and establishment gaps.





All roster gaps are escalated to the temporary staffing team at Roster sign off, and made available to bank staff, this gives a minimum of 6 weeks before the roster goes live. At 4 weeks pre-working date gaps are released to tier 1 agencies, to optimise an ability to gain Tier 1 fill. This is line with regional activity. During December no shifts were filled with Tier 4 or Tier 5 agency nurses.



Tier 3 agencies were used to cover additional bed capacity on ward 10/ ASU and have nurses with an emergency care skill set, which is a more cost effective option than an off-framework nurse (Thornbury). Red shifts are filled with tier 2 or tier 3 agencies which accounts for those wards without additional beds but have been deemed as 'red' for shift cover priority.

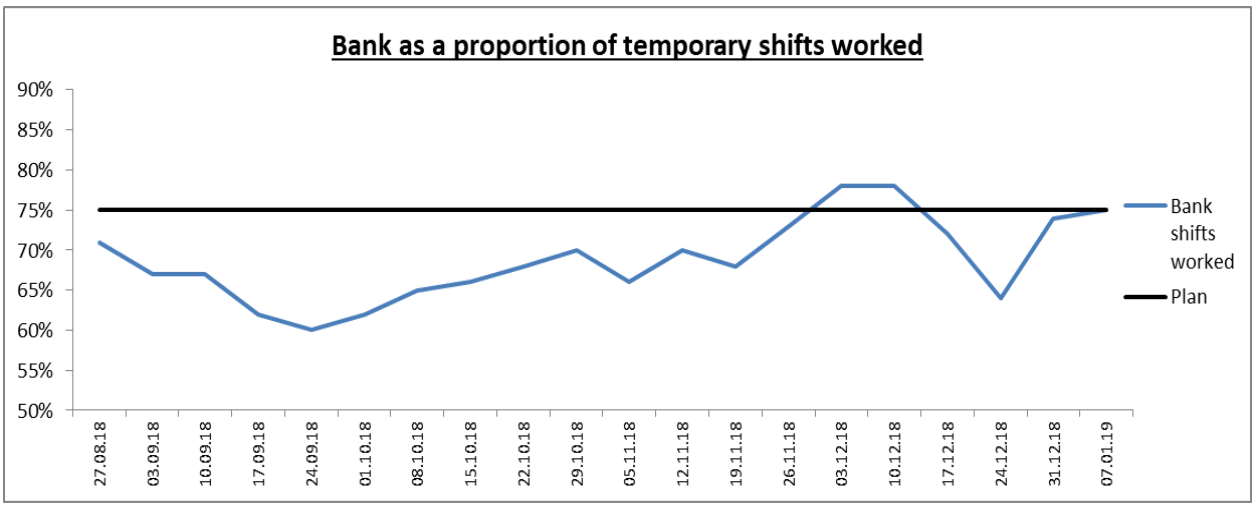
During the level 4 internal gold escalation period in house escalation rates were agreed at Director level for a number of shifts when temporary staffing cover was required but with continued difficulties in securing that cover from bank or agencies. The table below shows the number of hours and rates that were offered and worked for both registered nurses and Clinical support workers. The overall cost to the organisation to cover that period was around £37k due to the enhanced rates being taken up.

No agency CSW was used and the position of no off-framework nurses was maintained. All escalation rates were within temporary staffing framework capped levels. An options paper for bank escalation rates is being developed for consideration by Trust Board. Currently an interim position for escalated rates at a declared Level 4 status, has been agreed until the options paper has been discussed and a decision taken.

	Week commencing 24-Dec			Week commencing 31-Dec		
	Hours	Hourly Cost	Total Cost	Hours	Hourly Cost	Total Cost
RN	52	£65	£3,380	477.5	£65	£31,038
	18.5	£30	£555	171.5	£50	£8575
				34.5	£40	£1380
				23	£35	£805
CSW	46.5	£20	£930	537.5	£20	£10,750
				29	£16	£464
TOTAL			**£4,865**			**£53,012**

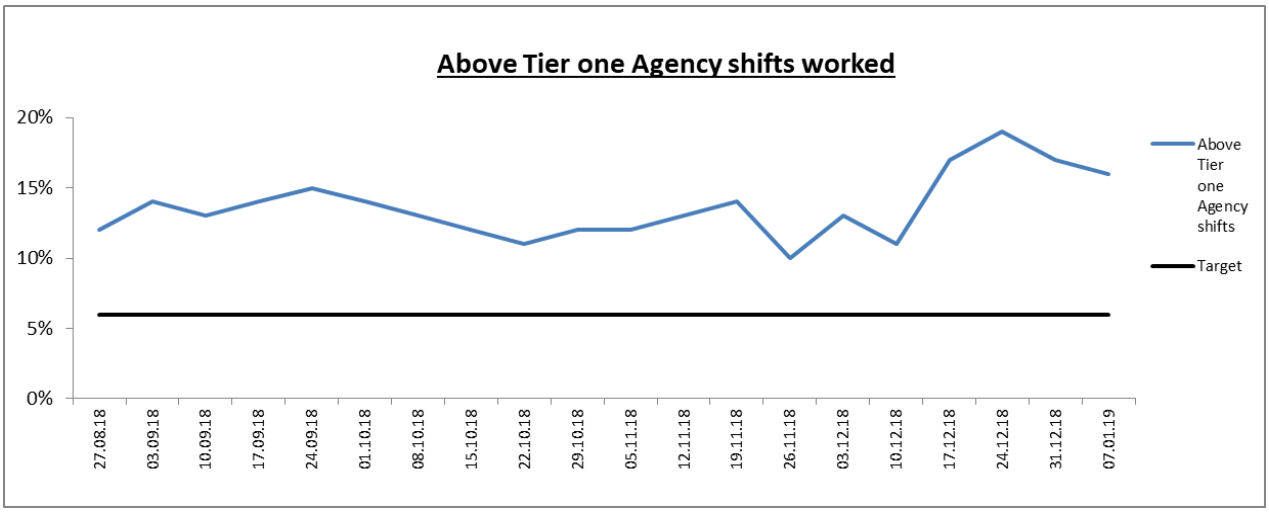
	Hrs	Enhanced Rate	Normal Rate	Increased Cost
Xmas (26th -28th Dec)	117.0	6,227	2,606	3,621
New Year (31st - 6th Jan)	1209.5	64,027	30,588	33,440
7th-9th Jan	290.2	9,526	4,792	4,734
Total	**1616.7**	**79,780**	**37,986**	**41,795**

The target of 75% temporary staff shift fill using bank cover was exceeded for the first time this year during December when two consecutive weeks achieved a fill rate of 78%. This followed a general increase in uptake of bank shifts seen since the beginning of November. Recruitment to the nurse bank continues proactively in order to increase the availability of bank staff for shift cover which will support our efforts to use more bank staff instead of agency staff.

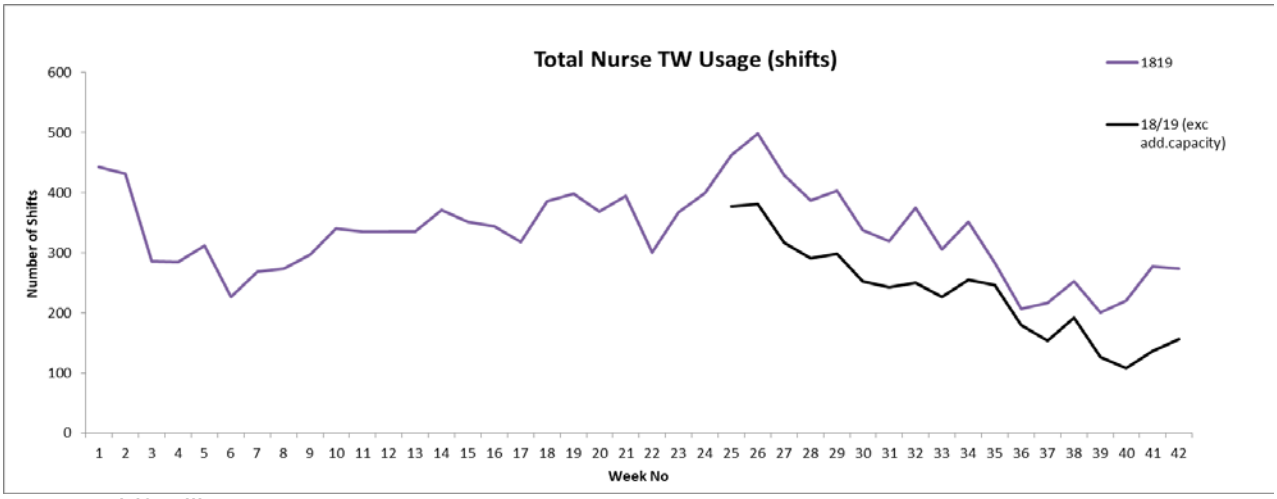


	Shifts		Hours		%	
Week commencing	Bank	Agency	Bank	Agency	Bank	Agency
03-Dec	732	207	5890	1679	78%	22%
10-Dec	768	217	6129	1879	78%	22%
17-Dec	664	252	5377	2207	72%	28%
24-Dec	361	201	2903	1745	64%	36%

The target of 6% shift fill for use of temporary staffing above Tier 1 has never been achieved in year as yet, with the best position so far being achieved at 10% during November. December saw a rise up to 16% of above tier 1 agencies being used, due to increase in demand, short notice fill and reduction in supply from tier 1 agencies. The 6% target will be adjusted next year to reflect a more realistic and achievable target.



A range of control measures have been implemented and put in place since September to ensure the temporary staffing use and spend position improves and that rosters are of a quality standard, efficient and fair. The grip and control that is now being embedded into practice is reflected in the table below which shows a trend of reduction in total use with and without additional capacity staffing.



2.1.2 Shift Fill

Shift fill rates data is used to populate the monthly Hard Truths return, submitted to NHS Digital. This submission is a mandatory requirement for NHS Trusts. The fill rate submission requires information on in-patient areas but not ambulatory care, short stay and ED. Appendix 1 shows fill rate data.

The average fill rate for registered nurses in December 2018:

- 92.15% for day shifts
- 96.82% for night shifts

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Day	RN	95.84%	95.10%	95.22%	97.33%	95.09%	92.15%
	CSW	91.90%	92.40%	91.33%	94.64%	94.47%	92.80%
Night	RN	96.22%	94.57%	95.19%	97.35%	97.81%	96.82%
	CSW	97.46%	97.72%	96.59%	99.19%	99.68%	99.36%

Of the 23 areas reported on during December 2018, a number of areas worked with less than 90% of nurses and less than 80% of CSW's on a number of occasions.
All staffing shortfalls are risk assessed daily and staff are redeployed accordingly.

- 6 areas recorded less than 90% shift fill rate on days for RN
  - Wards 1/ 2 / 3 / 9 / 29 /AMU.
- 3 areas recorded less than 90% shift fill rate on nights for RN
  - Ward 1 / 9 / AMU
- 2 areas recorded less than 80% shift fill rate on days for CSW
  - Wards ICU / 9.
- 1 area recorded less than 80% shift fill rate on nights for CSW
  - Ward ICU

		Number of areas with <90% shift fill					
		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Days	RN	4	2	3	0	4	6
Night	RN	2	4	3	1	1	3

		Number of areas with <80% shift fill					
		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Days	CSW	3	1	3	3	8	2
Night	CSW	1	1	1	2	2	1

2.1.3 CHPPD

The CHPPD data continues to show unwarranted variation. The reasons for this are currently being explored but the initial impression is one of inconsistency in data recording and data entry, without validation from the Divisional Directors of Nursing. The process for data collection and data submission is being reviewed to strengthen the governance around this and reduce the variation in CHPPD that the Trust is currently reporting. This variation is reflected in Model Hospital when

compared to our peer group. Further work to improve this position and to then fully understand the impact of the CHPPD is being undertaken.

The full NHS Digital upload is provided in Appendix 2.

2.1.4 Reported incidents

Month and Year	PU Total	PU's per 1,00 admissions	Med Omissions	Med Omissions per 1,00 admissions	Patient Fall	Patient Falls per 1,00 admissions	Staffing	Staffing per 1,00 admissions
Oct 18 (Oct-17)	49 (51)	7.4 (8.2)	24 (25)	3.6 (4.0)	82 (97)	12.43 (15.5)	65 (59)	9.9 (9.4)
Nov 18 (Nov-17)	56 (59)	8.5 (9.3)	18 (26)	2.7 (4.1)	74 (83)	11.2 (13.0)	85 (54)	12.9 (8.5)
Dec 18 (Dec-17)	43 (48)	7.1 (8.8)	14 (31)	2.3 (5.7)	90 (97)	14.9 (17.8)	130 (66)	21.5 (12.1)
2017 - 2018 comparison notes:	**Pressure ulcers:** 4 fewer incidents reported but rate lower in 2018		**Medicines omissions:** fewer incidents reported and significantly lower rate in Nov / Dec.		**Patient Falls:** 5 fewer incidents reported but the rate is lower in 2018		**Staffing:** Significant increase in Nov & Dec 2018 in both numbers reported and rate against admissions.	

Safe staffing levels have a direct impact on outcomes for patients. For all wards with an average fill rate of 90% or less, it is essential to identify correlating harm to patients through reported incidents and poor patient experience.
The number of incidents reported as shown in the table above that relate to staffing concerns do not directly correlate with a corresponding increase in quality issues or concerns as this position remains fairly static overall. However this will be monitored closely over the near future as staffing pressures continue, so actions can be taken in a timely manner if a correlation between staffing and quality is identified as a concern.

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2.1.5 Daily staffing Reviews

Meetings to discuss staffing levels and staffing gaps occur twice daily, with an aim of identifying and applying a priority to the shift gaps in order to secure temporary staffing cover and to develop an operational staffing plan. Gaps are deemed to be no longer required, amber (25% RN gap, with/without red flags) or red (50% RN gap with / without red flags). 'Red' shifts are escalated to agencies above tier 1.
The Matrons attend the meeting and have made progress in their approach to prioritising shifts within their own ward and Divisional areas, but there is more progress to be made to shift the mind set to an organisational cross site approach to redeployment of staff when needed not just across own Division

but across the site. Overall the meetings have had a positive impact in helping the Matrons and Divisional Directors of Nursing to understand the daily staffing position and in better planning for the seven days in advance with regards to a daily changing staffing picture.
This meeting will continue to be supported by the Director of Nursing Directorate until a level of confidence in the Matrons execution of wider cross site thinking is embedded.

2.2 Rostering

Roster KPIs	Target	Tolerance	Actual				
			MLTC	D of Surgery	WCCSS	Community	Overall
Efficiency							
Compliance with sign off on correct date	100%		All areas compliant	5 out of 6 areas	All areas compliant	0 out of 1 area	22 out of 24 areas
95% of Shifts to BANK at Sign-Off compliance	100%		10 out of 11 areas	5 out of 6 areas	N/A	All areas compliant	16 out of 18 areas
* Contractual Hours Unused within Roster Period (Total)	0						
* Time Balance - Total No. of Hours Owed to Trust	0						
* Time Balance - Total No. of Hours Owed to Employees	0						
Safety							
Planned number of shifts without NIC cover	0		5 out of 11 areas	3 out of 6 areas	3 out of 6 areas	0 out of 1 area	11 out of 24 areas
Actual number of shifts without NIC cover	0		6 out of 11 areas	2 out of 6 areas	4 out of 6 areas	All areas compliant	12 out of 24 areas
Fairness							
Planned sickness headroom (not ESR data)	3.3%		3 out of 11 areas	2 out of 6 areas	1 out of 6 areas	1 out of 1 area	6 out of 24 areas
Actual sickness headroom (not ESR data)	3.3%		9 out of 11 areas	No areas compliant	No areas compliant	No areas compliant	21 out of 24 areas
Planned study leave headroom (not within tolerance)	3%	+/-1 %	All areas compliant	All areas compliant	All areas compliant	All areas compliant	All areas compliant
Actual study leave headroom (not within tolerance)	3%	+/-1 %	All areas compliant	All areas compliant	All areas compliant	All areas compliant	All areas compliant
Planned annual leave headroom (not within tolerance)	14%	+/-3 %	6 out of 11 areas	3 out of 6 areas	1 out of 6 areas	0 out of 1 area	10 out of 24 areas
Actual annual leave headroom (not within tolerance)	14%	+/-3 %	5 out of 11 areas	4 out of 6 areas	2 out of 6 areas	All areas compliant	11 out of 24 areas
* to be reported in future reports							

A spike in short term sickness was experienced in most clinical areas through December and this compounded the staffing challenge regarding ensuring safe staffing levels. All senior nursing teams are being supported to address sickness issues within their areas and a proactive approach to managing this as an issue is being taken. Some staff behavioural and attitude issues have been identified in response to the control measures and establishment changes that have been implemented recently are being reflected in the short term sickness behaviours. This is being addressed.

Unused hours will be reported from next month and will give an overview of total hours unused and how this splits to individuals who either owe or are owed more than the 11.5 hours threshold. Intensive work through December and January to get a grip on this position has been undertaken and will be reported on next month.

Unpaid leave is being discussed with all ward managers. The emerging themes are unauthorised absence and not returning from annual leave when due to return. These themes have been identified through the discussions held with the ward managers and picked up through the unpaid leave report which is produced monthly. Progress is being made around reducing the incidence of unpaid leave

where there is no legitimate reason to do so and for December 2018 134 hours of unpaid leave was taken compared to December 2017 678 hours of unpaid leave was taken. Further work to embed best practice is being progressed with the ward managers and Matrons.

2.3 Workforce Development

The leadership and management development programme starts in January and will be delivered to all ward managers over two cohorts and one cohort of Matrons. The programme will have nine modules delivered over twelve months, with a clear expectation of application of learning to practice when in role.

An internal expressions of interest for the CSW Band 2 Response Team is currently out to advert within the organisation which will support the daily operational staffing pressures as part of the staffing support offer.

The first cohort of Trainee Nursing Associates qualified at the end of December 2018 and 18 have been offered substantive contracts within the organisation. Following the receipt of their PIN in January 2019 they will then move into their substantive Nursing Associate roles and be included in the ward establishments. This supports the reduction of the establishment gap from February 2019.

2.4 Establishments

The current establishment gap from ESR as mid January 2019 (excluding theatres) are shown below with numbers of pipeline recruits over January - March. The establishment gap is positively reducing and this will contribute to enhancing the staffing levels and reducing agency usage. All new starters will be offered a bank contract on appointment to the Trust.

Division	Establishment Gap – RN (FTE) Vacancy gap	Long Term Sickness Gap (FTE)	Maternity & Adoption Leave (FTE)	Total Gap – FTE	Establishment Gap Rate %	Pipeline - Jan	Pipeline – Feb	Pipeline – Mar	Total
SURGERY	19.33	6.22	3.44	28.99	10.30%	5.92	3.00	4.00	12.92
MLTC	34.6	7.94	10.41	52.95	15.51%	20.10	1.00	4.00	25.10
WCCSS	17.6	0.59	12.35	30.54	6.44%	5.00	1.00	2.00	8.00
						31.02	5.00	10.00	46.02

During December there were ten registered nurses and thirteen CSWs that joined the bank with a further cohort of CSW's to be recruited to a February start date, ongoing recruitment to bank will continue as a long term ongoing action.

Four overseas nurses arrived at the Trust during December and four apprentice CSW have recently qualified and are now in substantive posts on Ward 9 and Ward 20a.

A recent decision made through NMAF supports the move to the recruitment of Mental Health Nurses which is about to start, we are currently working on the clinical support structure for these nurses when appointed to a general nursing post to have assurance we are ready to offer them a comprehensive package of support prior to going to advert.

AMU and Ward 29 establishment changes occurred in December due to an increase in core bed base once it was identified that both ward areas were using additional beds over their original core bed base, on a permanent basis. This required an adjustment to their establishments which were enacted within the December rosters to provide immediate staffing support on an agreed and established basis.

AMU

Ward						Patient:Nurse Ratio		Default Staff Mix (Peak Day Shift)			Default Staff Mix (Night Shift)			SkillMIx
		Beds	Occupancy	Patients	Acuity (1,2,3,4 etc)	Staff Minimum (Day Shift)	Staff Minimum (Night Shift)	Reg	HCA	Total	Reg	HCA	Total	Reg %
Medicine:														
Original	AMU	30	100%	30	4a	9.09	6.00	5	5	10	4	4	8	50%
Original	AMU (monitored)	12	90%	10.8	5	3.18	2.70	3	1	4	3	0	3	83%
	Total	42				12.27	8.70	8	6	14	7	4	11	
Revised	AMU	33	100%	33	4a	10.00	6.60	5	5	10	4	5	9	48%
Revised	AMU (monitored)	12	90%	10.8	5	3.18	2.70	3	1	4	3	0	3	83%
	Total	45				13.18	9.30	8	6	14	7	5	12	
Change	Total Change	3				0.91	0.60	0	0	0	0	1	1	

WARD 29

Ward						Patient:Nurse Ratio		Default Staff Mix (Peak Day Shift)			Default Staff Mix (Night Shift)			SkillMIx
		Beds	Occupancy	Patients	Acuity (1,2,3,4 etc)	Staff Minimum (Day Shift)	Staff Minimum (Night Shift)	Reg	HCA	Total	Reg	HCA	Total	Reg %
Medicine:														
Original	Ward 29	26	95%	24.7	3	7.06	3.09	4	3	7	3	2	5	58%
Revised	Ward 29	31	95%	29.45	3	8.41	3.68	5	3	8	3	3	6	59%
Change	Total Change	5				1.35	0.59	1	0	1	0	1	1	

3.0 RECOMMENDATIONS

The Committee is requested to note the report and make recommendations as necessary.

4.0 CONCLUSIONS

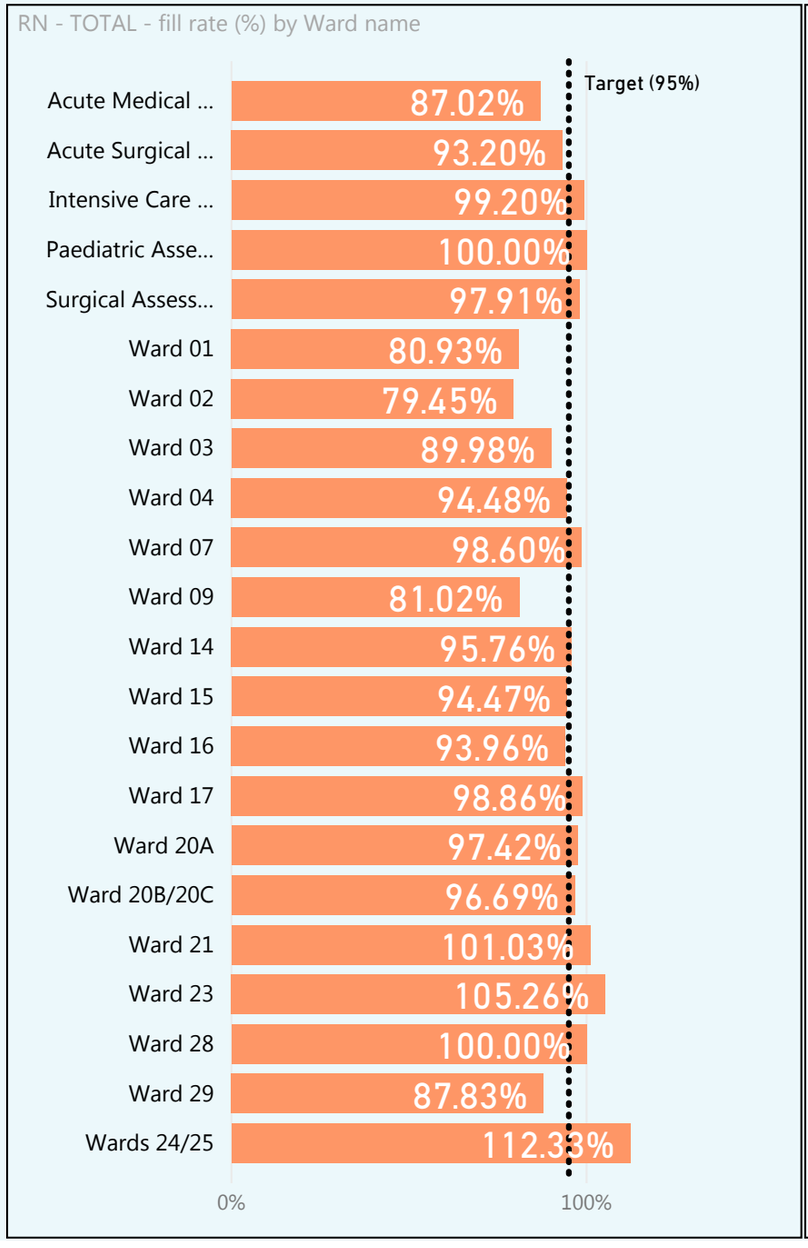
The report is presented to reflect the on-going nursing workforce transformation and will continue to reflect the progress being made and the improvements in grip and control across temporary staffing and rosters in particular but enhanced by workforce developments and agreed safe establishments according to national guidance and best practice.

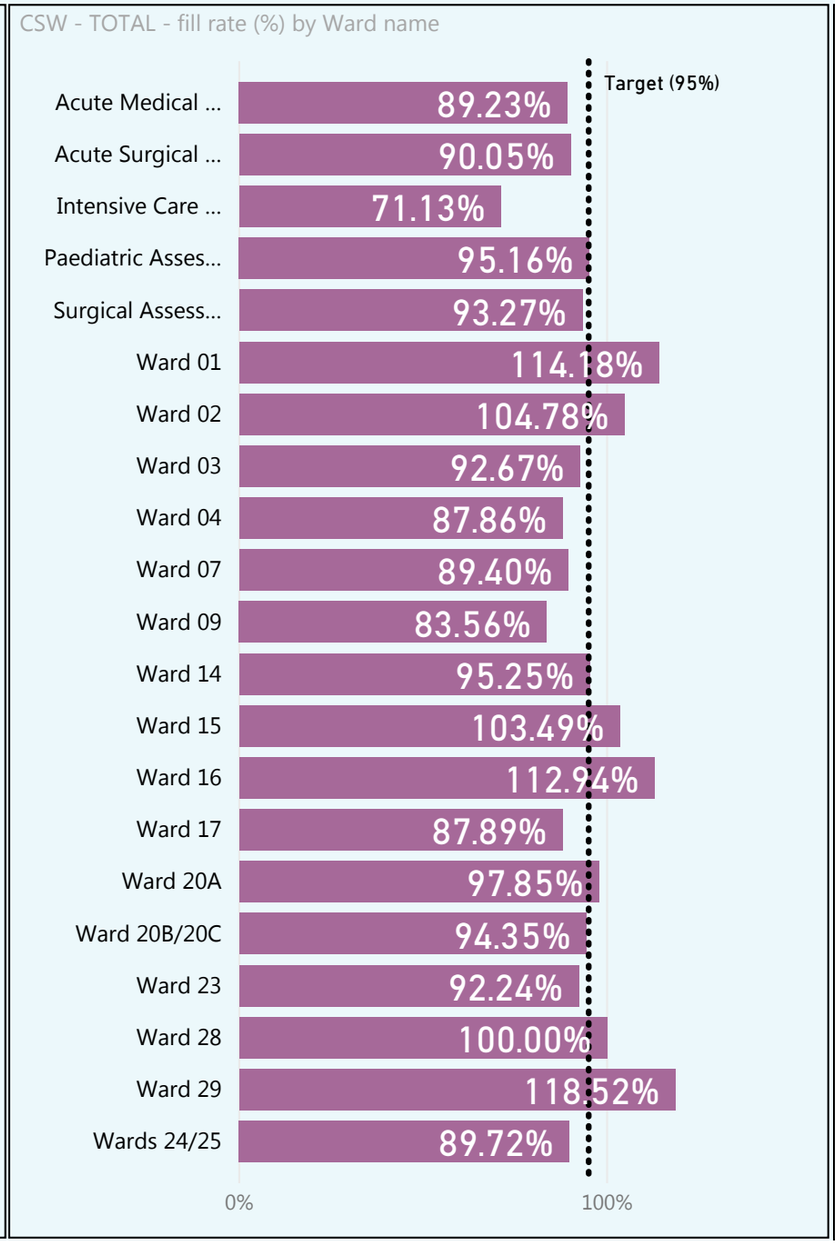
Appendix 1: Fill rate data
Appendix 2: NHS Digital Upload

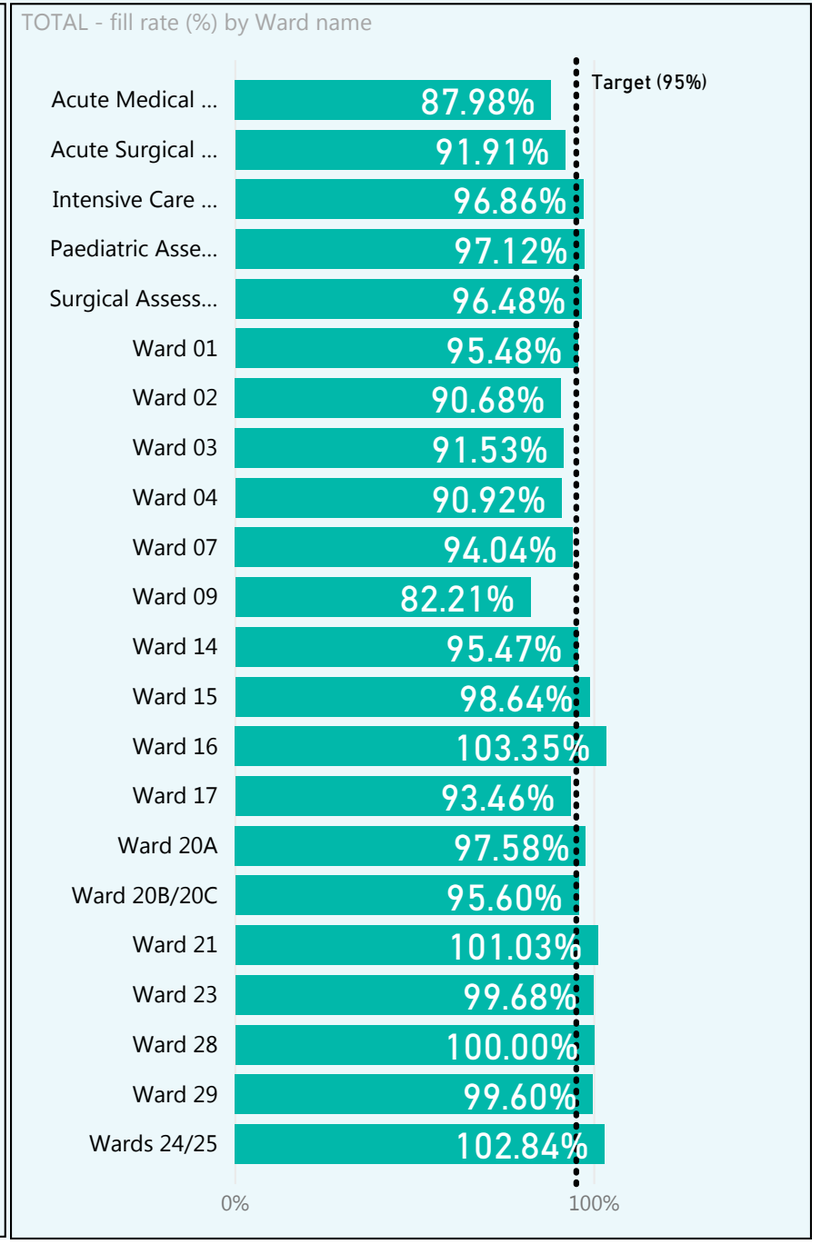
MonthInCalendar

01 December 2018

Safe Staffing Return - Overall Fill Rate split by Ward by RN / CSW



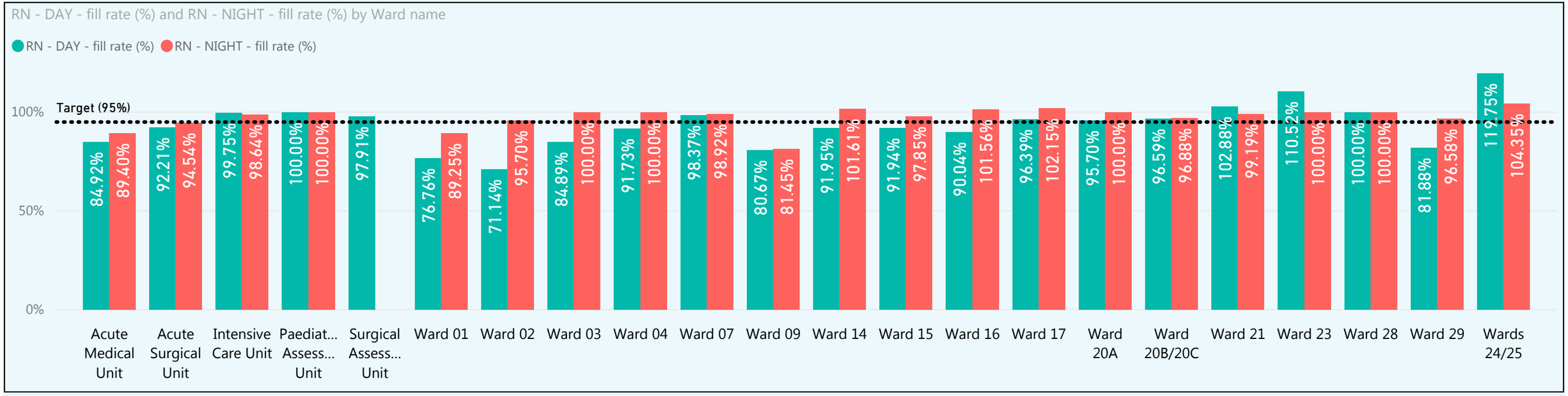


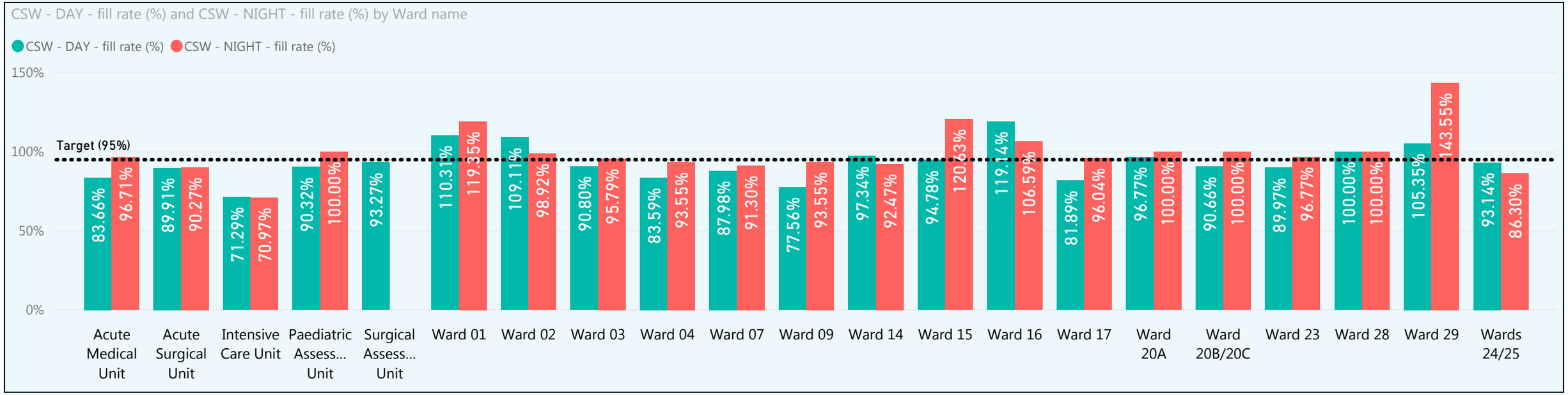


MonthInCalendar

01 December 2018

Safe Staffing Return - Fill Rate for RN / CSW split by Day & Night





Appendix – Safe staffing information for Nursing, Midwifery and Care staff

Dec-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		92.10%	89.91%	94.54%	90.27%	76.17%	85.15%	44.51%	61.76%	3.4	2.3	5.7	5	100.00%	6	0	0	0	0	1	6	0	100.00%
Paediatric Assessment Unit		100.00%	90.32%	100.00%	100.00%	100.00%	77.38%	100.00%	76.34%	31.7	44.3	76.0	0	-	0	0	0	0	0	0	0	0	-
Ward 01		76.76%	110.31%	89.25%	119.35%	74.54%	86.20%	59.04%	57.66%	2.5	2.7	5.2	7	90.32%	10	1	1	1	0	0	5	0	80.00%
Ward 02		71.14%	109.11%	95.70%	98.92%	96.14%	83.59%	83.15%	82.61%	2.5	2.6	5.1	4	100.00%	9	1	0	1	0	0	3	0	100.00%
Ward 03		84.89%	90.80%	100.00%	95.79%	84.68%	74.05%	82.26%	64.08%	1.8	2.5	4.3	5	100.00%	4	1	0	0	0	0	5	2	100.00%
Ward 04		91.73%	83.59%	100.00%	93.55%	76.95%	59.56%	72.58%	49.43%	2.6	2.8	5.4	5	85.19%	10	1	0	1	0	0	5	0	100.00%
Acute Medical Unit		84.92%	83.66%	89.40%	96.71%	88.70%	91.45%	73.71%	87.07%	3.9	3.1	7.0	44	91.43%	2	0	0	1	0	0	4	1	86.11%
Ward 07		98.37%	87.98%	98.92%	91.30%	95.40%	87.14%	96.74%	86.90%	3.7	3.3	7.0	3	100.00%	2	0	0	0	0	0	2	0	100.00%
Surgical Assessment Unit		97.91%	88.26%	-	-	73.70%	70.23%	-	-	65.3	27.7	93.0	0	100.00%	2	0	0	0	0	0	0	0	92.06%
Ward 09		80.67%	77.56%	81.45%	93.55%	71.56%	76.42%	76.92%	50.41%	3.0	2.7	5.7	3	100.00%	11	0	0	0	0	0	0	0	100.00%
Ward 14		91.95%	97.34%	101.61%	92.47%	46.34%	91.57%	36.51%	59.30%	2.3	3.1	5.4	3	90.48%	12	0	0	0	0	0	2	1	92.59%
Ward 15		91.94%	94.78%	97.85%	120.63%	90.24%	91.79%	34.07%	78.95%	2.7	2.6	5.3	2	96.00%	2	0	0	1	0	0	8	0	94.44%
Ward 16		94.04%	119.14%	101.56%	106.59%	80.69%	81.85%	38.46%	71.13%	2.6	3.1	5.7	9	95.83%	7	0	0	0	0	0	6	0	100.00%
Ward 17		96.39%	81.89%	102.15%	96.04%	90.67%	93.86%	55.79%	63.12%	3.2	2.8	6.0	7	90.00%	2	0	0	1	0	0	6	0	91.89%
ICU		99.75%	71.29%	98.64%	70.97%	90.90%	89.45%	87.03%	90.91%	22.8	1.5	24.3	5	92.31%	1	0	0	0	1	0	0	0	100.00%
Ward 20A		95.70%	96.77%	100.00%	100.00%	79.24%	58.33%	87.10%	74.19%	3.8	2.3	6.1	0	100.00%	1	0	0	0	0	0	0	1	100.00%
Ward 20B/20C		96.59%	90.66%	96.88%	100.00%	83.90%	90.41%	91.94%	90.32%	3.3	2.8	6.1	3	100.00%	3	0	0	0	0	0	0	0	97.56%
Ward 21		102.88%	-	99.19%	-	91.72%	-	91.06%	-	6.6	0.0	6.6	0	-	0	0	0	0	0	0	0	0	90.20%
Ward 23		110.52%	89.97%	100.00%	96.77%	100.00%	93.30%	96.77%	86.67%	4.9	3.2	8.1	0	100.00%	1	0	0	0	0	0	0	0	100.00%
Wards 24/25		119.75%	93.14%	104.35%	86.30%	98.91%	59.46%	95.87%	57.31%	3.8	2.2	6.0	2	-	0	0	0	0	0	0	0	1	87.50%
Ward 28		100.00%	100.00%	100.00%	100.00%	96.82%	100.00%	97.65%	100.00%	10.8	1.3	12.1	0	100.00%	0	0	0	0	0	0	0	0	-
Ward 29		81.88%	105.35%	96.58%	143.55%	62.98%	91.84%	29.20%	75.28%	3.1	2.6	5.7	0	100.00%	4	1	0	0	0	0	5	0	100.00%
TOTAL FILL RATE																							

fill rate key

<81% - 90%>	
<80%	
>115%	

MEETING OF THE PUBLIC TRUST BOARD – 7 FEBRUARY 2019			
Improvement Update			**AGENDA ITEM: 9**
Report Author and Job Title:	Suzie Loader Improvement Consultant	**Responsible Director:**	Richard Beeken Chief Executive
Action Required	Approve ☐ Discuss ☒ Inform ☐ Assure ☐ (select the relevant action required)		
Executive Summary	This paper aims to update the Trust 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 organisation for the next CQC inspection. The paper outlines the key issues for December 2018 as follows: 1. The CQC could visit the trust at any time to carry out unannounced spot inspections, which will be followed later by the Well-Led and Use of Resources inspections in March and February '18 respectively. 2. 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 last engagement visit was to A/E on the 11th January 2019. Time was also spent with the Head of Clinical Governance & the interim COO. Feedback was very positive, with the CQC recognising excellent team working and leadership across A/E. 3. Key issues of compliance relating to regulatory, must and should do actions are outlined in the following table which demonstrates there has been improvement this month with only 3 areas of concern: the number of open SI actions which were due to have been completed, lack of compliance with DNACPR & MCA which remains low at 56% and the number of out of date policies & clinical guidelines still remains a concern, but there has been some positive movement in this area. Compliance with documentation continues to improve to 85.7% this month.		

	
Recommendation	Members of the Trust Board are asked discuss and challenge the content of this report
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF001 Failure to deliver consistent standards of care to patients' across the Trust results in poor patient outcomes and incidents of avoidable harm
Resource implications	Undertaking this work will require people's time on a regular basis; particularly participation in peer review audits and board development.
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒ / Care at home ☒ Partners ☒ / Value colleagues ☒ Resources ☒

CQC Preparedness Update: January 2019

Purpose

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

Recommendations

2. The Trust Board are asked to:
   - Discuss and challenge the content of this report and notice improvements made in the key performance indicators.

The Report

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

CQC Inspection Preparation

1. The trust anticipates that there will be a number of unannounced inspections during January 2019. A series of all staff briefing sessions, have been held across the Trust, with 745 attendances. The Chief Executive was supported by Miss Joshi, ED Clinical Director & CQC Specialist Advisor and Dan Hodgkiss, Patient Safety Manager. They explained the inspection process, what the CQC look for and importantly, and in the spirit of Appreciative Inquiry, asked staff to think about what we are proud of, what has gone well and examples of what has improved since the last inspection.

2. Preparations have been made for the Use of Resources inspection which is being carried out by NHSI (NHS Improvement) on the 08 February 2019. The executive team's self-assessment against the new Use of Resources Framework (CQC, 2018) is now complete, has been signed off by PFIC (19 December 18) and submitted to the CQC by the deadline of 21 December 2018. Following submission, there has been a refresh of the slide pack with updated data from the Model Hospital. A board development session is being held on the 17th January, to offer both challenge and support to Execs and 'strength-testing' their preparation prior to the inspection on the 8th February 2019.

3. A well-led inspection will be conducted by the CQC on the 19-21 March 2019. A number of board members will be interviewed and the CEO has been invited to undertake a presentation on: the trust vision, organisational strategy, performance, plans and the self-assessment of leadership capacity and capability. A number of board development sessions are planned during January, February & March '19 in order to prepare the board for these inspections. The Teams of Three (TOT's) from the Divisions and Care Groups are receiving support to ensure they understand the well-led domains and how they apply to their area of responsibility. The well-led action plan which was developed following the board self-assessment against the well-led domains is updated by each Director individually and monitored via TMB. There will be a board development session specifically on this on the 29 January 2019.

4. The CQC visited the trust on the 11th January 2019, to carry out the third of the new style engagement sessions with the trust. The A&E Team, the Head of Clinical Governance & interim Chief Operating Officer spoke to the CQC. The feedback was extremely positive, with evidence of excellent teamwork across the A/E department, good visibility of the Care Group leadership team and the Director of Nursing and Chief Executive. Staff were clearly bought in to the improvement plans and there was evidence of a learning culture with staff able to talk about changes made following incidents. Care of patients with Dementia was held up as an example of excellent practice. The only areas which required improvement, related to the poor environment which would it was recognised, improve with the new build and the need to work closer with the paediatric team.

The Patient Care Improvement Programme (PCIP)

5. The PCIP continues to develop and includes many more actions 'additional' to the must and should do actions from the 2017 inspection report and the 2018 maternity inspection. Care Groups are developing their local PCIPs which will be connected to PowerBI in phases. The potential for an interactive PCIP hub remains and is reliant on Office 365 development and the use of the enterprise version of PowerBI.

6. In the interim, snapshot PDF versions of the individual PCIPs for core services and care groups linked to PowerBI are available on InfoHub and are refreshed each month.

7. Key issues of compliance relating to regulatory, must and should do actions are outlined in the following table which demonstrates there has been improvement this month with only 3 areas of concern: the number of open SI actions which were due to have been completed, lack of compliance with DNACPR & MCA which remains low at 56% and the number of out of date policies & clinical guidelines still remains a concern, but there has been some positive movement in this area. Compliance with documentation continues to improve to 85.7% this month.

Issue	Improve / decline
VTE performance has dipped slightly to just below the target at 94.67%	↓
Nurse staffing vacancies positively remain below the national average	
Midwife to Birth ratio is not available in time for December 18, but was 27.3 in November 2018 (nat. average 28:1)	
Appraisal compliance is just below target at 88.19%	→
DNACPR & MCA compliance has remained at 56%	→
Compliance with documentation has improved to 85.7% in December	↑

Issue	Improve / decline
The Records policy has been approved	
Safeguarding training is largely compliant, however for the past 2 months, L2 paediatric safeguarding has dipped below the 85% target to 83.78%.	
Number of expired SI actions has increased to 6	
Mandatory training is at 85.45%	
Best Practice – 2 CAS alerts remain overdue; NICE Technology appraisals are 100%; 27.5% of guidelines remain overdue	
96% of outpatient staff have completed competencies	
The number of out of date policies is significant, but reducing. Additional resource has been assigned to support the revision process.	
Concerns regarding information governance were raised in September 2018. The actions to provide additional training and support have resulted in a reduction in reported incidents from 35 in August 2018 to 9 in December. Observational audits will be conducted to confirm that good practice is being followed	

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

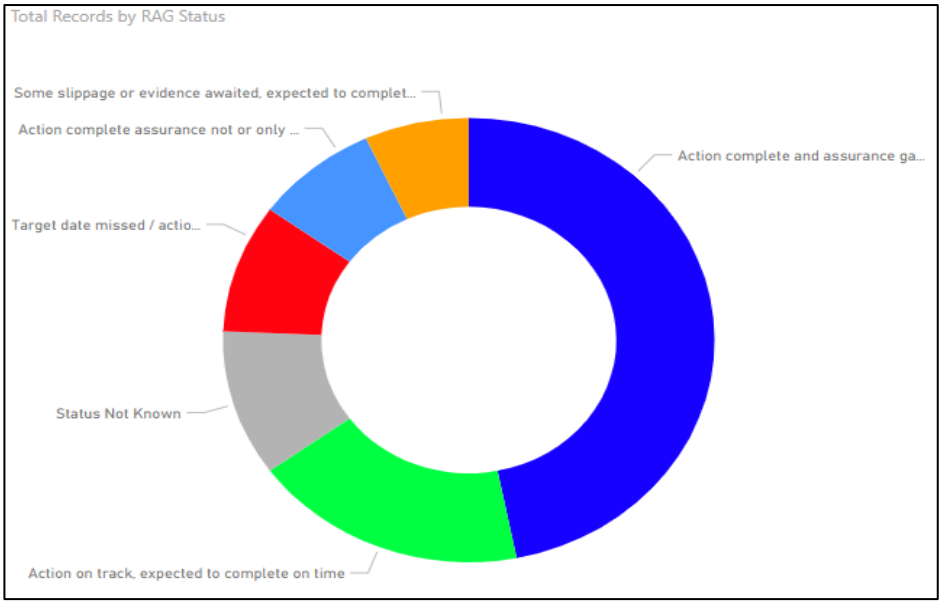
Progress with the PCIP actions

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

9. The table provided below provides a snapshot of the position at the time this report is produced, as actions are changing frequently. The cascade of actions related to Trust level regulatory breach has been completed for the core service and Care Groups PCIPs linked to PowerBI. To enable monitoring of these regulatory actions, similar must/should do actions have been re-designated as regulatory actions. This has led to an increase in the number of regulatory actions seen in this report but helps to identify where there are local issues and the actions being taken. This can then inform the Trust-level actions and RAG ratings.

10. The chart and table below shows progress against the now 306 actions identified within the overarching PCIP.

11. 44.3% of actions recorded have been completed and assurance gained via evidence provided; with a further 5.86% of actions completed but awaiting full assurance; 50.16% completed in total, a slight reduction from last month, showing the impact of adding regulatory actions which require assessment at the time of reporting are hence are 'status not known'.



RAG Status	Dec No.	Jan No.	Dec %.	Jan %
Action complete and assurance gained	130	136	45%	44.3%
Action complete assurance not or only partially gained	23	18	8%	5.86%
Action on track, expected to complete on time	88	91	30.5%	29.97%
Some slippage or evidence awaited, expected to complete on time	13	13	4.5%	4.23%
Status Not Known	5	20	2%	6.51%
Target date missed	19	18	6.5%	5.86%
Action start date not due	10	10	3.5%	3.26%
Total	288	306	100%	100%

12. Appendix D provides further details in relation to compliance against a) the overarching PCIP and b) the regulatory and must do actions. Areas of concern are highlighted in 8 above.

Conclusion

13. The trust continues to focus on delivering the fundamental aspects of care being explicit with staff regarding their professional and personal responsibilities.

14. Work is on-going to enhance the quality of leadership within the organisation through the use of the well-led action plan and development of a leadership strategy and associated leadership programmes.

15. 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

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)	Update (Nov 18)	Update (Dec 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%	94.3%	~~90.2%~~ 94.63%	95.11%	94.67%
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%	7.61%	
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% traiing compliance 68% (August 2018)	98.496% training compliance 80%	97.6% Training compliance 75.71%	97.90% Training compliance 56%	98.04% Training compliance 56%
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			One incident in Sept. however SOP followed appropriately	No incidents reported in October	The new unit opened on 1st December 2018	

Regulatory Issue	Trust Target	Update (June '18)	Update (July 18)	Update (Aug. 18)	Update (Sep 18)	Update (Oct 18)	Update (Nov 18)	Update (Dec 18)
		2018 opening.						
Staff were not up-to-date with **mandatory training**. There were a number of modules that had completion rates significantly lower than the trust's target.	90% compliance by 30th June 2018.	78.76% (Run chart ap. A)	83.6%	85.46%	85.21%	85.21%	85.07%	85.45%
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%	SG Paeds: L1 = 96.70% L2 = 83.54% L3 = 91.51% SG Adults L1 = 95.65% L2 = 91.23% L3 = 87.52% MCA: 97.9%	SG Paeds: L1 = 96.45% L2 = 83.78% L3 = 90.91% SG Adults L1 = 94.31% L2 = 91.44% L3 = 90.50% MCA: 97.9%
Staff were not consistently completing **patient records**. There	Secure accurate, complete contemporaneous	A new multiprofessional audit is	Medical Documentation Audit	Audit conducted and results	Very slight improvement from	Not recorded centrally this month	Compliance with documentatio	The overall compliance was **85.75%**

Regulatory Issue	Trust Target	Update (June '18)	Update (July 18)	Update (Aug. 18)	Update (Sep 18)	Update (Oct 18)	Update (Nov 18)	Update (Dec 18)
were trust documentation that was not completed. Staff were not always on signing entries. There were a number of entries where there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times. Patients' records were taken home by the community children's nursing team when they were not returning to the office. We were not assured of the confidentiality or security of records for the	records by ~~1~~ 1st ~~March 2018.~~ 90% compliance against professional standards by December 2018 Develop a work stream plan to address the physical condition of the paper records by 31st March 2018 Confirm Trust strategy for EPR by 30th June 2018. 'Mobile' notes implemented across community	in development (completion 31.07.18) which will be piloted alongside the other fundamental standards peer review audits commencing 15.08.18	scheduled for 24.08.18 & agreed that MD documentation audit to be piloted across the trust commencing 15.08.18	indicated approx. 30% compliance. Each Division have individually agreed a plan to improve compliance by December 2018	previous audit, but still more required		n improved from 30% (Sept) to 81.3% (Nov)	with a range of 69% to 97% compliance across the 16 audits received.
		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	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	Update Nov '18	Update Dec '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	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	See Appendix A	See Appendix A Additional details added
Patient medical notes are kept secure at all times	Must	90% compliance against the trust policy by January 2019	Policy is being developed for implementation & audit	Policy is being developed for implementation & audit	Policy is being developed for implementation & audit	Policy is being developed for implementation (Oct. 18) & audit	Policy is being developed for implementation (Dec. 18) & audit	The Records Policy has been approved	The Records Policy in place A reduction in reported IG incidents has been observed following additional training and audit. Further observational audits will be undertaken in January / February to confirm good practice has led to a reduction in

Issue	Must	Trust Target	Update June '18	Update July '18	Update Aug '18	Update Sep '18	Update Oct '18	Update Nov '18	Update Dec '18
									incidents.
All staff are trained and competent when administering medications via syringe driver	Must	75% of relevant staff have undergone syringe driver equipment training 75% of relevant staff have undergone syringe driver competency training	80% compliance (Alaris PCAM)	Figures not available	Population which requires training currently unknown, but numbers of staff trained known.	See Appendix	First report is due in November	See Appendix A	See Appendix A For training data and change to target for compliance
Staff follow best practice national guidance (NICE, CAS alerts, Royal College Guidance, local clinical guidelines etc.)	Must	Zero CAS alerts outstanding 100% Technology Appraisals, assessment & implementation within 90 days Zero Clinical Guidelines out of date by xxxx	2 CAS Alerts outstanding: Review of clinical guidelines	See Appendix A	See Appendix A	See Appendix A CAS alerts outstanding ; NAPSIPS outstanding and 89 out of date clinical guidelines	See Appendix A	See Appendix A CAS – 2 alerts overdue NICE Technology Appraisals - =100% Guidelines overdue reduced to 65	See Appendix A CAS – 2 alerts overdue NICE Technology Appraisals - =100% Guidelines overdue = 27.5%
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	SNCT & midwife:birth ratio in place 1:27.3	SNCT & midwife:birth ratio in place.1:27
All staff receive an appraisal in line	Must	90%	83.41%	87.56%	90.04%	89.73%	88.91%	88.19%	88.06%

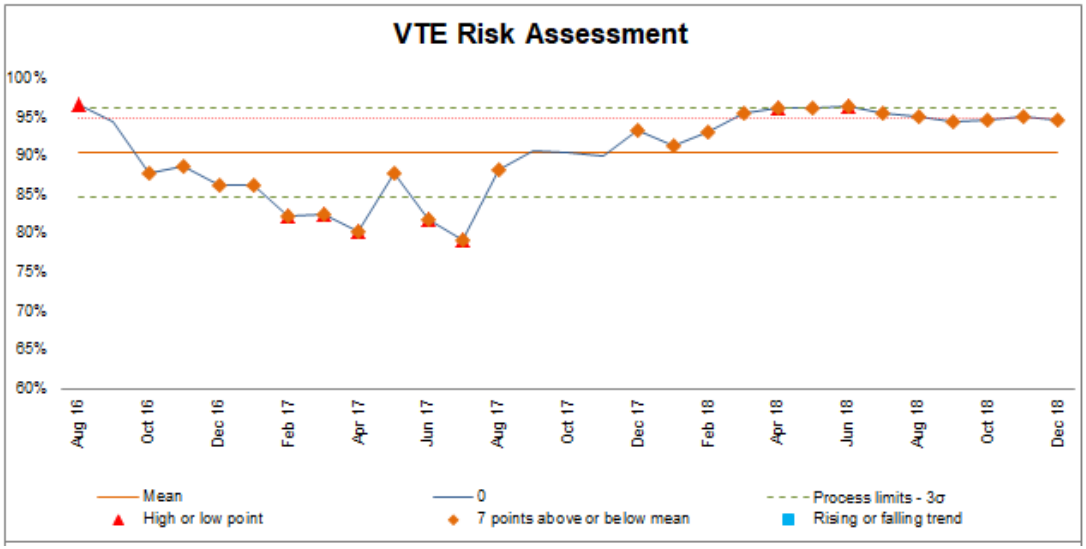
Issue	Must	Trust Target	Update June '18	Update July '18	Update Aug '18	Update Sep '18	Update Oct '18	Update Nov '18	Update Dec '18
with local policy									
COMMUNITY FOR CHILDREN & YOUNG PEOPLE: Continue to follow standard operating procedures with medicines in special schools	Must	100%	100%	100%	100%	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	November Audit shows compliance	Complaint
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	1 action remains - appraisals	1 action remains - appraisals
SAFEGUARDING: adults and Safeguarding children policies are up to date and include relevant references to external guidance	Must	100%	Revised Adult policy by 31.07.18 Revised Children's Policy TBC	Adult Policy completed. Revised Children's Policy TBC	Adult Policy completed. Revised Children's Policy TBC	Adult Policy completed. Revised Children's Policy is now out to consultation	Adult Policy completed. Revised Children's Policy is nearing approval	Adult Policy approved. Children's policy to be approved at the January TMB	Policies now approved Children's policy awaiting publishing
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%		Staff are on-track to reach full compliance by 01.01.19	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%	96%	96%

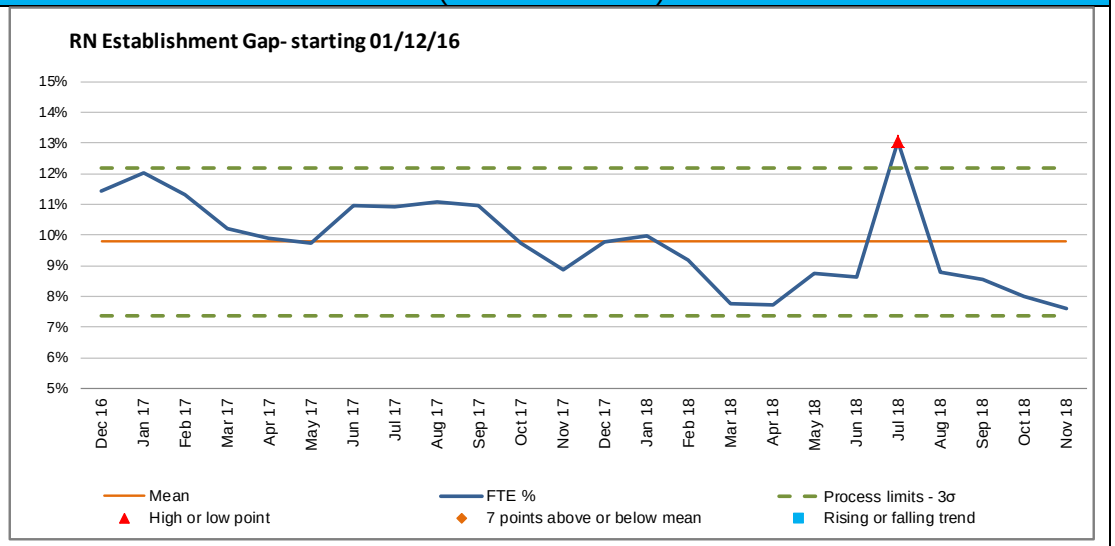
Issue	Must	Trust Target	Update June ‘18	Update July ‘18	Update Aug ‘18	Update Sep ‘18	Update Oct ‘18	Update Nov ‘18	Update Dec ‘18
OUTPATIENTS: All outpatient clinics are suitable for the purpose for which they are being used (This relates specifically to the Fracture Clinic)	Must	100%		See appendix 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	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

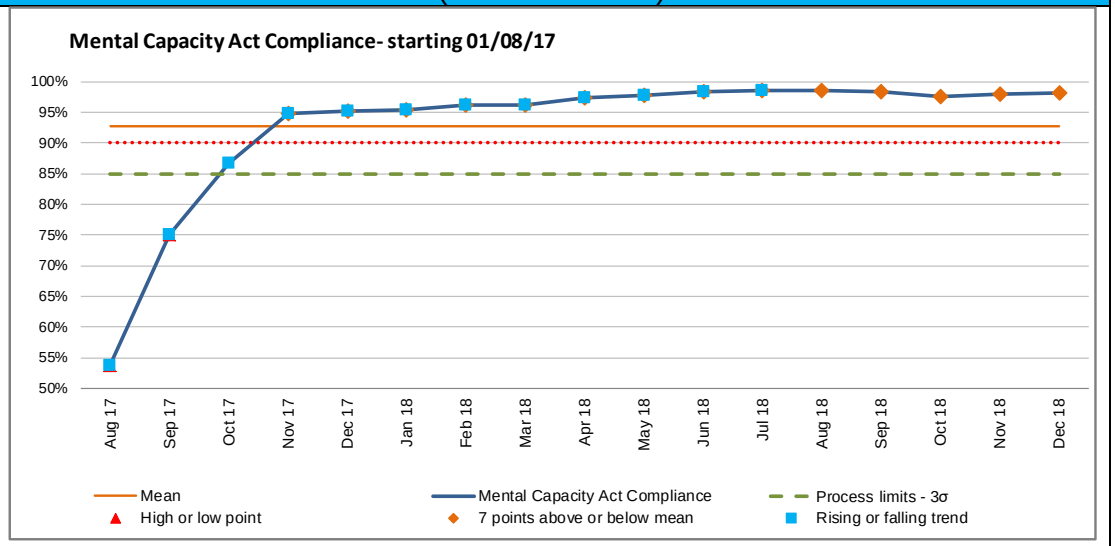
Appendix B

Update on Regulatory & MUST DO Actions (November 2018)

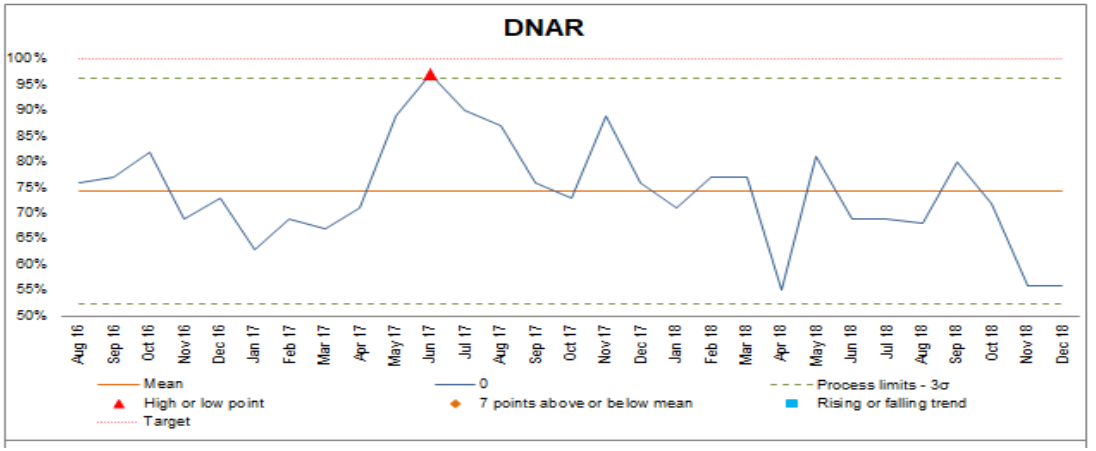
REGULATORY ACTION UPDATE:

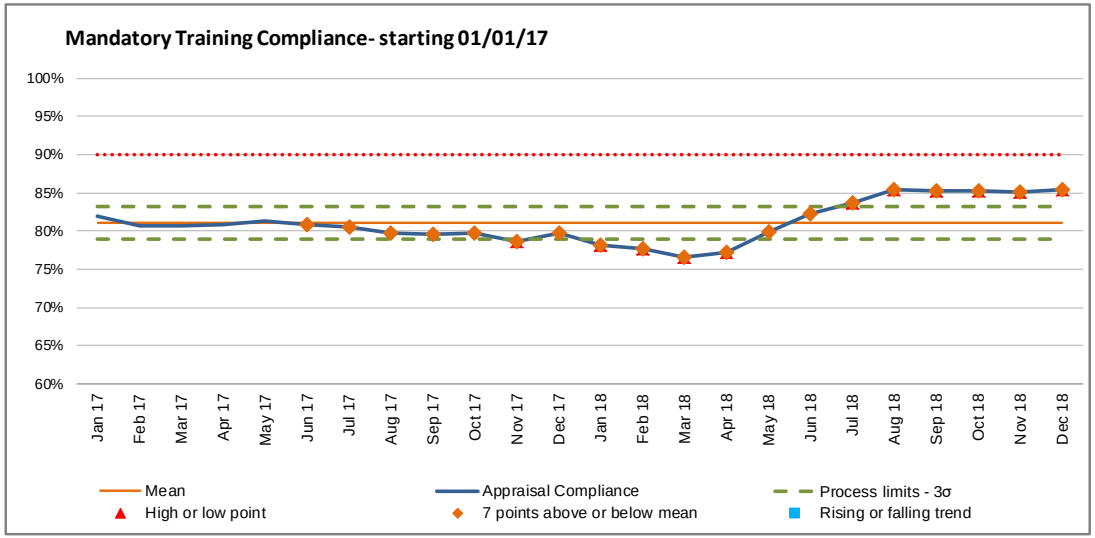
Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (November 2018)
Thromboembolism assessments were not carried out for all patients at risk.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	95% are assessed on admission March 2018.	**December performance = 94.67%, below the 95% target** 
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 = 7.61% - November 2018** The Registered Nursing (RN) establishment gap is reflective of all clinical colleagues, both acute and community. Outturns are reported a month in arrears for completeness. At Nov-18 month-end the gap stood at 7.61% (100 FTE). This is a 5.5% improvement, since the Jul-18 high point and indicative of 70 FTE extra Nursing colleagues commencing service during Q3 17/18.

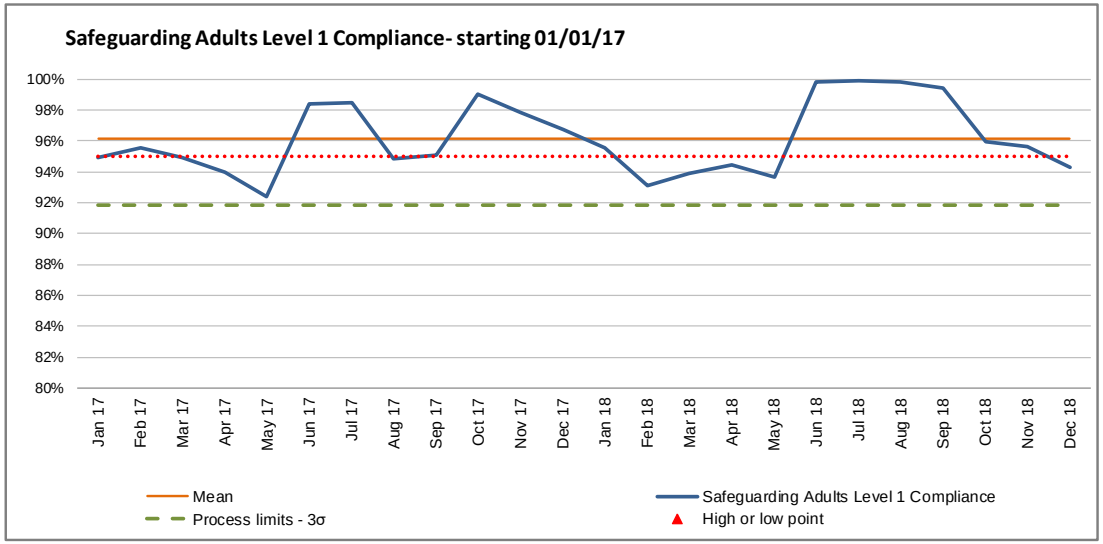
Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (November 2018)
			 **Midwifery Staffing / Birth Ratio 1:27 (December 2019)**
12 (2)(a) Not all staff were compliant or completed timely assessments for patients- in accordance with the Mental Capacity Act 2005 or Deprivation of Liberty (DOL).	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	90% compliance with MCA training By March 2018 Compliance with MCA when completing DNA CPR decisions by March 2018.	**MCA Training compliance = 98.05% - target is being achieved** Mental Capacity Act (MCA) training was recorded in ESR post August 2017. Since then there has been a 45% improvement in compliance, reflective of a 93% average during the past 17 months. Unlikely some other competencies; MCA compliance increased slightly during Q3 18/19 and is on a positive trajectory

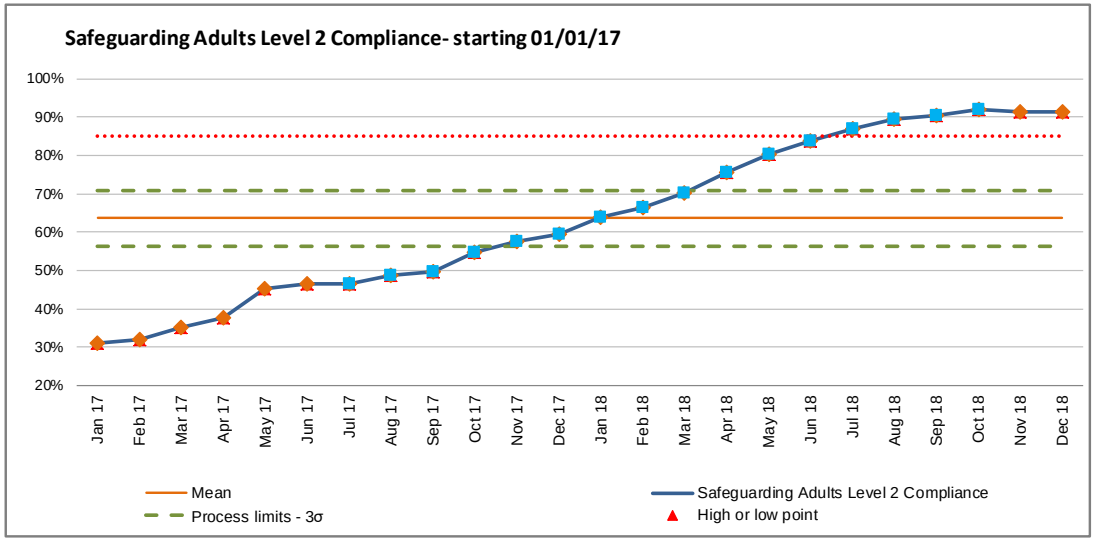
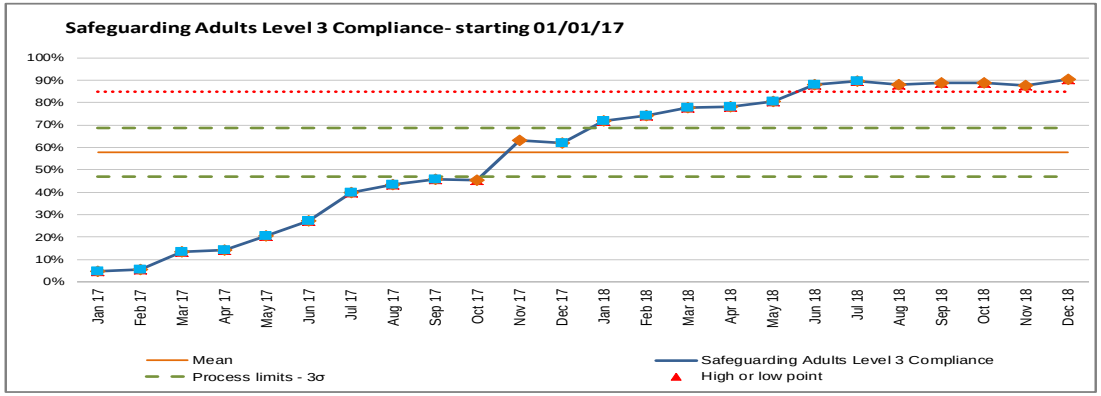
Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (November 2018)
			

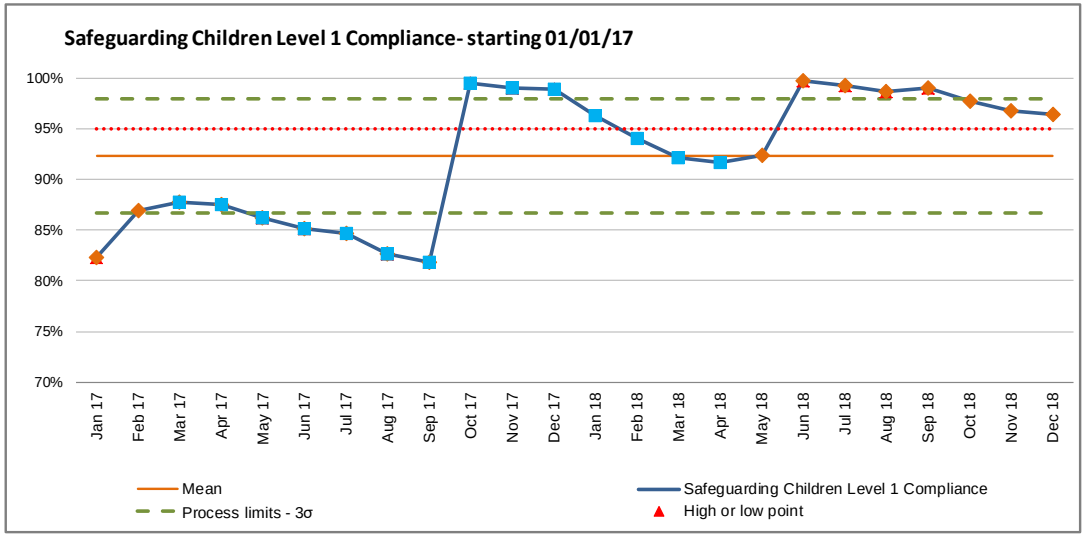
Compliance with completion of part 2 of the DNACPR form in relation to MCA remains at 56%

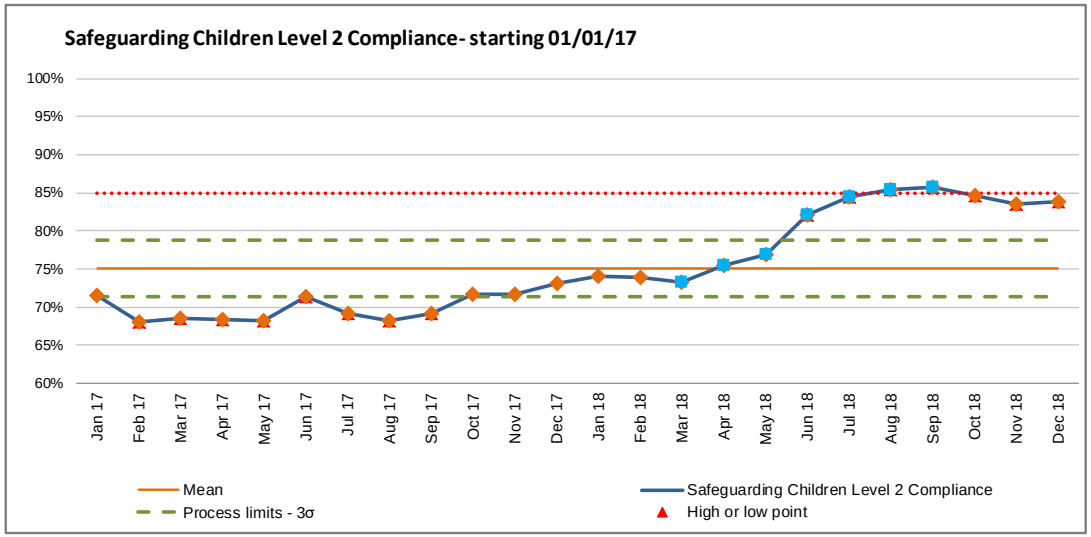


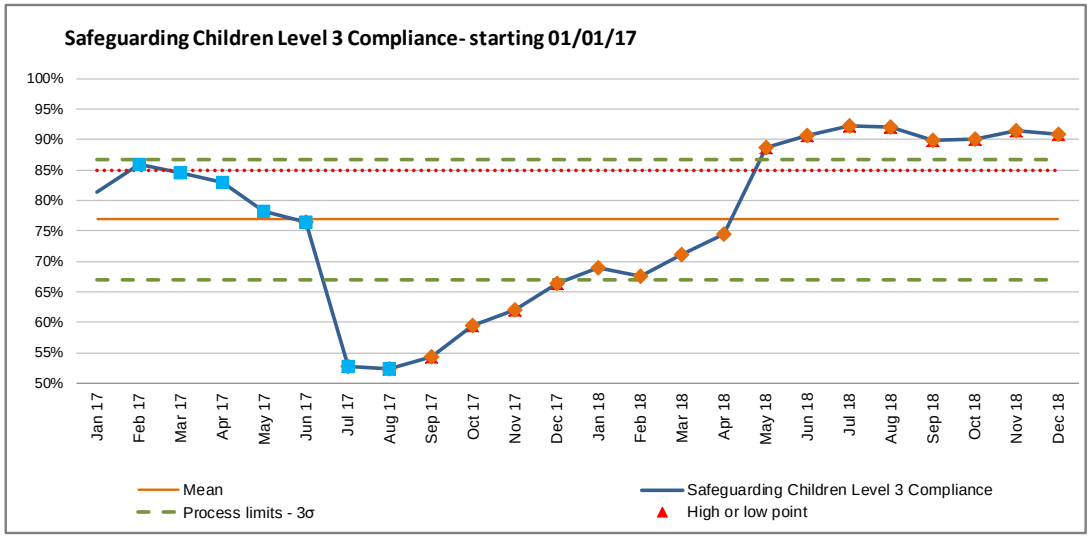
Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (November 2018)
The critical care environment had only one isolation room. This provision was not meeting the needs of patients so was not sufficient to maintain safe management of infectious patients.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	Revised SOP February 2018 New build October 2018.	The new Critical Care Department opened on 1st December 2018. There are now individual rooms which provide sufficient isolation facilities. This regulatory action is therefore complete.
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.	**December achievement; 85.45%**  Mandatory Training improvement trends have been sustained during the past 5 months; with the 85.45% November 18 outturn improves upon a 24 month compliance high point. Compliance across individual core competencies improved by up to 18% since 17/18, with an average 11% rise amongst the three levels of Safeguarding Children training.
Blind cords were not secured in all of the	Regulation 12 HSCA (RA)	By March 2018. Risk	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

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (November 2018)
rooms at the child development centre	Regulations 2014 Safe care and treatment	assessment Permanent solution to be implemented. Audit of compliance.	2018.
Safeguarding training completion rates were low for both medical and nursing staff. Not all staff were trained in level 3 safeguarding children, which is a requirement set by the Intercollegiate document (2014).	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment	Achievement of targets for all levels of Children and Adult Safeguarding by end June 2018 Level 1=95% Level 2 & 3=85% PREVENT=85%	**Safeguarding adults training compliance: November 2018** • **Level 1 = 94.31%** Adults Level 3 represents the most consistent Safeguarding competency, with compliance averaging 96% during the past 24 months. Compliance has fallen for the third consecutive month and will need to be monitored to ensure no special cause variation is present. It remains the 2nd best performing Safeguarding competence. 

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (November 2018)
			• **Level 2 = 91.44%**  Adults' level 2 has risen by 60% during the past 24 months. Compliance has currently plateaued at 91%, against a 64% average during the past 2 years. This maintains a Trust high for this competence, sitting 6% above the target. • **Level 3 = 90.50%** 

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (November 2018)
			Adults Level 3 compliance rose from a low of 5% to 91% during Dec-18. This is 1% above the target and continues a 24 month improvement trajectory. **safeguarding children training compliance: November 2018** • **Level 1 = 96.45%**  Children Level 1 is the best performing Safeguarding competency, with the 96% Dec-18 outturn 1% above target. Compliance has fallen slightly over the past 3 months, from a high of 99% during Sep-18. This trajectory will be monitored to ensure only common cause variation is present, with a view to maintaining the current 92% compliance average of the past 24 months.

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (November 2018)
			• **Level 2 = 83.78%**  The Dec-18 outturn of 84% represents a 12% compliance improvement during the past 24 months and is favourable against the 75% average across this period. As with other competencies; the trend of falling compliance during Q3 18/19 will be monitored

Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (November 2018)
			• **Level 3 = 90.91%**  Children Level 3 experienced significant lows during late summer 2017, before rising to compliance highs of 91% during Nov-18. This above target compliance rate was maintained during Dec-18, outperforming the 24 month average for this competency by 14%.
Staff were not consistently completing patient records. There were trust documentation that was not completed. Staff were not always on signing entries. There were a number of entries where there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times.	Regulation 17 HSCA (RA) Regulations 2014 Good governance	Secure accurate, complete contemporaneous records by ~~1~~ 1st ~~March 2018~~. Target revised to 90% compliance by end of December 2018 (quality of records) & 90% compliance by January 2019 (security of	Nursing Documentation Audit was conducted in December 2018 The overall compliance was 85.75% with a range of 69% to 97% compliance across the 16 audits received.

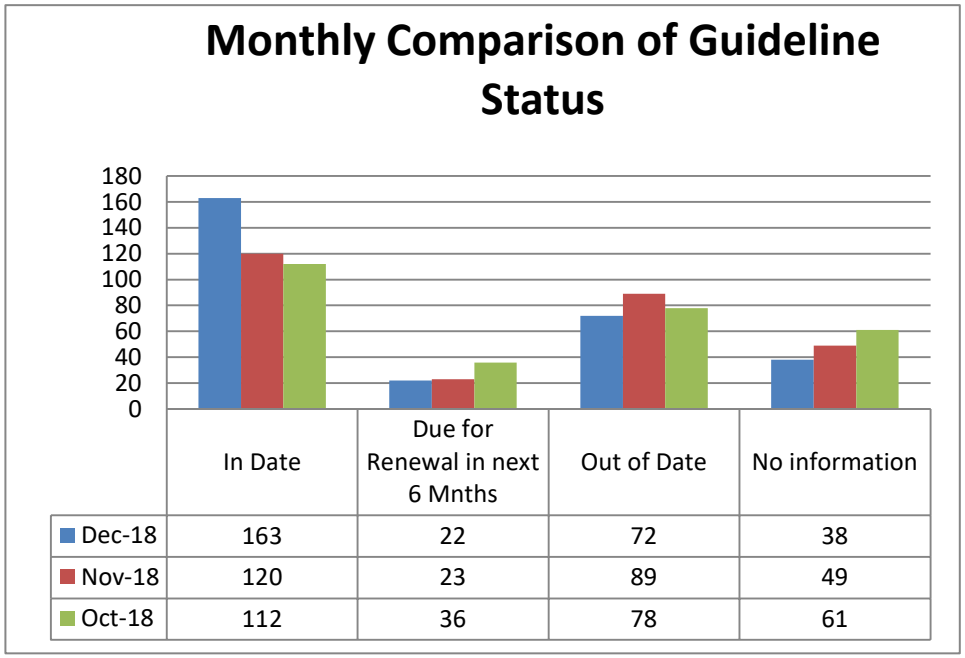
Issue	Regulatory breach	Trust Target & RAG status	Update / Run Chart (November 2018)
Patients' records were taken home by the community children's nursing team when they were not returning to the office. We were not assured of the confidentiality or security of records		records). Develop a work stream plan to address the physical condition of the paper records by 31st March 2018 Confirm Trust strategy for EPR by 30th June 2018.	
			Total Mobile note system implemented

MUST DO ACTION UPDATE:

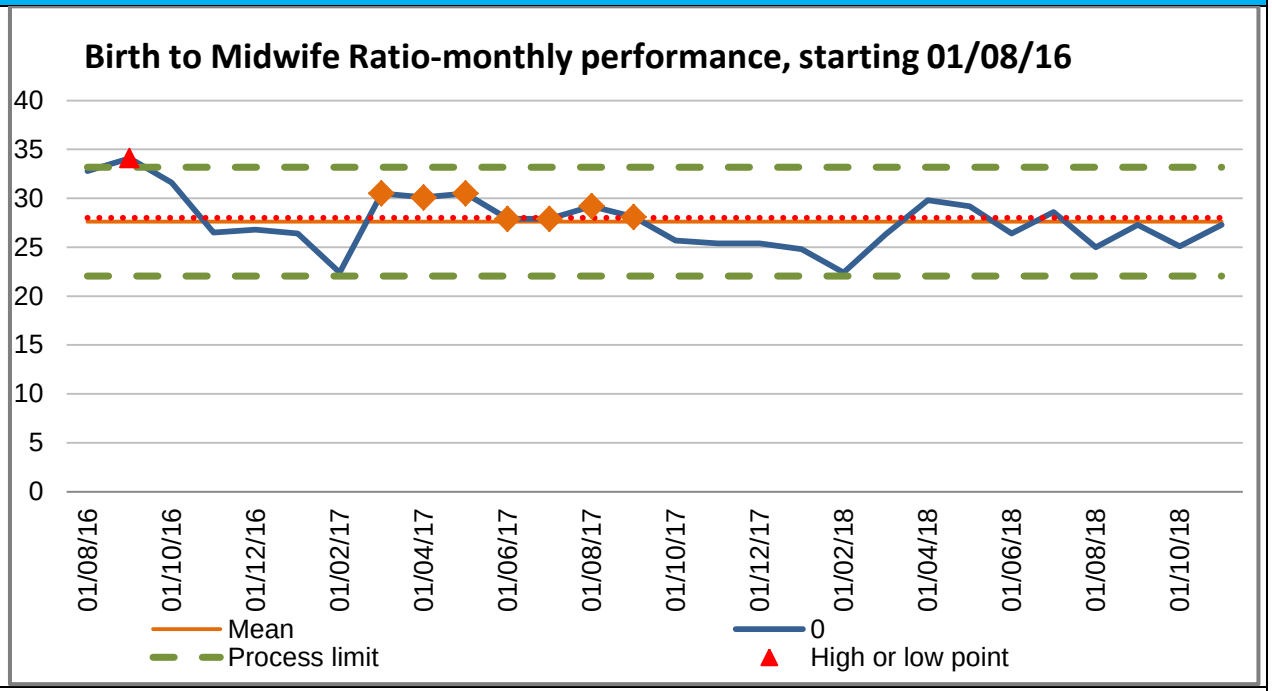
<table>
<tr><th>Issue</th><th>Must</th><th>Trust Target & RAG status</th><th>Update / SPC Chart</th></tr>
<tr><td>Action plans are monitored and managed for serious incidents</td><td>Must</td><td>Zero outstanding by January 2019</td><td>The number of outstanding SI actions are reported to the Risk Management 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="9">SI’s with actions outstanding past completion date</th></tr>
<tr><th>Apr 2018</th><th>May 2018</th><th>Jun 2018</th><th>July 2018</th><th>Aug 2018</th><th>Sept 2018</th><th>Oct 2018</th><th>Nov 2018</th><th>Dec 2018</th></tr>
<tr><td>WCCSS</td><td>6</td><td>8</td><td>8</td><td>9</td><td>5 (6 open actions)</td><td>6 (7 open actions)</td><td>7 (8 open actions)</td><td>2 (2 open actions)</td><td>2 (2 open actions)</td></tr>
<tr><td>Surgery</td><td>2</td><td>2</td><td>1</td><td>1</td><td>1 (5 open actions)</td><td>0</td><td>1 (3 open actions)</td><td>2 (2 open actions)</td><td>4 (5 open actions)</td></tr>
<tr><td>MLTC</td><td>5</td><td>3</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Corporate</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1 (2 open actions)</td></tr>
<tr><td>Total SI’s</td><td>13</td><td>13</td><td>9</td><td>10</td><td>6</td><td>6</td><td>9</td><td>4</td><td>7</td></tr>
</table>
The position has worsened in month - the WCSS actions were expected to be completed before the end of December. The Surgery actions are being reviewed with one re-opened an extension requested for the other. The corporate action concerns a fall in the revolving entrance door.</td></tr>
<tr><td>Lessons are disseminated effectively to enable staff learning from serious incidents, incidents and</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
Patient Safety Boards in each area – updated with incidents at a glance, top risk and incident</td></tr>
</table>

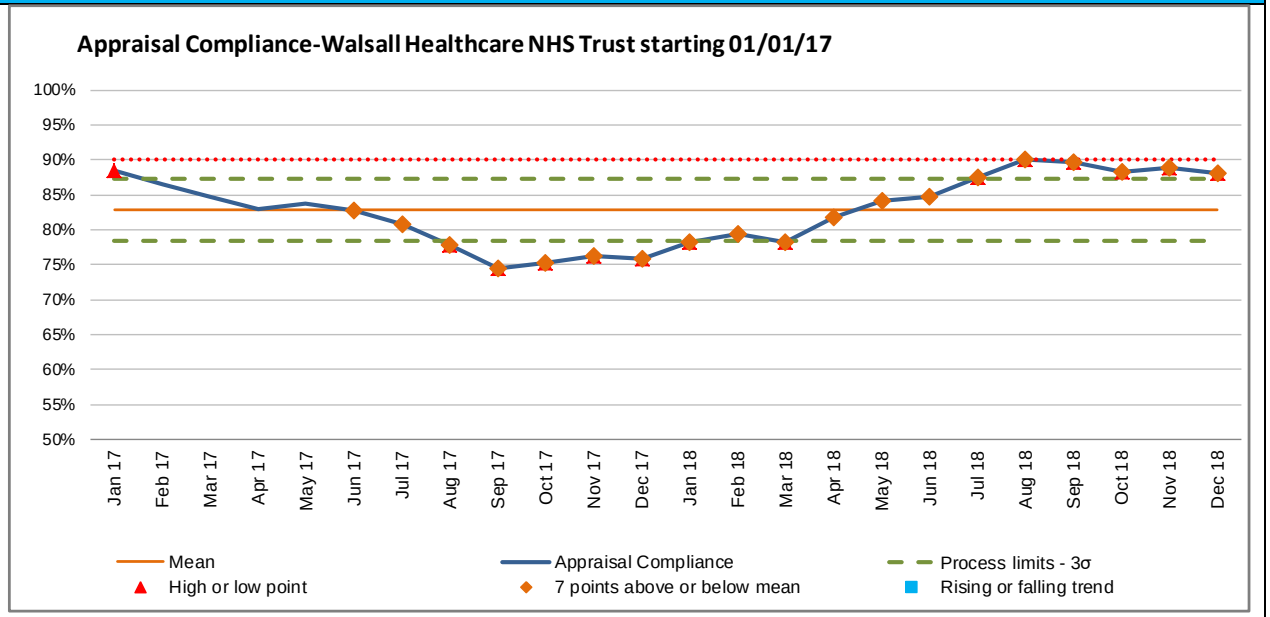
Issue	Must	Trust Target & RAG status	Update / SPC Chart
complaints.			themes, LfE • Quarterly Patient Safety/Risk Roadshows • 'Incidents at a glance' one page summaries describing the incident, lessons learned - discussed at Care Groups as part of their quality meeting agenda and in MLTC are added to the ward display boards at the entrance to the ward. • Incident at a Glance quarterly pack disseminated to all wards sharing lessons from multiple divisional serious incidents, also shared via the Patient Forum Group to review content of lessons • Weekly ward based drop in sessions to share learning from incidents and risks and to answer staff questions • Monthly Lessons learned bulletin • Monthly Care Groups quality/audit meeting • Specialty Governance meetings – i.e. General surgery, TACC, Junior Doctors Forums e.g. Elderly Care. • Monthly Learning from Excellence Steering Group with learning shared to Care Groups and Departmental • Workshops covering professional responsibilities and human factors/ Appreciative Inquiry - 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. • Bespoke training sessions and regular training to: Preceptorship Nursing, Newly Qualified Nurses, Nurse Trainee Associates, Junior Doctors from FY1 – Registrars • Attendance at Grand Rounds (Quarterly) • Chief Executive's Briefing session in June 2018 focusing on AI and LfE moving to Safety II Culture • November follow up sessions in all Divisions on the lessons learned and CQC briefs • New learning events are being planned to take place four times a year to provide feedback in a large forum. **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

Issue	Must	Trust Target & RAG status	Update / SPC Chart
			• 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 approved • Checklist developed & circulated to wards / departments to use to check compliance
All staff are trained and competent when administering medications via syringe driver (McKinley T34)	Must	75% of relevant staff undergone syringe driver equipment training 75% of relevant staff have undergone competency training	Training for T34 McKinley Syringe Pumps, the following actions have been progressed: The population for training has been identified and training is being delivered. Syringe Pump Training Session 1 – 22.18% of staff required to have training now have now received it. This is a 10% improvement from November 2018. There were no significant clinical incidents related to syringe pumps during the month The initial training target is 75% which will be increased to 85% when 75% is reached.
Staff follow best practice national guidance (NICE, CAS alerts, Royal College Guidelines, local clinical guidelines etc. etc.	Must	Zero CAS alerts outstanding 100% NICE Technology Appraisals, assessment & implementation within 90 days 95% Clinical Guidelines in date by March 2019	There are 2 **CAS Alerts** outstanding: • **NATSIPPS** – this remains open pending evidence of embedded audit and evidence of continuing improvement. All services are now using LocSSIP checklists. The Audit and Effectiveness Team are supporting audit analysis. • **Luer lock connectors** (aiming for closure January 2019) – The product is now available and a meeting is being held with the supplier on 18th January 2019 to take this forward. 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 – October– 100% of TAs were received and reviewed in year **Clinical Guidelines** have recently been reviewed. The report provided has changed and now provides a month end position. At 31st December, there were 295 clinical guidelines recorded in the database. 185 (63%) of guidelines are in date with 72 (24%) out of date. The provenance of 38 (13%) of these is still being established. The new team is starting to have a positive impact with more guidelines now in date and reductions in those out of date and where information about documents is still being obtained: these are being reviewed individually and so far include care pathways, care bundles etc. rather than guidelines. The focus in December 18 was doing a similar piece of work on policies.

Issue	Must	Trust Target & RAG status	Update / SPC Chart
			
The service uses an acuity tool to evidence safe staffing (nursing & midwifery)	Must	100%	SNCT & midwife: birth ratio in place. Figures not available for December 18

	In Date	Due for Renewal in next 6 Mnths	Out of Date	No information
Dec-18	163	22	72	38
Nov-18	120	23	89	49
Oct-18	112	36	78	61

Issue	Must	Trust Target & RAG status	Update / SPC Chart
			
All staff receive an appraisal in line with local policy	Must	90%	**December: 88.06%** Appraisal compliance has exceeded the 83% average for the past 8 months, recovering from low points late 2017/early 2018. Rating remains Amber as the performance remains 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. The re-audit by the Care Group now demonstrates compliance.
ED: completes	Must	100% of actions	ED has reviewed the previous action plan. Only one of the four actions now remains open:

Issue	Must	Trust Target & RAG status	Update / SPC Chart
the action plan completed following the CQC inspection carried out in September 2015		completed within specified timeframes with desired outcomes achieved	• Improving staff appraisal rates - 11th January position was 86%
SAFEGUARDING: adults and Safeguarding children policies are up to date and include relevant references to external guidance	Must	100%	Revised Adult Policy Approved Revised Children's Policy revised and awaiting approval at the 15th January 2019 TMB
CRITICAL CARE: All staff working within the outreach team are competent to do so	Must	100% by 01.01.2019	All the staff who were in post at the time of setting this trajectory are now competent so 100% has been achieved. New members of the team subsequently appointed are working towards compliance. The competencies take a minimum of 6 months to achieve so this will be a reiterative process moving forward as the team grows, rotation, staff leaving.
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 January = 96%
OUTPATIENTS: All outpatient clinics are suitable for the purpose for which they are	Must	100% of actions completed within the specified timeframes with desired outcomes achieved	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. 2. Areas de-cluttered and maintained. 3. Risk assessment is now completed and has been added to the risk register.

Issue	Must	Trust Target & RAG status	Update / SPC Chart
being used			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. 6. H&S carried out a Premises & Equipment Audit which demonstrated 99% compliance.

Appendix C

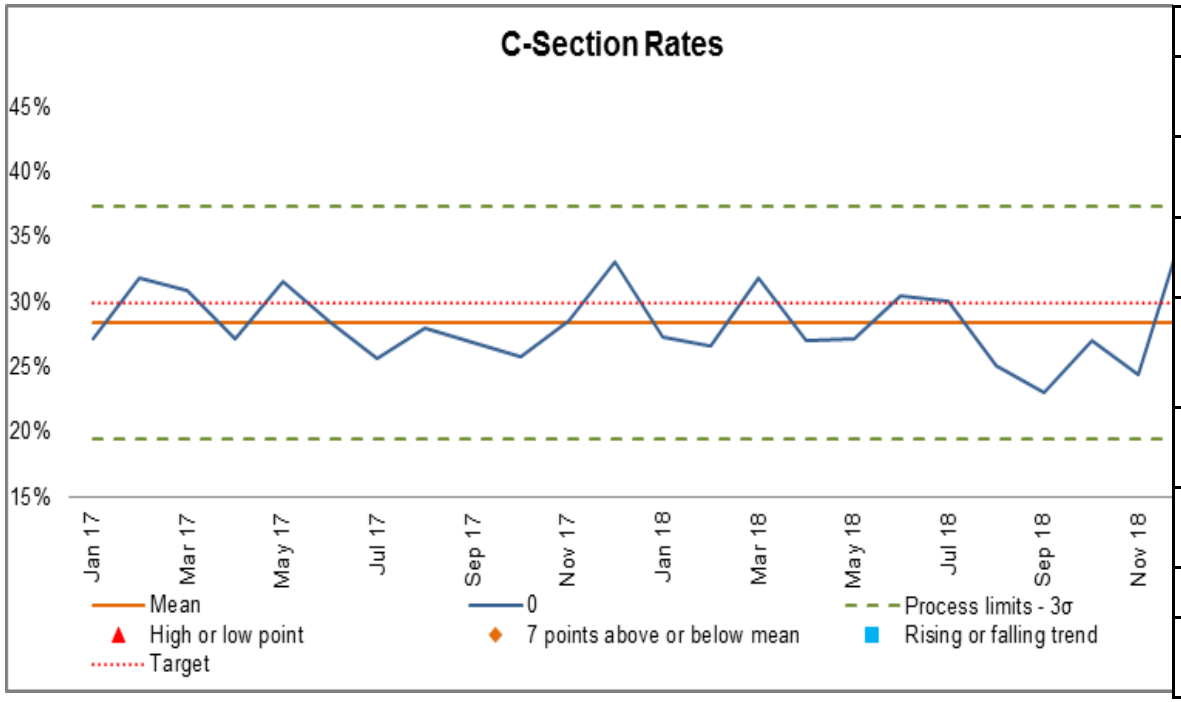
C Section Rates – Maternity Services

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 – 14th January 2019

RAG Status

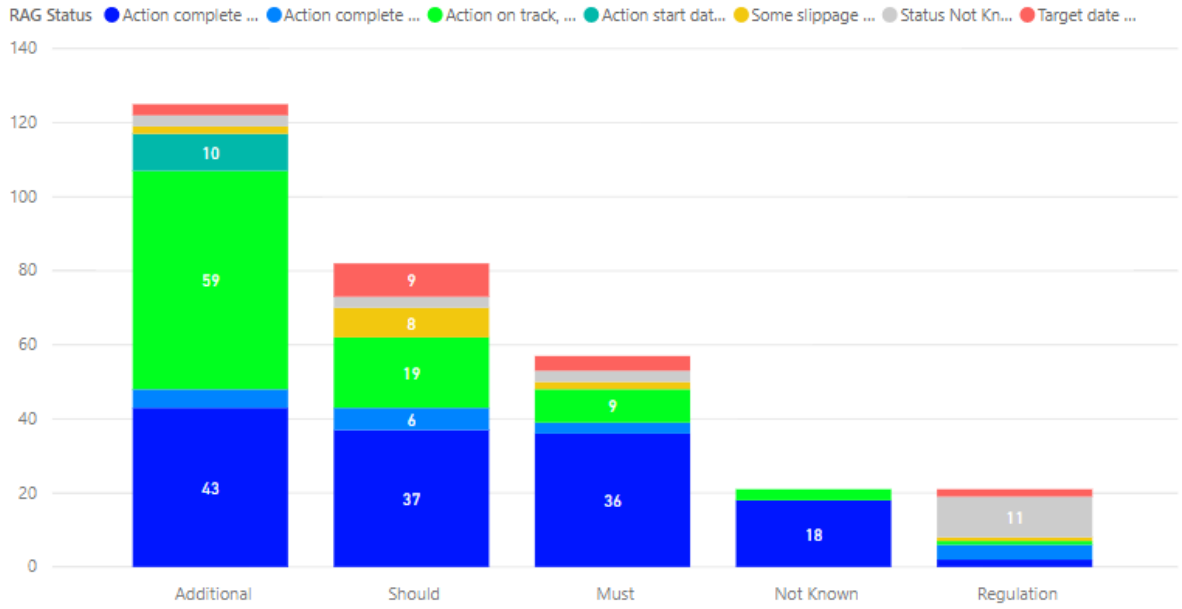
- [ ] Select All
- [x] Action complete and assurance gained
- [x] Action complete assurance not or only partially gained
- [x] Action on track, expected to complete on time
- [x] Action start date not due
- [x] Some slippage or evidence awaited, expected to complete on ti...
- [x] Status Not Known
- [x] Target date missed / actions unachievable

RAG Status	Additional	Must	Not Known	Regulation	Should	Total
Action complete and assurance gained	43	36	18	2	37	**136**
Action complete assurance not or only partially gained	5	3		4	6	**18**
Action on track, expected to complete on time	59	9	3	1	19	**91**
Action start date not due	10					**10**
Some slippage or evidence awaited, expected to complete on time	2	2		1	8	**13**
Status Not Known	3	3		11	3	**20**
Target date missed / actions unachievable	3	4		2	9	**18**
Total	**125**	**57**	**21**	**21**	**82**	**306**

RAG Status	%GT Total Records
Action complete and assurance gained	44.30%
Action complete assurance not or only partially gained	5.86%
Action on track, expected to complete on time	29.97%
Action start date not due	3.26%
Some slippage or evidence awaited, expected to complete on time	4.23%
Status Not Known	6.51%
Target date missed / actions unachievable	5.86%
Total	**100.00%**

Compliance with KPI Measure - RAG	Total Records
Fully Compliant	85
Non Compliance	25
Partially Compliant	112
Status Not Known	83
Total	**307**

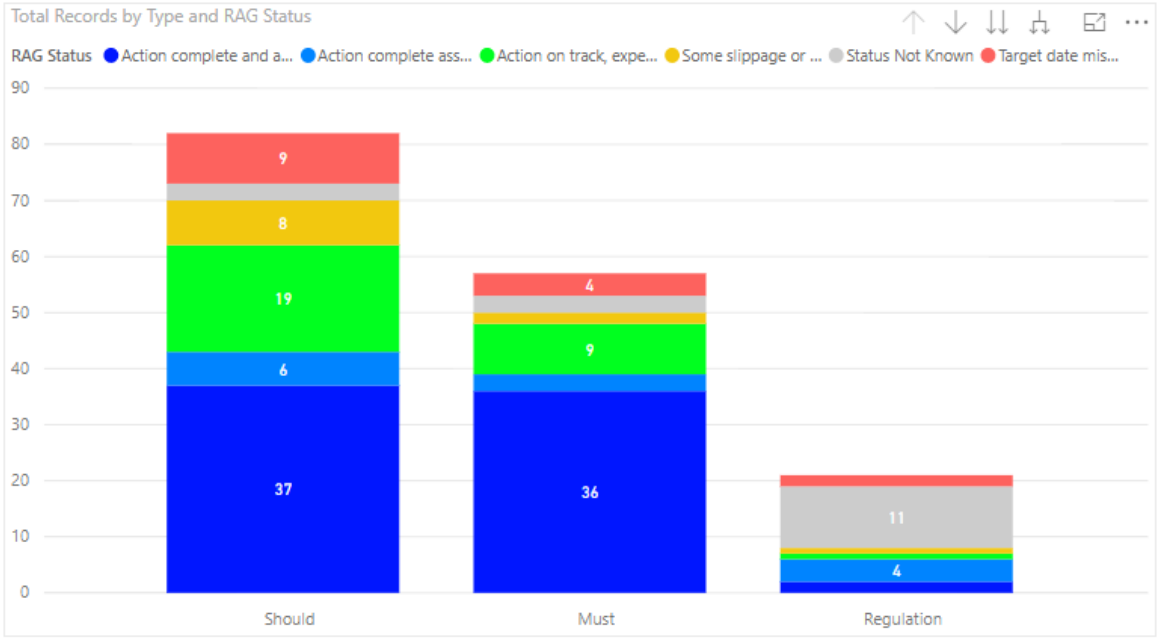
Total Records by Type and RAG Status



Core Service

- [ ] Select All
- [x] Acute Children and Young People's Services
- [x] Acute Medical Care
- [x] Community Adults
- [x] Community Children and Young People's Services
- [x] Corporate
- [x] Critical Care
- [x] Diagnostics / Imaging
- [x] Gynae
- [x] Maternity & Obstetrics
- [x] Medical Care
- [x] Outpatients
- [x] Surgery
- [x] Urgent & Emergency

b) The Must do / Should do / Regulatory Actions position – 14th January 2019



RAG Status	Must	Regulation	Should	Total
Target date missed / actions unachievable	4	2	9	**15**
Status Not Known	3	11	3	**17**
Some slippage or evidence awaited, expected to complete on time	2	1	8	**11**
Action on track, expected to complete on time	9	1	19	**29**
Action complete assurance not or only partially gained	3	4	6	**13**
Action complete and assurance gained	36	2	37	**75**
Total	**57**	**21**	**82**	**160**

Note: The cascading of regulatory actions to the core services and care groups and the re-designation of some must/should do actions as 'regulations' has increased the number of regulatory actions by 12, and as the RAG status is being determined, these appear in the ''status not known".

MEETING OF THE PUBLIC TRUST BOARD – 7th February 2019			
Learning From Deaths Report			**AGENDA ITEM: 10**
Report Author and Job Title:	Mrs J Adams Business Manager to the Medical Director	**Responsible Director:**	Dr Matthew Lewis Medical Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	This report aims to demonstrate **Performance** • How the trust performs against national mortality indicators • What data analysis tells us about deaths occurring in the trust **Reviewing and Learning** • How the trust can assure patient safety by complying with national guidelines relating to learning from deaths as outlined in the CQC report Learning, Candour and Accountability, December 2016 and the National Quality Board Learning from Death Guidelines, March 2017 to reduce the risk of failing to recognise and learn from events that contribute to avoidable deaths. **Next steps and considerations** • Implement the actions outlined in the CQC review. • Embed the Learning from Death processes and governance from specialty through to board. • The plans to implement statutory changes in respect of scrutiny of deaths and revision of the death certification process with the introduction of a Medical Examiner role within the trust. Appendices are published to the reading room for Board members.		
Recommendations	Members of the Board are asked to support the actions as outlined in the CQC report and the governance for delivery of the Learning from Death strategy		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Performance against the National Standard Hospital Mortality Index SHMI is recorded as a risk for the trust. The processes and governance relating to learning from death are to assure that the trust is focussed on recognising issues in care or process that may contribute to deaths, learning lessons and taking actions, along with health and social care partners to demonstrate an understanding of SHMI performance and root cause and reduce the risk of a subsequent deterioration in SHMI performance.		

Resource implications	The business case for the role of the Medical Examiner ME and associate infrastructure to support the Learning from Death processes and governance has an associated cost pressure in the region of £230k recurring. A proportion of this cost may be offset by central government funding for the ME role.	
Legal and Equality and Diversity implications	The equality and diversity implications to the trust in respect of patients with learning disabilities are managed as per the trust policy and LeDeR recommendations. The policy must assure that all patients care within the organisation is equitable and addresses and takes into account all elements diversity to respond to clinical, ethnicity, social and psychological needs as a patient to avoid premature death and during the end of life phase and after death.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Report to the Trust Board
Learning From Deaths

Introduction

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

How we are performing

National Benchmarks

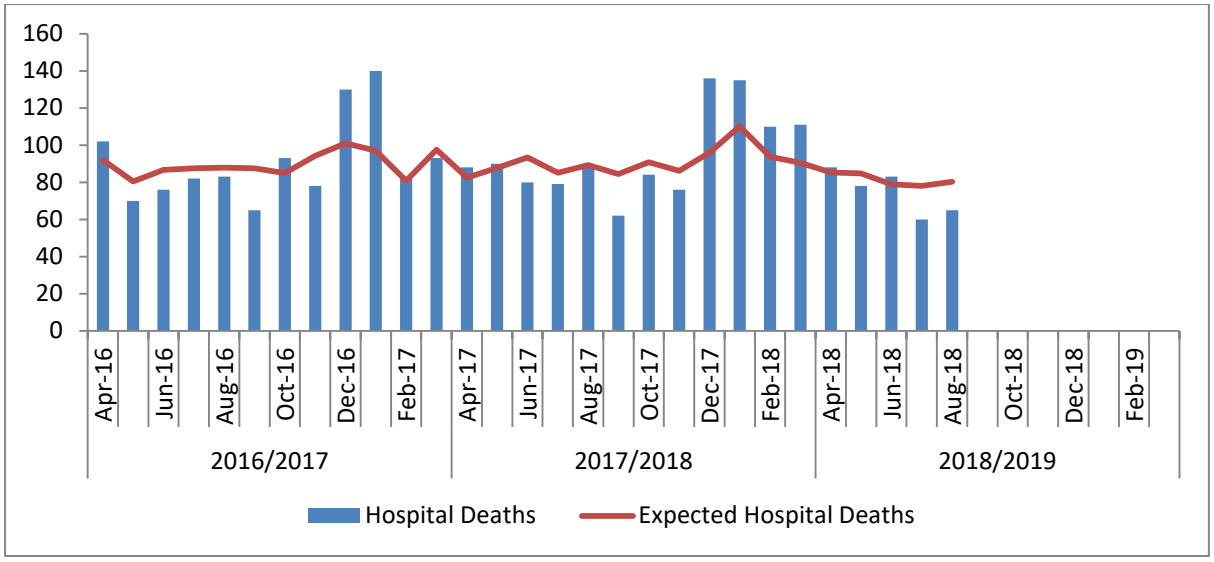
The Trust uses two key national benchmarks as the primary indicator for mortality, Hospital Standard Mortality rate, HSMR, and Standard Hospital Mortality Index, SHMI. Data is provided by NHS Digital and hosted by Healthcare Evaluation Data, HED.

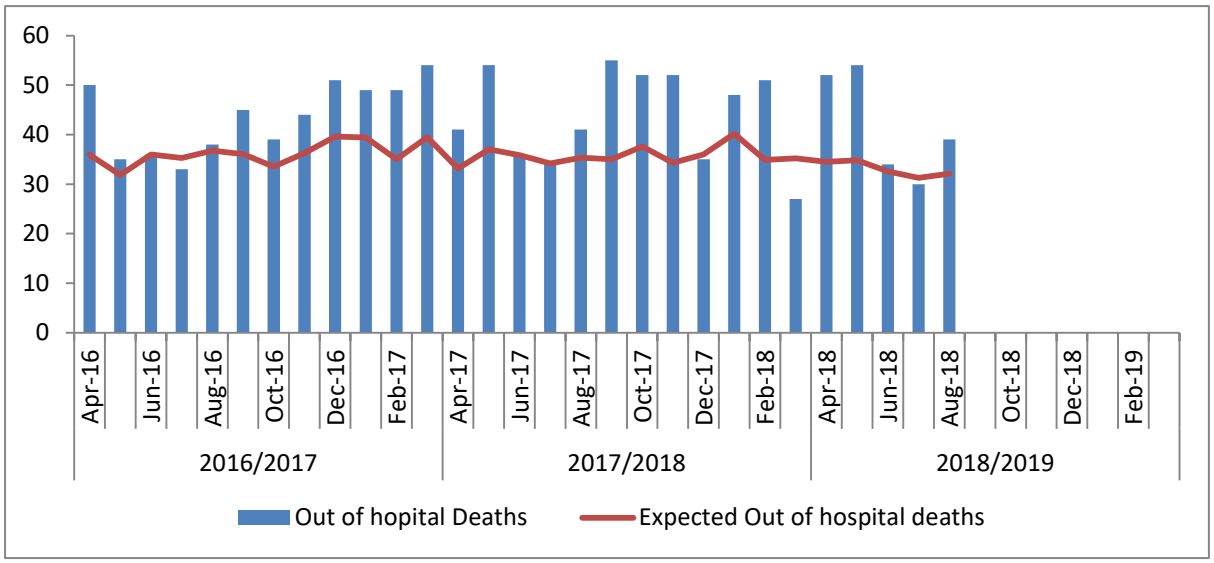
HSMR has been variable for the current year, for the months of August and September performance has improved reporting below 100 for both months for the current year 2018-2019. The HSMR as of October is reported as 87.52 and a year to date performance of 96.59.

SHMI has been reported up to the end of August 2018. SHMI performance had improved significantly from December (129.53) to March (109.80), with an end of year position of 109.72. SHMI had been reported via our provider HED for Q1 and July for Q2. HED had advised that the data should be considered with caution as there may be some under reporting in relation to out of hospital deaths. Revision of the data has now been undertaken. SHMI for August has been reported as 92.58 and a year to date performance of 101.84.

The trust continues to perform well in comparison to regional peers for HSMR remaining in the 1st quartile. The regional comparison for SHMI has remained unchanged. (Appendix 1) Regional comparison during November to January shows a similar trend.

The number of deaths has risen over the past 2 years with peaks occurring during winter periods. An increase in the difference between expected and observed has also been seen year on year for both hospital and out of hospital deaths.



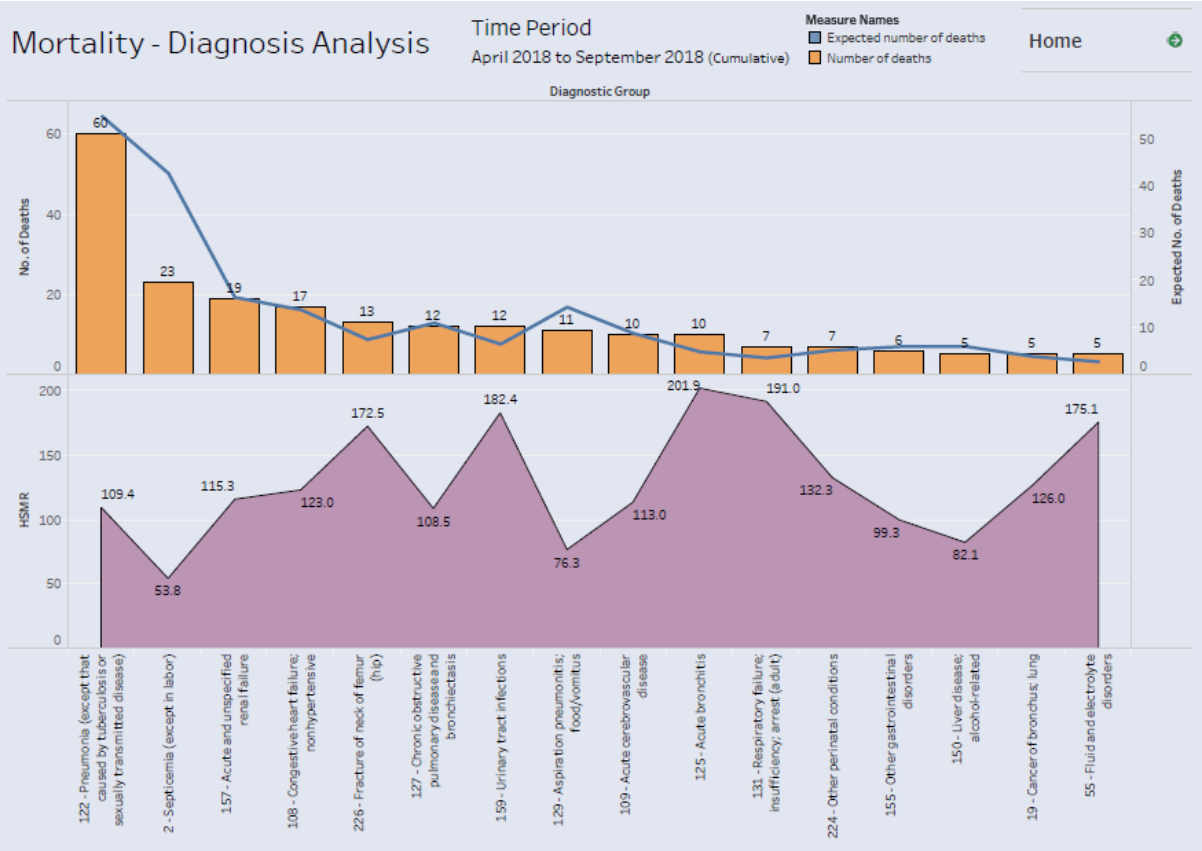


Data Analysis and Triangulation

There are a number of data and intelligence sources that can be used to analyse and triangulate information to identify key areas for review and understanding causation of performance against the national indicators. Single source data is a “smoke signal” that there may be an issue. Use of multi-source data and intelligence including formal structured judgement reviews (SJR) of individual patients is essential to identify issues in care or process, identify lessons learnt and develop action plans to improve outcomes and assures that the trust is sighted on reducing the risk of contributing to avoidable or premature death. Working with partners is also an essential part of the learning from death process to ensure the whole care pathway is reviewed.

Data and Intelligence available

SHMI and HSMR provide extensive data relating to diagnostic groups and can reflect on-going trends and variance from expected number of deaths. Deaths relating to respiratory diseases feature prominently.



The tables below identify the monthly top ten relating to cause of death

Top 10 causes of death derived from HSMR

Diagnosis groups		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Running Total
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	Deaths	10	18	18	14	9	9	18						96
	HSMR	73.49	118.92	114.91	127.92	92.73	101.17	103.07						
2 - Septicemia (except in labor)	Deaths	8	5	5	5	3	6	9						41
	HSMR	61.06	46.87	49.99	52.16	24.58	75.38	76.74						
157 - Acute and Unspecified Renal Failure	Deaths	5	4	4	6	7	4	3						33
	HSMR	137.20	81.51	112.27	132.80	216.61	160.83	141.40						
108 - Congestive heart failure; nonhypertensive	Deaths	7	3	3	5	5	6	3						32
	HSMR	176.10	79.44	88.49	188.32	109.02	140.70	72.72						
129 - Aspiration pneumonitis; food/vomitus	Deaths	0	5	1	5	6	4	4						25
	HSMR		74.05	27.88	205.09	152.09	108.52	60.28						
127 - Chronic obstructive pulmonary disease and bronchiectasis	Deaths	4	3	4	1	3	2	3						20
	HSMR	121.05	109.25	130.20	53.87	79.83	118.01	109.78						
226 - Fracture of neck of femur (hip)	Deaths	4	1	6	2	0	1	2						16
	HSMR	134.10	95.55	264.56	145.79		126.03	119.91						
131 - Respiratory failure; insufficiency; arrest (adult)	Deaths	5	1	0	1	3	3	3						16
	HSMR	288.46	674.87		89.26	123.63	241.09	129.77						
159 - Urinary Tract Infections	Deaths	2	5	4	1	3	0	0						15
	HSMR	124.99	211.04	312.86	71.49	136.46								
109 - Acute cerebrovascular disease	Deaths	6	1	3	0	1	2	2						15
	HSMR	149.97	104.57	121.40		177.24	230.73	636.55						
125 - Acute bronchitis	Deaths	2	2	4	2	1	0	0						11
	HSMR	136.49	117.16	382.49	262.96	87.19								

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

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

Each month the HSMR and SHMI data identifies outliers, those diagnostic groups with a significantly high HSMR or SHMI above 100. This indicator may not necessarily be an area of concern.

A trigger or alert may relate to a random variation, poor data, quality or coding issues or case mix.

During October there were 2 deaths with an extreme HSMR of 636. Both patients were diagnosed with acute cerebral disease. Both patients had significant life limiting conditions.

CuSum, Cumulative Sum Control Chart, identifies significant changes and persistent deviation from the expected. This is reported for the trust as a whole and at diagnostic level. A trigger on the CuSum report records at greater than 5. (Appendix 2)

During April to October the overall CuSum for the trust has not reported any significant or sustained alerts. One alert was reported during May whereby a single death occurred against an expected of 0.15, recording a HSMR of 679. The patient presented at ED unresponsive and died shortly after admission.

National Alerts are received by the trust relating to the outputs from national audits, National Emergency Laparotomy Audit NELA, Colorectal Cancer Audit. Alerts from an independent monitoring body, Royal Imperial College London (RICL), monitor SHMI and advice of deviation.

Alerts have been received based on data for 2017/18.

A review of patients audited as part of the NELA and Colorectal Cancer Audit are currently being undertaken using a multidisciplinary approach.

An alert from Royal Imperial College London Dr Foster Unit (DFU) was received relating to a deviation in deaths for patients with a diagnosis of fluid and electrolyte imbalance. Following a review of the 6 patients that triggered the alert in December 2017 some issues relating to coding based on medical documentation were noted and corrected. Issues relating to concise and clear medical documentation have been escalated and discussed at MAC.

A further request was received by the trust from the CQC for a review of all patients being treated initially for electrolyte and fluid imbalance during the period February 2017 to January 2018.

The report identifying findings, lessons learnt and an action plan has been shared with the CQC and CCG. (Appendix 3)

Locally collated data and intelligence

As part of the implementation of the national learning from deaths guidelines the trust clinical teams are required to review deaths using a recognised tool to support in identifying any issues or concerns in care, system or process that may have contributed to a patient's death. An electronic tracker identifying demographic and pathway themes and trends and review triggers as identified in the NQB guidelines. (Appendix 4) are also used to inform the analysis and subsequent identification of lessons learnt and development of action plans to support improvements in care, system and process.
The table below identifies the number of deaths occurring within the trust each month, the number requiring review as determined by use of the NQB triggers.

April 2018		**May 2018**	
Total Number of Deaths	90	Total Number of Deaths	78
Total Number to be Reviewed	60	Total Number to be Reviewed	50
June 2018		**July 2018**	
Total Number of Deaths	85	Total Number of Deaths	68
Total Number to be Reviewed	56	Total Number to be Reviewed	48
August 2018		**September 2018**	
Total Number of Deaths	68	Total Number of Deaths	66
Total Number to be Reviewed	53	Total Number to be Reviewed	42
October 2018		**November 2018**	
Total Number of Deaths	83	Total Number of Deaths	85
Total Number to be Reviewed	59	Total Number to be Reviewed	49
December2018		**January 2019**	
Total Number of Deaths	34	Total Number of Deaths	
Total Number to be Reviewed	18	Total Number to be Reviewed	
February 2019		**March 2019**	
Total Number of Deaths		Total Number of Deaths	
Total Number to be Reviewed		Total Number to be Reviewed	

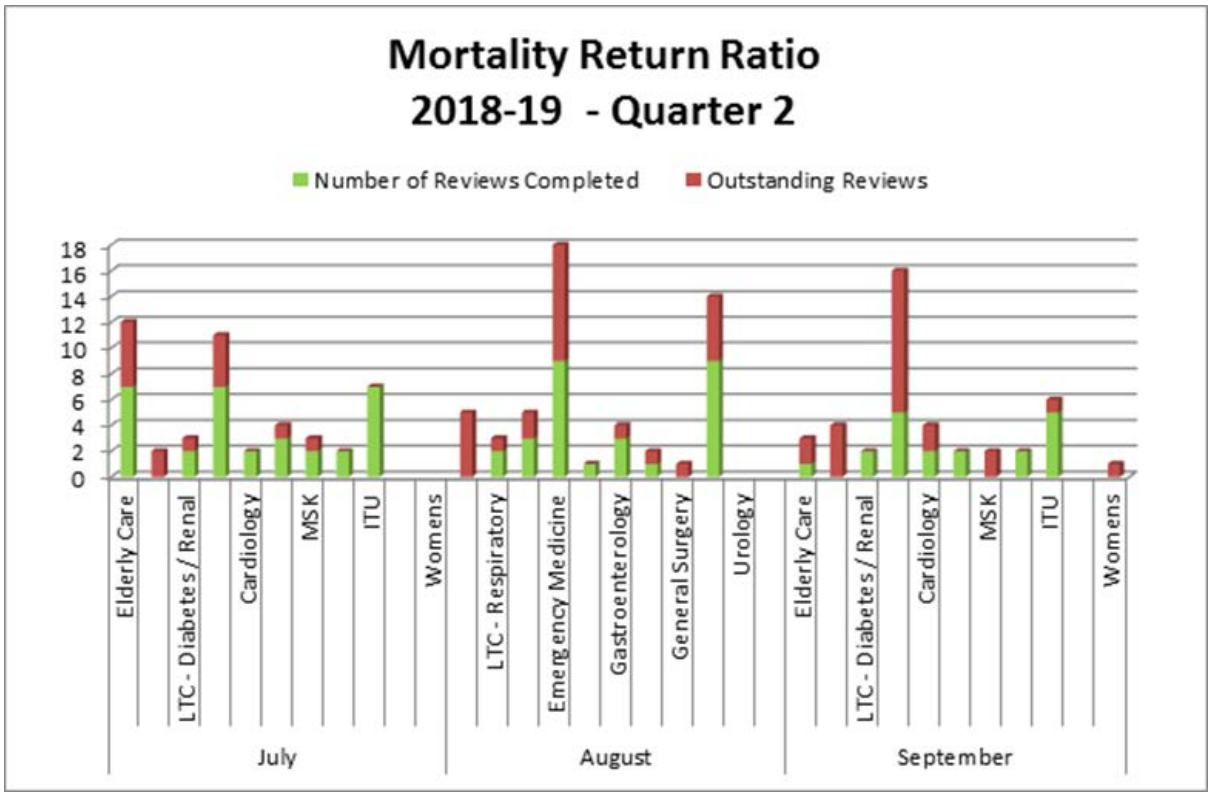
Flags Applied	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
1. All deaths where bereaved families and carers or staff have raised a significant concern about the quality of care provision	3	5	3	2	3	2	0	1	0			
2. All patients with a learning disability	1	0	0	0	0	0	0	2	0			
3. All patients with a mental health illness	0	0	0	3	6	0	0	0	0			
4. All maternal deaths	0	0	0	0	0	0	0	0	0			
5. All children and young people up to	0	0	0	0	0	0	0	0	0			

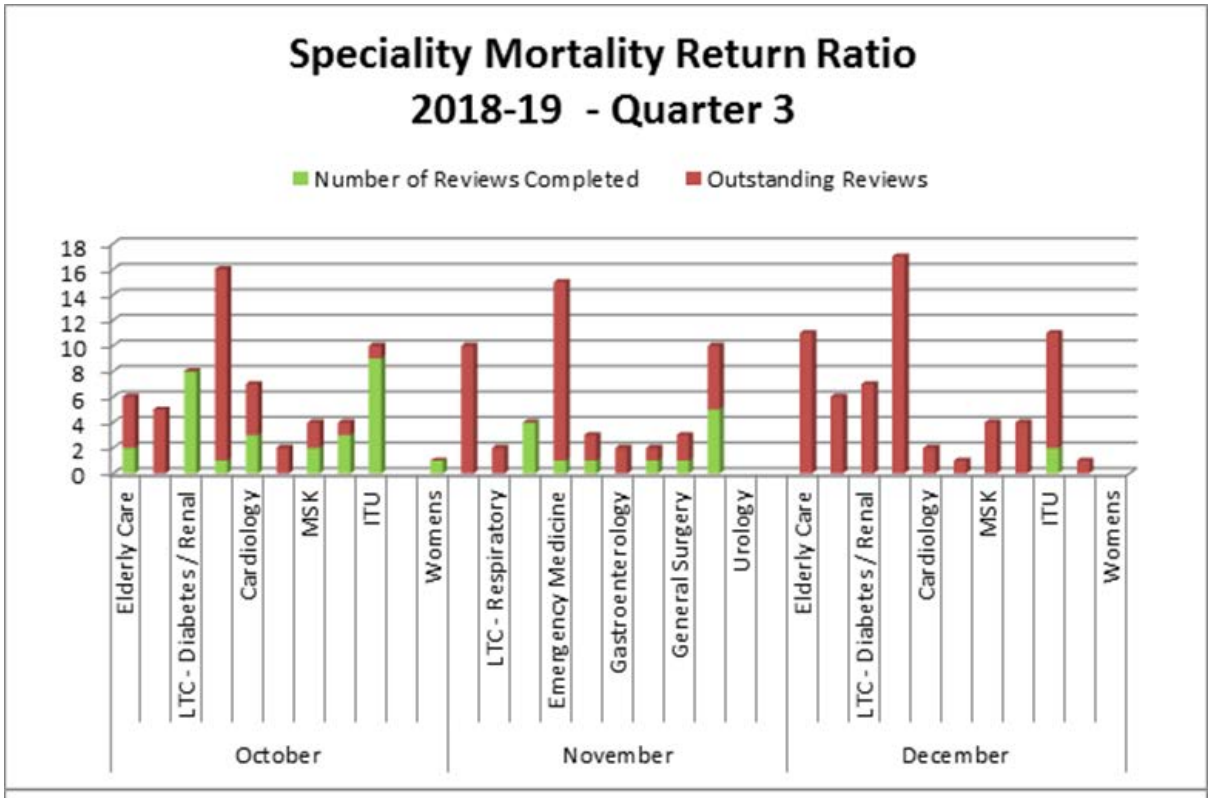
19 years of age												
6. All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work	0	0	0	0	0	0	0	0	0			
7. All 0-1 day LOS who are not receiving specialist palliative care	14	14	9	8	11	14	10	14	8			
8. All patients admitted out of hours who die within 5 days, excluding those receiving specialist palliative care	31	15	21	22	21	19	21	17	6			
9. All elective surgical patients	1	0	0	1	0	1	0	0	0			
10. All none elective surgical patients	11	10	12	6	7	4	10	5	2			
11. All unexpected deaths/ coroner reported	27	16	21	15	21	14	1	1	0			
12. Deaths in critical care	13	2	6	7	14	6	10	10	5			
13. A random selection of 20% of those other than listed above	7	11	7	6	5	6	13	9	1			
14. 20 patients per month to be reviewed by the palliative care team to review EOL care	20	20	20	20	20	20	20	20	20			
15. All deaths were an internal indicator is flagged readmissions within 30days	12	9	8	6	11	9	12	7	3			
16. All deaths were an internal indicator is flagged readmissions >4 in 12 months	8	10	10	7	8	9	10	9	1			

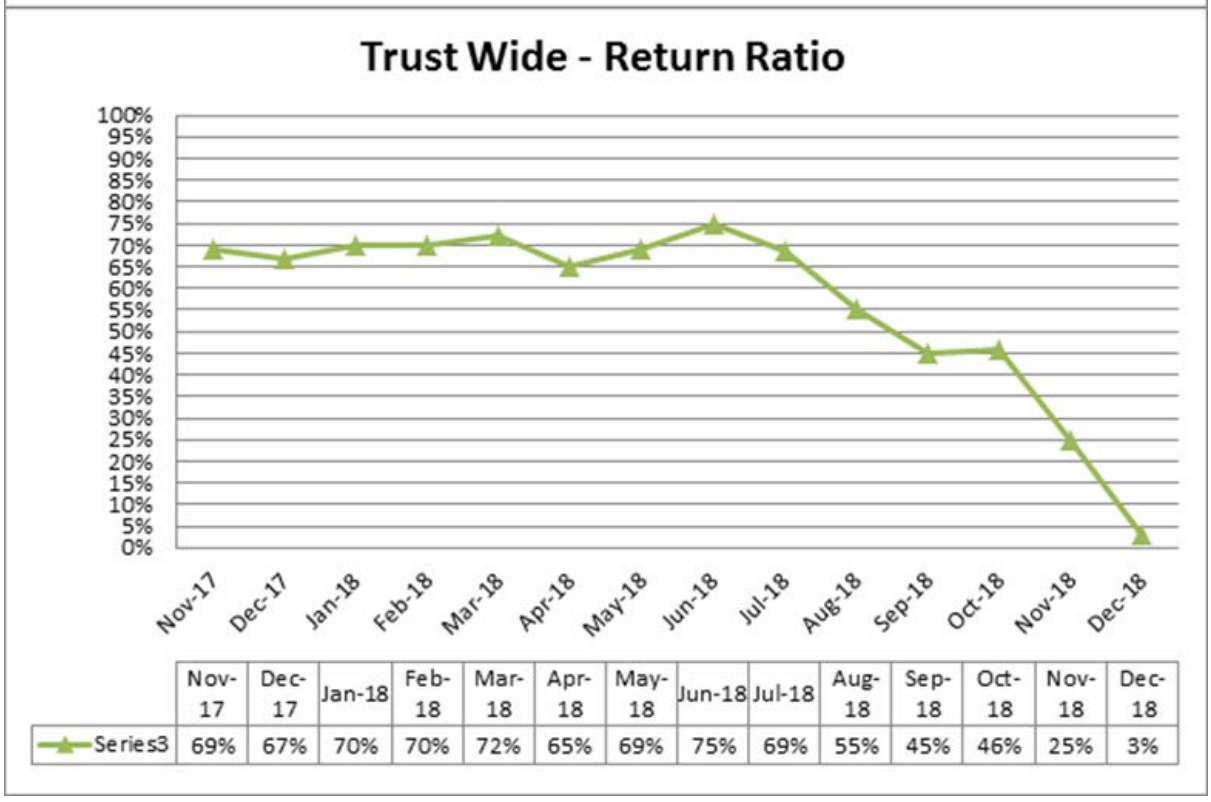
Reviewing and Learning

The Trust currently aspires to review the majority of deaths based on the application of the NQB triggers, local trends, national alerts and triggers identified from SHMI and HSMR, referencing the NQB triggers and using the SJR tool. Analysis of the reviews should identify areas of good practice, issues in care, system and process, lessons learnt. From which the clinical teams supported by the clinical governance team should develop action plans with clear ownership and actions and demonstrate clear measureable outcomes and improvements in care.

Current performance for undertaking clinical reviews of deaths is poor.







	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Series3	69%	67%	70%	70%	72%	65%	69%	75%	69%	55%	45%	46%	25%	3%

Recent reviews of patient deaths have identified the following themes to be addressed

- Early identification of patients with life limiting and frailty conditions to implement EOL pathways and support for relatives

- Communication and support for patients and carers as part of an EOL pathway
- Management of patients with inserted devices, appendix 5
- A proportion of patients with existing DNAR in place whose care may have been appropriate to manage within the community setting.
- Support for nursing homes in care of the dying patient
- IDT and community in reach working collaboratively with health economy partners to expedite discharges.
- Limited undertaking and quality of mortality reviews.
- Nutritional support for dying patients and feeding at risk and comfort feeding.
- Review of patients dying out of hospital within 30 days of discharge
- 2 LD deaths have occurred during November

Actions being taken

- The Consultant Lead for palliative care will be attending the obstetrics and gynaecology quality group to give support and guidance in managing patients and their EOL needs.
- A trust wide seminar will take place March 14 to include a presentation by the palliative care lead relating to effective communication with patients and carers
- Actions from the Nutrition Steering Group to improve feeding patients and risk and comfort feeding processes to be shared trust wide. Appendix 10
- Actions from the RCA relating to a patient with an inserted device, tracking, monitoring and follow up arrangements to become more robust.
- Review of the commissioner/acute collaborative learning from death framework in conjunction with Public Health and Social Care.
- Advert for the ME role to be action during January
- The 2 LD deaths will undergo SJR supported by specialist nurse leads for safeguard and patient safety , outputs will be presented at the February MSG
- Review of ED deaths

Next Steps and Considerations

In June 2018, the Department of Health proposed a statutory requirement for the role of Medical Examiner.

A business case has been submitted and agreed at board level to resource and recruit to the Medical Examiner role and fund the Learning from Death infrastructure. This business case has been supported. (Appendix 6) The scrutiny, review documents, mortality governance and job descriptions for the ME team have been developed in keeping with the national profiles

The implementation of the national strategy will begin commencing with scrutiny of all deaths and identifying those that require formal SJR review.

It is anticipated from evidence from the pilot trusts that this process will reduce formal reviews to approximately 50% of all deaths, whilst ensuring that robust

governance processes are in place to capture any untoward or unexpected care or process issues for all deaths.

Following an appointment into the role of Medical Examiner (ME) the principles of scrutiny of all deaths will be implemented to determine those deaths that require formal RCP SJR.

The implementation of the ME role, supporting infrastructure and policies will be implemented and embedded via a multi-disciplinary working group., engaging and working with all stakeholders to implement the revised scrutiny, death certification and support for bereaved relative principles as outline in the national agenda by April 2019. The ME role and function will align and support in embedding the Learning from Death strategy. Appendix 7 and 8

The trust governance policy is currently being revised, Appendix 9, to assure governance frameworks are clear through clinical teams to board. The governance proposes an increased focus on ownership of learning from death by the clinical teams, driving reviews, action plans and changes in care, system and process.

The trust currently aspires to review all those deaths which are identified using the NQB triggers using the SJR tool; his equates to approximately 60-70% of all deaths. This has proved challenging and presents a risk in assuring that any elements of care or process have not contributed to the death of a patient.

Although the trust has developed and published the Learning from Death Policy, identified and trained clinical mortality leads, embedding the process and governance through the clinical teams will be a priority.

Engagement sessions have commenced with all clinical leads and patient safety leads to embed and focus ownership of mortality reviews, the quality of the review, learning and actions within the clinical teams and improve performance for reviews.

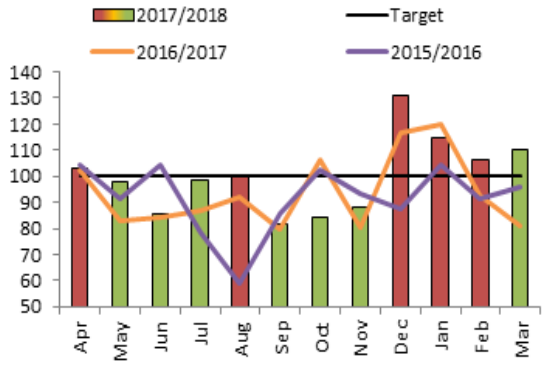
The systems, processes and governance will be revised to support and embed a consistent approach to reviewing all deaths, identifying lessons learnt, acting on learning and sharing that learning.

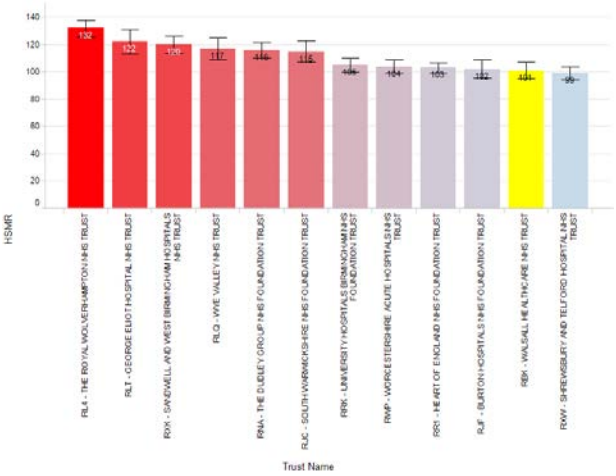
A further review will need to be undertaken in respect of the bereavement support required to fully implement the NQB and DH guidelines and identify the interdependencies with the Learning from Death strategy.

A key element to be scoped further is partnership working with commissioners to identify whole pathway improvement opportunities and incorporate reviews of out of hospital deaths.

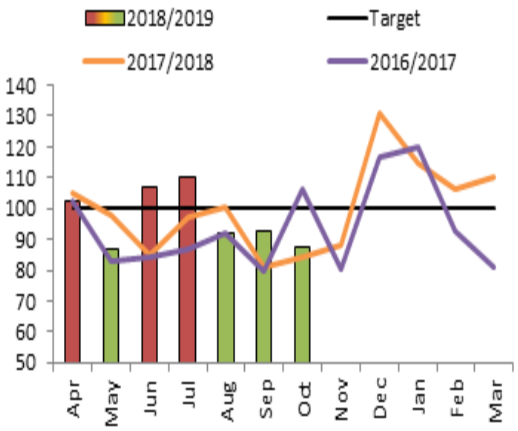
Appendix 1

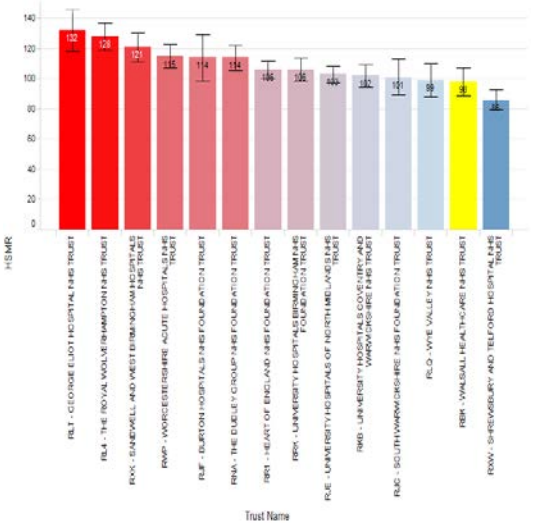
HSMR performance 2017/18 and regional comparison



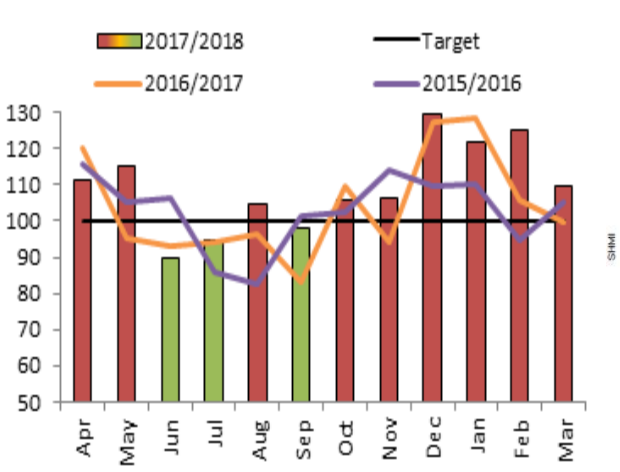


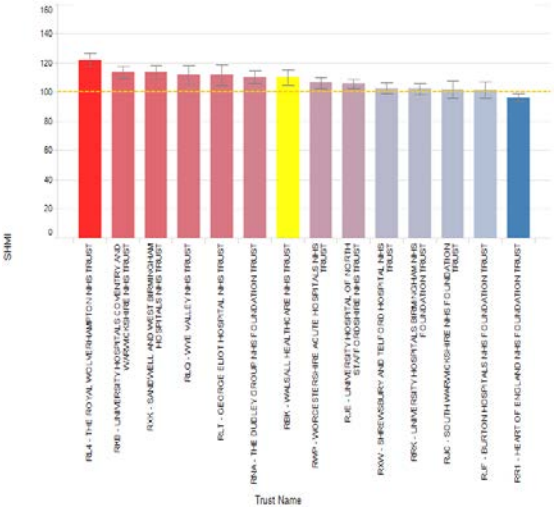
HSMR performance 2018/19 and regional comparison

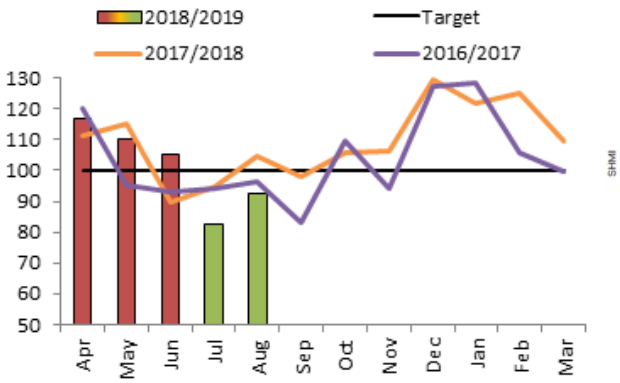


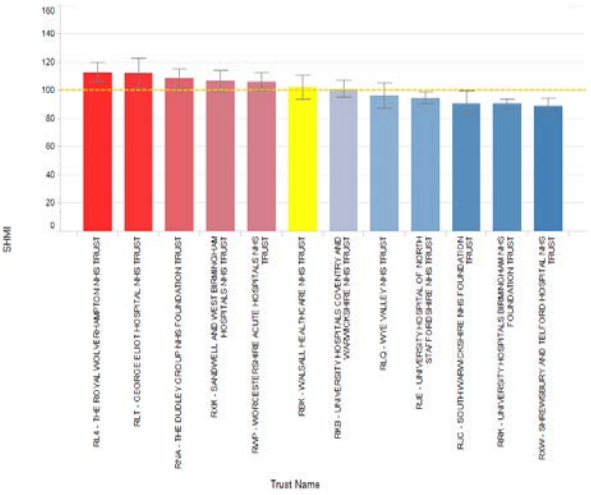


SHMI performance 2017/18 and regional comparison

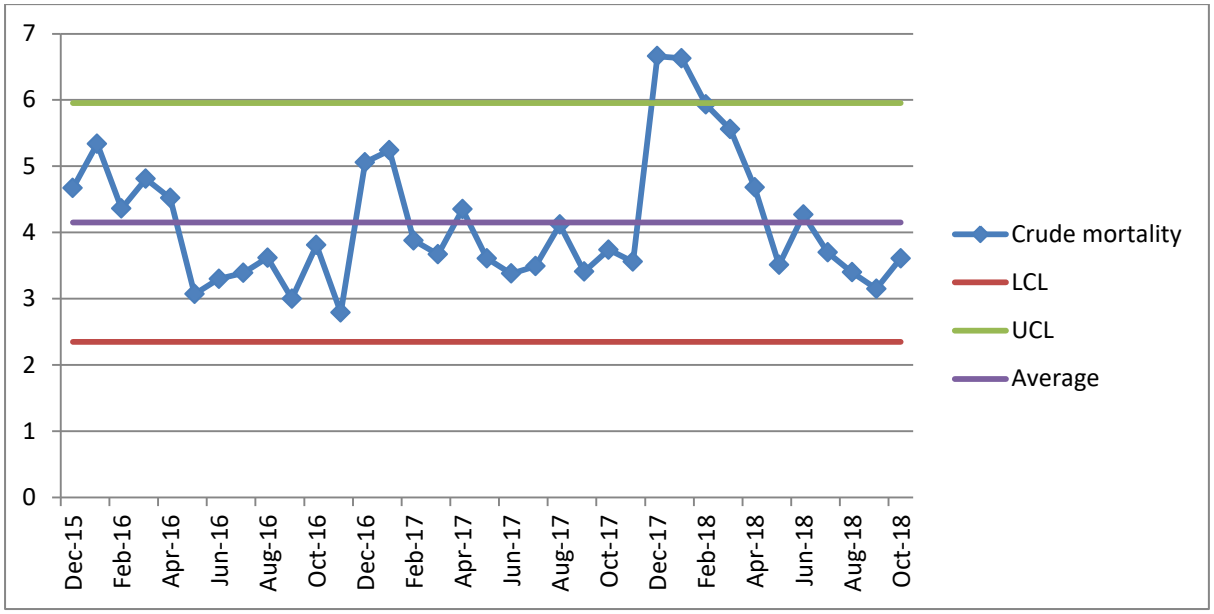




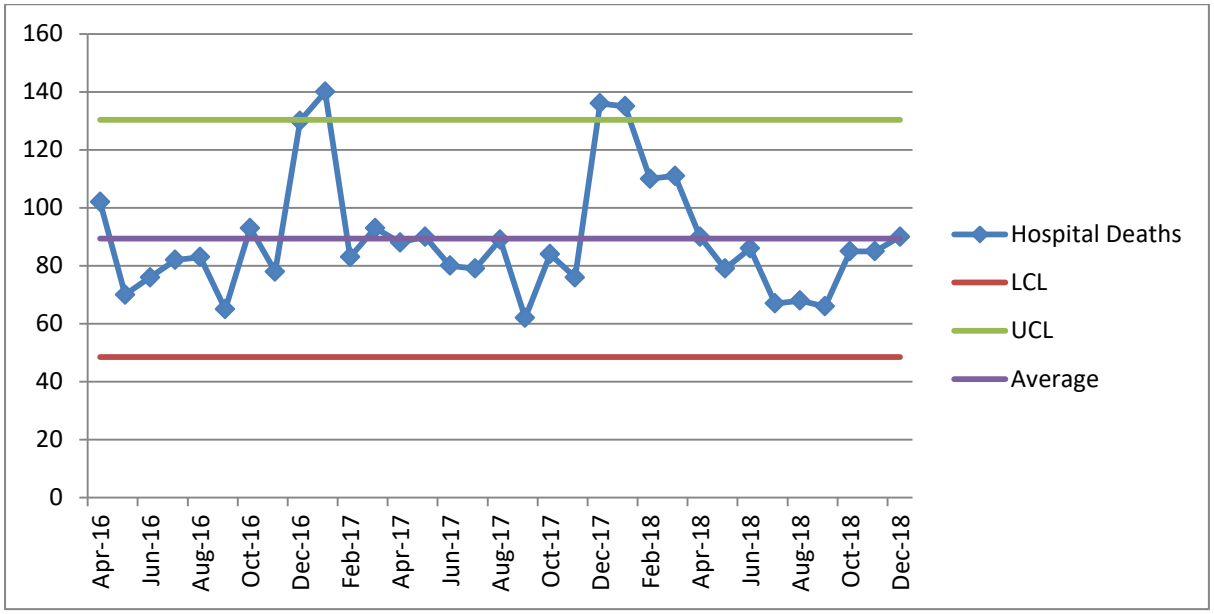




Crude Mortality September 2018



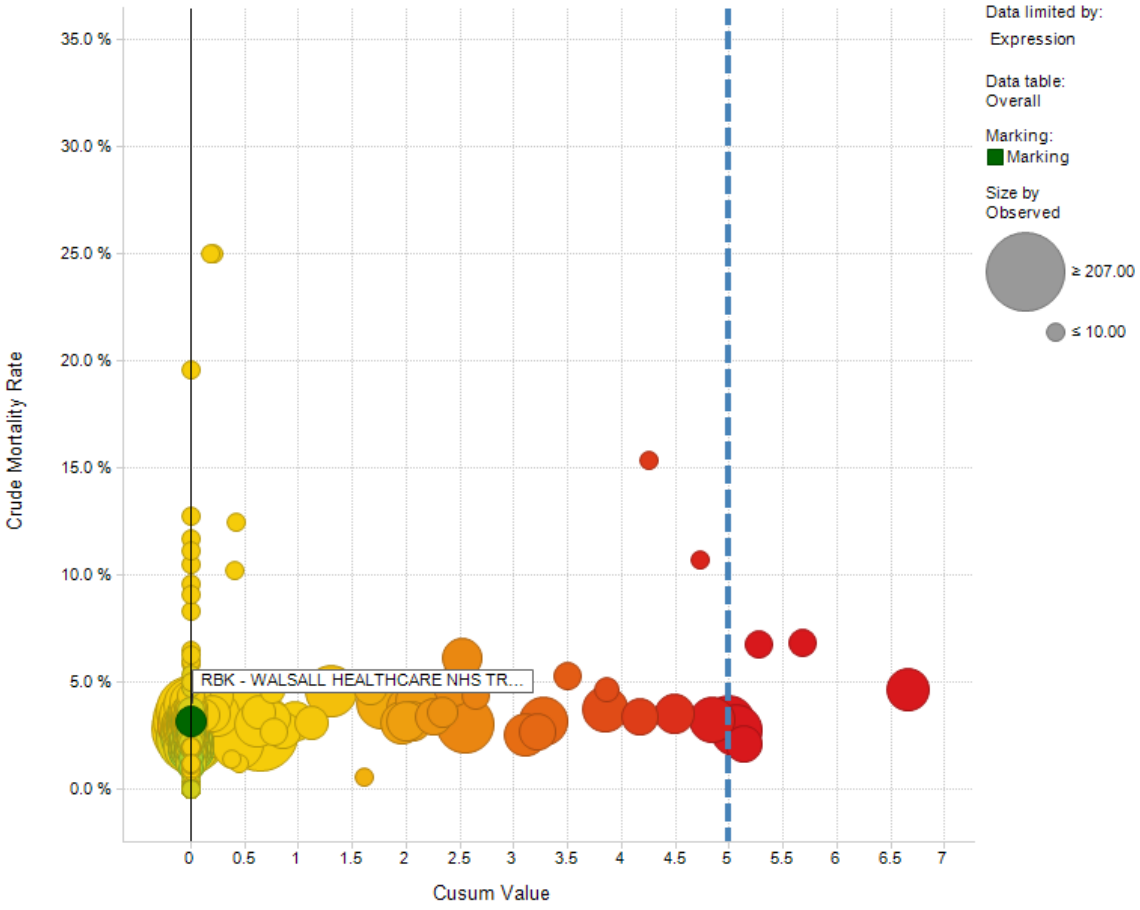
Hospital Deaths



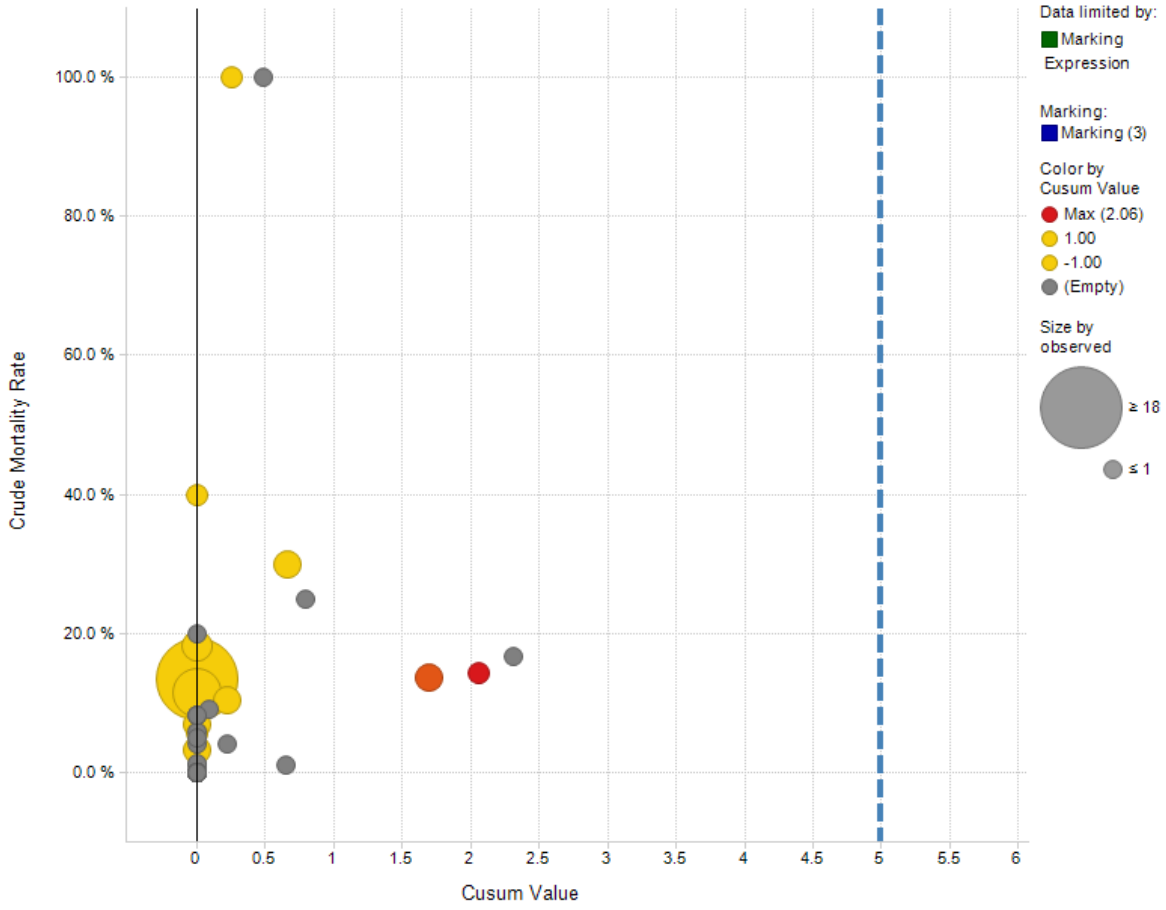
Deaths by specialty

Year Financial	Grp By	(01) Apr	(02) May	(03) Jun	(04) Jul	(05) Aug	(06) Sep	(07) Oct	(08) Nov	(09) Dec	Total
Year 2018/19	CARDIOLOGY	4	3	5	3	2	6	6	5	2	**36**
	COLORECTAL SURGERY	0	1	0	0	0	0	0	0	0	**1**
	DIABETIC MEDICINE	2	7	4	1	1	4	6	6	8	**39**
	ENDOCRINOLOGY	1	0	0	0	0	0	0	1	0	**2**
	GASTROENTEROLOGY	8	3	7	7	5	5	6	5	2	**48**
	GENERAL MEDICINE	31	21	31	21	34	26	33	37	28	**262**
	GENERAL SURGERY	7	5	9	4	2	0	4	3	8	**42**
	GERIATRIC MEDICINE	20	21	13	18	8	8	10	9	16	**123**
	GYNAECOLOGICAL ONCOLOGY	0	1	0	0	0	1	0	0	0	**2**
	GYNAECOLOGY	0	0	0	0	0	0	1	0	0	**1**
	NEPHROLOGY	0	0	2	0	1	3	2	1	2	**11**
	REHABILITATION	1	2	3	1	3	2	2	5	4	**23**
	RESPIRATORY MEDICINE	6	9	3	4	6	6	6	10	12	**62**
	TRAUMA AND ORTHOPAEDICS	3	2	7	3	2	1	3	2	4	**27**
	UROLOGY	0	1	0	0	0	0	1	0	1	**3**
	WELL BABIES	3	3	2	5	2	2	4	1	2	**24**
	ZZZ Treatment not known	4	0	0	0	2	2	1	0	1	**10**
	Total	**90**	**79**	**86**	**67**	**68**	**66**	**85**	**85**	**90**	**716**

Appendix 2
CuSuM Overall for the Trust September 2018



CuSum for September 2018 by Diagnosis



Appendix 3

Walsall Hospital NHS Trust CQC mortality r

Appendix 4
Review Triggers

- All deaths where bereaved families and carers or staff have raised a significant concern about the quality of care provision
- All patients with a learning disability
- All patients with a mental health illness
- All maternal deaths
- All children and young people up to 19 years of age
- All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work
- All 0-1 day LOS who are not receiving specialist palliative care
- All patients admitted out of hours who die within 5 days, excluding those receiving specialist palliative care
- All elective surgical patients
- All none elective surgical patients
- All unexpected deaths/ coroner reported
- All deaths in critical care
- A random selection of 20% of those other than listed above
- 20 patients per month to be reviewed by the palliative care team to review EOL care
- All patients readmitted within 30 days
- Those patient with 4 or more inpatient admissions within a 12 month period

Appendix 5

Closure Sheet.pdf

Appendix 6
Medical Examiner Business Case

ME business case v6.docx

Appendix 7
Learning from Death Flow

ME flow V3.pptx

Appendix 8

Learning from Death Governance

MSG governance v1.pptx

Appendix 9

Learning from Death TOR

Mortality Surveillance Group draft TOR 031

Appendix 10

MinutesNov18.docx

MEETING OF THE PUBLIC TRUST BOARD – 7TH FEBRUARY 2019			
Nursing Strategy			**AGENDA ITEM: 13**
Report Author and Job Title:	Karen Dunderdale, Director of Nursing	**Responsible Director:**	Karen Dunderdale, Director of Nursing
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The Director of Nursing is proud to present the Nursing Strategy for Walsall Healthcare NHS Trust. The strategy was developed following an engagement event attended by nurses, patients and volunteers across all services. The aim of the Nursing Strategy is to develop a culture that places quality at the heart of everything that we do, where we deliver a positive patient experience and improve outcomes. This Nursing Strategy is critical in establishing a coherent direction by which nurses can develop and deliver appropriate, compassionate, knowledgeable and skilled practice. It is applicable to all Registered Nurses, Care Support Workers and ward support staff. There are four principles in this strategy which reflect the commitment to quality and the expectations of high quality nursing care.		
Recommendation	Members of the Trust Board are asked to approve and support the implementation of the Nursing Strategy.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF No 001 Failure to deliver consistent standards of care to patients' across the Trust results in poor patient outcomes and incidents of avoidable harm.		
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 ☐		

Walsall Healthcare NHS
NHS Trust

Nursing Strategy
2019-2024
Walsall Healthcare NHS Trust




Caring for Walsall together

Safe, high quality care
Care at home
Partners
Value colleagues
Resources
Respect
Compassion
Professionalism
Teamwork

Nursing Strategy
2019-2024

Director of Nursing Introduction

I believe our vision for nursing should combine compassion, dignity and respect with some of the most advanced technologies, which together provides the cornerstone of our commitment to patients and their families. A Nursing Strategy is critical in establishing a coherent direction by which nurses can develop and deliver safe, appropriate, knowledgeable and skilled practice.

Nursing is involved in many care interventions, therefore nursing is ideally placed to make a positive difference in the patient's experience. Nurses need a range of technical skills, and a high level of education to enable them to be effective and be critical thinkers, and decision makers. However, it is not just what we do, but how we do it, that is important, and the core values of care, compassion, dignity and respect cannot be overestimated.

It is often suggested that nurses should focus on basic nursing care. However, there is no such thing as "basic care". Often things that are described as basic are anything but basic to the patient. Often interventions are counted in terms of cost, when we should actually be thinking of them in terms of value to the patient. Some of the things that really matter have no cost, but are of great value. (For example maintaining privacy and dignity and listening to patients).

As well as investing in tangible resources, we also need to invest time and effort in creating a culture of trust, collaboration and respect. There is plenty evidence to support the view that staff satisfaction increases patient satisfaction and vice versa, and it is therefore essential that we support the development of the next generation of nursing role models, to ensure that nursing, and nurses, are still valuable and valued, and are central to the business of the Trust.

To develop nursing, we will need new roles and skills to ensure we deliver care which is safe and responsive to all of our patients and stakeholders' needs. Everything we undertake at Walsall Healthcare Trust is aimed at improving the experience and outcomes our patients have of our care and services.

It is a privilege to be a nurse to aspire to make a difference to a life in times of need. The nurses in the trust will be inspirational clinical leaders, be curious and innovative, using our professional voice to ensure we are seen and impactful.

Dr Karen Dunderdale
Director of Nursing

Aim of the Nursing Strategy

The aim of the Nursing Strategy is to develop a culture that places quality at the heart of everything that we do, where we deliver a positive patient experience and improve outcomes. In developing this strategy I have engaged with nurses, patients and volunteers across all our services. I have asked nurses to consider what we need to do to provide outstanding care delivered by competent staff to a consistently high standard reflecting the Trust's values. This Nursing Strategy is critical in establishing a coherent direction by which nurses can develop and deliver appropriate, compassionate, knowledgeable and skilled practice. This strategy is applicable to all Registered Nurses, Care Support Workers and ward support staff. There are four principles in this strategy which reflect the commitment to quality and the expectations of high quality nursing care.

Enhance and maintain patient safety

Expectation: The safety of our patients is pivotal to everything we do and nurses must take responsibility for prevention and reducing risks to patients, clients, visitors and themselves. We want every nurse to take this responsibility seriously and to understand the role they play in reducing risks. Nurses have a key role to play in protecting patients from adverse events. We will focus on those areas that are high risk and which our staff can influence, including falls, pressure sores, nutrition, healthcare acquired infection, medicines management and identification and management of the deteriorating patient. Our aspiration is to improve system safety by increasing awareness of Human Factors and becoming a High Reliability Organisation.

What we will do:

- Robust recruitment and retention plans will be in place, along with succession planning strategies, for all staff groups in order to ensure safe and effective clinical teams.
- We will strive to prevent and reduce our healthcare associated infections by monitoring key nursing indicators in relation to infection.
- A multi-disciplinary approach will be taken in the fight against infection with both the Director of Nursing and Medical Director, jointly leading on the infection control agenda.
- A zero tolerance approach will support hand hygiene and isolation of infected patients.
- All nurses will be responsible for ensuring a safe and clean environment.
- We will use nursing key performance indicators through a quality dashboard to monitor and review safety issues such as pressure sores, nutrition and hydration, falls, hand-washing, deteriorating patient and other key performance indicators relevant to specialities.
- We will foster a culture of incident reporting.
- We will make it easier to deliver safe care by improving systems and processes that support staff to deliver and improve services and make it harder to deliver unsafe care.

How we will achieve this:

- We will behave in a way that is open, transparent and honest.
- We will apply the trust values in all communication (written and verbal and nonverbal).
- We will become independent and supplementary nurse prescribers where it has been identified that this will benefit patient care or ensure efficient delivery of treatment.
- Ward establishments and nursing team skill mix will be reviewed annually by the Director of Nursing, in order to ensure the appropriate skills are available to deliver a high quality of care to our patients.
- The acuity and dependency of the patients will be reviewed twice a year to inform the ward and nursing team establishment reviews.
- All nurses will comply with Trust policies for Infection Prevention and Control.
- Our senior nurses will ensure that the patients' environment is cleaned to the highest standard and will be empowered to take action to address any issues that may arise.
- Nurses will be well informed about each person in their care and accountable for assessing, implementing, evaluating and documenting the care they provide.
- The Nursing Care quality dashboard will continue to be monitored daily as well as other key indicators identified in the Trust Quality Strategy and Patient Experience Strategy. Outcomes from these measures will be used to improve patient care.
- Staff will continue to be involved in Root Cause Analysis, to enable understanding of why safety issues occur along with the lessons learnt, enabling practices to be changed if required.
- We will feed back to reporters promptly and effectively the results on incident investigations.
- We will commence schwartz rounds to allow staff to connect and learn vicariously from episodes of harm.

Positive patient experience

Expectation: Every person matters, their story is important, unique and of value. Our patients and clients will be treated with compassion, dignity and respect at all times and will be encouraged to participate in all aspects of their care planning and delivery. We will improve the care we provide by actively listening to patients and their carers to better understand their needs, concerns and wishes.

What we will do:

- The patients and clients under our care will be kept well informed and will be treated with compassion, dignity and respect. When required we will provide clarity regarding their care and, where appropriate, their relatives and carers when required.
- We will care for our patients in an environment that provides them with privacy, dignity, and respect and takes into account their spiritual and religious needs.
- We will actively seek to involve patients in forums for discussion and feedback.
- When reviewing pathways and developing new services we will encourage active participation of patients.
- Nurses will participate in the development of the Trust's information technology strategy, including patient monitoring, electronic patient records, e-prescribing and e-rostering to ensure delivery of effective patient care.

How we will achieve this:

- We will continue to ask our patients for feedback on how we are doing and act on the results. We will use "You Said, We Did" Boards and other strategies as appropriate.
- We will listen to and use patient stories and case studies to help us understand patients' experience, ensuring that issues are acted on at Ward, Division, Community and Trust Board level.
- We will talk to our seldom heard groups to ensure we are inclusive of all patients and clients.
- We will use experiences of spiritual and religious care in staff training and develop religious care champions.
- We will use complaints and issues raised by patients and relatives to help us understand how we can improve care.
- We will improve care by learning from excellence.
- We will ensure that feedback received from patients and their carers is acted upon to improve the quality of our service which promotes a positive experience.
- We will cultivate patient leaders and patient leadership.
- We will use experience based co-design in our service development.
- We will be actively involved in using technology to support the care and treatment of patients.

Enhanced professionalism

Expectation: The nurses within our Trust will visibly portray the behaviours, attitudes and values expected of a professional nurse and of their governing body and will use the Nursing and Midwifery Council (NMC) Code as a guide for their everyday practice thereby enhancing confidence in caring for and caring about our patients.

What we will do:

- We will embed the trust values of Respect, Compassion, Professionalism and Teamwork in all we do.
- We will embed the agreed standards of behaviour in our workplace.
- Patients and colleagues will be treated with respect and dignity.
- Professional attitudes and compliance with Trust policies will be expected at all times by both staff and students.
- We will engage and communicate with each other in a way that engenders the trusts values.
- We will strengthen the role of our Matrons, Sisters/Charge nurses, Managers and Community staff and their ability to act.
- Nursing roles will be clarified to ensure professional standards and the purpose of nursing is shared in the Trust.
- We will establish a mechanism for reward and recognition of outstanding performance.
- We will embrace and support the Nursing & Midwifery Council revalidation process.

How we will achieve this:

- The Trust will support our nurses in challenging unacceptable behaviour and support will be given for all staff to promote an environment where unacceptable behaviour is not tolerated.
- There will be strict adherence to Trust Dress Policy.
- We will actively engage in regular clinical supervision, coaching and mentorship that enhance the profession.
- We will develop a recruitment and retention strategy for nurses that attracts and retains exceptional applicants.
- We will engage staff to learn from their experiences and work to maintain high levels of morale.
- We will actively engage in quality improvement projects with a multi-disciplinary team to ensure learning across disciplines to avoid silo working and improve pathways of care.

Clinical leadership closest to the patient

Expectations: We will actively promote the development of nursing leadership skills and will maximise opportunities for learning; we will use education to support the delivery of expert care.

We will ensure that we have robust assurance processes in place to provide both the internal and external assurances that are required. We know of the direct relationship between service quality, reputation and income. We will therefore deliver care which is built on evidence which has a strong research base. We will create a culture that empowers patient centred care, based on that which is important to the patient and their carer, through a safe and trusting relationship.

What we will do:

- Our nurses will lead by example in the clinical/service areas and consistently act as role models to our more junior staff and students.
- Senior nursing roles will be reviewed to ensure they provide visible leadership at the place where patient care is delivered.
- We will ensure all senior nurses (band 6 and above) have Quality improvement training to empower them to lead and support local improvement projects.
- We will ensure that every nurse joining the trust attends a session on their role in Quality Improvement.
- We will ensure that we support staff in developing their understanding of their role and support senior staff in learning from their developing understanding of how the service works.
- Support will be given to our nurses in identifying the knowledge and skills they require to perform their roles within their teams.
- We will ensure access to appropriate learning and development opportunities for nurses in line with the needs of the patients in their care.
- We will ensure mentors and support of pre-registration nurses are in place to enable students to achieve their learning needs.
- We will develop new nursing roles where appropriate, which are designed to provide better care for patients.
- We will continue to develop clinical practice placement opportunities for students as services evolve.
- We will improve the profile of nursing research in the Trust.
- We will make use of research undertaken by our nurses at undergraduate and post-graduate level and support its publication.
- We will improve the integration of nursing research into the Trust research programme.
- We will continue to develop and enhance our strategic partnerships with education commissioners, Higher Education Institutions (HEI) and other external partners. In doing so we will ensure a robust quality assured educational practice placement learning experience.
- We will ensure that we can equip nurses in hospital, or in the community, to work with advances in technology and information technology in clinical practice.
- We will ensure that we can equip nurses with the skills to lead care delivery and redesign in multiprofessional settings and across organisational boundaries.
- We will foster the stance of the standard you walk past is the standard you accept.
- We will ensure the ward/service review process continues to be framed in the Care Quality Commission (CQC) standards.

How we will achieve this:

- There will be a clear nursing structure, within our organisation.
- We will ensure a commitment that ward/service leaders will have a protected time allowance so they are not rostered for clinical duties. This will enable them to provide clear leadership and work to support their teams.
- We will be honest and act with integrity.
- We will provide access to leadership programmes/ coaching and external mentoring, for our nurses in order to develop our future leaders and enhance the skills of those in leadership roles at present.
- We will ensure each Ward and Department has a Vision for their area which encompasses what will/does good care look like here.
- Nurse leaders will be visible and known to staff within the Trust.
- We will use jargon free language.
- We will actively seek to increase the amount of nursing research undertaken in the Trust and seek to establish roles where research is a required component.
- We will encourage and share innovation and best practice in nursing service delivery within the Trust by delivering a Best Practice Day, annually.
- We will utilise national examples of service innovation and modernisation.
- All nurses will attend mandatory training and role specific training in line with the Trust's policy.
- All staff will actively participate and be responsible for delivery of their objectives through annual appraisal.
- All nurses will complete their mandatory training in safeguarding. There will be appropriate reporting of cases and evidence that people using the services, families and the public will be safer as a result.
- We will develop new roles and flexibility at the boundaries of professional roles linked to service development.
- We will develop frailty awareness and competencies.
- We will provide quality service improvement training and development for nurses to support them in making changes.
- We will provide training in continuous quality improvement methods.
- We will involve all staff within QI projects, irrespective of their role.

Conclusion

This Nursing Strategy sets out our commitment to ensuring that all our patients experience a high standard of dignity, respect and compassionate care and treatment. Nursing will aim to have a reputation that drives credibility, excellence, innovation and progressive care that ensures individual professionals are clear about the opportunities Walsall Healthcare Trust provides.

We know we have further work to do in ensuring that this strategy is implemented for every patient all of the time in every area.

We will use robust clinical governance mechanisms to drive and demonstrate improved performance. This strategy will be reviewed annually through the Quality Patient Experience & Safety Committee and the Nursing Midwifery Advisory Forum (NMAF).

Nursing Strategy
2019-2024

Walsall Healthcare NHS Trust

Issue 01: January 2019

Caring for Walsall together

MEETING OF THE TRUST BOARD – 7 FEBRUARY 2019			
Board Assurance Framework - Delivery of 7 Day Services			**AGENDA ITEM: 12**
Report Author and Job Title:	Mrs J Adams Business Manager to the Medical Directorate	**Responsible Director:**	Matthew Lewis – Medical Director
Action Required	Approve ☒ Discuss ☒ Inform ☐ Assure ☒		
Executive Summary	The report provides an oversight of the Trust's performance against the 4 priority 7 Day Service Standards, the Board Assurance Framework template as developed by NHSI and recommendations relating to improving areas of performance. The Quality, Patient Experience and Safety Committee are recommending that the Board consider the governance requirements for the 6 remaining 7 Day Service Standards.		
Recommendation	Members of the Trust Board are asked to discuss the content of the report and raise any question in relation to the assurance provided and consider the recommendations: • To scope options to improve the delivery of standard 8 • Develop governance for delivering, monitoring and reporting progress for the six standards relating to continuous improvement		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are currently no risks associated to the delivery of 7 Day Services 4 priority standards. The delivery of a 7 day service will contribute to reducing Trust risks and delivering key indicators relating to the 4 hour wait and patient flow, managing the deteriorating patient, patient experience and support and supervision of junior colleagues.		
Resource implications	A potential resource implication has been identified relating to the delivery of standard 8 (once daily reviews, 7 days a week), unless it has been determined that this would not affect the patient pathway. This implication would need to be considered as an integral element relating to the medical workforce review, planning and service delivery strategies and Walsall Together strategy.		
Legal and Equality and Diversity implications	The national requirements is that all patients regardless of demographic, social, physical or psychological and physiological needs have access to the full range of services of a predetermined standard 7 days a week.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Delivery of 7 Day Services Summary Report
Trust Board January 2019

PURPOSE OF REPORT

The purpose of the report is to outlines the foundations of the national strategy for the delivery of 7 Day Services, the activities the trust has been engaged in to develop a gap analysis, benchmark and identify key areas of work to be undertaken to mitigate any gaps in delivering the 7 Day Service NHS agenda.

The report focuses on the four priority standards and seeks guidance in developing governance, reporting and implementing the remaining six standards.

BACKGROUND

In February 2013 the inaugural meeting of the NHS Services, Seven Days a Week forum took place. This forum, established by Professor Bruce Keogh, was an output from the NHS England paper "Everyone Counts" December 2012. The Forum believes that patients' experience of care is particularly affected at weekends by a lack of integration across all health settings and with social care services. However, given the immediate need to reduce the higher mortality risk for patients admitted at weekends, the forum focused, as a first stage, on the part played by the acute hospital's weekend service and specifically on urgent and emergency care and supporting diagnostics.

The Clinical Reference Groups for this forum found significant variation in outcomes for patients admitted as an emergency over the weekend in mortality, length of stay, readmissions and patient experience. The forum established key themed work streams to explore some of the issues critical to delivering a 7 day service model.

- Clinical standards
- Workforce and organisational development
- Finance and costing
- Incentives, rewards and sanctions
- Service models

The Forum and CRG recommended the adoption of ten clinical standards that describe the standard of emergency care patients should expect to receive 7 days a week.

1. Patient experience
2. Time to first consultation
3. MDT reviews
4. Shift handovers
5. Diagnostics
6. Interventions

7. Mental health
8. On-going review
9. Transfer of care
10. Quality improvement

It has been determined that there are four priority clinical standards of the suite of ten which are considered to be fundamental on improving “out of hours” and weekend care and have a positive impact in 4 key areas:

- Better Patient Experience
- Improved Patient flow
- Patient Safety
- Better clinical supervision across the week

Priority Standards

2. Time to first consultant review, within 14 hours in the acute admission setting
5. Availability of diagnostics
6. Consultant led interventions
8. On-going consultant review, all patients to be reviewed every 24 hours.

NHS Improvement has determined key milestones for the delivery of these priority standards to the population of England. By April 2018, 7 day services will be available to 50% of the population and April 2020 available to 100% of the population.

Key Challenges

A number of key challenges have been identified for acute providers in achieving delivery of 7 day services.

Workforce: a number of challenges present themselves, identifying gaps in existing workforces, the cost pressure or ability to recruit, particularly too difficult to recruit to posts in Emergency Medicine, redesign and development of new roles to support 7 day services.

Reconfigurations and networks: developing a whole health and social care system change, further development of ambulatory and urgent care facilities, development of 7 day and improved access to general practitioner services.

IT and integrated communication: developing solutions across acute, primary and community care providers.

A fundamental requirement to delivering 7 day services in the acute setting is to ensure that 7 day services are available within primary care. Access should be available in the GP setting, urgent care centres and ambulatory care settings to ensure only those accessing acute emergency services and occupying acute beds are appropriate. 7 day services across the health economy will support in patient flow, experience and outcomes. A key risk identified to enable the delivery of these 7 day services will be the ability to recruit to General

Practitioner in the Midlands and East Region. NHSE have suggested the gap in provision of an adequate GP workforce to deliver 7 day services within the Midlands and East regions will be approximately 1389 posts.

ACTIVITIES

The Trust has participated in the NHSI 7 Day Service national audits since September 2016. The audits have supported in determining a gap analysis and benchmarking against peers The outputs from the audits are as per the diagram below.

It should be considered that the performance during September 2016 is not representative of the trust performance due to limited data submission.

During April 2018 the trust was given the opportunity to validate the submission after the original closing date. This revalidation improved the trust performance.

	Survey			
	September 2016	March 2017	September 2017	April 2018
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	62%	79%	79%	92%
Proportion of patients seen every 24 hours		88%		99%

In November 2018 NHSE and NHSE notified all trusts that the existing self-assessment currently being undertaken through a nationally supported program and portal would cease. A formal introduction of a Board Assurance Framework to measure and report the delivery of 7 Day Services would be implemented (Appendix 1).

The Trust have completed the BAF template for submission to NHSI by 28th February based on the Spring 2018 self-assessment data analysed by NHSI (Appendix 2). The BAF makes specific measured references to the 4 priority standards.

KEY ISSUES

The trust performs above the required level of overall performance for both standard 2 and standard 8. There are 2 elements for standard 8 relating to daily review or twice daily review as appropriate. All emergency admissions should be reviewed once every 24 hours once a clear pathway of care has been established, unless it has been established that this would not affect the patients care pathway.

For this standard the self-assessment identified that we were compliant for those patients requiring twice daily review during the week and at weekends, we were compliant for those patients requiring once daily review during the week but not at weekends.

These findings are consistent with the current medical workforce job plans by where routine ward rounds do not take place by a senior decision maker on the acute medical wards on Sundays.

The trust is required to provide a summary of progress in relation to the 6 remaining 7DS standards for continuous improvement.

The Trust is required to implement an internal self-assessment strategy for the four priority standards, providing board assurance internally and to NHSI.

RECOMMENDATIONS

- The trust provides BAF to NHSI by 28th February 2019.
- The trust implements an internal self-assessment process to align to the national process. *Complete JA*
- The Trust scopes the options and risks of delivering 7 day ward rounds. Issues to consider will relate to the challenges of potential recruitment, the consultant contract terms and conditions and any associated cost pressures. High level analysis to deliver Sunday ward rounds with associated junior doctor support suggests a cost pressure in the region of £175k for five ward areas. To flex elective outpatient activity to release workforce this presents an income loss of approximately £400k. The options should be scoped in conjunction with the job planning work stream, productivity and service sustainability work and the Walsall together strategy.
- The trust identifies owners to monitor, manage and report for the remaining six continuous improvement standards and contribute to the National Board Assurance Framework requirements.

APPENDICES

1. https://improvement.nhs.uk/documents/3489/7DS_board_assurance_framework_-_introduction_v2.pdf
2. Trust Board Assurance Framework

7DS BAF 24 Jan 2019 v1.xlsm

7 Day Hospital Services Self-Assessment

Organisation	**Walsall Healthcare NHS Trust**
Year	**2018/19**
Period	**Autumn/Winter**

Walsall Healthcare NHS Trust: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The range of compliance for this standard was recorded at 86% - 100%. As reported via the 7 Day Service Self Assessment Tool portal. Achieiving an overall compliance of 91% in week , 95% at weekends and an overall perdormance of 92%. This performance has seen an improvement from September 2016 of 62% and March 2017 of 79%. the lowest performaing specialties in week were General surgery at 77% and during weekend periods General surery at 50%. Peadiatrics recorded a 50% complinace in week based on 2 admissions. the patient record refers to discussions with a senior clinician , documentation does not categorically reflect a face to face clinical review. Final NHSi data following application of a standard methodology confirms this perfomance reflecting a performance above the national and regional mean for the trust. The trust is in the process of developing a robust job planning programme of work and reviewing workforce requirements to support a 7 day service. General surgery complaince to this standard will be considered as part of this work.	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	MRI within the standards is not available for diagnostic or reporting . Patients requiring MRI within this time frame would potentially be major trauma patiets who would not be managed at the trust and would be redirected from source oor on arrival to a major trauma centre as per network agreements.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	No the test is not available	No the test is not available	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Interventional Endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	the trust achieves this standard via a combination of inhouse and off site arrangement	Emergency Renal Replacement Therapy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Urgent Radiotherapy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Stroke thrombolysis	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	the trust achieved 100% for those patients requiring and receiving twice daily reviews. In respect of receiving a once daily review every 24 hours, the 7 Day Service Self Assessment portal results show performance for this standard varies Monday to Sunday between 83% and 96%. The lowest perforance being Sunday. This performance resulted in an inweek perforane of 94% and weekend performacne of 88%, the latter being below the performance standard of 90%, with an overall performance of 92%. This performance is represented in the RAG rating shown. Following the application of the NHSi methdology the Trust has reported a perfomacne of 99% in week and 97% at the weekend, with an overall performane for this standard of 99%. Using both indicators the trust has performed above the required 90% performance for this standard. Demonstrating a performance above the national and regional mean. To improve performance for this element of the standard robust job planning, workforce reviews and service develoments will take into consideration this element. The work will need to focus on the provision of a routine ward round taking place on all wards across the trust.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
1Patient Experience, the Deputy Director of Nursing is leading on the patient experience quality improvement strategies supported by the Divisional Heads of Nursing, utilsing Friends and Family testing performance indicators. The trust is also implementing strategies to improve access and resources to provide appropriate patient information and improve practices and awareness in obtaining consent from patients. The PALs are working with providers to improve access to translation services and accessible information. A key issue identified in the national patient experience survey. 3 MDT Review, 4 Shift handover, 7 Mental Health, services are commissioned by Walsall CCG to support patients admitted as part of an acute pathway requiring a mental health assessment or intervention. These services are available 24/7. 9 Transfer to community, primary and social care. 10 Quality improvements, Launch of the Quality Improvement Academy, development of the trust wide PCIP owned at Care Group level, aligning to the CQC domains and referencing national and local guidelines. The DON has launched the nursing quality metric assurance framework to increase accountability and monitor performance and development of action plans to improve the quality of care.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Stroke 7DS site visit 23/2/18

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

MEETING OF THE TRUST BOARD – 7th February 2019			
FTSU Trust Guardian Report			**AGENDA ITEM 13**
Report Author and Job Title:	Shabina Raza Kim Sterling Val Ferguson Trust Guardians	**Responsible Director:**	Catherine Griffiths – Director of People and Culture
Action Required	Approve ☒ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report provides a summary of the cases the guardian role has worked on in 2018/19 (1st April 2018 to date 31st January 2019). The report outlines; o Development of the Freedom to Speak Role within the Trust. o Reports on the cases that have been recorded and monitored through FTSU Guardians for the period above. o The Achievements and Next Steps of FTSU for Walsall Healthcare.		
Recommendations	1. Members of the Trust Board are asked to note the paper and approve the action plan attached as part of NHS Improvement Self-assessment tool. 2. Members of the Trust Board are asked to note the work of the guardians, and to pledge to support them to improve patient and staff safety.		
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	Having a supportive culture within the organisation will impact on staff morale and ensure maximum productivity from teams. This will in turn decrease sickness leave, grievances and increase output, staff retention and patient safety leading to a more efficient service.		
Legal and Equality and Diversity implications	Freedom to Speak and all activities involved will ensure that Equality and Diversity and Inclusiveness are embedded in the workforce. Protected Characteristics of staff raising concerns will be monitored by the Freedom to Speak Up Reporting record.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

Trust Guardians report- Freedom to speak up

1. PURPOSE OF REPORT

The purpose of the report is to provide an update on the concerns raised via the guardians during the period 1st April 2018 to 31st January 2019 and to highlight the actions to date.

2. BACKGROUND

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

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

http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_Executive-summary.pdf

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

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

The self-review tool accompanying the guide (see Appendix 1) enables trust boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

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

3. DETAILS

At Walsall Manor Hospital, there are three Freedom to Speak up Guardians, all of whom are front line clinicians. They consist of a community clinician (Podiatrist), a senior sister (Ward Manager) and an acute trust clinician, (Lead in Antimicrobials). The guardians conduct their role throughout the week between them (Monday to Friday, alternating to out of hours/weekends to accommodate the needs of the staff raising concerns).

With their varied experiences and skill sets, they are able to deliver the role of the guardian successfully to meet the needs of various staff groups of the trust.

Since the introduction of the role in October 2016, the guardians have faced many challenges throughout this period. Despite this, they have been able to maintain the confidence of staff about their role and with the support of their new board members, are now able to overcome the majority of these challenges.

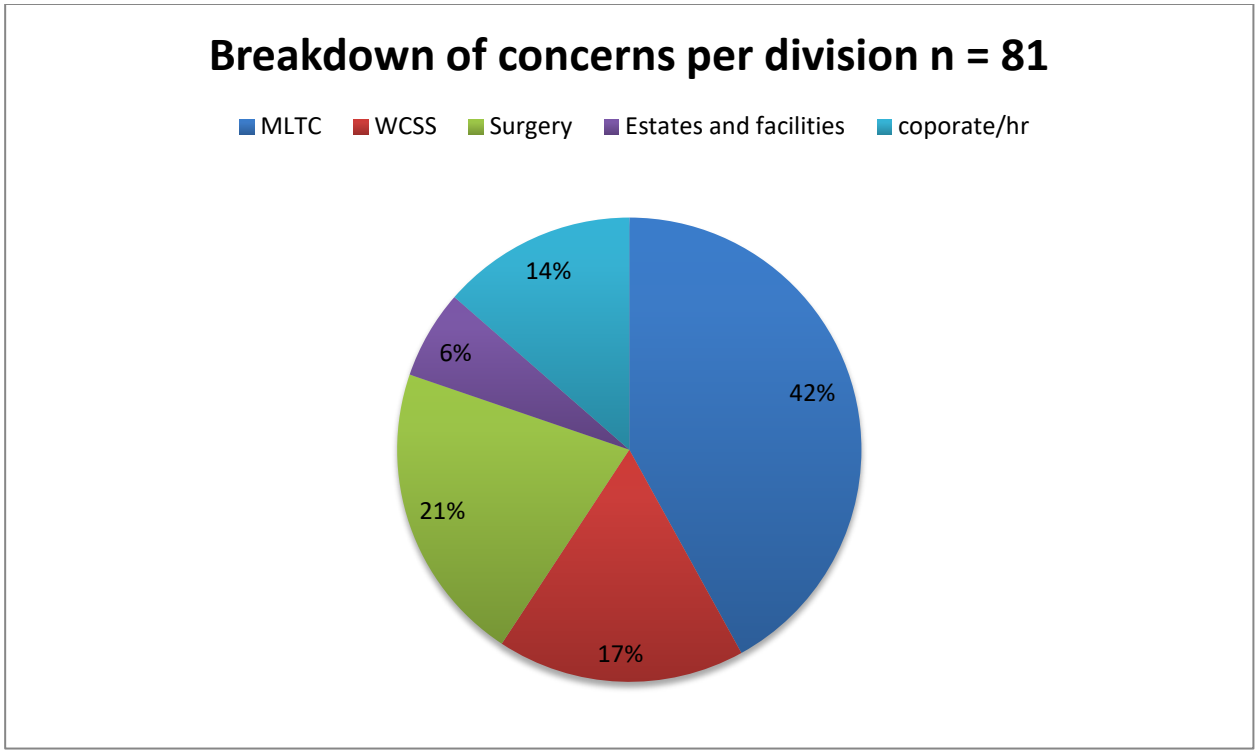
The table below summarises the challenges since the last report and the progress to date:

Challenge	Progress	Status in 2017/18	Status in 2018/19
Retirement of NED	Recruitment of new committed NED		
No consistency of support from interim HR director	Recruitment and full support of committed OD/Cultural change HR director		
Retirement of one of the FTSU guardians	Fully established and recruited FTSU guardian		

Ring fenced time to meet the demands of the role for one guardian refused and implications suffered by guardian as a result of conducting the role	Work in progress - hours provided to meet some demands of the role		
Resistance from leaders within the organisation to support the role and protect the guardians or people raising concerns from any detriment	Working progress- currently support provided from CEO, HR director, NED, DoN and MD to protect staff. Full board engagement and commitment required to enable the role to function more confidently see appendix 1		
Nil concerns reported in previous quarters	Increased number of staff are speaking up and raising concerns		

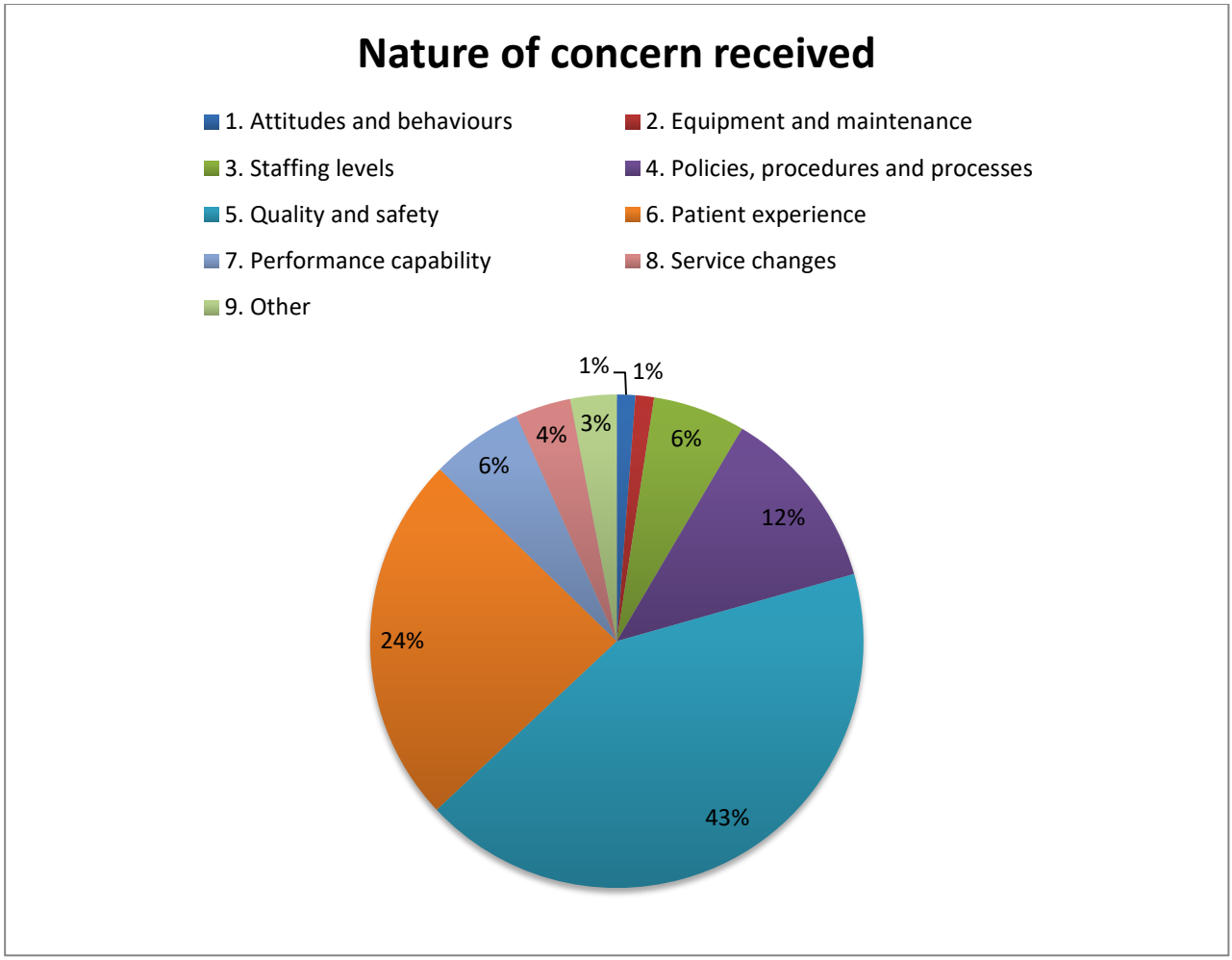
During the period April 2018 to January 2019 a total of 81 concerns were raised to a guardian, where staff have felt confident in speaking up to a guardian for help and support to ensure action is taken. The more cases that have been dealt with successfully, the more confidence the staff have had with raising issues via internal routes and this in turn has helped deliver change in the culture of the organisation.

The pie chart below summarises the concerns that have been received since this financial year 1st April 2018 to 31st January 2019 per division:



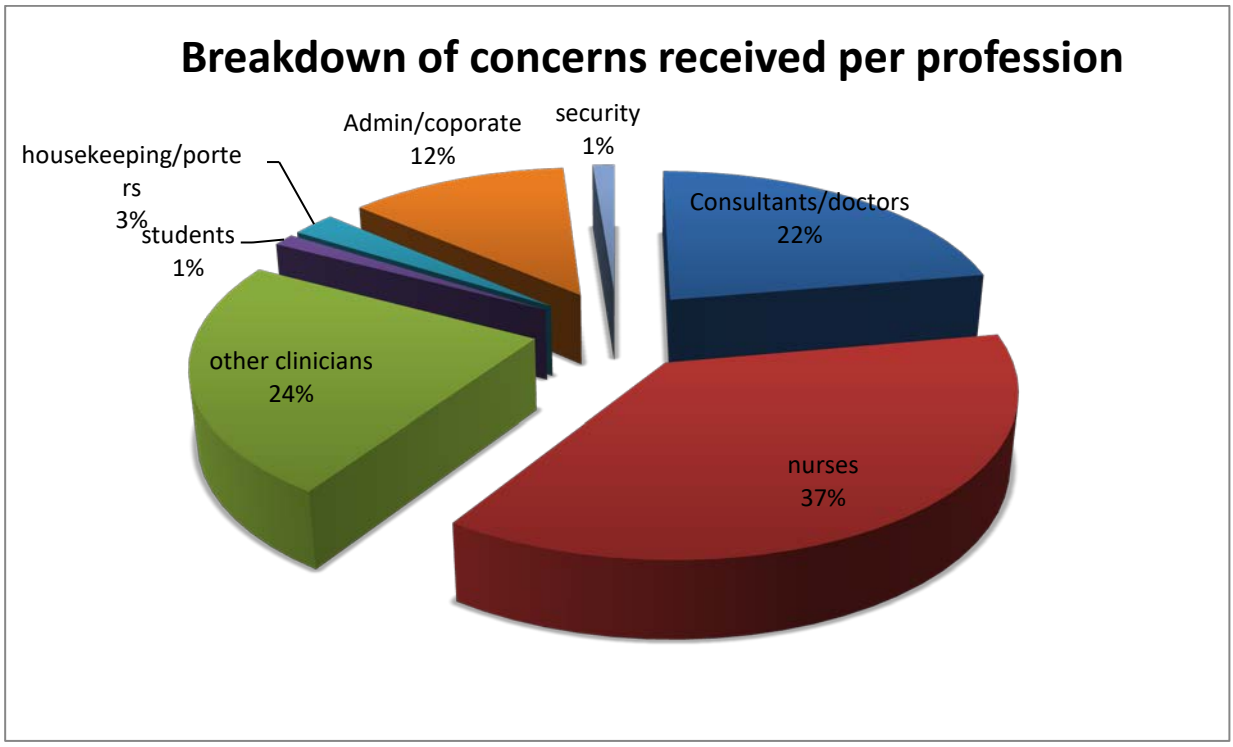
It is important to note that an increased number of concerns in one division doesn't necessarily highlight a 'hot spot area' but reflects on the ability of staff to speak up about concerns which they may have.

Each concern has been broken down into a category which reflects the nature of the concerns received. The diagram on the next page demonstrates this:



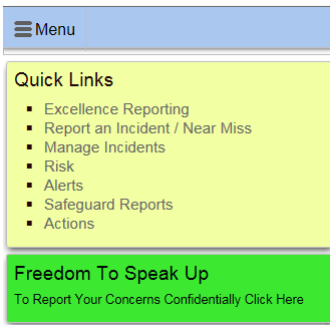
A large proportion of the concerns raised to the guardian had an element of quality and safety (43%) which in turn affected patient experience (24%). Each concern was broken down according to the best category they fitted in. However, after further investigation of the patient safety concerns, it was found that the majority of these concerns also had an element of bullying and harassment which affected the quality of care that was delivered by staff.

A variety of staff ranging from admin staff to consultants have raised concerns to the guardian. This increased their confidence in the organisation once serious concerns were raised directly to the appropriate directors and immediate action taken. Clinicians raised 83% of concerns, whilst non-clinical staff raised the remainder 17% of concerns. Over 70% of concerns had already been raised via the internal concerns escalation process but with no outcomes.



Progress on Improving the Reporting of Freedom to Speak

The guardians have completed work with the support of governance to work on the Safeguard system in order 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. The FTSU area of Safeguard launched on 1st February 2019 and staff can now raise their concerns directly on Safeguard.



The guardians have reviewed trends over the past year and have compiled a FTSU vision/pledge and strategy in order support further improvements on Freedom to Speak within the Trust. These are contained at appendix 2.

In order to change the culture of the organisation, unity of strong leadership and accountability is needed so staff, regardless of grade or profession within the NHS, are confident in raising concerns and reassured that appropriate action will be taken and feedback given. The guardian role is a very lonely role and is key in driving cultural change within the NHS. It is therefore imperative that support and reassurance from the board and senior members is given to each guardian to protect them and our staff and patients.

Recommendations

1. The indicators from the self-review tool have been used as the basis for a revised action plan on Freedom to Speak for Walsall Healthcare Trust (see Appendix 1) for delivery over the 2019-2020 year. The Trust Board are asked to note and approve the action plan.

2. A number of staff (including guardians) reported they faced challenges a result of speaking up and therefore we ask for 100% commitment from the board to further develop and fully support a speaking up culture within the organisation and put processes in place to protect the individual raising the concern so staff feel confident and safe about raising genuine concerns. The support and protection of the board in supporting the work of the guardians is a crucial element to help foster this change. The Trust Board is asked to note and approve the Freedom to Speak vision/pledge and the strategy (see Appendix 2).

APPENDICES
(List any appendices)

Appendix 1- Guidance to Boards on FTSU and Freedom to Speak up Self-review tool for NHS trusts and foundation trusts (action plan).

Appendix 2 – FTS Vision/Pledge and Strategy

National Guardian
Freedom to Speak Up

NHS
Improvement

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

May 2018

How to use this tool

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

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

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

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

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

KEY: Green = regular assurance in place, effective action and plan to deliver outcome with evidence of Board oversight for processes, governance, evidence of improvement in cultural indicators e.g. NHS survey/LiA Pulse: **Amber** = partial assurance in place, Board aware, evidence from plans not yet seen: **Red** = limited assurance to Board.

	Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met? (RAG Rate)	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	Our expectations			
1	**Leaders are knowledgeable about FTSU**			
1.1	Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.		• Further support and awareness raising at all senior levels for cascade.	• Chair role and support from the Trust Board. • Dedicated NED/CEO lead • Dedicated Executive sponsor • Teams of Three / Senior Leaders awareness
1.2	Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.		• One page plan with FTSU vision to Trust Board Feb 19 • Quarterly reporting to include key learning.	• Quarterly reporting to PODC and to Trust Board on themes – in place.

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1.3	They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.		• Introduction of a Trust wide strategy for leadership and management development [Link to Well-Led action plan]	• FTSU Guardians attend leadership forums to raise awareness of the importance • FTSU Guardians attend Trust induction every fortnight for new starters
1.4	Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.		• Launch Strategy and vision for FTSU following Trust Board in February 2019	• Board Development session completed November 2018 • Strategy and Vision aligned to Trust Four Key priorities
2	**Leaders have a structured approach to FTSU**			
2.1	There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.		• Launch strategy and vision for FTSU following Trust Board in February 2019 • Provide structured support for FTSU Guardians including clinical supervision	• As above

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2.2	There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.		• Policy launched and updated supporting guidance cascaded	• Trust Speaking Up Policy reviewed and updated
2.3	The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.		• Launch strategy and vision for FTSU following Trust Board in February 2019	• FTSU Guardians have been developing strategy during Q3 with stakeholders
2.4	Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.		• Following Trust Board in February 2019 – develop suitable metrics	
3	**Leaders actively shape the speaking up culture**			
3.1	All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.			• Executive Engagement Sessions in place • Board Development in place • Reports to Trust

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				Board in place • Commitment at Leadership Team
3.2	They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.		• Trust reports FTSU concerns, Patient Safety incidents and employee cases and links these (triangulate data) to Trust Board and sub-committees	• Listening into action established improvements in place • Shared Learning with neighbouring Trusts in place through Board Development. • Trust Values and Improvement Academy in place
3.3	Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.			• Executive Engagement Sessions in place • Executive Board Walks in place
3.4	Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.		• Frequent reports to Board by FTSU Guardians in place	• Regular Reporting to Trust Board • Quarterly reports to

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				PODC
3.5	Senior leaders model speaking up by acknowledging mistakes and making improvements.			• Visibility of Trust Board members and engagement through Board Walks and Briefings • Trust values and leadership behaviours for role modelling established
3.6	The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.		• FTSU Guardians plan to use the "Francis wheel" as a baseline – this work will launch in February 2019. • Repeat the survey in 12 months to provide comparison data • Campaign raising awareness of FTSU throughout 2019. • Annual Report to	• Campaign of awareness during October 2018. • Staff Survey 2018 demonstrates improved metrics on speaking up.

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			Board in February 2019 • Data and reporting in place from Safeguard	
4	**Leaders are clear about their role and responsibilities**			
4.1	The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.			• All named executives and non-executives in place with executive sponsor for FTSU Guardians. • Board Development session completed during November 2018.
4.2	They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.			• Formal quarterly meetings in place. • Regular access on at least a monthly basis in place. • Executive Director

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				access to diaries in place as required FTSU Guardians
4.3	Other senior leaders support the FTSU Guardian as required.		• Further awareness raising throughout the Trust • Support networks being established by the FTSU Guardians through established groups	• Board Development in place. • FTSU is on the annual plan for PODC. • All Executive Director diaries are open on request for FTSU Guardians to access
5	**Leaders are confident that wider concerns are identified and managed**			
5.1	Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.		• Complete the development of Safeguard and the reporting and business intelligence to	

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			ensure triangulation of data.	
5.2	The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.			• Awareness from FTSU Guardian that there is open access to senior leaders and meetings are regularly held.
6	**Leaders receive assurance in a variety of forms**			
6.1	Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.		• Policy update and effective communication and training plan in place and reviewed March 2019.	
6.2	Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic		• Analysis of data to date and action plan required with identified action to be considered by	• Safeguard system re-design allows the data to be captured for

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	(BAME), workers and agency workers		EDIC during Q4.	groups of staff.
6.3	Speak up issues that raise immediate patient safety concerns are quickly escalated		• Standard escalation guidance as part of policy to be included review Q4.	• Open access to executive and non-executive diaries in place.
6.4	Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority		• Reporting from Safeguard will provide the data and evidence – further work to complete, review Q4.	
6.5	Lessons learnt are shared widely both within relevant service areas and across the trust		• Process required with an action plan – report to PODC as standard element of quarterly reporting – from Q1 2019-2020.	
6.6	The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented		• Audit required on FTSU processes and policy once the policy is in	

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			place.	
6.7	FTSU policies and procedures are reviewed and improved using feedback from workers		• Review to be scheduled – Q1.	
6.8	The board receives a report, at least every six months, from the FTSU Guardian.		• Scheduled update to Trust Board due in February 2019	• Verbal report and update to Trust Board provided in July 2018. • Board Development session held in November 2018.
7	**Leaders engage with all relevant stakeholders**			
7.1	A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.		• FTSU Vision and Plan to be completed and approved at Trust Board.	• A full engagement plan based on the Trust Values completed and workshops completed

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7.2	Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.			• Updates are provided as part of the PRM.
7.3	Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).		• Trust Board update for Annual FTSU report to Board in February 2019	• Verbal Report received by Trust Board in July 2018, PODC and Board have regular update reports
7.4	The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.		• Report due to Trust Board in February 2019	
7.5	Reviews and audits are shared externally to support improvement elsewhere.		• To be contained within report in February 2019	
7.6	Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture		• Lessons learnt nationally and regionally to be shared within the Trust	• Links made with the Regional Lead • Links made with the National Guardians Office

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7.7	Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and local FTSU G's		• Lessons learnt nationally and regionally to be shared within the Trust	• Links made with the Regional Lead • Links made with the NG Office
7.8	Senior leaders request external improvement support when required.			• External improvement support is in place within the Trust
8	**Leaders are focused on learning and continual improvement**			
8.1	Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.		• Explicit evidence to better quality care to be included in quarterly reporting • Links to the Trust Quality Improvement Academy to be explicitly made	• Quarterly reporting to PODC and Trust Board identifies base data
8.2	Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.		• Further engagement and development sessions to plan	• Link and shared development with other Trusts and best practice

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			for best practice	included in Board Development day
8.3	Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.		• Explicit evidence to improvement possibilities to be included in quarterly reporting	• Board Development session completed
8.4	Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.			• Listening into Action completed Trust wide • Quality Improvement Academy established within the Trust
8.5	The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right		• FTSU Strategy to be approved at Trust Board with measures and metrics February 2019	• Data reporting in place through PODC on qualitative and quantitative basis

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	indicators are being used to measure success.			
8.6	The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.		• Policy Review required.	
8.7	A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored		• Internal Audit to be scheduled to review practice during 2019-2020 audit year.	

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8.8	Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.		• Explicit evidence of positive outcomes to be included in quarterly reporting	
	Individual responsibilities			
9	**Chief executive – Richard Beeken** **Chair – Danielle Oum**			
9.1	The chief executive is responsible for appointing the FTSU Guardian.			• Three FTSU Guardians in place and established in role.
9.2	The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.		• Review the effectiveness of the planned actions and support for full assurance	• Action plan in development based on completed self-assessment • Support in place for the FTSU

KEY: Green = regular assurance in place, effective action and plan to deliver outcome with evidence of Board oversight for processes, governance, evidence of improvement in cultural indicators e.g. NHS survey/LiA Pulse: **Amber** = partial assurance in place, Board aware, evidence from plans not yet seen: **Red** = limited assurance to Board.

				Guardians
9.3	The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.		• Annual report due to Trust Board in February 2019	
9.4	The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.		• Lessons learnt nationally and regionally to be shared within the Trust	• Board Development session with regional Guardian completed 2018
9.5	Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.			• In place with regular meetings, action plan in progress.

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10	**Executive lead for FTSU- Catherine Griffiths: Director of People and Culture**			
10.1	Ensuring they are aware of latest guidance from National Guardian's Office.			• Update bulletins and Executive Briefings in place
10.2	Overseeing the creation of the FTSU vision and strategy.		• FTSU vision and strategy required for Trust Board as part of the Annual FTSU report in February 2019	• Board development session and self-assessment completed to inform vision and strategy
10.3	Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.			• The Trust has three FTSU Guardians in role and established in their approach
10.4	Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and		• Requirements scoped for budget setting for 2019-	• Review of current arrangements completed

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	unplanned absence.		2020 year.	
10.5	Ensuring that a sample of speaking up cases have been quality assured.		• Internal Audit review required as part of 2019-2020 audit plan	
10.6	Conducting an annual review of the strategy, policy and process.		• Internal Audit review required as part of 2019-2020 audit plan	
10.7	Operationalising the learning derived from speaking up issues.		• Internal Audit review required as part of 2019-2020 audit plan	
10.8	Ensuring allegations of detriment are promptly and fairly investigated and acted on.		• Policy in place, review of effectiveness required to provide full assurance	• Policy review completed

KEY: Green = regular assurance in place, effective action and plan to deliver outcome with evidence of Board oversight for processes, governance, evidence of improvement in cultural indicators e.g. NHS survey/LiA Pulse: **Amber** = partial assurance in place, Board aware, evidence from plans not yet seen: **Red** = limited assurance to Board.

10.9	Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.		• Annual FTSU report to Trust Board due February 2019	• FTSU quarterly reporting is on the PODC annual plan
11	**Non-executive lead for FTSU- Anne Baines**			
11.1	Ensuring they are aware of latest guidance from National Guardian's Office.			• In place through regular meetings
11.2	Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.		• Launch Strategy following Trust Board approval.	
11.3	Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.			• In place through Trust Board and supporting Committees
11.4	Role-modelling high standards of conduct around FTSU.			• In place through regular meetings, promoting and raising awareness

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11.5	Acting as an alternative source of advice and support for the FTSU Guardian.			• In place through regular meetings and access
11.6	Overseeing speaking up concerns regarding board members.			• In place within the policy review and through regular meetings and access
12	**Human resource and organisational development directors**			
12.1	Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.		• Protocol Required to make HR and FTSU roles clear and to support the triangulation of data	
12.2	Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.		• Awareness training and development required.	

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12.3	Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.		• Awareness training and development required.	• Communications campaign has raised awareness. • Trust values underpin this approach.
13	**Medical director and director of nursing**			
13.1	Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.		• Awareness training and development required.	• FTSU Guardians regularly meet and have open access to Executives
13.2	Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.		• Awareness training and development required.	• FTSU Guardians regularly meet and have open access to Executives

KEY: Green = regular assurance in place, effective action and plan to deliver outcome with evidence of Board oversight for processes, governance, evidence of improvement in cultural indicators e.g. NHS survey/LiA Pulse: **Amber** = partial assurance in place, Board aware, evidence from plans not yet seen: **Red** = limited assurance to Board.

Walsall Healthcare NHS
NHS Trust

Freedom to Speak Up

OUR VISION FOR WALSALL HEALTHCARE TRUST

It's time to Speak Up

When you Speak Up: **We respond**

A truly safe and caring culture is underpinned by the Trust Values chosen by our staff.

Walsall Healthcare Trust is committed to proactively promoting a culture of openness and transparency.

The organisational culture will be one which allows each employee the confidence and opportunity to safely speak up about concerns.

We will always welcome and thank those who raise concerns. The trust pledges to act on the findings and provide feedback.

Walsall Healthcare NHS
NHS Trust

Freedom to Speak up Strategy for Walsall Health Care Trust

Purpose

Sir Robert Francis's 'Freedom to Speak Up' Review highlighted the need to create cultures that support staff to raise concerns. The report identified 20 key Principles for the NHS to implement, which included an emphasis on creating a culture of safety, raising concerns, culture free from bullying, visible leadership and valuing staff

Our Strategy

- **Our policies and procedure will enable the difference between a grievance and raising concerns to be clearly recognised.**

- Our policies will focus on resolution, transparency, reflective practice and support. Where necessary accountability will be clear.

- We will provide training to all our staff so they are clear how to raise their concerns.

- We will provide communication to all our staff on concerns that have been raised and the learning whilst maintaining confidentiality.

- We will ensure regular feedback to staff members once a concern has been raised.

- We will react in a supportive and neutral way when concerns are raised to ensure all staff feel confident to raise concerns.

- We will review our approach to raising concerns annually with those who have raised concerned and best

practice guidance to ensure consistency within our approach.

- The Organisational Development Plan for the trust will support the development of the culture described in this strategy.

1. Roles and Responsibilities

Our Freedom to Speak up Guardian/s will support the Vision and Strategy by:

- Supporting Staff to raise concerns, through confidential advice and support.
- Helping to raise the profile of raising concerns
- Provide feedback to staff who raise concerns.
- Facilitate events that support staff to speak out.

- **Providing advice and updates to the Board, Sub committees and relevant senior leaders.**

<u>The Director responsible for raising concerns will ensure.</u>

- **This Strategy is delivered.**
- **The Freedom to Speak Up policy is devised and implemented.**
- **Staff are thanked and supported for raising a concern.**
- **The Organisational Development plan supports the required cultural development.**

<u>The Raising Concerns Non-Executive Director will seek</u>

- **Assurance that staff are encouraged and supported to raise concerns.**
- **Provide a further avenue for staff to raise concerns.**

- **All concerns are appropriately investigated.**

- **Any concerns relating to a Director are managed appropriately.**

The Board and Senior leaders are committed to a safe, open and values based culture

<u>How will we know that our Freedom to Speak Up Vision is working?</u>

We will review progress based on feedback and information from the following reports:

- **Freedom to Speak Up Reports**
- **Annual and quarterly staff survey results**
- **Channels available for staff to raise concerns including internal/external**
- **Policy implementation and case review**

The Strategy will be reviewed annually.

National Guardian
Freedom to Speak Up

NHS
Improvement

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

May 2018

Contents

Introduction

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

This guide sets out our expectations of boards in relation to Freedom to Speak Up (FTSU). Meeting the expectations set out in this guide will help a board to create a culture responsive to feedback and focused on learning and continual improvement.

This guide is accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to FTSU will help boards to identify areas of development and improve.

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

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

About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office and represents current good practice.

We want boards to treat this guide as a benchmark; review where they are against it and reflect on what they need to do to improve. We expect that the board, and in particular the executive and non-executive leads for FTSU, will complete the review with proportionate support from the trust's FTSU Guardian.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better performance.

The attitude of senior leaders to the review process, the connections they make between speaking up and improved patient safety and staff experience, and their judgements about what needs to be done to continually improve, are much more important.

Key terms used in this guide

- **The board**: we use this term when we mean the board as a formal body.
- **Senior leaders**: we use this term when we mean executive and non-executive directors.
- **Workers**: we use this term to mean everyone in the organisation including agency workers, temporary workers, students, volunteers and governors.

We will review this guide in a year. In the meantime, please provide any feedback to enquiries@improvement.nhs.uk

Our expectations

Leaders are knowledgeable about FTSU

Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.

Leaders have a structured approach to FTSU

There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement. There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian). It aligns with existing guidance from the National Guardian. Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.

Leaders actively shape the speaking up culture

All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. Senior leaders model speaking up by acknowledging mistakes and making improvements. The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.

Leaders are clear about their role and responsibilities

The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. Other senior leaders support the FTSU Guardian as required. For more information see page 8 below.

Leaders are confident that wider concerns are identified and managed

Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.

Leaders receive assurance in a variety of forms

The executive lead for FTSU provides the board with a variety of reliable, independent and integrated information that gives the board assurance that:

- workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process
- steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- speak up issues that raise immediate patient safety concerns are quickly escalated
- action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- lessons learnt are shared widely both within relevant service areas and across the trust
- the handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented
- FTSU policies and procedures are reviewed and improved using feedback from workers.

In addition the board receives a report, at least every six months, from the FTSU Guardian. For more information see page 11 below. Boards should consider inviting workers who speak up to present their experience in person.

Leaders engage with all relevant stakeholders

A diverse range of workers' views are sought, heard and acted on to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.

The organisation is open and transparent about speaking up internally and externally. Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. Reviews and audits are shared externally to support improvement elsewhere.

Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture. Likewise, senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians. Senior leaders request external improvement support when required.

Leaders are focused on learning and continual improvement

Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.

The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.

The FTSU policy and process are reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. A sample of cases is audited to ensure that:

- the investigation process is of high quality; outcomes and recommendations are reasonable and the impact of change is being measured
- workers are thanked for speaking up, are kept up to date throughout the investigation and are told of the outcome
- investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored.

Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. This is demonstrated in organisational data and audit.

Individual responsibilities

Chief executive and chair

The chief executive is responsible for appointing the FTSU Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. The chief executive and chair are responsible for ensuring the annual report contains information about FTSU and that the trust is engaged with both the regional Guardian network and the National Guardian's Office.

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.

Executive lead for FTSU

The executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- overseeing the creation of the FTSU vision and strategy
- ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- ensuring that the FTSU Guardian has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence.
- ensuring that a sample of speaking up cases have been quality assured
- conducting an annual review of the strategy, policy and process
- operationalising the learning derived from speaking up issues
- ensuring allegations of detriment are promptly and fairly investigated and acted on
- providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.

Non-executive lead for FTSU

The non-executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement
- role-modelling high standards of conduct around FTSU
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up concerns regarding board members – see below.

We appreciate the challenges associated with investigating issues raised about board members, particularly around confidentiality and objectivity. This is why the role of the designated non-executive director is so important. In these circumstances, we would expect the non-executive director to take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and
- if so, whether an investigation is proportionate and what the terms of reference should be.

Depending on the circumstances, it may be appropriate for the non-executive director to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive director does take the lead, they should inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive director should inform NHS Improvement and CQC that they are overseeing an investigation into a board member. NHS Improvement and CQC can then provide them with support and advice. The trust would need to think about how to enable a non-executive director to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the

confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Human resource and organisational development directors

The human resource (HR) and/or organisational development (OD) directors are responsible for:

- ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up
- ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust
- ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.

Medical director and director of nursing

The medical director and director of nursing are responsible for:

- ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues
- ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up
- ensuring learning is operationalised within the teams and departments they oversee.

FTSU Guardian reports

Reports are submitted frequently enough to enable the board to maintain a good oversight of FTSU matters and issues, and no less than every six months. Reports are presented by the FTSU Guardian or a member of the trust's local Guardian network in person.

Reports include both quantitative and qualitative information and case studies or other information that will enable the board to fully engage with FTSU in their organisation and to understand the issues being identified, areas for improvement, and take informed decisions about action.

Data and other intelligence are presented in a way that maintains the confidentiality of individuals who speak up.

Board reports on FTSU could include:

Assessment of issues

- information on what the trust has learnt and what improvements have been made as a result of trust workers speaking up
- information on the number and types of cases being dealt with by the FTSU Guardian and their local network
- an analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

Potential patient safety or workers experience issues

- information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built

Action taken to improve FTSU culture

- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up
- details of any assessment of the effectiveness of the speaking up process and the handling of individual cases
- information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement
- information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively

Learning and improvement

- feedback received by FTSU Guardians from people speaking up and action that will be taken in response
- updates on any broader developments in FTSU, learning from case reviews, guidance and best practice

Recommendations

- suggestions of any priority action needed.

Resources

Care Quality Commission (2017): Driving Improvement Accessed at: www.cqc.org.uk/sites/default/files/20170614_drivingimprovement.pdf

National Guardian Office (2017): Example job description Accessed at: http://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

National Guardian Office (2017): Annual report Accessed at www.cqc.org.uk/sites/default/files/20171115_ngo_annualreport201617.pdf

NHS Improvement (2014) Strategy development toolkit Accessed at https://improvement.nhs.uk/resources/strategy-development-toolkit/

NHS Improvement (2016) Freedom to speak up: whistleblowing policy for the NHS Accessed at https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/

NHS Improvement (2017): Creating a vision https://improvement.nhs.uk/resources/creating-vision/

NHS Improvement (2016/17): Creating a culture of compassionate and inclusive leadership Accessed at https://improvement.nhs.uk/resources/culture-leadership/

NHS Improvement (2017): Well Led Framework Accessed at: https://improvement.nhs.uk/resources/well-led-framework/

National Framework (2017): Developing People - Improving Care Accessed at: https://improvement.nhs.uk/resources/developing-people-improving-care/

National Guardian Office (2018): Guardian education and training guide

Accessed at: http://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf

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This publication can be made available in a number of other formats on request.

May 2018 Publications code: CG 64/18

MEETING OF THE PUBLIC TRUST BOARD – Thursday 7th February 2019			
Guardian of Safe Working Hours Report			**AGENDA ITEM: 14**
Report Author and Job Title:	Dr R Bavakunji Guardian of Safe Working	**Responsible Director:**	Matthew Lewis – Medical Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The report covers the following elements: • Introduction and context in respect of the role of Guardian of Safe Working • New Junior Doctor Contract and its implications • Guardians quarterly report • Progress and concerns		
Recommendation	The Trust Board is asked to note the actions taken by the Trust and its appointed Guardian of Safe Working		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no associated risks recorded		
Resource implications	Implementation of the revised Junior Doctor contract may adversely impact on rotas and the ability to cover services effectively resulting in additional workforce requirements		
Legal and Equality and Diversity implications	National requirement for the effective guardian role and the management of junior doctors working terms and conditions as per the 2016 contract ensuring any exceptions are reported , recorded and managed as per the national guidelines		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☒		

Guardian of Safe Working Report April 2018

1. Introduction and background

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

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

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

The Guardian will:

- Champion safe working hours.
- Oversee safety related exception reports and monitor compliance.
- Escalate issues for action where not addressed locally.
- Require work schedule reviews to be undertaken where necessary
- Intervene to mitigate safety risks.
- Intervene where issues are not being resolved satisfactorily.
- Distribute monies received as a result of fines for safety breaches.
- Give assurance to the board that doctors are rostered and working safe hours.
- Identify to the board any areas where there are current difficulties maintaining safe working hours.
- Outline to the board any plans already in place to address these.
- Highlight to the board any areas of persistent concern which may require a wider, system solution.

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

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

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

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

2. *Guardian of Safe Working Report*

High level data

Current number of doctors in training on 2016 TCS (1st August 2018)	151	
Lead Employer Trainees	19 posts 16 filled	
LTFT trainees on new contract	6 trainees	

Engagement

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

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

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

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

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

Allocate and Rota software systems

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

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

Workload

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

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

Junior Doctors Forum – A requirement of the new contract

JDF with new trainees has formed and had 5 meeting since implementation of new contract in 2016.

Dr James Haddock
Dr Al Sukhaini
Dr Faith Hirri (Current)

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

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

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

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

Exception Reports and Fines.

The whole point of the exception reporting system is to allow employers to address issues and concerns as they arise, in real time, and to keep doctors' working hours, both rostered and actual, within safe working limits. If the

system of work scheduling and exception reporting is working correctly, in anything other than truly exceptional circumstances, the levying of a fine indicates that the system has failed or that someone – the supervisor, Guardian or the individual doctor concerned – has failed to discharge his or her responsibilities appropriately. Any levying of a fine should therefore be followed by an investigation in to why it was necessary and remedial action to ensure that it does not happen again. The most important thing to remember is that fines should rarely, if ever be applied at all.

From 1th May to 12 December 79 exception episodes from 16 doctors.

- All reports until 30th April are given TOIL or closed with satisfactory outcomes.
- All reports from 1st May until 12th December
- Mostly from surgical juniors
- There are no genuine immediate patient safety concern
-

Exception frequency: There is a surgical spike in reporting. Many juniors unbale to take TOIL hence will lead to fine.

When TOIL is given it impacts other juniors who are not yet able to report.

Allocate issues :

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

Submitted	Doctor	No. episc	ISC	Rota	Type
29 Nov 2018 15:19	1	19		O&G	Hours
20 Nov 2018 11:28	2	1		Surgery FY0	Hours
24 Oct 2018 19:31	2	1		Surgery FY1	Hours
24 Oct 2018 19:28	2	1		Surgery FY1	Hours
24 Oct 2018 19:25	2	1		Surgery FY1	Hours
08 Nov 2018 18:09	3	1		Medicine FY1	Hours
12 Aug 2018 22:15	4	5		Medicine FY1	Hours
18 Sep 2018 20:47	5	1	yes	Surgery FY1	Hours
12 Nov 2018 17:19	6	1		Surgery FY1	Hours
03 Nov 2018 16:28	6	1		Surgery FY1	Hours
03 Nov 2018 16:22	6	1		Surgery FY1	Hours
03 Nov 2018 16:20	6	1		Surgery FY1	Hours
10 Oct 2018 13:08	6	1		Surgery FY1	Hours
02 Oct 2018 17:39	6	1		Surgery FY1	Hours
01 Oct 2018 19:14	6	1		Surgery FY1	Hours
12 Nov 2018 21:52	7	1		Surgery FY1	Hours
29 Sep 2018 20:14	7	1		Surgery FY1	Hours
04 Sep 2018 16:59	7	2		Surgery FY1	Hours
23 Aug 2018 18:16	7	1		Surgery FY1	Hours
23 Aug 2018 17:37	7	1		Surgery FY1	Hours
23 Aug 2018 17:27	7	1		Surgery FY1	Hours
23 Aug 2018 17:18	7	1		Surgery FY1	Hours
24 Oct 2018 16:51	8	4		Surgery FY1	Hours
26 Aug 2018 22:05	8	1		Surgery FY1	Hours
09 Aug 2018 21:46	8	2	yes	Surgery FY1	Service Sup
30 Oct 2018 20:16	9	1		Med MG 1:13 RMC	Hours
30 Oct 2018 20:15	9	1		Med MG 1:13 RMC	Hours
18 Oct 2018 22:43	9	1		Med MG 1:13 RMC	Hours
10 Dec 2018 12:37	10	1		Surgery FY1	Hours
22 Oct 2018 09:37	10	1		Surgery FY1	Hours
20 Oct 2018 09:53	10	1		Surgery FY1	Hours
16 Oct 2018 20:35	10	1		Surgery FY1	Hours
28 Sep 2018 12:15	10	1		Surgery FY1	Hours
05 Sep 2018 17:22	10	1		Surgery FY1	Hours
05 Sep 2018 17:17	10	1		Surgery FY1	Hours
21 Oct 2018 14:20	11	1		Surgery FY1	Hours
14 Oct 2018 20:53	11	3		Surgery FY1	Hours
08 Nov 2018 18:09	12	1		Medicine FY1	Hours
30 Nov 2018 06:55	13	1		O&G	Pattern
08 Aug 2018 05:29	14	1		T&O Junior traine	Hours
20 Nov 2018 21:02	15	1		Surgery FY1	Hours
20 Nov 2018 21:01	15	1		Surgery FY1	Pattern
20 Nov 2018 20:59	15	1		Surgery FY1	Hours
19 Nov 2018 19:50	15	1		Surgery FY2	Hours
04 Nov 2018 16:14	15	1		Surgery FY3	Hours
12 Aug 2018 22:16	16	5		Medicine FY1	Hours
	Total	**79**			

Department	No. episodes	Actions entered by CS/ES/Trainee	Solutions put in place
Gastro	11	0	TOIL + Fines
Gen Surg	2	0	TOIL recommended

Exception reports (response time)
Due to the nature of pre-population of data and limitations of software, Allocate. It is has been difficult to get this data. I cannot assure the trust that 100% reports led to meeting with trainee within recommended times by ES. All Immediate Safety concerns actioned within 24 hours by my direct involvement. Nationally this software flaw has been raised to the software company at Guardians Meeting at London regarding limitations of the software and at other meetings.

Work Schedule reviews

None

TOIL report / Fines and work schedule review/ Rota

Surgery Hours and fines details below

Grade	Total Hours		Cost per Shift Enhanced Rate	4 x enhanced Rate	Total Hours	Rate (1.5 enhanced rate)	Pay to Doctor
F1	12.5	17.48	£34.96	£139.84	12.5	26.22	£327.75
					12.5		£327.75

Medicine Hours and fines details below

Grade	Total Hours	Rate	Cost per Shift	4 x Rate	Total Hours	Rate (1.5 basic rate)	Pay to Doctor
F1	8	17.48	£34.96	£139.84	8	26.22	£209.76
							£209.76

IMMEDIATE SAFETY CONCERNS

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

Vacancy report / Rota Gaps

											Vacancies by month (Deanery training posts)
Specialty	Grade	May 18	June 18	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Total gaps (average)	Number of shifts uncovered
A&E	F2	0	0	0	1	1	1	1	0	0.5	84
Anaesthetics	ST1/2	0	0	0	3	3	3	3	3	1.875	318
Medicine	ST1/2	0	0	0	1	1	1	1	0	0.5	83
Medicine	ST3/6	1	1	1	1	2	2	2	2	1.5	240
Obs &Gynae (Including GUM & Radiology)	F2	0	0	0	0	0	1	1	1	0.375	47
Obs &Gynae (Including GUM & Radiology)	ST1/2	0	0	0	0	0	3	3	3	1.125	62
Obs &Gynae (Including GUM & Radiology)	ST3/6	0	0	0	0	0	1	1	1	0.375	60
Paeds	ST1/2	0	0	0	1	1	1	1	1	0.625	89
Surgery (Includes ENT & Urology)	F2	0	0	0	1	1	1	1	0	0.5	85
Surgery (Includes ENT & Urology)	ST3/6	0	0	0	1	1	0	0	0	0.40	48
Total		1	1	1	6	7	11	11	8	7.775	1116

Agency Locum

Locum bookings (agency) by department to 12.12.18				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Gen Medicine	59	59	737.50	717.50
General Surgery	67	67	813.50	813.50
O&G	16	16	200	200
Total	142	142	1751	1751

Where possible, staff are re-organized and moved around to reduce the requirement for paid locum shifts. Normal working days are left uncovered and request are made for any Out of Hours shifts

Locum bookings

Locum bookings (bank) by department to 12.12.18					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
A&E	84	81	0	705.5	705.5
Anaesthetics	318	318	0	3716	3716
General Medicine	320	261	59	3144.5	2407
General Surgery	133	66	67	1571.50	758
Obs & Gynae	169	153	16	1871.50	1671.50
Pediatrics	89	87	0	811.25	795.25
Total	1113	966	142	11820.25	10053.25

Locum bookings (agency) by grade 12.12.18				
Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F2	35	35	437.50	437.50
ST1	37	37	462.5	462.5
ST3	41	41	512.5	512.5
ST4	29	29	338.50	338.50
Total	142	142	1751	1751

Networking

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

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

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

Issues arising :-

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

Actions taken to resolve issues:-

1. *A&E Rota review undertaken by relevant CD/Medical Staffing; no further concerns from trainees. Payment & Fine applied*
2. *O&G Rota review escalated to leads*
3. *Regular emails to departments such as Orthopaedics raising no concerns*

GUARDIANS CONCERNS

REPORTING CONCERNS

Delayed or no reporting from some juniors, hence no opportunity to support early and avoidable fines.

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

Juniors not taking the agreed TOIL and requesting payment

ROTA

No issues

Immediate next steps & Challenges

1. JDF meeting to be organised with new JDF rep
2. Meeting with surgical team and juniors to iron out issues
3. To make a document on reporting and circulate to juniors and ES/CS on timely reporting and meetings.

3. Conclusion

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

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

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

4. Recommendation

The Board are asked to read and note this Quarterly report which covers from 1st May to 12 December 2018 from the Guardian of Safe Working.

Author	**Dr Riaz Bavakunji Guardian of Safe Working Hours**
Executive Lead	**Chief Executive Mr Richard Beeken**
Date	**12/12/2018**

Walsall Healthcare NHS
NHS Trust

Performance Report

January 2019

(December 2018 Results)

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

Caring for Walsall together

Safe, high quality care | Care at home | Partners | Value colleagues | Resources | Respect Compassion Professionalism Teamwork

Walsall Healthcare NHS Trust

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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

- Target achieved for 1:1 care in established labour
- Inpatient FFT 'would recommend' score achieved the Trust target for last 2 consecutive months
- Maternity Antenatal FFT 'would recommend' target achieved for first month since August 2018
- Reduction in falls on Ward 3 each month during Oct-Dec 2018

Key Areas of Concern

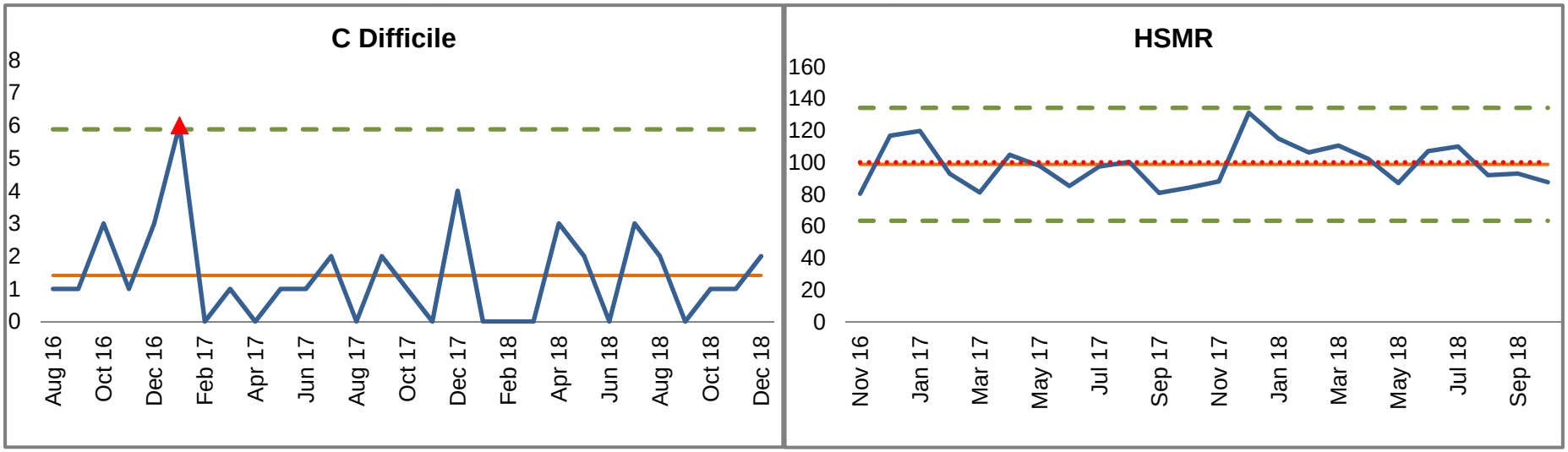
- Two MSA breaches in ICU; it is anticipated these breaches will improve now new unit has opened
- Two falls on Ward 14 resulting in fractures, investigations in progress and RCA meeting dates in January 2018
- 15 Never Events reported relating to orthopaedic prosthesis in theatres
- Hospital acquired infection initially reported as an MRSA bacteraemia downgraded to a MSSA bacteraemia however the patient still received a hospital acquired avoidable infection linked to a peripheral cannula
- Safeguarding level 2 children's training compliance not achieved for the 3nd consecutive month

Key Focus for Next Committee

- Focus on dementia
- Focus on any link between c-section rate, instrument delivery and FFT in maternity
- The committee have asked for a specific update on the standards expected for improving services for people with mental health needs in ED.

Quality, Patient Experience and Safety Committee

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



Narrative (supplied by Director of Nursing)

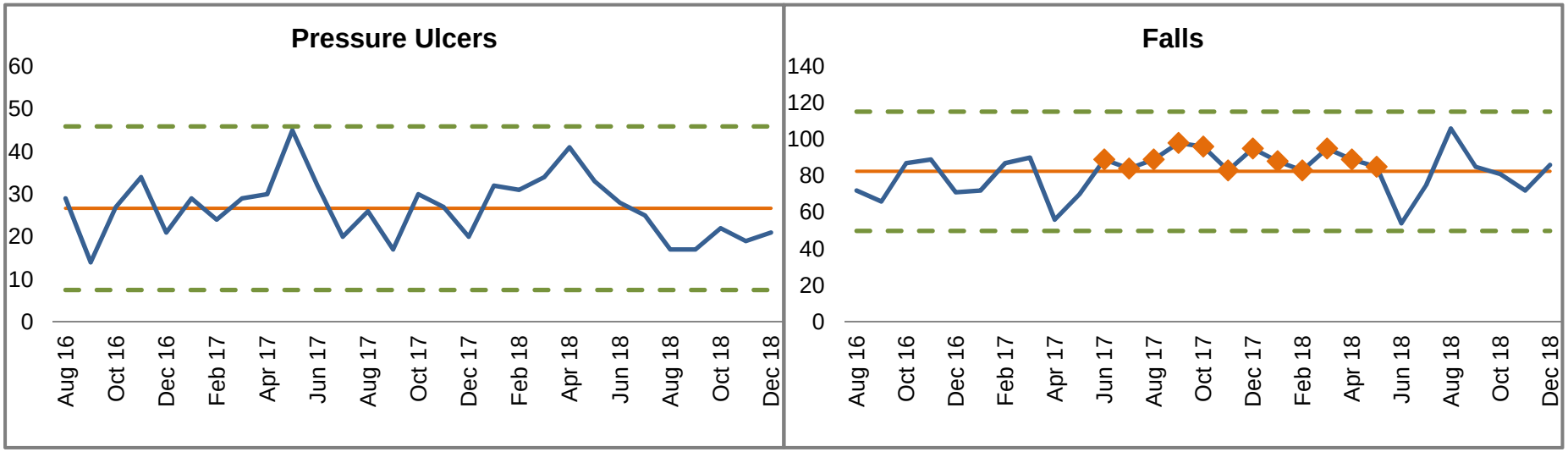
The number of CDiff cases YTD is 14 against a Trust Target for 2018/2019 of 17 cases.
There were 2 CDiff cases in December 2018. The 1st case occurred on Ward 29 and deemed avoidable due to the delay in obtaining the stool sample.
The 2nd case occurred in ITU, this was an incidental finding due to the patient having a previous CD infection and the build of toxins from a bowel obstruction.

Narrative (Supplied by Medical Director)

The Medical Examiner (ME) post is vacant but the advert will be circulated imminently. The intention is to appoint a lead ME from one division, with the assistant MEs in the two other divisions. Once these posts have been appointed, we will commence Structured Judgmental Reviews (SJR) of death in line with Learning from Deaths (LfD) framework.
The Mortality Steering Group will be reconfigured to include all three MEs so that all divisions are represented each month. Our trust has made contact with an exemplar (Kettering) to gain more understanding of the mortality process and ME role in action.

Quality, Patient Experience and Safety Committee

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



Narrative (supplied by Director of Nursing)

In December 2018 there were 21 hospital or community acquired pressure ulcers across the Trust, an increase from the 19 reported in the previous month. There was a total of 11 category two pressure ulcers, 1 category three pressure ulcer and 9 unstageable pressure ulcers reported across the organisation. The category 3 pressure ulcer and 8 of the unstageable pressure ulcers were all attributed to the hospital

The decrease in the number of pressure ulcers seen in Q2 and Q3 is largely attributed to the reduction in community acquired pressure ulcers. Hospital acquired pressure ulcers remain a concern with focused improvement work being undertaken.

Narrative (supplied by Director of Nursing)

The Trust had 86 falls in December 2018 compared to the 71 falls reported in November 2018, this equates to a 20% increase from the previous month. Falls per 1,000 bed days also increased to 5.68. This is disappointing given the falls initiative work which commenced in November and the initial reduction seen at that time.

Wards with the highest number of falls include: Ward 1, Ward 2, Ward 4 and Ward 14

Walsall Healthcare NHS Trust

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE 2018-2019

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no..	HSMR (HED)	109.96	91.91	92.96	87.52				100.00		N
no..	SHMI (HED)	82.36	92.58						100.00		BP
no	MRSA - No. of Cases	0	0	0	0	1	0	2	0	0	N
no	Clostridium Difficile - No. of cases	3	2	0	1	1	2	14	17	11	N
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired Avoidable per 1,000 beddays (current two months figs are unvalidated)	1.00	0.45	0.60	0.74	0.26	0.12				L
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired Avoidable per 10,000 CCG Population (current two months figs are unvalidated)	0.03	0.10	0.03	0.17	0.03	0.03				L
no..	Falls - Rate per 1000 Beddays	5.09	6.94	6.21	4.60	4.81	5.68		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	2	1	3	0	2	1	12	0	8	BP
%..	VTE Risk Assessment	95.57%	95.08%	94.38%	94.63%	95.11%	94.67%	95.39%	95.00%	88.49%	N
no	National Never Events	0	0	1	0	1	15	17	0	3	N
no..	Midwife to Birth Ratio	1:28.6	1:25.0	1:27.3	1:25.1	1:27.3	1:27.7		1:28	1:26.3	N
%..	C-Section Rates	30.03%	25.17%	23.10%	27.08%	24.41%	36.27%	27.88%	30.00%		BP
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	9.94%	10.64%	10.93%	11.13%	10.18%		10.65%	10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	85.48%	87.24%	82.74%	83.47%	82.49%	81.04%	85.29%	100.00%	89.33%	N/L
%..	Compliance with MCA 2 Stage Tracking	69.00%	68.00%	80.00%	72.00%	56.00%	56.00%		100.00%		BP
%..	Friends and Family Test - Inpatient (% Recommended)	94.00%	95.00%	96.00%	95.00%	96.00%	96.00%		96.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	98.75%	98.29%	97.78%	96.48%	96.10%	96.27%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	89.59%	90.42%	90.38%	88.99%	89.53%	90.37%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	99.92%	99.83%	99.44%	95.92%	95.65%	94.31%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	87.04%	89.53%	90.52%	91.85%	91.23%	91.44%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	89.64%	87.89%	88.72%	88.63%	87.52%	90.50%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	99.26%	98.67%	98.98%	97.75%	96.70%	96.45%		95.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	93.69%	85.37%	85.67%	84.67%	83.54%	83.78%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	92.24%	92.08%	89.92%	90.02%	91.51%	90.91%		85.00%		L

Walsall Healthcare NHS
NHS Trust

Integration

Caring for Walsall together

Safe, high quality care
Care at home
Partners
Value colleagues
Resources
Respect
Compassion
Professionalism
Teamwork

Integration – Highlight Page

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

Key Areas of Success

The two ANP vacancies in Rapid Response are now in post. Skill mix is now enhanced and a full staff team in place.

Community respiratory nurses continuing to integrate within localities. All moves will be complete by 31st January.

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.

One Walsall have appointed four successful candidates for the social prescribing project. Two of these candidates will be based within the North and West locality teams.

The new stroke pathway and the transfer of care process continues to work well.

Key Areas of Concern

A couple of Practices withdrew from the MDT's due to poor attendance. This is being resolved for future meetings

Key Actions Taken

MDT Coordinator actively recruiting GP Practices to the MDT's

Continued work around the joint referral form for Health and Social care within localities and to pilot within the West locality.

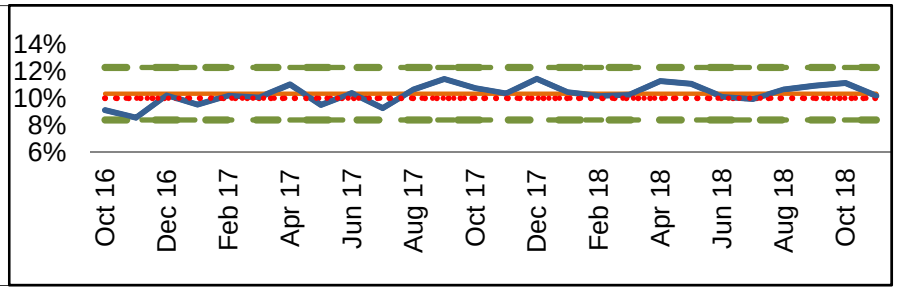
Key Focus

To secure extra space / accommodation within the North and West locality teams to support integrated place based teams

Integration

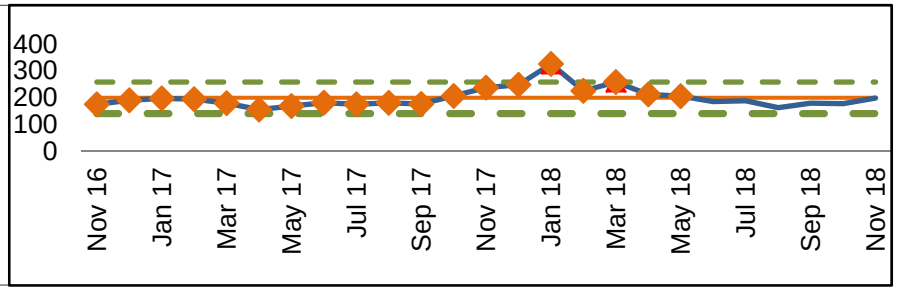
SPC Key — Measure — Mean — Process limit — High or low point — 7 points above or below mean — Rising or falling trend

Emergency Readmissions



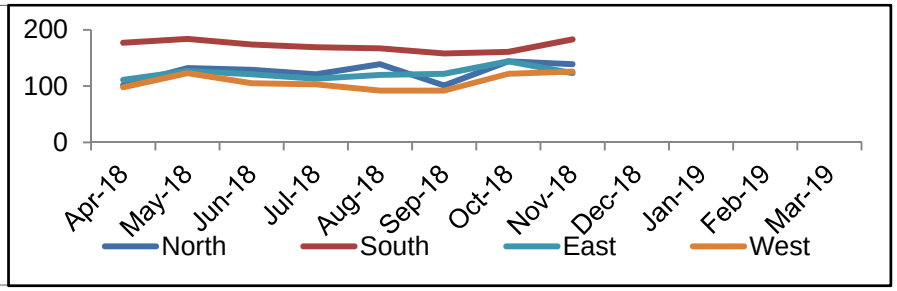
Narrative (supplied by Director of Strategy & Improvement)
The teams continue to maintain a normal distribution pattern compared to last year and are operating very close to the target of 10%. Additional specialisms have been added to the teams, Continence specialists were added in Q1, COPD specialists are currently being recruited however, this has encountered some delays. The last vacancy is due in post during March 2019.

Rapid Response – Avoidable Att / Adm



The rapid response team continues to be 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. The team have been actively supporting ED to help relieve pressure in the Emergency pathway. ANP are now in post and working within the team.

Readmissions by Locality



This chart shows the number of emergency readmissions within 30 days of discharge by locality (all patients not specifically community caseload patients) . The chart has been updated to compare the 4 localities, the highest readmitting locality is the South area. A further analysis of the data will be undertaken to identify sub cohorts. The trial to split the teams in the north is under way on a 3 month trial.

Walsall Healthcare NHS Trust

INTEGRATION
2018-2019

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-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)	9.94%	10.64%	10.93%	11.13%	10.18%		10.65%	10.00%		L
no	Rapid Response Team - Total Referrals	195	174	195	203	238	248				L
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission	188	162	179	177	198	218				L
%	Rapid Response Team - % of patients referred requiring a 2 hour response who are subsequently seen within 2 hours	48.00%	56.00%	59.00%	54.00%	69.00%	58.00%				L
	CARE AT HOME										
%..	ED Reattenders within 7 days	7.46%	7.58%	7.59%	6.86%	7.76%	8.01%	7.44%	7.00%	6.76%	BP
	RESOURCES										
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only	32	31	36	42	42	37				L
no	Average Number of Medically Fit Patients - Trust	36	42	48	39	45	42				L
	PARTNERS										
Rate	Occupied Beddays per Locality - Rate per 1000 GP Population (GP Caseload)	33.17	34.83	31.63	40.35	35.76	34.80				L
no	Nursing Contacts per Locality - Total	19796	19807	18387	19649	18324	17854	169693			L
Rate	Emergency Readmissions per Locality - Rate per 1000 GP Population (GP Caseload)	1.67	1.71	1.56	1.89	1.89	1.84				L
no	No. of patients on stroke pathway in partnership with Wolverhampton (one month in arrears)	9	4	8	9	6					L

Walsall Healthcare NHS
NHS Trust

People and Organisation Development Committee

Caring for Walsall together

Walsall Healthcare NHS
NHS Trust

People and Organisation Development Committee – Highlight Page

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

Key Areas of Success

1. Mandatory training and PDR compliance improved over a 6 month period, further analysis is required to support continued improvement to meet Trust target.
2. Flu – multi disciplinary team (including staff side) now meet every other week to deliver the campaign to effectively support the health and wellbeing of staff through the up take of the vaccine within the Trust, the Trust has been identified as amongst the most improved Trusts nationally.
3. The Nursing workforce transformation programme is in place, led by Director of Nursing and PODC and JNCC updated each month.
4. Staff engagement on values and behaviours has involved 1,500 employees and provides a firm foundation to embed and learn from positive practice and to call out unacceptable behaviours.

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.
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. Organisational culture remains a concern discussed at PODC and EDIC – further action required.
3. Workforce resourcing and use of agency, locum, temporary resource – approach to new workforce roles to provide a sustainable workforce for the future.

Key Actions Taken

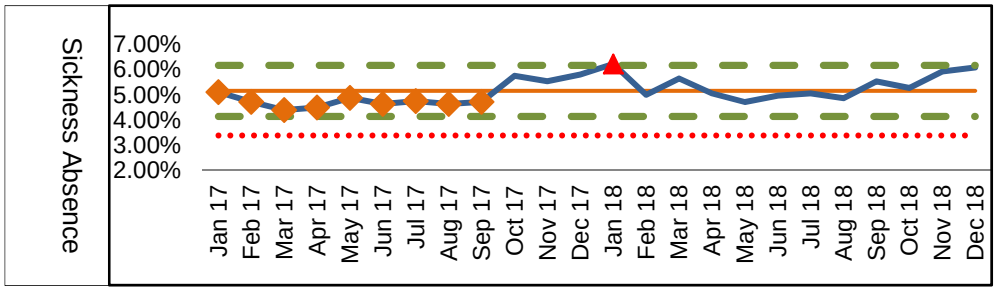
1. Flu campaign – peer vaccinators are continuing the campaign to the end of the campaign period in February.
2. On-going requirements for Staff Engagement Lead, proposal in place and view on long term approach being developed for next financial year.
3. Review of approach to attendance management discussed at PODC – JNCC agreed a detailed review of policy framework and approach and stakeholder engagement workshops completed during November and December – new target, new policy framework completed by end of Q3, implementation due in Q4.
4. FTSU workshop and self assessment completed, quarterly reporting to National Guardian Office in place Q3 reported, new system in Safeguard launched Q4. Report to Trust Board in February 2019, ongoing action required through FTSU action plan in order to provide full assurance.

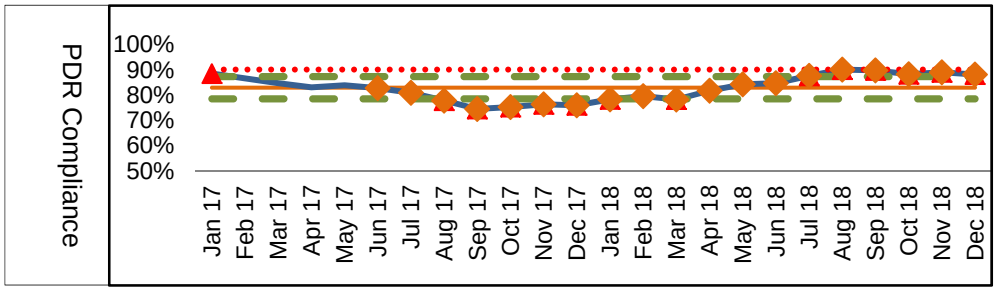
Key Focus for Next Committee

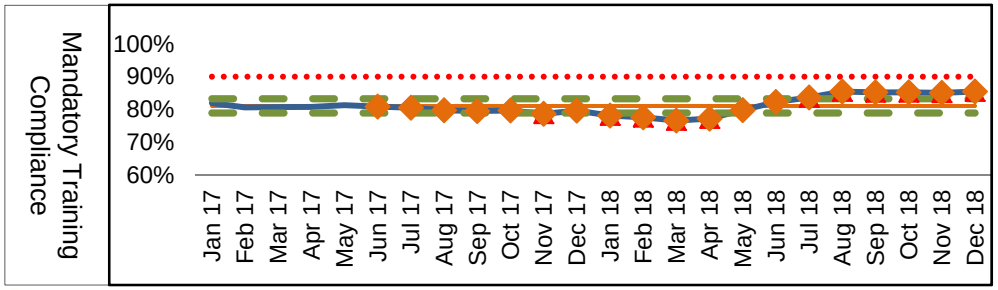
1. EPR - Implications of electronic patient record and business change including patient administration review.
2. EDI strategy is in draft, action plan being finalised and implementation of the approach within the Trust to mitigate the risks highlighted to Trust Board in BAF.
3. People Strategy review and update of the workforce strategy in line with Trust Walsall Together as a strategic partnership approach across the STP system.
4. Reviews of strategic approach to Leadership Development, management capability and talent management approach.
5. Review strategic approach to OCH and wellbeing and assessment of the Call to Action on Bullying and impact of interventions.

People and Organisation Development Committee

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







Narrative (supplied by Director of People and Culture)

Sickness levels remain above Trust target and above previous year outturn month on month. The managing attendance approach has been reviewed with a focus on Wellbeing and early intervention. The sickness target has been reviewed, subject to approval at Trust Board. The proposed metric is to achieve 3.75% (model hospital national median performance) by April 2020. The Health and Wellbeing Steering Group terms of reference have been updated to support this work and to meet standards such as the BMA Fatigue and Facilities Charter for doctors in training.

PDR appraisal rates remain amber. The appraisal policy has been reviewed to include the Trust values and behavioural framework. The Trust is taking part in the national pilot for NHSi's Organisational Talent Management Diagnostic Tool and will use the learning from this to increase the maturity of the systems and processes supporting team and individual performance and development as well as the Trust approach to managing talent, promoting inclusion and developing succession and career plans.

Mandatory training compliance levels remain amber rated. Compliance is below trust target, targeted improvement action is planned to improve compliance in hotspot areas showing low compliance currently as well as targeting specific areas of training. Information governance training is an area requiring improvement and several classroom sessions are scheduled to improve access and uptake.

Walsall Healthcare NHS
NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 2018-2019

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD Actual	18/19 Target	17/18 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Mandatory Training Compliance	83.63%	85.46%	85.21%	85.21%	85.07%	85.45%		90.00%	76.61%	L
.	Equality, Diversity & Inclusion - new metric under development										
.	Equality, Diversity & Inclusion - new metric under development										
	VALUE COLLEAGUES										
%..	Sickness Absence	5.06%	4.87%	5.53%	5.27%	5.93%	6.09%		3.39%	5.30%	L
%..	PDRs	87.56%	90.04%	89.73%	88.19%	88.95%	88.06%		90.00%	78.17%	L
.	Staff Referral to Occupational Health - new metric under development										
	RESOURCES										
no	Staff in post (Budgeted Establishment FTE)	4121	4123	4121	4039	4029	3981	3981			L
%..	Turnover (Normalised)	9.44%	9.74%	10.57%	10.64%	11.06%	11.29%		10.00%		
.	Time to Recruit - new metric under development										

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

Caring for Walsall together

Walsall Healthcare NHS
NHS Trust

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, with RTT performance above local trajectory
- MRI and Integrated Critical Care Unit opened and operational, Maternity Theatre and Neo-Natal Unit construction commenced and on trajectory
- Emergency Department Business Case approved at Strategic Outline Case (SOC) and Outline Business Case endorsed by regional office
- Trust has received notification of a capital allocation totalling £36.2m in support of the Emergency Department works from NHSI

Key Areas of Concern

- Emergency Department 4 hour wait performance remains below plan and deteriorated further in December
- Current run rate requires improvement in order to attain the 2018/19 revised forecast deficit outturn of £24m (£0.3m off plan at month 9)
- **Risk to delivery of the revised plan for a £24m deficit estimated to total £3m**
- Temporary workforce costs continue at higher than planned levels(remaining above £2m in month)
- Cost Improvement Programme (CIP) has performed well, though is behind plan owing to productivity schemes not attaining income projections, this is a key component of the financial recovery plan that must deliver in the last quarter of the financial year.

Key Actions Taken

- SAFER deployed within the Trust to support enhanced ED performance, FES re-organised to reduce elderly admissions
- Regular monitoring of Financial Recovery Plan to escalate and address variation to revised run rate and forecast outturn target with a focus on increased grip and control and enhanced productivity for the remaining months of the calendar year (enhanced focus placed on closing additional capacity)

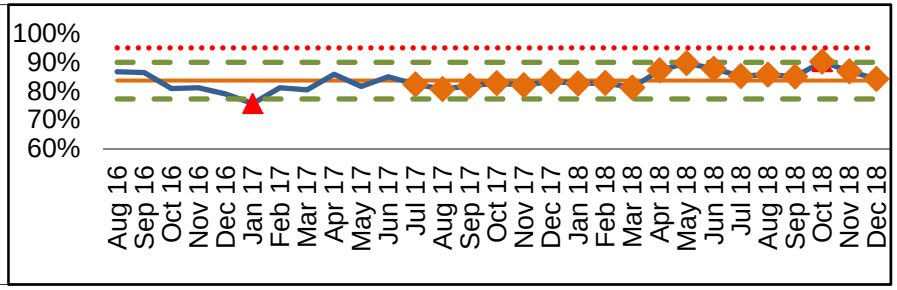
Key Focus for Next Committee

- Continued focus on performance against constitutional standards, focus on ED 4 hour performance
- Delivery of the Financial Recovery Program and revised deficit outturn of £24m with oversight provided by PFIC on the following;
    - Monitoring of run rate reductions compared to plan month on month, in accordance with the Financial Recovery Programme (FRP)
    - Assurance over delivery of the revised outturn, reviewing performance against agreed plans and seeking mitigations for slippage
    - Oversight of key risks, Income performance driven by CIP attainment (productivity within Theatres and Outpatients) and temporary workforce controls
    - Monitoring of grip and control initiatives to ensure cost benefit without service impact
- Forward trajectories contained within the Financial Recovery Plan are to be monitored through;
    - Weekly Performance meetings
    - Performance & Finance Executive
    - Performance, Finance & Information Committee (PFIC)

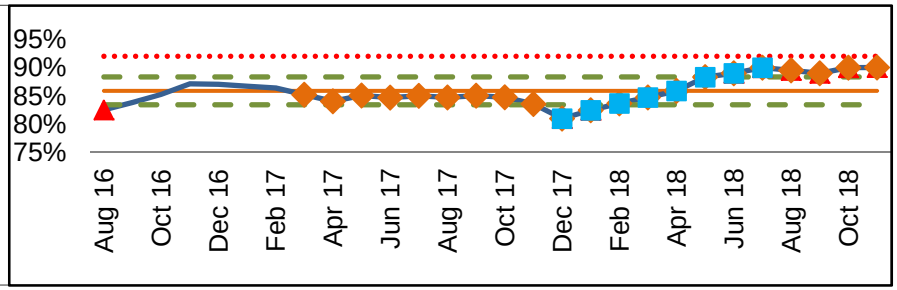
Performance, Finance and Investment Committee

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

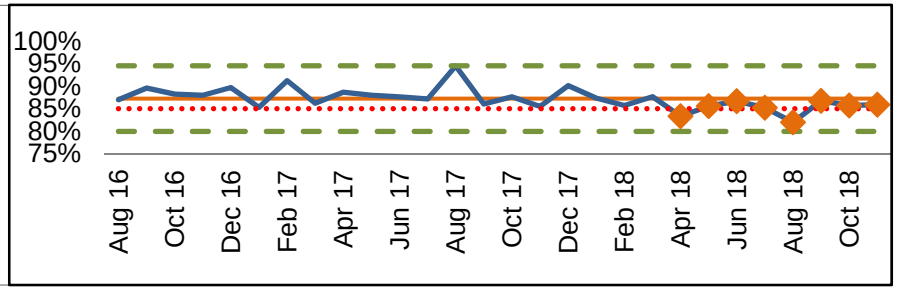
ED - % within 4 hours – Overall (Type 1 & 3)



18 weeks RTT – Incomplete Pathways



Cancer 62 Day RTT



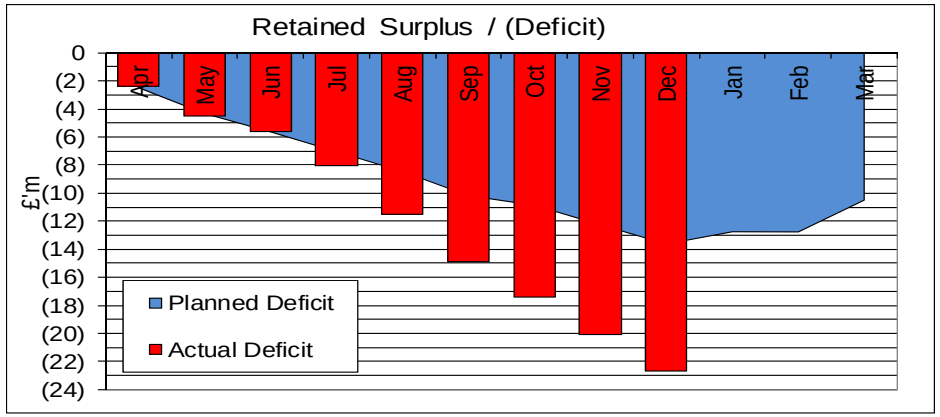
Narrative (supplied by interim Chief Operating Officer)

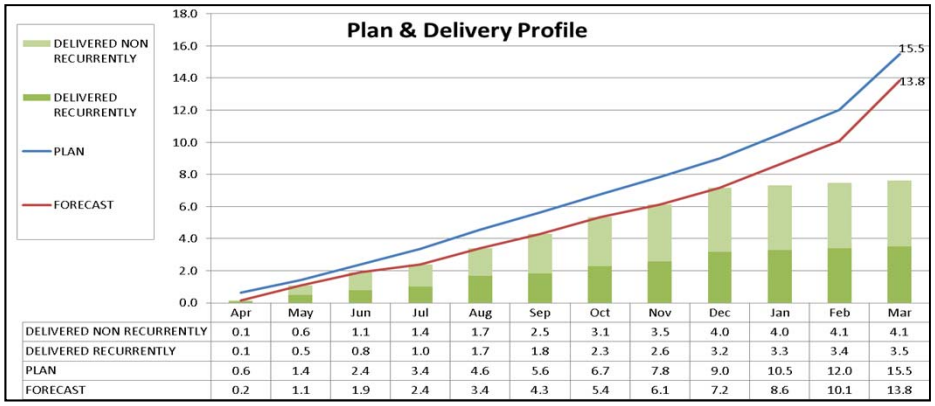
- Type 1 performance has improved on the same period last year in spite of increased demand (+681). CCG work to reduce demand has clearly been successful in terms of type 3 (-1703) however this has reduced the relative improvement in all type performance (denominator calculation).
- The improved type 1 performance has been achieved, with a lower than predicted Winter bed base between Oct – Dec. The Trust has exceeded the planned bed utilisation by 14 beds for 2 weeks in January 2019.

RTT has sustained its improvements and achieved 90.01% in December, despite reduced elective activity over the holiday period. The number of patient pathways has increased slightly on the November position to 14,499. This is reflective of the reduced activity during the month. Pathways, however, are below the required year end position. There were no incomplete 52 week breaches in December. Patients waiting over 40 weeks were at the lowest level this year, with only 8 patients over 40 weeks. Planning has commenced in relation to improving performance in quarter 4 to further reduce waiting times and ensure numbers of pathways are below the 14,688 end of March position.

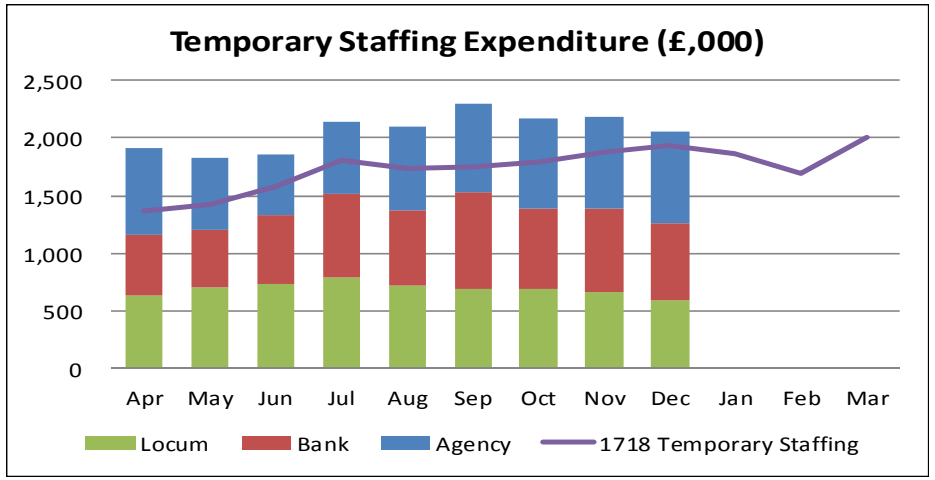
Confirmed Cancer performance for November shows achievement of all National cancer measures. The locally agreed consultant upgrade target failed to achieve by 6.5 breaches, these were made up of 4 complex pathways and 2.5 patient choice resulting in a performance of 78.3% against an 85% target.

Financial Performance to December 2018 (Month 9)





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.1	0.6	1.1	1.4	1.7	2.5	3.1	3.5	4.0	4.0	4.1	4.1
DELIVERED RECURRENTLY	0.1	0.5	0.8	1.0	1.7	1.8	2.3	2.6	3.2	3.3	3.4	3.5
PLAN	0.6	1.4	2.4	3.4	4.6	5.6	6.7	7.8	9.0	10.5	12.0	15.5
FORECAST	0.2	1.1	1.9	2.4	3.4	4.3	5.4	6.1	7.2	8.6	10.1	13.8



Financial Performance

- The financial position at M9 is a deficit of £22.6m, when comparing this to the original plan this results in a £9m adverse variance (includes £2.7m of lost PSF income)
- The Trust was unable to recover this level of adverse performance in year and has therefore revised its forecast outturn for the 2018/19 financial year to a deficit of £24m. In delivery of the revised deficit the Trust is reporting an adverse performance of £0.3m in December 2018 and managing a risk to delivery of £3m
- Contracted income shows under performance on Adult and Neonatal Critical care (NHSE) and on lower than plan births (our main commissioner) offset by performance on other CCG contracts
- Expenditure is overspent £6.7m YTD, with pay (£5.2m) a consequence of temporary staffing costs in Medical and Nursing.

Cash

- The Trust's planned cash holding is £1m (borrowing requirement). Actual cash holding is £1.1m
- The Trust's agreed borrowing for 2018/19 is £10.6m, reflecting the deficit plan. The adverse deficit to plan is placing greater pressure on cash flow and servicing debt

Capital

- The year to date capital expenditure is £9.4m, with the main spends relating to ICCU (£4.4m), Estates Lifecycle (£1.4m), Maternity (£2.8m) and Medical Equipment (£0.3m)

Financial Performance - Period ended 31st December 2018

Description	Annual Budget	Budget to Date	Actual to Date		Variance
	£'000	£'000	£'000		£'000
Income					
CCGs	199,489	149,398	149,567		169
NHS England	19,083	14,204	13,661		(543)
Local Authorities	9,600	7,199	7,389		190
DoH and Social Care	7,787	5,359	2,424		(2,935)
NHS Trusts	830	618	772		155
Non NHS Clinical Revenue (RTA Etc)	4,441	3,463	3,885		422
Education and Training Income	7,249	5,509	5,588		79
Other Operating Income (Incl Non Rec)	5,075	3,992	4,154		161
Total Income	**253,554**	**189,743**	**187,441**		**(2,302)**
Expenditure					
Employee Benefits Expense	(174,208)	(129,620)	(134,889)		(5,269)
Drug Expense	(15,069)	(13,775)	(13,756)		19
Clinical Supplies	(17,931)	(13,591)	(14,946)		(1,355)
Non Clinical Supplies	(16,083)	(12,067)	(12,681)		(614)
PFI Operating Expenses	(5,043)	(3,783)	(3,914)		(131)
Other Operating Expense	(20,148)	(18,467)	(17,840)		627
Sub - Total Operating Expenses	**(248,481)**	**(191,303)**	**(198,026)**		**(6,723)**
Earnings before Interest & Depreciation	**5,074**	**(1,560)**	**(10,586)**		**(9,025)**
Interest expense on Working Capital	51	38	42		3
Interest Expense on Loans and leases	(9,195)	(7,181)	(7,563)		(383)
Depreciation and Amortisation	(6,560)	(4,920)	(4,578)		342
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(15,705)**	**(12,063)**	**(12,100)**		**(38)**
Total Expenses	**(264,185)**	**(203,366)**	**(210,127)**		**(6,761)**
RETAINED SURPLUS/(DEFICIT)	**(10,631)**	**(13,623)**	**(22,686)**		**(9,063)**
Adjustment for Gains on Donated Assets			76		76
Adjusted Financial Performance (Control Total)	**(10,631)**	**(13,623)**	**(22,610)**		**(8,987)**

Use of Resources Ratings (M9)

Finance and use of resources rating	03AUDITPY	03PLANYTD	03ACTYTD	03PLANCY	03FOTCY
i	Audited PY 31/03/2018 Year ending Number	Plan 31/12/2018 YTD Number	Actual 31/12/2018 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		4
Agency rating	2	1	3	1	3

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending December 2018	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	(15,163)
Depreciation and Amortisation	4,578
Donated Assets Received credited to revenue but non-cash	(92)
(Increase)/Decrease in Trade and Other Receivables	(650)
Increase/(Decrease) in Trade and Other Payables	(1,590)
Increase/(Decrease) in Stock	2
Interest Paid	(7,563)
Net Cash Inflow/(Outflow) from Operating Activities	**(20,478)**
Cash Flows from Investing Activities	
Interest received	**42**
(Payments) for Property, Plant and Equipment	**(9,510)**
Receipt from sale of Property	**0**
Net Cash Inflow/(Outflow)from Investing Activities	**(9,468)**
Net Cash Inflow/(Outflow) before Financing	**(29,946)**
Cash Flows from Financing Activities	28,742
Net Increase/(Decrease) in Cash	**(1,204)**
Cash at the Beginning of the Year 2018/19	2,277
Cash at the End of the November	**1,073**

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending December 2018	Balance as at 31/03/18	Balance as at 31/12/18	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Total Non-Current Assets	**140,656**	**145,889**	**5,233**
Current Assets			
Receivables & pre-payments less than one Year	17,214	17,607	393
Cash (Citi and Other)	2,277	1,073	(1,204)
Inventories	2,277	2,275	(2)
Total Current Assets	**21,768**	**20,955**	**(813)**
Current Liabilities			
NHS & Trade Payables less than one year	(30,702)	(29,067)	1,635
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)**	**(36,382)**	**55,492**
Net Current Assets less Liabilities	**(70,106)**	**(15,427)**	**54,679**
Non-current liabilities			
Borrowings greater than one year	(127,859)	(206,273)	(78,414)
Total Assets less Total Liabilities	**(57,309)**	**(75,811)**	**(18,502)**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	58,318	62,501	4,183
Revaluation	16,023	15,897	(126)
Income and Expenditure	(131,650)	(131,524)	126
In Year Income & Expenditure	-	(22,685)	(22,685)
Total TAXPAYERS' EQUITY	**(57,309)**	**(75,811)**	**(18,502)**

Walsall Healthcare NHS
NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2018-2019

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-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)	85.21%	85.74%	85.04%	90.24%	86.90%	84.20%	86.91%	95.00%	82.67%	N
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	71.95%	71.68%	71.86%	77.57%	75.51%	69.72%	75.05%	85.00%	65.80%	BP
no	Ambulance Handover - No. of Handovers completed over 60mins	7	4	13	3	7	10	50	0	236	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	97.64%	95.04%	93.56%	90.82%	97.19%	95.03%	94.70%	93.00%	95.45%	N
%..	Cancer - 62 day referral to treatment of all cancers	85.23%	81.36%	86.73%	85.71%	85.90%	96.88%	85.68%	85.00%	88.05%	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	90.01%	89.51%	89.02%	90.01%	90.04%	90.01%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	0	0	0	0	1	0	1	0		N
%..	Diagnostic Waits - % waiting under 6 weeks	99.75%	99.61%	99.83%	99.71%	99.90%	99.85%	99.66%	99.00%	99.06%	N
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission	188	162	179	177	198	218				L
no	No. of Open Contract Performance Notices	7	7	7	8	8	8		0	7	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	7.46%	7.58%	7.59%	6.86%	7.76%	8.01%	7.44%	7.00%	6.76%	BP
	RESOURCES										
%..	Outpatient DNA Rate (Hospital and Community)	10.45%	10.59%	10.27%	9.88%	10.14%	11.35%	10.52%	8.00%	12.16%	L
%..	Theatre Utilisation - Touch Time Utilisation (%)	84.44%	81.50%	79.79%	92.29%	80.40%	85.24%	83.58%	75.00%		L
%..	Delayed transfers of care (one month in arrears)	3.65%	4.07%	3.95%	4.92%	2.82%		3.82%	2.50%	2.56%	L
no	Average Number of Medically Fit Patients	88	92	107	104	100	91		80		L
no..	Average LoS for Medically Fit Patients (from point they become Medically Fit)	9	8	9	11	10	11		5		L
£	Surplus or Deficit (year to date) (000's)	-£8,012	-£11,496	-£14,888	-£17,455	-£20,157	-£22,610	-£22,610		-£23,267	L
£	Variance from plan (year to date) (000's)	-£553	-£3,038	-£4,711	-£6,589	-£7,905	-£8,987	-£8,987		-£2,511	L
£	CIP Plan (YTD) (000s)	£3,182	£4,554	£5,620	£6,747	£7,800	£9,000	£9,000			L
£	CIP Delivery (YTD) (000s)	£2,391	£3,405	£4,158	£5,351	£6,100	£7,200	£7,200			L
£	Temporary Workforce Plan (YTD) (000s)	£5,935	£7,502	£9,156	£10,836	£12,600	£14,400	£14,400			L
£	Temporary Workforce Delivery (YTD) (000s)	£7,733	£9,836	£12,140	£14,301	£16,500	£18,500	£18,500			L
£	Capital Spend Plan (YTD) (000s)	£4,105	£5,027	£5,842	£6,287	£6,600	£7,600	£7,600			L
£	Capital Spend Delivery (YTD) (000s)	£3,946	£5,487	£6,391	£6,890	£8,600	£9,400	£9,400			L

Walsall Healthcare NHS
NHS Trust

Glossary

Caring for Walsall together

Safe, high quality care | Care at home | Partners | Value colleagues | Resources | Respect Compassion Professionalism Teamwork

Glossary

A
ACP – Advanced Clinical Practitioners
AEC – Ambulatory Emergency Care
AHP – Allied Health Professional

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

AMU – Acute Medical Unit
AP – Annual Plan
B
BCA – Black Country Alliance
BR – Board Report
C
CCG/WCCG – Walsall Clinical Commissioning Group
CGM – Care Group Managers
CHC – Continuing Healthcare
CIP – Cost Improvement Plan
COPD – Chronic Obstructive Pulmonary Disease
CPN – Contract Performance Notice
CQN – Contract Query Notice
CQR – Clinical Quality Review
CQUIN – Commissioning for Quality and Innovation
CSW – Clinical Support Worker
D
D&V – Diarrhoea and Vomiting
DDN – Divisional Director of Nursing
DoC – Duty of Candour
DQ – Data Quality
DQT – Divisional Quality Team
DST – Decision Support Tool
DWMHPT – Dudley and Walsall Mental Health Partnership NHS Trust
E
EACU – Emergency Ambulatory Care Unit
ECIST – Emergency Care Intensive Support Team
ED – Emergency Department
EDS – Electronic Discharge Summaries
EPAU – Early Pregnancy Assessment Unit
ESR – Electronic Staff Record
EWS – Early Warning Score
F
FEP – Frail Elderly Pathway
FES – Frail Elderly Service
G
GAU – Gynaecology Assessment Unit
GP – General Practitioner
H

HALO – Hospital Ambulance Liaison Officer

HAT – Hospital Acquired Thrombosis
HCAI – Healthcare Associated Infection
HDU – High Dependency Unit
HED – Healthcare Evaluation Data
HofE – Heart of England NHS Foundation Trust
HR – Human Resources
HSCIC – Health & Social Care Information Centre
HSMR – Hospital Standardised Mortality Ratio
I
ICS – Intermediate Care Service
ICT – Intermediate Care Team
IP - Inpatient
IST – Intensive Support Team
IT – Information Technology
ITU – Intensive Care Unit
IVM – Interactive Voice Message
K
KPI – Key Performance Indicator
L
L&D – Learning and Development
LAC – Looked After Children
LCA – Local Capping Applies
LeDeR – Learning Disabilities Mortality Review
LiA – Listening into Action
LTS – Long Term Sickness
LoS – Length of Stay
M
MD – Medical Director
MDT – Multi Disciplinary Team
MFS – Morse Fall Scale
MHRA – Medicines and Healthcare products Regulatory Agency
MLTC – Medicine & Long Term Conditions
MRSA - Methicillin-Resistant Staphylococcus Aureus
MSG – Medicines Safety Group
MSO – Medication Safety Officer

Glossary

M cont
MST – Medicines Safety Thermometer
MUST – Malnutrition Universal Screening Tool
N
NAIF – National Audit of Inpatient Falls
NCEPOD – National Confidential Enquiry into Patient Outcome and Death
NHS – National Health Service
NHSE – NHS England
NHSI – NHS Improvement
NHSIP – NHS Improvement Plan
NOF – Neck of Femur
NPSAS – National Patient Safety Alerting System
NTDA/TDA – National Trust Development Authority
O
OD – Organisational Development
OH – Occupational Health
ORMIS – Operating Room Management Information System
P
PE – Patient Experience
PEG – Patient Experience Group
PFIC – Performance, Finance & Investment Committee
PICO – Problem, Intervention, Comparative Treatment, Outcome
PTL – Patient Tracking List
PU – Pressure Ulcers
R
RAP – Remedial Action Plan
RATT – Rapid Assessment Treatment Team
RCA – Root Cause Analysis
RCN – Royal College of Nursing
RCP – Royal College of Physicians
RMC – Risk Management Committee
RTT – Referral to Treatment
RWT – The Royal Wolverhampton NHS Trust
S

SAFER – Senior review - All patients will have an expected discharge date - Flow of patients - Early discharge – Review

SAU – Surgical Assessment Unit
SDS – Swift Discharge Suite
SHMI – Summary Hospital Mortality Indicator
SINAP – Stroke Improvement National Audit Programme
SNAG – Senior Nurse Advisory Group
SRG – Strategic Resilience Group

S cont
SSU – Short Stay Unit
STP – Sustainability and Transformation Plans
STS – Short Term Sickness
SWBH – Sandwell and West Birmingham Hospitals NHS Trust
T
TACC – Theatres and Critical Care
T&O – Trauma & Orthopaedics
TCE – Trust Clinical Executive
TDA/NTDA – Trust Development Authority
TQE – Trust Quality Executive
TSC – Trust Safety Committee
TVN – Tissue Viability Nurse
TV – Tissue Viability
U
UCC – Urgent Care Centre
UCP – Urgent Care Provider
UHB – University Hospitals Birmingham NHS Foundation Trust
UTI – Urinary Tract Infection
V
VAF – Vacancy Approval Form
VIP – Visual Infusion Phlebitis
VTE – Venous Thromboembolism
W
WCCG/CCG – Walsall Clinical Commissioning Group
WCCSS – Women's, Children's & Clinical Support Services
WHT – Walsall Healthcare NHS Trust
WiC – Walk in Centre
WLI – Waiting List Initiatives
WMAS – West Midlands Ambulance Service
WTE – Whole Time Equivalent

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

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

MEETING OF THE PUBLIC TRUST BOARD – 7 FEBRUARY 2019			
Operational Planning and Contracting 2019 / 20			**AGENDA ITEM: 16**
Report Author and Job Title:	Jane Hayman Service Improvement Programme Manager	**Responsible Director:**	Daren Fradgley, Director of Strategy and Improvement
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐ (select the relevant action required)		
Executive Summary	Each year NHS trusts and commissioners are required to submit operational plans to their regulators. For 2019/20 plans require a suite of operational plans with set deadlines – the first of which was for draft activity data which was submitted on 14 January. It is expected that all Integrated Care Systems (ICSs) and Sustainability and Transformational Plan (STP) footprints will produce a system operating plan for the year which will set the priorities for the forthcoming year and will be the foundation for refreshed five-year strategic plans. The system operating plan consists of the system operating plan overview and the system data aggregation. The two sections are required to be consistent and aligned. The plans should include: • System priorities and deliverables • Activity assumptions • Capacity planning • Workforce requirements, gaps and plans • System financial position and risks • System-wide efficiencies with long-term transformation plans All plans should be triangulated between commissioner and provider plans and related contracts to ensure alignment in activity, workforce and income and expenditure assumptions. The Trust has a task and finish group, which meets regularly and is charged with producing the submissions in a timely manner. Executive leads are assigned to each element of plans. The organisation's plan will be supported with information data from the following (not exhaustive): - Strategic objectives		

	- Demand and capacity - Contracting - Quality Service Improvements including NHS RightCare programme, CIP, benchmarking data - Finance Workforce Risks and mitigations - Walsall Together Governance is provided through the Executive Groups and Trust Committee's and a timetable of activities and milestones is attached for information.	
Recommendation	The Board is requested to note the requirements of the Annual Plan.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF001 Failure to deliver consistent standards of care to patients' across the Trust results in poor patient outcomes and incidents of avoidable harm. BAF002 Failure to achieve financial plans as agreed by the Board and communicated to NHSI BAF003 If the Trust does not agree a suitable alliance approach with the Local Health Economy partners it will be able to deliver a sustainable integrated care model. BAF006 High levels of sickness absence within the Trust impacts upon the Trust's resourcing plan and ability to deliver safe and high quality care and also impacts upon the Trust's ability to effectively use resources and deliver the financial plan.	
Resource implications	The Annual plan will describe future activity models, financial planning and outline predicted efficiency savings	
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 ☒	

Operational Planning and Contracting 2019 / 20

1. PURPOSE OF REPORT

The purpose of the report is to provide overview of the requirements for the Annual Plan submission for 2019 / 20. The report provides context and data / narrative responsibilities for the Trust and indicates the publication and submission deadlines in Appendix 1.

2. BACKGROUND

With the announcement of a five year funding settlement by the Government for an additional £20.5 billion a year in real terms by 2023/24, the NHS is being asked to secure the best outcomes for patients and the public from this investment. The guidance sets out the requirement for a bold set of service redesigns to reduce pressure across the NHS and improve care access and quality.

For 2019 / 20 every NHS trust, NHS foundation trust and clinical commissioning group (CCG), will need to agree organisation-level operational plans which combine to form a coherent system-level operating plan. This will provide the start point for every Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) to develop five-year Long Term Plan implementation plans now, covering the period to 2023/24. It is anticipated that productivity and clinical effectiveness will only be delivered by organisations working together, at scale.

The system operating plan will have two elements:

- An overview of how the system will work to deliver population needs within allocated resources using assumptions around activity, capacity, efficiency, workforce plans, transformation and risks.
- System data aggregation which show how individual organisations align to the system plan.

Further details of the planning guidance can be found here:

https://www.england.nhs.uk/wp-content/uploads/2018/12/NHS-Operational-Planning-and-Contracting-Guidance-201920-FULL-VERSION.pdf

3. DETAILS

Each year NHS trusts and commissioners are required to submit operational plans to their regulators. With the announcement of a five year funding settlement by the Government for an additional £20.5 billion a year in real terms by 2023/24, the NHS is

being asked to secure the best outcomes for patients and the public from this investment.

The Trust's FPR submission was based on 2018/19 forecast out turn (FOT). This year, to support organisations in generating robust planning submissions, NHS England and NHS Improvement have agreed a more statistically rigorous approach to estimating 2018/19 forecast outturns, based on historical time series data. The data submitted was in alignment with the CCG data and NHSI recommendations.

The guidelines for 2019/20 plans require a suite of operational plans, which are a combination of narrative with supporting data and set deadlines – the first of which was for draft activity data, submitted on 14 January.

All Integrated Care Systems (ICSs) and Sustainability and Transformational Plan (STP) footprints are required to produce a system operating plan for the year which will set the priorities for the forthcoming year and will be the foundation for five-year strategic plans. The plan should include an overview of the system and data aggregation. The two sections are required to be consistent and aligned.

The guidance indicates that bold plans are required to reduce system pressures, while improving access to and quality of care.

3.1. Elements of the Plan

The plan has two elements:

1: An overview of how the system will use its financial resources to meet the needs of the population and what it will deliver in 2019/20. This will need to be underpinned by activity assumptions, capacity, efficiency, and workforce plans, transformation objectives and risks and mitigations.
2: A system data aggregation covering activity, workforce, finance and contracting demonstrating how all individual organisational plans align to the system plan.

The plans should include:

- System priorities and deliverables
- Activity assumptions
- Capacity planning
- Workforce requirements, gaps and plans
- System financial position and risks
- System-wide efficiencies with long-term transformation plans

All plans should be triangulated between commissioner and provider plans and related contracts to ensure alignment in activity, workforce and income and expenditure assumptions.

3.2 Implications for the Trust

The Trust has a task and finish group, which meets regularly and is responsible to produce the submissions in a timely manner with executive leads assigned to each element of plans. The organisation's plan will be supported with information data from the following (not exhaustive):

- Strategic objectives
- Demand and capacity
- Contracting
- Quality Service Improvements including NHS RightCare programme, CIP, benchmarking data
- Finance Workforce Risks and mitigations
- Walsall Together

3.2.1 Strategic objectives

The Trust's five headline strategic objectives will remain the same, though the emphasis for each will reflect our priorities.

3.2.2 Demand and capacity

The Trust has developed robust demand and capacity plans, which will also be reflected in contracted activity and workforce plans. These will feed into the wider STP calculations.

3.2.3 Contracting and Activity

As reflected above, the contracted activity should reflect the Trust's capacity, with consideration for required efficiencies and local and national priorities.

3.2.4 Quality Service Improvements

Improvement opportunities have been highlighted through benchmarking data such as Model Hospital, and national and local standards and efficiencies. Plans should also reflect recommendations set out in the Long Term plan including system-wide approaches to:

- addressing population health inequalities and the prevention agenda through partnership working (see 3.2.7)
- Respiratory disease and Cardiovascular disease has been highlighted in the LTP and is a focus in the Annual plan. We are addressing this in partnership with our key partners as a matter of local priority
- Continued focus on RTT for 2 week waits

- Dementia friendly environments and a focus on rapid discharge to prevent deterioration in hospital
- Continued investment in technology, including expanding use of Total Mobile and a new PAS

Further quality improvement goals include:

- Reduce bed occupancy by long stay patients by 25% to release 4,000 beds compared to 2017/18
- Support 'right place first time approach' by appropriately resourcing the Directory of Services, thus reducing A&E as a default position
- Redesign urgent care services to include designated Urgent Treatment Centres (UTCs) ensuring that they meet published standards.
- Zero tolerance of ambulance to hospital handover delays over 30 minutes
- Existing NHS Constitutional standards remain in place for urgent and emergency care. New clinical standards to be published in spring 2019 and implemented from October 2019. These standards will also set out expectations for RTT
- Community providers should make progress towards implementing the new service models set out in the long-term plan.

Quality improvements within the organisation will be supported by the Quality Improvement Academy and the quality improvement methodology we have committed to adopting. We have also undertaken sustainability reviews, and the 14 services identified with the greatest opportunity for improvement will be supported using triangulated data from RightCare, Model Hospital, GIRFT and internal data to enable robust clinical discussion and service redesign, with patient access, quality and safety a priority.

3.2.5 Workforce

Both the LTP and the Annual Plan appreciate the significant workforce challenge around supply and retention. Walsall have addressed local the 'Bank first' approach to temporary staffing and have begun to implement Nurse Associate roles with 18 due to qualify in January. We have also developed draft generic competencies for Care Support Workers in Surgery.

The Trust continues to support the training and development of Non-Medical prescribers to enhance the skills and competencies of our existing workforce.

Therapy remains a challenge nationally and we are currently looking to develop and grow local innovative models in this area to address our shortfall.

3.2.6 Finance

A full financial plan is required taking account to changes in national and local tariffs. Providers are expected to plan against rebased control totals. Providers in deficit will need to reflect a further 0.5% efficiency requirement on top of the mandated 1.1%.

Financial implications in the guidance include:

- A 'blended' payment model for non-elective admissions, A&E attendances and ambulatory / same day care
- Subject to consultation, the uplift in national tariff will be set at 3.8% for 2019/20, to include the AfC pay awards that were paid directly to providers in 2018/19
- Prescribed Specialised Services and CQUIN schemes will be reduced in value from April 2019, by 50% to 1.25.
- The Marginal rate emergency tariff and 30 day readmission rule to be abolished
- Implementation of updated Market Forces Factor
- 2019 / 20 to be the first year of a re-set of the financial framework for NHS providers
- It is proposed to make the maternity pathway tariffs non-mandatory, but it is expected these prices will still be used for contracting in 2019/20
- Reforming of the Provider Sustainability Fund
- Creation of a new Financial Recovery Fund
- Providers expected to plan against rebased control totals. Providers in deficit will need to reflect a further 0.5% efficiency requirement on top of the mandated 1.1%
- Implementation nationally of the recommendations within the publication 'Evidence Based Interventions: Consultation response'

The Annual Planning guidance is reflective of Chapter 6 in the Long Term Plan "Taxpayers' investment will be used to maximum effect". We will ensure a co-ordinated approach to data by triangulating internal data, RightCare data and Model Hospital to inform decisions which will reduce waste and inform greatest opportunities for efficiencies.

3.2.7 Walsall Together

The Walsall health and care system partners are developing new integrated ways of working to improve the health and wellbeing outcomes of the population, increase the quality of care provided and provide long term financial sustainability for the system. This programme of work supports the wider Black Country Sustainability and Transformation Plans (STP) by enabling place based, partnership working to improve the health and wellbeing of a population (Kings Fund, 2018).

A Business case has been developed which lays out the future intentions of the Walsall provider and commissioner partners using a series of horizons, as they endeavour to deliver ever more integrated care and improved outcomes for the citizens of Walsall. This is a significant step forward, creating an outcome focused environment in which system partners are incentivised to deliver agreed outcomes.

3.2.8 Risks and Mitigations

As with all plans, the organisation has outlined key risks and mitigations to its plan.

3.3 The Trust's Approach

An initial meeting was convened with department leads on the 16 January 2019 to discuss the updates required for 2019 / 20 submission and to allocate tasks.

The executive lead for each area of the plan will be required to validate the information in time for the submission deadlines. The first draft of the operational plan will need to be submitted no later than 12 February 2019 to include narrative and full sets of supporting data.

The detailed plans will come to each relevant committee's as part of the planning sign off process. Draft plans will come through in February Committee's and final versions will come through in March 19.

4. RECOMMENDATIONS

The Board is requested to note the requirements of the Annual Plan, including the responsibility of each executive director to ensure their relevant areas of responsibility are completed on time and with the relevant information.

APPENDICES

Appendix 1: National Timetable

5.2 Timetable

Milestone	Date
Publication of: • Near final 2019/20 prices • 2019/20 standard contract consultation	21 December 2018
2019/20 deliverables, indicative CCG allocations, trust financial regime and control totals and associated guidance for 2019/20	Early January 2019
NHS Long Term Plan	January 2019
2019/20 CQUIN guidance published	January 2019
2019/20 Initial plan submission – activity focused	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
STP/ICS net neutral control total changes agreed by regional teams	By 1 February 2019
Draft 2019/20 organisation operational plans	12 February 2019
Aggregate system 2019/20 operating plan submissions, system operating plan overview and STP led contract / plan alignment submission	19 February 2019
2019/20 STP/ICS led contract / plan alignment submission	19 February 2019
Final 2019/20 NHS Standard Contract published	22 February 2019
Local decision whether to enter mediation and communication to NHSE/I and boards/governing bodies	1 March 2019
2019/20 STP/ICS led contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Parties entering arbitration to present themselves to the Chief Executives of NHS Improvement and England (or their representatives)	22-29 March 2019
STP/ICS net neutral control total changes agreed by regional teams	By 25 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Submission of appropriate arbitration documentation	1 April 2019
Arbitration panel and/or hearing (with written findings issued to both parties within two working days after panel)	2-19 April 2019
Final 2019/20 organisation operational plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions, system operating plan overview and STP/ICS led contract / plan alignment submission	11 April 2019
2019/20 STP/ICS led contract / plan alignment submission	11 April 2019
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 30 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Autumn 2019

MEETING OF THE PUBLIC TRUST BOARD –7th February 2019			
Partnership Update			**AGENDA ITEM: 17**
Report Author and Job Title:	Andy Griggs Service Improvement Programme Manager	**Responsible Director:**	Daren Fradgley Director of Strategy and Improvement
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	This paper updates the Board Members on the key partnership working undertaken this month. This includes the following • Intermediate Care Service • Primary Care MDT's • Place Based Teams • Walsall Together • Estates Challenges		
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	BAF003 If the Trust does not agree a suitable alliance approach with the Local Health Economy partners it will be able to deliver a sustainable integrated care model. BAF004 Failure to progress the delivery of the Walsall Integrated model for health and social care.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

Partnership Report
January 2019

1. PURPOSE OF REPORT

This report is the monthly update on partnership activities that the Trust has been involved in. it is not designed to be a complete list but establish the key highlights and next steps.

2. INTERMEDIATE CARE SERVICE

Work on a collaborative information sharing agreement with partnering organisations is nearing completion; this will facilitate a smooth and seamless approach to system collaboration that is essential moving forward.

The number of medically safe for discharge (MSFD) patients reduced from circa 100 patients in November to 71 patients prior to Christmas. Although the numbers are lower than for the same period in the previous year, they remain higher than the aspiration of 80 MSFD patients.

With the support of the STP and the Better Care Fund allocations a number of initiatives are being undertaken to support early discharge to prevent patients from decompensating and reduction in length of stay. Work has also commenced on developing the revised model of therapy care regarding hospital discharge.

There is no doubt that a further push is required to deal with the next step change with this service. Some of those changes are outlined above with the review of therapy interaction and looking at what success has been had in other areas such as Sheffield. However, benefits to the management of flow through these services can also be gained by streamlining the flow of real-time data and the creation of a shared record, both of which are either in plan with the EPR journey or in the way in which we store a use data today that is being reviewed.

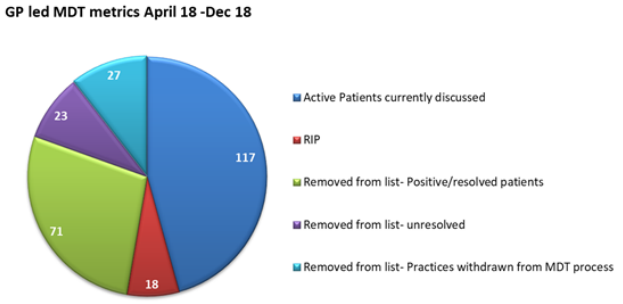
2.1 PRIMARY CARE MDT'S

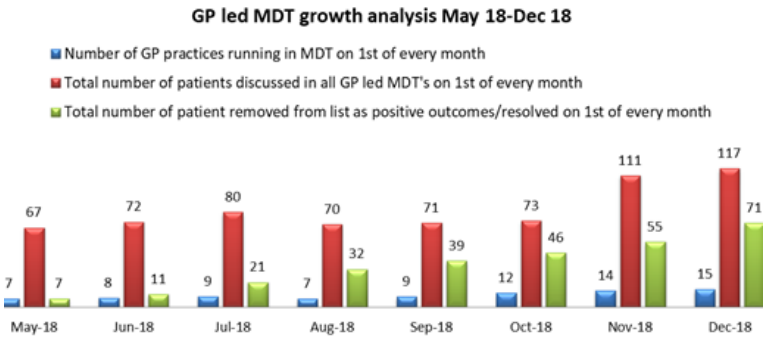
The GP Led MDT's are progressing very well with more practices joining, there are now 15 practices participating covering 33% of the population list size. A locality based MDT is due to be piloted in one locality as soon as approval is agreed by the CCG with the GP Leadership, this would see multiple 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.

The table below shows the continual improvement in this area.

Covered by GP Led MDT's				
	Oct	Nov	Dec	Trend
% Total Practices covered	23%	27%	29%	
% Population covered	25%	32%	33%	

Below are the initial outcome metrics that are being presented to the Place Based Team Project Group.





One Walsall has appointed four successful candidates for the social prescribing project. Two of these candidates will be based within the North and West locality teams.

2.2 PLACE BASED TEAMS

The table below shows analysis of admissions for patients seen by the Community Matrons and District Nurses, diagnostics of the data indicates that the North team are seeing a higher rate of patients. Further analysis has shown that the majority of patients are suffering from respiratory conditions and falls. The North team are looking to assigning more respiratory support and will monitor the situation closely.

Place Based Team	Population Size	Number of patients in hospital on CANAR alert system 17.01.19	Number of patients in hospital on CANAR alert system 21.01.19	Number of patients in hospital on CANAR alert system 22.01.19
East 1	32,930	13	18	17
East 2	42,530	14	15	17
North	58,115	30	33	39
South 1	41,068	9	9	8
South 2	49,060	11	15	16
West 1	39,817	13	14	12
West 2	39,131	5	9	11
Total	**302,651**	**95**	**113**	**120**

2.3 WALSALL TOGETHER

Refinement of the final business case has taken place this month in preparation for approval by the respective boards throughout February.

A draft digital strategy document has been created and will be referenced within the final business case; this document will form the main aim for the Technology Workstream.

Technology is a key enabler of the Trust's integrated care ambitions, and as part of the Walsall Together programme a series of stakeholder interviews have taken place. Combining the knowledge acquired through these with KPMG and our own experiences the IT strategy has been developed that outlines the alignment of the Trust and integrated care strategies.

This strategy has identified that what is needed is a common approach to communication which implies the need for a single, cloud based telephony solution, combined with voice over internet protocol (VOIP) communications, secure messaging and recording etc.

A scalable architecture will be required to deploy all of the identified services to all sites, and can then be easily deployed to new sites/services as the programme grows.

This requires a significantly different experience set to that of traditional healthcare I.T. personnel, and indeed that of the systems vendors. This challenge will need to be overcome.

2.4 ESTATES CHALLENGES

Meetings have taken place with CCG Estates managers to understand what void spaces are available within the Walsall area. This would allow the Place Based Teams to either expand into or be rehomed in more appropriate accommodation that better suits their needs in regards to multi organisational collaboration, thus supporting a better inter team MDT approach as seen in the West Locality.

Locality	Base	Comments
West 1 & 2	Darlaston	Accommodation meets requirements
North	Pinfold	Space is fully utilised, an additional room is available but will incur additional costs.
East 1	Brownhills	Building is not fit for purpose, does not accommodate the number of staff required, alternative accommodation needs to be identified for the team.
East 2	Anchor Meadow	
South 1	Beechdale	Building is no longer fit for purpose; it does not accommodate the number of staff required. Alternative accommodation has been identified but is subject to review.
South 2	Broadway	Building is no longer fit for purpose, does not accommodate the number of staff required.

3 RECOMMENDATIONS

Board members are asked to NOTE the information within this report.

MEETING OF THE PUBLIC TRUST BOARD – 7TH February 2019			
Board Assurance and Corporate Risk Register Report			**AGENDA ITEM: 18**
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 18 Corporate level risks recorded on the Safeguard risk management system. There has been no movement in the current risk scores associated with the strategic or Corporate risks however there has been a notable improvement in the timeliness of risk reviews and action progress updates since the last report. One new risk has been added to the Corporate Risk Register (Risk 1703) and has been re-articulated to address the risk issues pertaining to Risk 274		
Recommendation	Members of the Trust Board are asked to note the BAF and 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	The BAF identifies resourcing risks		
Legal and Equality and Diversity implications	The BAF identifies current legal, contractual and regulatory risks identified relating to Equality, Diversity and Inclusion.		
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 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.

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 and skill gaps leading to insufficient numbers of staff available in key areas and a subsequent impact on quality of patient care, pressure on staff, increases in temporary agency spend and ineffective use of bank and temporary workforce. Resourcing is ineffective due to high levels of absence including sickness absence (Score 20)*
- *BAF002 Failure to achieve financial plans as agreed by the Board and communicated to NHSI (Score 15)*

One new risk was added to the BAF during Quarter 3

- *BAF011 - IM&T systems which do not meet the requirements of the organisation (Score 12).*

Every BAF risk was the subject of a formalised review undertaken by the Executive Owner and within the specified timescale. The updated controls and assurances have been reported to the relevant sub-committee aligned to the risk although there has been no movement in the current 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 individual summaries detailing the assurance and controls in place. The current iteration of the report template has identified some formatting issues and further development work is being explored to produce a more logical and informative working document.

3.2 Corporate Risk Register

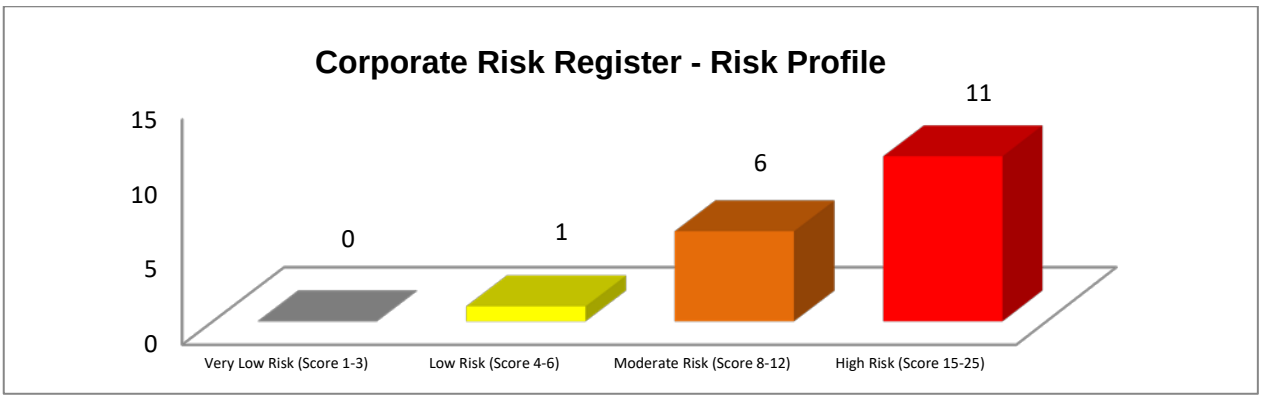
A comprehensive review of the Corporate Risk Register was also undertaken by the Executive Owners during Quarter 3 supported by the Acting Risk Manager and this report is reflective of that status. (Appendix 2)

There has been a significant improvement in the timeliness of risk reviews and actions updated in progress with no remarkable change in the current risk scores, thus demonstrating a stable reporting position of corporate risk activity.

The review identified that two risks were considered appropriate for de-escalation back to the Divisional tier level management.

One risk was deemed applicable for closure (*risk 274 – lack of resources to deliver the Capital Replacement Programme)* as the management had become too complex due to the significant change in the Trust's processes and controls since the initial assessment in 2016. The risk has been re-created to incorporate the current actions and mitigations within risk 1703. (*The Trust fails to appropriately resource and/or manage the equipment replacement programme within the capital resource envelope which could have a detrimental impact on the quality of care – risk score = 12*)

There are **18** accepted Corporate risks and the risk profile is shown below.



3.3 New Risks added to the Corporate Risk Register

Risk No.	Risk Description	Risk Score
1188	Risk of income loss to the Trust due to inability to code adequately the ED activity on the current Lorenzo / ECDS system	6
1703	The Trust fails to appropriately resource and/or manage the equipment replacement programme within the capital resource envelope which could have a detrimental impact on the quality of care.	12

3.4 Assurance

A robust monitoring and improvement programme will continue during the next Quarter 4 to ensure the Trust Board receives the appropriate oversight and assurance. This will be further underpinned by the implementation of the Risk Management Policy and enhanced training provision at all levels and forums throughout the organisation.

The establishment of a Risk Management Group will be effected from February 2019 and will be constituted to champion and promote highly effective risk management at all levels to ensure that there is a consistent and proactive process to ensure compliance with all strategic and operational objectives.

3.5 Annual Strategic Objectives

At the time of writing this report a Board Development Session is planned for 4 February 2019 in which the Board will review the Strategic Objectives for 2019/20 and agree the BAF risks associated with these objectives. The outcome of this exercise may result in a change to the BAF which will be made effective from April 2019.

4. RECOMMENDATIONS

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

APPENDICES

Appendix 1 – Board Assurance Framework
Appendix 2 – Corporate Risk Register Dashboard

BOARD ASSURANCE FRAMEWORK 2019 / 2020

Walsall Healthcare NHS
NHS Trust

Ref	Risk Statement	Monitoring Board Committee	Executive Lead	Initial Risk Score	Current Risk Score	Target Risk Score	Strategic Objectives
BAF001	Failure to deliver consistent standards of care to patients' across the Trust results in poor patient outcomes and incidents of avoidable harm.	Quality, Patient Experience An	Director Of Nursing	4 x 5 = 20	4 x 3 = 12	0 x 0 = 0	**Provide Safe High Quality Care Across Services** Continue Our Journey On Patient Safety And Clinical Quality Through A Comprehensive Improvement Plan
BAF002	Failure to achieve financial plans as agreed by the Board and communicated to NHSI	Performance Finance And Invest	Director Of Finance & Performa	4 x 5 = 20	3 x 5 = 15	0 x 0 = 0	**Use Resources Well To Ensure Sustainable** Improve Our Financial Health Through Our Robust Improvement Programme
BAF003	If the Trust does not agree a suitable alliance approach with the Local Health Economy partners it will be able to deliver a sustainable integrated care model.	Trust Board	Director Of Strategy & Improve	3 x 4 = 12	2 x 3 = 6	0 x 0 = 0	**Work Closely With Walsall Partners And Surrounding** Develop The Clinical Services Strategy Focussed On Service Integration In Walsall And In Collaboration
BAF004	Failure to progress the delivery of the Walsall Integrated model for health and social care.	Trust Board	Director Of Strategy & Improve	3 x 3 = 9	2 x 3 = 6	0 x 0 = 0	**Care For Patients At Home Whenever We Can** **Work Closely With Walsall Partners And Surrounding** Develop The Clinical Services Strategy Focussed On Service Integration In Walsall And In Collaboration
BAF005	The lack of leadership capability and capacity could lead to insufficient key performance improvement and the Trusts ability to be a high performing organisation.	People And Organisational Deve	Director Of People & Culture	4 x 4 = 16	3 x 3 = 9	0 x 0 = 0	**Value Colleagues So Recommend Us Place Of Work** Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership
BAF006	High levels of sickness absence within the Trust impacts upon the Trust's resourcing pland and ability to deliver safe and high quality care and also impacts upon the Trust's ability to effectively use resources and deliver the financial plan. The current policy framework for the Trust does not adequately support Staff Health and Wellbeing and does not effectively mitigate absence levels.	People And Organisational Deve	Director Of People & Culture	5 x 5 = 25	4 x 5 = 20	0 x 0 = 0	**Value Colleagues So Recommend Us Place Of Work** Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership
BAF007	Failure to improve organisational Culture impacts on staff well being, retention and the Trusts ability to attract and recruit new staff	People And Organisational Deve	Director Of People & Culture	4 x 4 = 16	3 x 2 = 6	0 x 0 = 0	**Value Colleagues So Recommend Us Place Of Work** Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership
BAF008	Healthy organisation - failure to understand the health and welbeing of the workforce and implement appropriate initiatives	People And Organisational Deve	Director Of People & Culture	4 x 4 = 16	3 x 2 = 6	0 x 0 = 0	**Value Colleagues So Recommend Us Place Of Work** Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership
BAF009	Failure to promote, develop and support a culture which values equality, diversity and inclusion	People And Organisational Deve	Director Of People & Culture	5 x 4 = 20	3 x 2 = 6	3 x 2 = 6	**Value Colleagues So Recommend Us Place Of Work** Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership
BAF010	Freedom to Speak Up - there is a risk that the systems and processes for raising a concern are insufficient and not robustly embedded within the Trust	People And Organisational Deve	Director Of People & Culture	4 x 4 = 16	3 x 4 = 12	0 x 0 = 0	**Value Colleagues So Recommend Us Place Of Work** Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership
BAF011	IM&T systems which do not meet the requirements of the organisation	Performance Finance And Invest	Director Of Strategy & Improve	4 x 4 = 16	4 x 3 = 12	0 x 0 = 0	**Use Resources Well To Ensure Sustainable**

Care For Patients At Home Whenever We Can

Develop The Clinical Services Strat2egy Focussed On Service Integration In Walsall And In Collaboration

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	3 x 3 = 9
CURRENT RISK SCORE (Impact x Likelihood = Total)	2 x 3 = 6
TARGET RISK SCORE (Impact x Likelihood = Total)	0 x 0 = 0

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
BAF004	Failure to progress the delivery of the Walsall Integrated model for health and social care.	Director Of Strategy & Improve	Trust Board

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	POTENTIAL CONSEQUENCES OF THE RISK
	What are the key potential consequences (up to 4) of the risk?
	Quality of services of compromised Organisational reputation is compromised challenging future sustainability Opportunities are missed to link in with partners with like minded ideas and strategies

Potential or actual origins that have led to the risk...

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	LINKED CORPORATE RISKS
New model does not deliver a sustainable health economy for Walsall. New model financially destabilises one or more providers and therefore can't be agreed. The new clinical model does not align with wider work on sustainable clinical models Lack of alignment between commissioners and providers in delivering the new model/integration programme Sufficient focus on the new model and integration programme with other challenges	

The risks are CONTROLLED by...

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Trust Strategy
C2	Black Country Partnership Agreement

The REPORTING mechanisms are...

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		
R2		

These are the POSITIVE ASSURANCES actually received...

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L1 - Trust Strategy approved by Board February 2016 Full consultation process undertaken through Board Committees and staff (800 respondants) Strategic objectives aligned to operational objectives Annual operational overview plan developed and included in Annual Operational Plan Quarterly udate to Board and Committees --- L2 - CCG, LA, PH, LMC review of Strategy NHSI review of Strategy --- L3 -	✓	✓		
L1 - Partnership update to Trust Board Board Development seminar Sustainability reviews undertaken and review of workforce implications underway PFIC consideraiton of financial model for award of contract --- L2 - Walsall Together reports Walsall Together Partnership board Walsall Together Case for Change Walsall Together programme plan --- L3 - Review and appointment of host provider	✓	✓	✓	

The GAPS IN CONTROL / NEGATIVE ASSURANCES are...

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
	Care Group plans on page	Establishment of host provider and governance arrangements; management structures and pathways	31/12/2018
		Undertake review of community estate	31/12/2017
	Develop and implement a clinical service strategy Governance arrangements for Walsall together Develop and seek approval for business case - appointment of host provider.	Establish single point of access for all partners	30/04/2018

Assurance Strength Key		Action Deadline Key	
Red - Weak	Amber - Moderate	Red - Passed Target Date	Amber - Passed Reminder Date
	Green - Strong		Green - Before Target Date

Provide Safe High Quality Care Across Services

Continue Our Journey On Patient Safety And Clinical Quality Through A Comprehensive Improvement Plan

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 5 = 20
CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12
TARGET RISK SCORE (Impact x Likelihood = Total)	0 x 0 = 0

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
REF	STRATEGIC RISK		
BAF001	Failure to deliver consistent standards of care to patients' across the Trust results in poor patient outcomes and incidents of avoidable harm.	Director Of Nursing	Quality, Patient Experience An

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	POTENTIAL CONSEQUENCES OF THE RISK
	What are the key potential consequences (up to 4) of the risk?
	A widespread loss of control over standards of safety and quality of patient care, which could result in multiple incidents of severe, avoidable harm and poor clinical outcomes for a large number of patients

Potential or actual origins that have led to the risk...

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	LINKED CORPORATE RISKS
Increase in Never Events Increase in patient falls and pressure ulcers Concerns regarding safe staffing remain; use of agency / temporary workforce risk Poor audit results of fundamental standards of care	

These are the POSITIVE ASSURANCES actually received...

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L1 - PCIP Report to CQC preparation group and Quality, Patient Experience and Safety Committee and updates to Board Governance structure policy in place for PCIP agreed at TMB Overaching database in place to monitor delivery of PCIP Dashboard demonstrating compliance reviewed by QPES and Board --- L2 - NHSI Assurance meetings oversight of PCIP --- L3 - Further scrutiny of PCIP delivery required	✓	✓	✓	
L1 - Quality, Patient Experience and Safety Committee meeting structure and review of quality governance, such as audit, effectiveness, medicines management, mortality, incidents Director of Nursing appointed Establishment of Nursing & Midwifery Forum --- L2 - National recognition awards for patient safety within Care Groups Internal Audit report on Risk Management Clinical Quality Review Group (CQRGs) in place with all NHS commissioners. --- L3 - Culture of ownership of incidents at an operational level is still developing	✓	✓	✓	
L1 - Risk Management Committee scrutiny of risk register All Committee's reviewing risks relating to their area --- L2 - Internal Audit report on risk management --- L3 - System of internal control around risk management assessed as improving	✓	✓	✓	
L1 - Values and Behaviours framework launched Listening into action events undertaken Staff Engagents in place Values based recruitment in place Staff awards event and recognition Opportunities for staff involvment and engagement expanded, eg Tuesday staff sessions Appraisal paperwork updated based on values and behaviours framework Pulse survey --- L2 - Staff survey Friends and family re place of care --- L3 - Improvement in staff survey outcomes for staff	✓	✓	✓	
L1 - CQC preparation group CQC report to Quality, Patient Experience and Safety Committee and Board Self assessment against KLOE --- L2 - Monthly oversight meetings with NHSI CQC Relationship meetings monthly Enable East informal inspection --- L3 - CQC well led inspection due 2019	✓	✓	✓	
L1 - Clinical Audit Plan 3 month half day funademental standards of care audit pilot and outcome report CQC Action Plan developed and actions in relation to fundamental standards of care being tracked on a weekly basis. Latest update shows good progress PCIP incorporating audit results --- L2 - National audit returns Specialist advisor audits carried out on Infection Control and Safeguarding	✓	✓	✓	

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L3 - Improved delivery of fundamental standards and positive improvements in audits				
L1 - Reports to PFIC, QPES on delivery of the action plan Monthly safer staffing report to QPES and Board Performance reports on KPIs Nursing Establishment reviews Roster review clinics	✓	✓	✓	
L2 - Regular NHSI oversight meetings NHSI Specialist Advisor report on Establishment and controls for temporary workforce				
L3 - Reduction in temporary workforce (agency use) Increase in bank workforce (as appropriate)				

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Patient Care Improvement Plan
C2	Quality Governance structures including resources, strategies and policies. Ward to Board governance structures through Care Group, Division and Committee
C3	Risk Management Strategy
C4	Staff engagement action plan
C5	CQC well led action plan
C6	Trust wide audit plan against the fundamental standards of care
C7	Nursing establishment workstream project plan

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		
R2		
R3		
R4		
R5		
R6		
R7		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
		Implementation of the Safer Bundle	31/08/2018
		Delivery of NHSI Safer Staffing recommendations	30/09/2018
		Development of a plan for medical staffing including robust job planning.	31/03/2019
	Delivery of well led action plan within timeframes identified in plan.	Development of a Nursing strategy	31/12/2018
	Some evidence of non-compliance with Infection Control Standards Poor adherence to Information Governance standards Knowledge of MCA/DOLS inconsistent Environmental issues such as storage Training on safeguarding	Development of an Integrated Improvement Plan	31/03/2019
	Delivery of staff engagement action plan	Implementation of the Behaviour Framework	31/03/2019
	Clear roles and responsibilities for those responsible for quality governance. Standardisation of Board to Ward governance structures including Agenda and reports Out of date Risk Management Strategy Lack of processes and procedures for managing risk Inadequate risk management training and awareness throughout the Trust Escalation process and scrutiny.	Revised Quality Governance Structure	31/01/2019
	Delivery of safer staffing recommendations from NHSI review Development on Nursing Strategy Delivery of nursing establishment workstream project plan.	Delivery of the Nursing Workforce workstream	31/03/2019

Assurance Strength Key			
Red - Weak	Amber - Moderate	Green - Strong	

Action Deadline Key		
Red - Passed Target Date	Amber - Passed Reminder Date	Green - Before Target Date

Use Resources Well To Ensure Sustainable

Improve Our Financial Health Through Our Robust Improvement Programme

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	**4 x 5 = 20**
CURRENT RISK SCORE (Impact x Likelihood = Total)	**3 x 5 = 15**
TARGET RISK SCORE (Impact x Likelihood = Total)	**0 x 0 = 0**

What is the strategic risk to be controlled?		**EXECUTIVE DIRECTOR OWNER**	**BOARD COMMITTEE OWNER**
REF	**STRATEGIC RISK**		
BAF002	Failure to achieve financial plans as agreed by the Board and communicated to NHSI	Director Of Finance & Performa	Performance Finance And Invest

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	**POTENTIAL CONSEQUENCES OF THE RISK**
	What are the key potential consequences (up to 4) of the risk?
	If the Trust is unable to achieve its financial plans; Caused by the scale of any deficit and the effectiveness of plans to reduce it; It may result in widespread loss of public and stakeholder confidence with the potential for regulatory action such as parliamentary intervention, special administration or suspension of CQC registration.

Potential or actual origins that have led to the risk…	**LINKED CORPORATE RISKS**
What are the most significant origins (up to 10) which could or have led to the risk?	
ORIGIN	
Increase in temporary workforce spend Decrease in productivity Failure to delivery CIP Inability to pay creditors	

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	**L1**	**L2**	**L3**	**EVIDENCE** *What is the minute reference?*
L1 - PIDs for each CIP Financial recovery plan meetings Vacancy control panel Performance meeting with Divisions and Corporate Directorates Accountability Framework and Standing Financial Instructions with limits approved by the Board Performance reports PFE review Discretional expenditure control panel. Check and challenge weekly NED meetings. Weekly performance review meetings QIA process to validate and sign off CIP's to ensure cost reductions do not adversely impact patient care PFIC review monthly reports Audit committee receives regular clinical and internal audit reports and annual external audit Exec team and Committees receive Audit Recommendations tracker --- L2 - Regular oversight meetings with NHSI NHSI review of temporary workforce NHSI review of financial recovery plan KPMG support on FRP External audit management letter which includes Audit review findings VFM review Internal Controls review --- L3 -	✓	✓		
L1 - Performance meetings in place with Divisions and Departments Terms of Reference for Performance meetings including standard agenda and KPIs SFI review undertaken and recommended by Audit Committee for approval --- L2 - --- L3 -	✓			
L1 - Reports to PFIC, QPES on delivery of the action plan Monthly safer staffing report to QPES and Board Performance reports on KPIs Nursing establishment reviews Roser review clinics --- L2 - Regular NHSI oversight meetings NHSI Specialist Advisor report on establishment and controls for temporary workforce --- L3 - Reduction in temporary workforce (agency use) Increase in bank workforce (as appropriate)	✓	✓	✓	
L1 - CIP reported performance to Executive, PFIC & Trust Board QIA process to validate and sign off CIP's to ensure cost reductions do not adversely impact patient care --- L2 - --- L3 -	✓			

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Financial recovery plan
C2	Accountability Framework and Standing Financial Instructions with limits approved by the Board
C3	Nursing establishment workstream project plan
C4	Robust CIP model developed and reports produced monthly detailing performance against plan by scheme, Division and at Trust level

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		
R2		
R3		
R4		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
		Medical workforce temporary staffing.	31/12/2018
	Delivery of safer staffing recommendations from NHSI review Development of a Nursing Strategy Delivery of nursing establishment workstream project plan	Implementation of NHSI workforce recommendations.	31/12/2018
	Robust temporary staffing expenditure control and monitoring Effectiveness of budget management and control at Division and Care Group levels.	Implementation of financial recovery plan.	28/02/2019
	CIP delivery, in particular cross cutting schemes and the realisation of recurrent savings versus the non-recurrent currently modelled to ensure future viability.	Delivery of CIP	28/02/2019
	Full implementation of Accountability Framework with Divisions and departments	Capacity modelling to be undertaken.	31/12/2018
		Dedicated PMO with PMO Director	31/01/2019

Assurance Strength Key		Action Deadline Key	
Red - Weak	Amber - Moderate	Red - Passed Target Date	Amber - Passed Reminder Date
	Green - Strong		Green - Before Target Date

Use Resources Well To Ensure Sustainable

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16
CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 3 = 12
TARGET RISK SCORE (Impact x Likelihood = Total)	0 x 0 = 0

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
REF	STRATEGIC RISK		
BAF011	IM&T systems which do not meet the requirements of the organisation	Director Of Strategy & Improve	Performance Finance And Invest

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	POTENTIAL CONSEQUENCES OF THE RISK
	What are the key potential consequences (up to 4) of the risk?
	It may result in the failure of the IT systems resulting in a lack of access to patient records by front line staff with poor standards of care delivered as a result and or lack of sufficently robust information on which to make informed decisions Failure to take connected partnership decisions to improve the care and responsiviness of our patients Reputation damage for the Trust as stakeholders and patients will expect integrated records to mirror the integrated approach we are taking with partners Failure to manage demand as strategically outlined due to a lack of modern and interfacible systems

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	LINKED CORPORATE RISKS
Most of the clinical functionality in Lorenzo was not deployed due to it not being ready at the time and the Trust electing to stay with Fusion or an alternative specialist / departmental system The Trust remains on two core systems The Trust has a variety of peripheral systems doing the role of an integrated EPR that adds risk and delays in message sharing The Trust has been unable to deliver a sustained IT development programme due to system complexities that have impeded transformation	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Trust Chief Clinical Information Officer (CCIO)
C2	Trust Wide digital needs assessment
C3	Local business continuity and resilience plans in place and owned by service managers
C4	Appropriate operational IM&T leadership, staffing and skill mix in place

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		
R2		
R3		
R4		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L1 - L2 - L3 -				
L1 - Report to Data Quality Group, Information Governance and Quality Committee, Trust Board Reports to PFIC on IT Planned EPR OBS in December and FBC in January System wide digital health and care strategy planned to coincide with Walsall Together Business Case L2 - L3 -	✓			
L1 - Reports on business continuity to IT programme board Business continity testing plan Nightly back up of systems L2 - Core Standards submission of compliance in Emergency Preparedness, Resilience and Response reported to NHS England L3 - Fully compliant with the core standards	✓	✓	✓	
L1 - L2 - L3 -				

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
	Match the needs assessment to the capabilities or planned future capabilities of the current systems.		29/11/2018
	Match the needs assessment to the capabilities or planned future capabilities of the current system	.	29/11/2018

Assurance Strength Key	Amber - Moderate	Action Deadline Key	Amber - Passed Reminder Date
Red - Weak	Green - Strong	Red - Passed Target Date	Green - Before Target Date

Use Resources Well To Ensure Sustainable

Improve Our Financial Health Through Our Robust Improvement Programme

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	**4 x 5 = 20**
CURRENT RISK SCORE (Impact x Likelihood = Total)	**3 x 5 = 15**
TARGET RISK SCORE (Impact x Likelihood = Total)	**0 x 0 = 0**

What is the strategic risk to be controlled?		**EXECUTIVE DIRECTOR OWNER**	**BOARD COMMITTEE OWNER**
REF	**STRATEGIC RISK**		
BAF002	Failure to achieve financial plans as agreed by the Board and communicated to NHSI	Director Of Finance & Performa	Performance Finance And Invest

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	**POTENTIAL CONSEQUENCES OF THE RISK**
	What are the key potential consequences (up to 4) of the risk?
	If the Trust is unable to achieve its financial plans; Caused by the scale of any deficit and the effectiveness of plans to reduce it; It may result in widespread loss of public and stakeholder confidence with the potential for regulatory action such as parliamentary intervention, special administration or suspension of CQC registration.

Potential or actual origins that have led to the risk…	**LINKED CORPORATE RISKS**
What are the most significant origins (up to 10) which could or have led to the risk?	
ORIGIN	
Increase in temporary workforce spend Decrease in productivity Failure to delivery CIP Inability to pay creditors	

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

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POSITIVE ASSURANCE *What is the report received that provided that assurance?*	**L1**	**L2**	**L3**	**EVIDENCE** *What is the minute reference?*
L1 - PIDs for each CIP Financial recovery plan meetings Vacancy control panel Performance meeting with Divisions and Corporate Directorates Accountability Framework and Standing Financial Instructions with limits approved by the Board Performance reports PFE review Discretional expenditure control panel. Check and challenge weekly NED meetings. Weekly performance review meetings QIA process to validate and sign off CIP's to ensure cost reductions do not adversely impact patient care PFIC review monthly reports Audit committee receives regular clinical and internal audit reports and annual external audit Exec team and Committees receive Audit Recommendations tracker --- L2 - Regular oversight meetings with NHSI NHSI review of temporary workforce NHSI review of financial recovery plan KPMG support on FRP External audit management letter which includes Audit review findings VFM review Internal Controls review --- L3 -	✓	✓		
L1 - Performance meetings in place with Divisions and Departments Terms of Reference for Performance meetings including standard agenda and KPIs SFI review undertaken and recommended by Audit Committee for approval --- L2 - --- L3 -	✓			
L1 - Reports to PFIC, QPES on delivery of the action plan Monthly safer staffing report to QPES and Board Performance reports on KPIs Nursing establishment reviews Roser review clinics --- L2 - Regular NHSI oversight meetings NHSI Specialist Advisor report on establishment and controls for temporary workforce --- L3 - Reduction in temporary workforce (agency use) Increase in bank workforce (as appropriate)	✓	✓	✓	
L1 - CIP reported performance to Executive, PFIC & Trust Board QIA process to validate and sign off CIP's to ensure cost reductions do not adversely impact patient care --- L2 - --- L3 -	✓			

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Financial recovery plan
C2	Accountability Framework and Standing Financial Instructions with limits approved by the Board
C3	Nursing establishment workstream project plan
C4	Robust CIP model developed and reports produced monthly detailing performance against plan by scheme, Division and at Trust level

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		
R2		
R3		
R4		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
		Medical workforce temporary staffing.	31/12/2018
	Delivery of safer staffing recommendations from NHSI review Development of a Nursing Strategy Delivery of nursing establishment workstream project plan	Implementation of NHSI workforce recommendations.	31/12/2018
	Robust temporary staffing expenditure control and monitoring Effectiveness of budget management and control at Division and Care Group levels.	Implementation of financial recovery plan.	28/02/2019
	CIP delivery, in particular cross cutting schemes and the realisation of recurrent savings versus the non-recurrent currently modelled to ensure future viability.	Delivery of CIP	28/02/2019
	Full implementation of Accountability Framework with Divisions and departments	Capacity modelling to be undertaken.	31/12/2018
		Dedicated PMO with PMO Director	31/01/2019

Assurance Strength Key		Action Deadline Key	
Red - Weak	Amber - Moderate	Red - Passed Target Date	Amber - Passed Reminder Date
	Green - Strong		Green - Before Target Date

Value Colleagues So Recommend Us Place Of Work

Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16
CURRENT RISK SCORE (Impact x Likelihood = Total)	3 x 4 = 12
TARGET RISK SCORE (Impact x Likelihood = Total)	0 x 0 = 0

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
BAF010	Freedom to Speak Up - there is a risk that the systems and processes for raising a concern are insufficient and not robustly embedded within the Trust	Director Of People & Culture	People And Organisational Deve

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	POTENTIAL CONSEQUENCES OF THE RISK
	What are the key potential consequences (up to 4) of the risk?
	Staff could be restricted from being able to speak up or provide information about wrongdoing, risk or malpractice which they believe could be putting others at risk and which could involve patients, colleagues or the organisation they work in. There is a risk that the Trust Board is not receiving adequate assurance on promoting, developing and supporting the Freedom to Speak Up approach in line with Trust values.

Potential or actual origins that have led to the risk...

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	LINKED CORPORATE RISKS

The risks are CONTROLLED by...

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Freedom to speak up

The REPORTING mechanisms are...

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		

These are the POSITIVE ASSURANCES actually received...

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L1 - Three independent Freedom to Speak up Guardians appointed Reports to People & OD Committee, QPES and Board. Policies relating to bullying, raising concerns and Whistleblowing in place Visibility plan for Board Fit and proper persons process	✓			
L2 -				
L3 -				

The GAPS IN CONTROL / NEGATIVE ASSURANCES are...

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
	Fully implement the values and behaviours framework NHSE tool for resourcing - self assessment to be undertaken	NHSE tool for resourcing - self assessment to be undertaken	31/12/2018
	Providing a single and confidential electronic point within the Trust for staff to report FTSU concerns including anonymously if required.	Planning for new database through Trust's Safeguard system has been completed and the system will launch in January 2019	31/01/2019

Assurance Strength Key		Action Deadline Key	
Red - Weak	Amber - Moderate	Red - Passed Target Date	Amber - Passed Reminder Date
	Green - Strong		Green - Before Target Date

Value Colleagues So Recommend Us Place Of Work

Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	**4 x 4 = 16**
CURRENT RISK SCORE (Impact x Likelihood = Total)	**3 x 3 = 9**
TARGET RISK SCORE (Impact x Likelihood = Total)	**0 x 0 = 0**

What is the strategic risk to be controlled?		**EXECUTIVE DIRECTOR OWNER**	**BOARD COMMITTEE OWNER**
REF	**STRATEGIC RISK**		
BAF005	The lack of leadership capability and capacity could lead to insufficient key performance improvement and the Trusts ability to be a high performing organisation.	Director Of People & Culture	People And Organisational Deve

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	**POTENTIAL CONSEQUENCES OF THE RISK**
	What are the key potential consequences (up to 4) of the risk?
	Low staff morale Poor outcomes & experience for large numbers of patients Less effective teamwork Reduced compliance with policies and standards High levels of staff absence High staff turnover

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	**LINKED CORPORATE RISKS**
Poor leadership development Lack of exposure to best practice Top down centralised approach in response to operational pressures.	

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	**L1**	**L2**	**L3**	**EVIDENCE** *What is the minute reference?*
L1 - Values and Behaviours framework launched Listening into action events undertaken Staff Engagents in place Values based recruitment in place Staff awards event and recognition Opportunities for staff involvment and engagement expanded, eg Tuesday staff sessions Appraisal paperwork updated based on values and behaviours framework Pulse survey --- L2 - Staff survey Friends and family re place of care --- L3 - Improvement in staff survey outcomes for staff	✓	✓	✓	
L1 - --- L2 - --- L3 -				
L1 - Trust Board approval of Strategy POD Committee monthly reports and review of workforce KPIs --- L2 - --- L3 -	✓			
L1 - --- L2 - --- L3 -				
L1 - Board level self assessment undertaken in Board Development seminar Routine updates provided to Board and POD --- L2 - --- L3 - Overall Staff Engagement scores increase to be in line with the National Average for Combined Acute and Community Trusts by 2019	✓		✓	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	**CONTROL**
C1	Staff engagement action plan
C2	West Midlands Leadership Academy diagnostic for all teams of three
C3	People Strategy 2016/20
C4	Policies and Procedures for People Management
C5	Well Led Action Plan

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	**REPORTING MECHANISM**	**FREQUEN**
R1		
R2		
R3		
R4		
R5		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	**GAP**	**ACTION PLAN**	**DEADLINE**
	There is not a structured approach in place for resourcing within the Trust including engaging staff and developing and retaining staff through career pathways and talent management. Staff values and behavioural framework needs embedding in policies & practices & training introduced.	Implementation of staff engagement action plan	31/03/2019
	There is not a structured Leadership and Management Development programme and framework in place and therefore people management expectations are not clear.	Leadership and management development programme to be defined. NHS Leadership diagnostic for teams of three to be completed. Well-led action plan actions to be delivered.	31/03/2019
	HR Policies are not consistent and are not in line with statutory and national guidelines these need to reflect best practice and relevant employment legislation to support manager and staff competency and development needs.	People Management Policies and the supporting governance Frameworks needs to be reviewed and updated.	31/12/2018
	The HR policy framework is complex and therefore people	People Management training and skills relating to	31/03/2019

A.S.	GAP	ACTION PLAN	DEADLINE
	management expectations are not clear and training for managers on key skills has not been sufficient.	implementation of the HR Policies is required at all levels - programme of development required.	
	The Trust has not identified its business critical posts and therefore there is not a workforce approach to succession planning.	Trust to identify business critical posts as part of the business continuity approach and develop a Succession Plan for key senior posts at tier 3 in first instance required	31/03/2019
	The approach, strategy and objectives for EDI are not defined within the Trust.	Design and publish the EDI Strategy and objectives on the Trust website and publicise the approach within the Trust	31/12/2018
	Current strategy does not adequately reflect the Trust's strategic direction of travel. The people management target and metrics require a refresh to bring them in line with current strategic priorities and to support the effective use of resources.	People Strategy to be reviewed	31/12/2018
	The approach to Freedom to Speak up requires greater understanding within the Trust and for managers	Self assessment and learning from best practice for Freedom to speak up and action plan to be developed to take this forward	31/03/2019

Assurance Strength Key	
Red - Weak	Amber - Moderate
	Green - Strong

Action Deadline Key	
Red - Passed Target Date	Amber - Passed Reminder Date
	Green - Before Target Date

Value Colleagues So Recommend Us Place Of Work

Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	5 x 5 = 25
CURRENT RISK SCORE (Impact x Likelihood = Total)	4 x 5 = 20
TARGET RISK SCORE (Impact x Likelihood = Total)	0 x 0 = 0

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
BAF006	High levels of sickness absence within the Trust impacts upon the Trust's resourcing pland and ability to deliver safe and high quality care and also impacts upon the Trust's ability to effectively use resources and deliver the financial plan. The current policy framework for the Trust does not	Director Of People & Culture	People And Organisational Deve
	adequately support Staff Health and Wellbeing and does not effectively mitigate absence levels.		

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	POTENTIAL CONSEQUENCES OF THE RISK
	What are the key potential consequences (up to 4) of the risk?
	Staff shortages and skill gaps leading to insufficient numbers of staff available in key areas Impact on quality of patient care Pressure on staff and consequently a negative impact on staff health and wellbeing and staff retention Increases in temporary agency spend and ineffective use of bank and temporary workforce impacting upon efficient use of resources.

Potential or actual origins that have led to the risk...

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	LINKED CORPORATE RISKS
Inability to recruit, retain and/or appropriately deploy a workforce with the necessary skills and experience has led to over-reliance on a temporary workforce Persistently high levels of sickness absence, with poor compliance with policy and controls High levels of temporary workforce usages	

The risks are CONTROLLED by...

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Nursing establishment workstream project plan
C2	Medical workforce project plan

The REPORTING mechanisms are...

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		
R2		

These are the POSITIVE ASSURANCES actually received...

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L1 - Reports to PFIC, QPES on delivery of the action plan Monthly safer staffing report to QPES and Board Performance reports on KPIs Nursing Establishment reviews Roster review clinics --- L2 - Regular NHSI oversight meetings NHSI Specialist Advisor report on Establishment and controls for temporary workforce --- L3 - Reduction in temporary workforce (agency use) Increase in bank workforce (as appropriate)	✓	✓	✓	
L1 - Monthly reports to PFIC and Board FRP plans for reducing medical workforce temporary spend PMO project --- L2 - KPMG have been commissioned to support in reviewing and assessing the FRP position, with a focus on temporary workforce. Meridian have been commissioned to undertake a programme of work to support in reducing medical workforce spend and productivity --- L3 - Reduction in temporary workforce spend for the medical workforce	✓	✓	✓	

The GAPS IN CONTROL / NEGATIVE ASSURANCES are...

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
	There was not a plan of action in place to respond to the findings of the 2017 NHS staff survey results	Action plan developed in consultation with staff across the Trust and Implementation of staff engagement action plan scheduled to substantially complete by December 2018	31/12/2018
	The current People Strategy 2016 to 2020 had not been reviewed for delivery outcomes	Update of People Strategy - the People Strategy to be reviewed for progress - and decision to be taken on refreshing the approach	31/12/2018
	Delivery of safer staffing recommendations from NHSI review Development of a Nursing Strategy Delivery of nursing establishment workstream project plan	Implementation of Nursing Transformation Workforce Plan	30/06/2018
	The operational plan identifies the current workforce position, however the process for defining future workforce needs and new roles is not adequately defined	Build on the operational plan for workforce and start looking at future workforce planning and assessment of new roles	31/03/2019
	There is not a single approach to reporting on People Management Metrics within the Trust - data governance is poor, data is drawn at different times and is therefore inconsistent.	Design a single set of metrics and use these as the standard set to report to Trust Board, People and OD committee and at Divisional Level, and thereafter to each of the organisational levels, Board to Division/Ward dashboards. To publish data on the Information Hub from April 2019	31/03/2019
	The Workforce Planning approach for the medical workforce is not fully in place	Undertake a review the medical establishment and establish controls for locum and agency spend	31/03/2019
	Workforce Planning for the Medical Workforce is not in place	Review new roles for medical posts and options for collaborating with other Trusts	31/03/2019
	The Trust Bank for nursing requires development and options for increasing supply within the region need to be explored.	Review of collaborative bank arrangements for nurse staffing	31/03/2019
	The medical workforce does not have a full set of job plans on the Allocate System and the Job Planning policy requires	Job planning policy and compliance requires improvement within the Trust	31/03/2019

A.S.	GAP	ACTION PLAN	DEADLINE
	update		
	The Trust sickness rates are persistently higher than national rates - Trust is persistently bottom quartile	High level sickness rate options for managing this need to be explored further - workshops to explore options for improving attendance and update Trust policy for managing attendance	31/01/2019
	Strategic and integrated approach to resourcing is required Trust wide that is part of the strategic approach to workforce planning	NHSE tool for resourcing - self assessment to be undertaken	31/03/2019

Assurance Strength Key	
Red - Weak	Amber - Moderate
	Green - Strong

Action Deadline Key	
Red - Passed Target Date	Amber - Passed Reminder Date
	Green - Before Target Date

Value Colleagues So Recommend Us Place Of Work

Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16
CURRENT RISK SCORE (Impact x Likelihood = Total)	3 x 2 = 6
TARGET RISK SCORE (Impact x Likelihood = Total)	0 x 0 = 0

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
REF	STRATEGIC RISK		
BAF007	Failure to improve organisational Culture impacts on staff well being, retention and the Trusts ability to attract and recruit new staff	Director Of People & Culture	People And Organisational Deve

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	POTENTIAL CONSEQUENCES OF THE RISK
	What are the key potential consequences (up to 4) of the risk?
	If engagement with staff is ineffective and inconsistent then they will have a lack of confidence in the organisation's approach to workforce issues

Potential or actual origins that have led to the risk...

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	LINKED CORPORATE RISKS
Poor staff retention and morale Deterioration in the quality of patient care Risk to the trust's reputation as an employer of choice	

These are the POSITIVE ASSURANCES actually received...

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L1 - --- L2 - --- L3 -				
L1 - Values and Behaviours framework launched Listening into action events undertaken Staff Engagents in place Values based recruitment in place Staff awards event and recognition Opportunities for staff involvment and engagement expanded, eg Tuesday staff sessions Appraisal paperwork updated based on values and behaviours framework Pulse survey --- L2 - Staff survey Friends and family re place of care --- L3 - Improvement in staff survey outcomes for staff	✓	✓	✓	
L1 - Trust Board approval of Strategy POD Committee monthly reports and review of workforce KPIs --- L2 - --- L3 -	✓			
L1 - Staff feedback from National Staff Survey - still below the national average. Ppulse check survey results reported to POD committee Staff engagement update report POD and Board meeting E&D Update report to POD and Board demonstrate actions taken. Listening into Action reports. Staff side attendance at POD committee Performance Report includes workforce metrics Annual Complaints report Engagents network on staff engagement and involvement Values Launch and evaluation of launch underway Walsall and Proud campaign --- L2 - National Staff Survey Friends and Family test --- L3 - Improvement in relevant staff survey measures	✓	✓	✓	

The risks are CONTROLLED by...

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	
C2	Staff engagement action plan
C3	People Strategy 2016/20
C4	Board visibility plan - Well Led

The REPORTING mechanisms are...

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		
R2		
R3		
R4		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are...

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
	Delivery of staff engagement action plan.	Implementation of staff engagement action plan	31/12/2018
		Self assessment and learning from best practice for Freedom to speak up and action plan to be developed to take this forward	31/12/2018
		Board pledge to be developed	31/12/2018
	The Trust has no ability to measure the impact of the work other than the pulse checks or other survey results, so it is hard to pinpoint successful initiatives.	Further implementation of Board visibility and evaluation of this	31/12/2018
		Medical staff oversight to be reviewed by POD	31/12/2018

A.S.	GAP	ACTION PLAN	DEADLINE
		Overall staff engagement score below national average	31/12/2018
	Current strategy does not accurately reflect the Trust's strategic direction of travel. The people management targets and metrics require a refresh to bring them into line with current strategic priorities and to support the effective use of resources.	Nursing workforce strategy to be developed	31/12/2018
		Medical workforce strategy to be developed linked into the sustainability reviews.	31/12/2018
		Communication and engagement plan specifically around engagement	31/12/2018

Assurance Strength Key	Amber - Moderate
Red - Weak	Green - Strong

Action Deadline Key	Amber - Passed Reminder Date
Red - Passed Target Date	Green - Before Target Date

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Develop The Culture Of The Organisation To Ensure Mature Decision Making And Clinical Leadership

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	4 x 4 = 16
CURRENT RISK SCORE (Impact x Likelihood = Total)	3 x 2 = 6
TARGET RISK SCORE (Impact x Likelihood = Total)	0 x 0 = 0

What is the strategic risk to be controlled?		EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
REF	STRATEGIC RISK		
BAF008	Healthy organisation - failure to understand the health and welbeing of the workforce and implement appropriate initiatives	Director Of People & Culture	People And Organisational Deve

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	POTENTIAL CONSEQUENCES OF THE RISK
	What are the key potential consequences (up to 4) of the risk?
	Could result in a risk of low staff morale, leading to poor outcomes, retention & experience for patients; less effective teamwork; reduced compliance with policies and standards; high levels of staff absence; and high staff turnover

Potential or actual origins that have led to the risk...

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	LINKED CORPORATE RISKS
Lower than national average staff survey results High levels of sickness and absence Lower than national average scores on Friends and Family test Potential impact on patient experience	

These are the POSITIVE ASSURANCES actually received...

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L1 - Health & Well Being Steering Group Reports to People & OD Committee, ED&I and Board Staff Side groups such as LNC and JNCC. Call to action group Baseline assessment undertaken Freedom to speak up guardians in place Leadership development programmes for executive, very senior and senior leaders, 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 Review of relevant policies and procedures How to Have a Great Meeting guide --- L2 - Staff Survey Friends and Family Test --- L3 - Improvements in relevant metrics	✓	✓	✓	
L1 - Staff flu vacination programme and reports to POD Workforce metrics - performance report reviewed by POD and Board Health & wellbeing steering group Occupational Health service Staff benefits Health & wellbeing initiatives such as emotional wellbeing, walking club etc --- L2 - National reporting on flu vaccination rates for staff Staff survey results --- L3 - Improvements in staff survey results relating to specific metrics	✓	✓	✓	

The risks are CONTROLLED by...

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Collective Call to action
C2	Health & Wellbeing Hub

The REPORTING mechanisms are...

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		
R2		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are...

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
	There is not a framework in place to ensure staff within the Trust learn from best practice and are empowered to continuously improve services - that links to the Quality Academy approach.	Research and explore methodology for learning from best practice from when things go well - build on listening into Action approach and review whether appreciative inquiry would be a suitable OD framework for the Trust. Define an approach to Organisational Development that aligns with the Quality Academy approach.	31/03/2019
	The staff within the Trust are frequently exposed to incidents and trauma and the support framework for staff health and wellbeing requires clarity and structure.	Structured approach to debriefing of staff involved in incidents and documented approach and offering to staff to support their health and wellbeing. This may include a range of support interventions from EAP, Schwartz Rounds etc. aimed at reducing impact on staff and improving their Health and Wellbeing	31/03/2019
	Health & Wellbeing approach and framework for implementation not clearly defined and documented	Health & Wellbeing Strategy to be developed as part of the phase 2 Health and Wellbeing work and supporting action plan to be co-designed with staff, managers and staff-side to include all staff groups and to encompass the Fatigue and Facilities Charter BMA approach for all staff	31/03/2019
	There was not a framework or benchmark by which to assess the Trust approach to staff health and wellbeing.	Compliance with best practice from advisory bodies to complete the NHSi self-assessment framework.	31/12/2018
	Board to support embedding values - pledge to be agreed in December 2018.	Developing a partnership approach to managing health & wellbeing with staff side	31/12/2018

A.S.	GAP	ACTION PLAN	DEADLINE
	Fully embedded values and behaviours framework		
	There is not a framework for Reward and Recognition within the Trust	Reward and Recognition Approach and Policy to be developed	31/03/2019
	The Trust Health and Wellbeing approach is not benchmarked or contained within a strategic framework	NHSE tool for health and wellbeing - self assessment to be undertaken	31/01/2019

Assurance Strength Key	Amber - Moderate
Red - Weak	Green - Strong

Action Deadline Key	Amber - Passed Reminder Date
Red - Passed Target Date	Green - Before Target Date

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STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	5 x 4 = 20
CURRENT RISK SCORE (Impact x Likelihood = Total)	3 x 2 = 6
TARGET RISK SCORE (Impact x Likelihood = Total)	3 x 2 = 6

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
BAF009	Failure to promote, develop and support a culture which values equality, diversity and inclusion	Director Of People & Culture	People And Organisational Deve

IMPACT ON CORPORATE OBJECTIVES (up to top 3)

POTENTIAL CONSEQUENCES OF THE RISK

What are the key potential consequences (up to 4) of the risk?

Rrisk of adverse impact on patient experience and staff experience
Risk that differential staff experience impacts adversely on staff engagement and involvement in improvement.

Equality Diversity and Inclusion - failure to promote, develop and support a culture which values equality, diversity and inclusion with the risk of adverse impact on patient experience and staff experience and the potential for the trust values to not be the lived experience of staff working within the Trust and patients being treated within the Trust. The risk that differential staff experience impacts adversely on staff engagement and involvement in improvement. The risk of the Trust not being able to attract and retain talent for the current and future workforce and in particular the ability to attract and retain a diverse workforce, inclusive and representative of the community it serves across all job groups and at all levels within the Trust. The risk that organisational controls are not sufficient to meet the Trust's Public Sector Equality Duty requirements, NHS Provider Contract requirements and the legal provisions of the Equality Act potentially resulting in discrimination on grounds of sex, age, sexual orientation, race, religion or belief, disability, marriage or civil partnership, gender reassignment or due to pregnancy. Risk of the Trust not being able to attract and retain talent for the current and future workforce and in particular the ability to attract and retain a diverse workforce, inclusive and representative of the community it serves across all job groups and at all levels within the Trust.
Risk that organisational controls are not sufficient to meet the Trust's Public Sector Equality Duty requirements, NHS Provider Contract requirements and the legal provisions of the Equality Act potentially resulting in discrimination on grounds of sex, age, sexual orientation, race, religion or belief, disability, marriage or civil partnership, gender reassignment or due to pregnancy

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	LINKED CORPORATE RISKS
Potential for the Trust values to not be the lived experience of staff working within the Trust and patients being treated within the Trust Not being recognised as a good practice EDI employer Not meeting our statutory duties and contractual requirements including publication	

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Equality, Diversity, Inclusion and Human Rights (EDHR) Strategy 2017 to 2020

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L1 - Equality, Diversity and Inclusion Group Self assessment against EDS2 Trust WRES Action plan and report against each nine indicators is in progress. Positive assurance on gender working	✓	✓	✓	
L2 - Compliance with Public Sector Equality Duty.				
L3 - Improvements in Staff survey relevant metrics Recognition as an EDI employer				

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
	Leadership and Pledge to become a recognised good practice EDI employer and uphold the Trust Values	Board Pledge - public Trust Board minutes	31/12/2018
		Recognition as an EDI employer	30/06/2019
	The current strategy does not adequately reflect the Trust's strategic direction of travel. The management of targets and metrics require a refresh. ED&I objectives required Equality impact assessments to be embedded further.	ED&I strategy required	31/12/2018
	Lack of defined EDI objectives and failure to publish these on Trust Website	ED&I objectives required	31/12/2018

A.S.	GAP	ACTION PLAN	DEADLINE
	Not meeting statutory and NHS contractual requirement to publish our Equality Objectives and supporting plans on public website	Not meeting our statutory publication requirements	31/01/2019
	The policies require a EIA as part of the governance and staff need to be aware of how to use these consistently in policy writing terms	Equality impact assessments to be embedded further	31/01/2019

Assurance Strength Key	Amber - Moderate
Red - Weak	Green - Strong

Action Deadline Key	Amber - Passed Reminder Date
Red - Passed Target Date	Green - Before Target Date

Work Closely With Walsall Partners And Surrounding

Develop The Clinical Services Strat2egy Focussed On Service Integration In Walsall And In Collaboration

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	3 x 4 = 12
CURRENT RISK SCORE (Impact x Likelihood = Total)	2 x 3 = 6
TARGET RISK SCORE (Impact x Likelihood = Total)	0 x 0 = 0

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
BAF003	If the Trust does not agree a suitable alliance approach with the Local Health Economy partners it will be able to deliver a sustainable integrated care model.	Director Of Strategy & Improve	Trust Board

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	POTENTIAL CONSEQUENCES OF THE RISK
	What are the key potential consequences (up to 4) of the risk?
	Quality of services of compromised Organisational reputation is compromised challenging future sustainability Money is wasted on services that are not longer sustainable and efficiently planned Opportunities are missed to link in with partners with like minded ideas and strategies

Potential or actual origins that have led to the risk…

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	LINKED CORPORATE RISKS
Strategic planning not embedded across the organisation - leading to short-termism/reactive operation	
Culture of organisation is focused on todays challenge and not forward looking	
IT systems are not seen/used as enablers	
Relationships with partners still developing	
Quality, accessible data and analytical resources not available to facilitate business decisions	
Poor demand and capacity modelling	
Staff not connected with the strategy and direction of travel	
Plans are developed in isolation and not shared	
objectives are often produced and then not monitored or refined	
Trust has limited experience of strategic modelling / simulation	

These are the POSITIVE ASSURANCES actually received…

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L1 - Exec involvement in STP development Board Development seminar Exec to Exec meetings with commissioners and other key stakeholders Engagement and participation in STPs. Partnership report monthly to Trust Board Sustainability reviews undertaken and review of workforce implications underway PFIC consideration of financial model for award of contract --- L2 - Walsall Together reports Walsall Together Partnership Board Walsall Together Case for Change Walsall Together programme plan --- L3 - Review and appointment of host provider	✓	✓	✓	
L1 - Approved by Trust February 2016 Full consultation process through Committees and 20% of staff (800 responses) Strategic objectives aligned to operational objectives and operational delivery areas (core services) in Strategy Annual operational overview plan is developed and included in the operational plan Quarterly updates to Board and sub committees --- L2 - CCG, LA, Public Health - review LMC - review NHSI - review --- L3 -	✓	✓		
L1 - Commercial Strategy linked directly with Trust Strategy Review and approval by PFIC and Board Part of business development processes New tenders follow scoring mechanim in Strategy- overseen by Executive --- L2 - --- L3 -	✓			

The risks are CONTROLLED by…

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Black Country Provider Partnership Agreement
C2	Trust Strategy
C3	Commercial Strategy

The REPORTING mechanisms are…

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		
R2		
R3		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are…

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
	Market analysis / share and opportunity reports not as robust as they could be	Develop and implement a clinical services strategy	31/03/2019
	Develop and implement a clinical services strategy Governance arrangements for Walsall together Develop and seek approval for full business case - appointment of host provider Completion of sustainability review process	Review and implement appropriate governance arrangements for Walsall Together	31/10/2018
		Undertake and implement the recommendations from the clinical sustainability reviews	30/09/2018
		Implement phase 3 of the sustainability reviews	31/03/2019
		Develop and seek approval for full business case - appointment of host provider	31/10/2018
	Care Group plan on page	Care Group plan on page due for refresh	31/03/2019

Assurance Strength Key		Action Deadline Key	
	Amber - Moderate		Amber - Passed Reminder Date
Red - Weak	Green - Strong	Red - Passed Target Date	Green - Before Target Date

Work Closely With Walsall Partners And Surrounding

Develop The Clinical Services Strat2egy Focussed On Service Integration In Walsall And In Collaboration

STRATEGIC RISKS

INITIAL RISK SCORE (Impact x Likelihood = Total)	3 x 3 = 9
CURRENT RISK SCORE (Impact x Likelihood = Total)	2 x 3 = 6
TARGET RISK SCORE (Impact x Likelihood = Total)	0 x 0 = 0

What is the strategic risk to be controlled?

REF	STRATEGIC RISK	EXECUTIVE DIRECTOR OWNER	BOARD COMMITTEE OWNER
BAF004	Failure to progress the delivery of the Walsall Integrated model for health and social care.	Director Of Strategy & Improve	Trust Board

IMPACT ON CORPORATE OBJECTIVES (up to top 3)	POTENTIAL CONSEQUENCES OF THE RISK
	What are the key potential consequences (up to 4) of the risk?
	Quality of services of compromised Organisational reputation is compromised challenging future sustainability Opportunities are missed to link in with partners with like minded ideas and strategies

Potential or actual origins that have led to the risk...

What are the most significant origins (up to 10) which could or have led to the risk?

ORIGIN	LINKED CORPORATE RISKS
New model does not deliver a sustainable health economy for Walsall. New model financially destabilises one or more providers and therefore can't be agreed. The new clinical model does not align with wider work on sustainable clinical models Lack of alignment between commissioners and providers in delivering the new model/integration programme Sufficient focus on the new model and integration programme with other challenges	

These are the POSITIVE ASSURANCES actually received...

What are the key actual positive assurances received through reporting (up to 20) that a control has remained effective and where can the evidence be located? Lines of defence shown below.

Line 1 = Internal line of defence - management/operational controls by functions that own & manage the risk.

Line 2 = Oversight functions - committees - monitor & facilitate implementation of risk mgt practrices, financial control, security, quality, inspection etc.

Line 3 = Independent assurance - internal audit or external reviews or inspections.

POSITIVE ASSURANCE *What is the report received that provided that assurance?*	L1	L2	L3	EVIDENCE *What is the minute reference?*
L1 - Trust Strategy approved by Board February 2016 Full consultation process undertaken through Board Committees and staff (800 respondants) Strategic objectives aligned to operational objectives Annual operational overview plan developed and included in Annual Operational Plan Quarterly udate to Board and Committees --- L2 - CCG, LA, PH, LMC review of Strategy NHSI review of Strategy --- L3 -	✓	✓		
L1 - Partnership update to Trust Board Board Development seminar Sustainability reviews undertaken and review of workforce implications underway PFIC consideraiton of financial model for award of contract --- L2 - Walsall Together reports Walsall Together Partnership board Walsall Together Case for Change Walsall Together programme plan --- L3 - Review and appointment of host provider	✓	✓	✓	

The risks are CONTROLLED by...

What are the key controls (up to 10) that are in place to mitigate these risks?

REF	CONTROL
C1	Trust Strategy
C2	Black Country Partnership Agreement

The REPORTING mechanisms are...

What are the key reporting mechanisms (up to 10) that will provide assurances that the key controls are effective? (E) = External assurance.

REF	REPORTING MECHANISM	FREQUEN
R1		
R2		

The GAPS IN CONTROL / NEGATIVE ASSURANCES are...

What are the remaining key gaps (up to 10) in the controls or negative assurances despite the stated controls and positive assurances in place?

A.S.	GAP	ACTION PLAN	DEADLINE
	Care Group plans on page	Establishment of host provider and governance arrangements; management structures and pathways	31/12/2018
		Undertake review of community estate	31/12/2017
	Develop and implement a clinical service strategy Governance arrangements for Walsall together Develop and seek approval for business case - appointment of host provider.	Establish single point of access for all partners	30/04/2018

Assurance Strength Key	Amber - Moderate
Red - Weak	Green - Strong

Action Deadline Key	Amber - Passed Reminder Date
Red - Passed Target Date	Green - Before Target Date

Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust - Corporate Risk Register

No	Title	Status	Date Entered Onto CRR	Risk Scores			Origin Division/Executive Lead/Committee	Owner	Monitoring Group	Comment/ Recommendation
				Initial SxL=R	Current Jan 2019 SxL=R	Target SxL=R				
1 - Agreed / Identified Risk										
19614	Failure to deliver the in year Financial Plan and NHS Financial control total.	1 - Agreed / Identified Risk	01/04/2011 ⇔	5x4=20	5x4=20	5x2=10	Corporate Function Performance Finance And Invest	Director Of Finance & Performa	Performance Finance And Invest	Assessment of financial outturn based on Board report presented in December 2018 indicating a revised outturn forecast of £24m. Trust is seeking to revise its outturn for the financial year accordingly with the regulator.
2782	Failure to have in place robust and tested Emergency Resilience and Response plans in each area.	1 - Agreed / Identified Risk	01/06/2016 ⇧	5x4=20	4x4=16	5x2=10	Corporate Function Audit Committee	Chief Operating Officer	Performance Finance And Invest	September 2017 Trust submitted evidence to support substantive compliance. So target score achieved. 10.
2116	Failure to recruit to the nursing body of the organisation leaves a deficit in nursing provision.	1 - Agreed / Identified Risk	20/12/2017 ⇧	3x3=9	4x4=16	3x3=9	Corporate Function	Director Of Nursing	Trust Board	Risk review
10055	The Trust has insufficient resources available to ensure the essential maintenance of the Trust's Estate.	1 - Agreed / Identified Risk	12/06/2017 ⇔	5x4=20	4x4=16	4x1=4	Estates And Facilities	Director Of Strategy & Improve	Performance Finance And Invest	further review meeting to be convened to review PAM and EPRR actions

Walsall Healthcare NHS Trust - Corporate Risk Register

No	Title	Status	Date Entered Onto CRR	Risk Scores			Origin Division/Executive Lead/Committee	Owner	Monitoring Group	Comment/ Recommendation
				Initial SxL=R	Current Jan 2019 SxL=R	Target SxL=R				
1 - Agreed / Identified Risk										
7074	Failure to comply with equality, diversity and inclusion standards for services leads to poor experience for patients causing increased complaints, impact on patient and staff experience and potential regulatory action	1 - Agreed / Identified Risk	02/02/2017 ⇧	4x4=16	4x4=16	4x1=4	Corporate Function	Director Of People & Culture	Quality, Patient Experience An	The review of progress over the last 12 months has demonstrated that the mitigating actions have not taken place. As a consequence addition resource has been brought to the Trust on a temporary basis to develop the action plan to mitigate this risk. The People and OD Committee will be receiving a number of reports on progress before Christmas 2018. The risk has been escalated to the BAF
11558	There is a lack of assurance that the retained estate complies with fire stopping regulations.	1 - Agreed / Identified Risk	03/11/2017 ⇧	4x4=16	4x4=16	5x1=5	Estates And Facilities	Director Of Strategy & Improve	Performance Finance And Invest	review updated
2083	Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks	1 - Agreed / Identified Risk	01/02/2016 ⇧	4x3=12	4x4=16	2x3=6	Medicine And Long Term Conditi	Chief Operating Officer	Performance Finance And Invest	Forecast for Q3 is a solid 82%

Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust - Corporate Risk Register

No	Title	Status	Date Entered Onto CRR	Risk Scores			Origin Division/Executive Lead/Committee	Owner	Monitoring Group	Comment/ Recommendation
				Initial SxL=R	Current Jan 2019 SxL=R	Target SxL=R				
1 - Agreed / Identified Risk										
2443	Failure to recognise and learn from events that contribute to deaths	1 - Agreed / Identified Risk	01/04/2011 ⇧	4x3=12	4x4=16	4x2=8	Corporate Function	Medical Director	Quality, Patient Experience An	The LFD policy is to be revised to incorporate the ME role. The ME role will be appointed to during February 2019. The LFD process is to be embedded to include scrutiny and care group ownership and revised governance. Engagement with the CCG to commence 11 January
7768	Non delivery of the in-year cost improvement programme may have an adverse impact on the Trust's Finance & Use of Resources Rating under the Single Oversight Framework which would result in financial special measures	1 - Agreed / Identified Risk	26/07/2017 ⇔	4x4=16	4x4=16	4x2=8	Corporate Function	Director Of Finance & Performa	Performance Finance And Invest	Risk remains high as forward indicators (KPIs) with regard to productivity gains targeted to deliver within the last quarter of the financial year indicate opportunity but not delivery.
2122	National shortages of Consultant and middle grade posts	1 - Agreed / Identified Risk	01/02/2016 ⇔	3x5=15	3x5=15	3x3=9	Medicine And Long Term Conditi	Medical Director	People And Organisational Deve	The risk has been reviewed. additional actions are being undertaken in respect of the medical workforce programme of work and aligning to the job planning programme and service sustainability .

Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust - Corporate Risk Register

No	Title	Status	Date Entered Onto CRR	Risk Scores			Origin Division/Executive Lead/Committee	Owner	Monitoring Group	Comment/ Recommendation
				Initial SxL=R	Current Jan 2019 SxL=R	Target SxL=R				
1 - Agreed / Identified Risk										
4110	Concerns with management of children and young people who have mental health problems, behavioural difficulties and delays accessing in-patient tier 4 provision and appropriate social care placements.	1 - Agreed / Identified Risk	01/05/2009	3x5=15	3x5=15	3x3=9	Womens, Childrens And Clinical	Director Of Nursing	Quality, Patient Experience An	Action reviewed
6655	Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation	1 - Agreed / Identified Risk	26/01/2017	4x4=16	4x3=12	2x2=4	Corporate Function	Director Of Strategy & Improve	Performance Finance And Invest	A draft business case has been developed for the Investment in Cyber Security. Daren Fradgley has requested a meeting to discuss this in more detail.

Walsall Healthcare NHS Trust - Corporate Risk Register

No	Title	Status	Date Entered Onto CRR	Risk Scores			Origin Division/Executive Lead/Committee	Owner	Monitoring Group	Comment/ Recommendation
				Initial SxL=R	Current Jan 2019 SxL=R	Target SxL=R				
1 - Agreed / Identified Risk										
3162	Staff non attendance for mandatory training leads to poor training compliance rates and staff not being up to date with mandatory training requirements which will compromise patient and colleague safety	1 - Agreed / Identified Risk	01/08/2015	3x4=12	3x4=12	3x3=9	Corporate Function	Director Of People & Culture	People And Organisational Deve	Updated
15721	Failure to adequately assess and record VTE assessments impacting on patient safety and care	1 - Agreed / Identified Risk	05/11/2018	3x4=12	3x4=12	3x1=3	Corporate Function	Medical Director	Quality, Patient Experience An	Performance continues to be labile but has achieved a number of months in the reporting period 2018/19. the VTE policy has been revised referencing new NICE guidelines. engagement with clinical teams continues in key points of entry and provision of patient and staff information and support. An audit will be undertaken in January to identify challenges and actions to maintain performance
15731	Failure to comply with the Trust's policies for the management of policies, procedures and clinical guidelines results in Patient Harm , regulatory action and reputational damage	1 - Agreed / Identified Risk	03/09/2018	3x4=12	3x4=12	3x1=3	Corporate Function	Director Of Governance	Quality, Patient Experience An	

Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust - Corporate Risk Register

No	Title	Status	Date Entered Onto CRR	Risk Scores			Origin Division/Executive Lead/Committee	Owner	Monitoring Group	Comment/ Recommendation
				Initial SxL=R	Current Jan 2019 SxL=R	Target SxL=R				
1 - Agreed / Identified Risk										
17031	The Trust fails to appropriately resource and/or manage the equipment replacement programme within the capital resource envelope which could have a detrimental impact on the quality of care.	1 - Agreed / Identified Risk	16/01/2019 ⇔	4x4=16	4x3=12	4x2=8	Estates And Facilities		Performance Finance And Invest	
11884	Risk of income loss to the Trust due to inability to code adequately the ED activity on the current Lorenzo / ECDS system	1 - Agreed / Identified Risk	01/12/2017 ⇔	2x4=8	2x3=6	2x2=4	Medicine And Long Term Conditi	Chief Operating Officer	Performance Finance And Invest	paper presented to DQB & Esec boards, agreed to escalate to corporate register
4 - Controlled - Target Risk Achieved										
663	Delivering a 7 day service as per the four critical standards in the NHSE guidance	4 - Controlled - Target Risk Achieved	25/01/2017 ⇩	3x4=12	2x4=8	2x4=8	Corporate Function	Medical Director	Quality, Patient Experience An	NHSi have reviewed the 7 day assessment process. the trust will be undertaking a trial self assessment and BAF reporting process February 2019 following an audit of patient admitted during January

MEETING OF THE PUBLIC TRUST BOARD – Thursday 7 February 2019			
Use of the Seal			**AGENDA ITEM: 19**
Report Author and Job Title:	Jackie White Interim Trust Secretary	**Responsible Director:**	Jenna Davies Director of Governance
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐ (select the relevant action required)		
Executive Summary	In accordance with the Trust's Standing Orders the report notifies the Trust Board that the Trust Seal has been used on the following occasion: On the 15 January 2019 the seal of the Trust was used for the land sale Pleck Road, Walsall. The documents were signed by Mr Daren Fradgley, Director of Strategy & Improvement in the presence of Ms Jenna Davies, Director of Governance. The register for the use of the seal was updated and the Register Numbers for the transactions is No. 159.		
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 (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☐	Care at home ☐	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

MEETING OF THE PUBLIC TRUST BOARD – 7th February 2019			
Performance, Finance & Investment Committee (PFIC) update report		**AGENDA ITEM: 21**	
Report Author and Job Title:	Mr R Caldicott – Director of Finance & Performance	**Responsible Director:**	Mr J Dunn – Chair of PFIC (Non-Executive Director)
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	The report indicates the key messages from PFIC for escalation to the Trust Board, namely; • Trust has a £20.2m deficit year to date and a run rate that would result in a £31.6m deficit. Key drivers being high temporary workforce costs, below plan income delivery (theatres and outpatients CIP) and Obstetric activity remaining significantly below plan • The targeted delivery of a £7.6m improvement has been endorsed by the Board in order to attain a £24m deficit at close of the financial year The Chair confirmed the role of Committee is to now provide assurance of delivering the delivering the £24m deficit, mitigating the risks of continued high temporary workforce costs, income productivity low and any impact from disputed balances with commissioners. The lead Executive for each scheme within the FRP then provided assurance the targeted improvement could be achieved. Key actions being: • Weekly performance meetings, reviewing FRP scheme delivery • Presentation by the COO at next PFIC on theatre productivity • Presentation by the MD at next PFIC on temporary workforce controls • A paper on risk associated with 2017/18 disputed balances • Confirmation of sale of properties identified this and prior year The financial escalation meeting with NHSI had occurred prior to PFIC and briefings were given in advance of the meeting with the wider Executive and Chair. It was made clear that severe consequences for non-delivery of the plan may arise, with movement from the forecast impacting adversely within the 'use of resources' assessment, the current run rate unacceptable. The Director of Finance presented an update in regards to 'Use of Resources' and the 500 word submission per KLOE required to be sent to NHSI by Friday 21st December. Directors had produced wording for each of the KLOE's for the submission and the Director of Finance and Chair of Committee agreed for the report to be distributed to the wider Board for comment prior to filing		

	with the regulator by Friday 21st December 2018. The Board development session scheduled for January 2019 will review the presentations for use on the day of assessment by NHSI (8th February 2019) ED performance was below trajectory, noting focus needing to be placed upon the medically fit for discharge. Cancer & 6 week diagnostic continue to perform well and delivering national targets, RTT is delivering to local trajectory The Chair requested the report on constitutional standards become forward looking so as to inform members of the plans submitted to NHSI, the performance forecast to be achieved for the period and factors affecting performance/mitigations. The COO agreed to develop the for the next meeting to reflect the forward look.	
Recommendation	Members of the Board are asked to note the business of the meeting and risk to delivery of the Financial Recovery Programme.	
Does this report mitigate risk included in the BAF or Trust Risk Registers?	This report aligns to the BAF risk associated with delivery of the financial plan, with the risk rated as red at present (high risk of failure to attain delivery).	
Resource implications	The implications centre upon financial support needed above current plan (increased interest charge impacts) and the affect on 'use of resources' rating	
Legal, Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

FINANCE PERFORMANCE AND INVESTMENT COMMITTEE HIGHLIGHT REPORT

KEY AREAS FOR CONSIDERATION BY THE BOARD

1. INTRODUCTION

The Committee reports to the Trust Board each month following its meeting, this report covering the key issues from the meeting held in December 2018.

2. KEY ISSUES

2.1 The meeting was declared quorate (as advised by the Director of Governance) and Chaired by Mr Dunn, Non-executive Director and Committee Chair.

2.2 Financial performance

The report indicates the key messages from PFIC for escalation to the Trust Board, namely;

- Trust has a £20.2m deficit year to date and a run rate that would result in a £31.6m deficit at close of the financial year. Key drivers being high temporary workforce costs, below plan income delivery (theatres and outpatients CIP) and Obstetric activity remaining significantly below plan
- The targeted delivery of a £7.6m improvement has been endorsed by the Board in order to attain a £24m deficit at close of the financial year

The Chair confirmed the role of Committee is to now provide assurance of delivering the £24m deficit, mitigating the risks of continued high temporary workforce costs, income productivity low and any impact from disputed balances with commissioners.

The lead Executive for each scheme within the FRP then provided assurance the targeted improvement could be achieved.

Key actions being:

- Weekly performance meetings, reviewing FRP scheme delivery
- Presentation by the COO at next PFIC on theatre productivity
- Presentation by the MD at next PFIC on temporary workforce controls
- A paper on risk associated with 2017/18 disputed balances
- Confirmation of sale of properties identified this and prior year

The financial escalation meeting with NHSI had occurred prior to PFIC and briefings were given in advance of the meeting with the wider Executive and Chair. It was made clear that severe consequences for non-delivery of the plan may arise, with movement from the forecast impacting adversely within the ‘use of resources’ assessment, the current run rate unacceptable.

2.3 Use of Resources

The Director of Finance presented the draft presentations for use of resources assessment to be used on the day of assessment on the 8th February 2018. The reports were draft and as such incomplete and it was noted they are to be developed in full and presented to Board members at the development session on the 17th January 2019.

The 'Use of Resources' presentations are then to be taken through the January 2019 Quality and Safety and Performance, Finance and Investment Committees, prior to then being used for the assessment on the 8th February 2019.

Members also received an update on production of a report to NHSI indicating performance against the 'Use of Resources' assessment that required 500 words to be written against each KLOE, with the oversight of production of the document through the Director of Finance (also populating two of the KLOE's) and the remaining KLOE's populated by the relevant Director lead officer.

The resultant outputs were then compiled into a report for submission to the regulator by the interim Model Hospital lead officer for the Trust.

The Director of Finance and Chair agreed for the report to be circulated to Board for review in advance of submission, with the Model Hospital lead officer sending the report to Trust Board members for comment and compiling the comments to submit the subsequent report by the deadline of the 21st December 2018 to NHSI.

2.4 Trust performance against constitutional standards

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

The Chair requested the constitutional standards report show forward trajectories against the plans signed off by the Trust at commencement of the financial year and the Chief Operating Officer agreed to revise the report accordingly.

3. RECOMMENDATION

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

MEETING OF THE PUBLIC TRUST BOARD – THURSDAY 7th FEBRUARY 2019			
People and Organisational Development Committee Highlight Report			**AGENDA ITEM: 22**
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 not quorate (hence decisions are subject to Trust Board approval) and was chaired by Philip Gayle, Non-Executive Director and Chair of the Committee.

In addition to reviewing the Board Assurance Framework, the key issues discussed were:

1. <u>Review Progress on Plans/Actions to Maximise Attendance:</u>
   Staffing levels over the Christmas and New Year period had been reviewed due to some of the wards not being fully staffed and patterns of exceptional absence being observed. It was confirmed that conversations were being held with the staff concerned with HR input. Members accepted in principle recommendations for the amendments to the attendance management policy. The Trust target for absence due to sickness has been set at national median performance (Model Hospital) 3.75 % to be achieved by April 2020.

2. <u>Review Progress on Plans/Actions to Improve Mandatory Training Compliance/Performance:</u>

The low compliance areas are being targeted with additional training sessions. It was noted that despite winter pressures and restricted access to the ESR system over the Christmas period, the compliance rates have held. Committee noted that new starters are asked to complete their mandatory training prior to their start date with Walsall Healthcare, this has been recognised nationally as best practice in line with moves to streamline recruitment and transfer processes.

3. Review the Strategic Approach to Equalities
   The Equality, Diversity and Inclusion strategy was received at Committee. It was acknowledged that there was further work to be undertaken around recruitment, specific targets and when they should be achieved as well as identifying the challenges for the organisation and how these would be addressed. The committee were informed that the CCG had expressed concerns about the availability of the EDI strategy on the Trust website and were informed that following amendment, the strategy will be uploaded to the Trust website.

4. Review Progress of Leadership, Talent Management & Succession Planning Approaches.
   The organisation is part of a national programme being co-ordinated by NHS Leadership Academy to be a pilot site for testing the Organsiational Talent Management Maturity Diagnostic Tool.

5. RECOMMENDATIONS

The recommendation to Board is to note the content of the report for information and to formally approve the decisions made.

APPENDICES

MEETING OF THE PUBLIC TRUST BOARD – 7TH February 2019			
Audit Committee update report			**AGENDA ITEM: 23**
Report Author and Job Title:	Mrs J Davies – Director of Governance	**Responsible Director:**	Mr J Dunn – Non-Executive Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	The report indicates the key messages from Audit Committee for escalation to the Trust Board, namely; • The Trust and Internal Auditors Grant Thornton are progressing the internal audit plan • The Committee were concerned about the number of outstanding audit actions, however were assured that there was a plan in place to reduce the outstanding action by the next meeting of the Committee. • The Committee received a paper outlining the Annual Filings plan		
Recommendation	Members of the Board are asked to note the business of the meeting.		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	This report aligns to overall good governance and the oversight of the Board Assurance Framework		
Resource implications	There are no resource implications associated with this report		
Legal, Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☒		

AUDIT COMMITTEE HIGHLIGHT REPORT

KEY AREAS FOR CONSIDERATION BY THE BOARD

1. INTRODUCTION

The Committee reports to the Trust Board each month following its meeting, this report covering the key issues from the meeting held on the 28th January 2019.

2. KEY ISSUES

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

2.2 Internal Audit Plan

The Trust's Internal Auditors presented an update against the Internal Audit Plan. The Internal Auditors raised some concerns about the progress of the plan, however noted the improved engagement of the Executive team in progressing the Audits. Internal Audit also outlined a revised escalation process to the Director of Governance.

2.3 Outstanding Audit Actions

The Committee received an update on the outstanding audit actions, the Committee noted an increasing number of actions, however the Director of Governance, and Internal Audit outlined the plan to reduce the number of outstanding actions.

2.4 Annual Filings

The Committee considered the Annual Fillings project plan. The project outlined the key dates for development and submission of the Annual Report and Accounts, the Annual Governance Statement and the Quality Account.

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3. RECOMMENDATION

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