Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 4 JULY 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	TIME
1.	Patients, Carer and Staff Story	Learning	Director of Nursing	Verbal	1400
2.	Board walk feedback	Information		ENC 1	
CHAIR'S BUSINESS					
3.	Apologies for Absence	Information	Chair	Verbal	
4.	Quorum and Declarations of Interest	Information	Chair	ENC 2	
5.	Minutes of the Board Meeting Held on 6th June 2019	Approval	Chair	ENC 3	
6.	Matters Arising and Action Sheet	Review	Chair	ENC 4	
7.	Chair's Report	Information	Chair	ENC 5	
8.	Chief Executive's Report	Information	Chief Executive	ENC 6	
SAFE HIGH QUALITY CARE					
9.	Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Director of Nursing	ENC 7	
10.	Emergency Department Review	Discussion	Director of Nursing	ENC 8	
11.	CQC Update	Information	Chief Executive	Verbal	
12.	Learning from Deaths	Review	Medical Director	ENC 9	
CARE AT HOME					
13.	Walsall Together Business Case and Terms of Reference	Review and Approval	Director of Strategy & Improvement	ENC 10	
14.	Walsall Together Programme update	Information	Director of Strategy & Improvement	ENC 11	
VALUE COLLEAGUES					
BREAK – TEA/COFFEE PROVIDED					

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
RESOURCES					
15.	Performance Report	Discussion	Director of Finance & Performance	ENC 12	
16.	The review of the winter plan for 18/19	Discussion	Chief Operating Officer	ENC 13	
GOVERNANCE AND COMPLIANCE					
17.	Quality, Patient Experience and Safety Committee Highlight Report	Information	Committee Chair	ENC 14	
18.	Performance, Finance & Investment Committee Highlight Report	Information	Committee Chair	ENC 15	
19.	POD Highlight Report	Information	Committee Chair	ENC 16	
20.	Integrated Care Partnership Committee	Information	Committee Chair	ENC 17	
21.	**QUESTIONS FROM THE PUBLIC**				
22.	**DATE OF NEXT MEETING** Public meeting on **Thursday 5 September 2019** at 14:00 at the Manor Learning and Conference Centre, Manor Hospital				
23.	**Exclusion to the Public** – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).				

MEETING OF THE PUBLIC TRUST BOARD – 4 July 2019			
Board Walk Quarterly report			**AGENDA ITEM:** **[PA insert number]**
Report Author and Job Title:	Jackie White Interim Trust Secretary	**Responsible Director:**	Karen Dunderdale Director of Nursing
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐ (select the relevant action required)		
Executive Summary	The purpose of the report is to update members on the outcomes of the Board walk programme which is one of the interventions the Trust has implemented to improve the visibility of the board, its members and its work within the Trust and to improve board members connection with and understanding of the organisation to help in their decision making. A summary of the key themes and issues identified during the visit has been included in the report along with the schedule of visits over the last 4 months.		
Recommendation	Members of the Trust Board are asked to discuss 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 ☒		

Visibility - Board Walk Quarterly report

1. PURPOSE OF REPORT

The purpose of the report is to update members on the outcomes of the Board walk programme which is one of the interventions the Trust has implemented to improve the visibility of the board, its members and its work within the Trust and to improve board members connection with and understanding of the organisation to help in their decision making.

2. BACKGROUND

Members are reminded that in May 2018 the Trust agreed a visibility plan for the Leadership Team in line with the publication 'The healthy NHS board 2013' the NHS Leadership academy which said that, while the importance of board visibility in the organisation has long been recognised, a more interactive process allows board members, staff and users to shape organisational values and culture through direct engagement. It also ensures that board members take back to the boardroom an enriched understanding of the lived reality for staff, users and partners.

The visibility plan focussed on a number of areas including the use of social media and blogs, open forums and engagement events, patient and staff stories and board walks.

In February 2019 a new Board day format was introduced along with a revised programme of board walk visits.

3. DETAILS

The Trust Board has an interactive process to allow members, staff and users to shape organisational values and culture through direct engagement. This includes patient and staff stories at Board, work shadowing, staff engagement and recognition, open forums and visits to service areas. It ensures that board members take back to the boardroom an enriched understanding of the lived reality for staff, users and partners.

Although Board walks/visits had been implemented in the Trust for some time, it was apparent that due to the unplanned scheduling that some areas of the Trust received frequent visits whereby others did not have any opportunity to meet with the Trust Board.

An opportunity for a revised Board day allowed Board walk visits to be rescheduled and a planned approach to visiting all parts of the Trust has been implemented. Over 40 service areas including inpatient wards, clinical and non-clinical departments, acute and community services have been visited since February. High level feedback has been captured following each visit by the Trust Secretary and this report sets out a summary of the key themes and issues identified.

Appendix 1 contains the list of areas visited over the last 4 months.

Key themes of visits include:

- Good understanding the Trust values
- Staff proud of what they were doing
- Examples of innovative practice taking place on a local level
- Lots of ideas for service change
- Enthusiastic / motivated staff
- Examples of going above and beyond roles
- General feeling by staff of the culture improving

Issues identified and action taken

- Issues relating to equipment being out of date, compatibility issues, work around's

  Medical equipment has now been through a risk assessment programme and the schedule has been shared with QPES and approved. This will improve our position. IT equipment is now subject to a refresh as part of the EPR programme over the next 24 months. We are creating a priority list as departments are being assessed. Operational work abounds are being reviewed as part of the process change for EPR

- Some lack of understanding on organisational wide service changes

  Briefings on this should come through the care group teams of three. When we do the next round of planning we will ask the care groups to cascade down. The COO and Director of Strategy will reinforce through the operational team meetings for the Hospital and Community divisional team meetings

- Need to consider wider support services when making service changes, eg portering

  This is now included in the business case template but will be reinforced through TMB challenge

- Opportunities for productivity not fully explored at local level with some capacity opportunities identified

  Team will be advised to raised with teams of three and will be considered as part of the CIP planning

- Feeling of focus on services within hospital

  The Trust continues through engagement and communication to ensure the focus is on delivery of services both in the community and in the hospital. The Trust Board will continue to meet in and outside of the Trust on Board days and engagement events and staff briefings continue to be held across both service areas.

Members should note that where an immediate risk was raised this was picked up at the meeting by the relevant Director.

4. RECOMMENDATIONS

The Board are asked to note the report and actions to address the issues highlighted.

APPENDICES
Schedule of visits

Board walk programme

7 March 2019, 11:00 – 12:30;

12:30 Feedback

Non Executive Director	Executive Director	Ward / Department	Contact name
Sukhbinder Heer / Alan Yates	Karen Dunderdale	**Switchboard** – (Next Door to ICCU – Buzzer to get it)	Julie Scofield
Pam Bradbury	Catherine Griffiths	**Catering** – (Route 237 – Opposite ward 18)	Linda Noakes
Anne Baines	Matthew Lewis	**Portering** – (In Catering, Route 237 – Opposite ward 18)	Andrew Williams
Liz England	Richard Beeken	**Car Parking** (To meet Paul at Main Reception at 11am)	Paul Richardson
Danielle Oum	Mags Barnaby	**HSDU** – (Across the road first building on the left)	Sarah Cutler
Philip Gayle	Jenna Davies	**Security**	Gary Wilks
Paula Furnival	Daren Fradgley	**Outpatients Appointments**, (Route 109)	Sandra Dawes
John Dunn	Russell Caldicott	**Information Systems** – (Nec Building, Up the Stairs, turn left then right)	Mandy Cater (Alisson Phipps On Training)

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Board walk programme

4th April 2019, 11:00 – 12:30;

12:30 Feedback

Non Executive Director	Executive Director	Ward / Department	Contact name
Philip Gayle	Richard Beeken	**Pharmacy –** Meet Gary at Pharmacy Reception.	Gary Fletcher
Danielle Oum	Karen Dunderdale	**Health & Safety –** No.20 New Manor Court	Simone Smith
John Dunn	Catherine Griffiths	**Clinical Coding –** Route 109	Neil Walton / Sandra Thorneywork
Anne Baines	Mags Barnaby	**Learning & Development –** HR	Karen Bendall
Alan Yates (apologies)	Jenna Davies	**Medical Staffing -** HR	Crystal O'Connell
Sukhbinder Heer	Matthew Lewis	**General Office**	Anyone
Liz England	Russell Caldicott	**Outpatients Appointments**, (Route 109)	Sandra Dawes/Jayne Cox
Pam Bradbury	Daren Fradgley	**Information Systems** – (Nec Building, Up the Stairs, turn left then right)	Alisson Phipps

Board Walk programme
Thursday May 2nd 9am – 12 midday
Please can members return to Pinfold Health Centre, Seminar Rooms 1 and 2 for feedback no later than 12.30

Non Executive Director	Executive Director	Community team/service	Contact name	Plan for travel
Alan Yates		Alan Yates – Clinical Intervention, patient visits Overview of services based at Hollybank	Donna Roberts	Clinicians to collect from Pinfold
Sukhbinder Heer		Children's services CCN	Caroline Whyte	SH to go to Ward 21, route 221 and ask for CCN office.
Pam Bradbury	Catherine Griffiths	Children's services Health visiting and School nursing	Caroline Whyte	Health visiting – CG to be at Anchor meadow for 9.30am School Nursing – PB to be at Harden health Centre for 9.30am
Sally Rowe	Matthew Lewis	Overview of West 1 and 2 and Dr Harlin role, patient visits	Kim Powell/Simon Harlin/Deb Watson	Clinician will collect Anne Baines and Dr Harlin will collect Matthew Lewis

Danielle Oum (Danielle needs to leave at 10.45am)	Richard Beeken	North 1 and 2 overview of MDT and QI and patient visits	Rachael Purohit	Team on site, locality lead will meet and provide an overview of the team structure and then clinicians will take ? Danielle and Richard out to visit patients
Liz England	Mags Barnaby	South 2/Community Stroke	Kelly Leek/Liz Brown	Clinicians to collect Liz (Stroke) and Mags (South2) from Pinfold
Philip Gayle	Jenna Davies	Palliative care services	Sindy Dhallu	Nurses will collect Philip and Jenna from Pinfold and take back to palliative care centre/patient visits
	Daren Fradgley	Nursing homes, enhanced case management , patient visits	Donna Roberts/Jessica Holmes Stanley/Ann Hawes	Jessica will collect Daren from Pinfold
	Russell Caldicott	East 2 overview of service and patient visits	Dawn Asbury	Nurses will collect John and Russell from Pinfold

Board walk programme

6 June 2019, 11:00 – 12:00;

12:30 Feedback

Non Executive Director	Executive Director	Ward / Department	Contact name
Philip Gayle	Richard Beeken	Imaging	Imaging A Reception – Route 234. Charity Matthews
Danielle Oum	Catherine Griffiths	ENT	route 008
Anne Baines	Mags Barnaby	Ophthalmology	Gemma Muller – lead Nurse Ophthalmology route 007
	Jenna Davies	Orthodontics / Oral Surgery -	Kerry Simms Lead Dental Nurse route 007
Sukhbinder Heer	Karen Dunderdale	Audiology	Tina Harris Route 007
	Russell Caldicott	Dermatology	route 107
Pam Bradbury	Daren Fradgley	Breast clinic	route 126
Sally Rowe	Matthew Lewis	Diagnostics	

MEETING OF THE PUBLIC TRUST BOARD – Thursday 4 July 2019			
Declarations of Interest			**AGENDA ITEM: 4**
Report Author and Job Title:	Jackie White Interim Trust Secretary	**Responsible Director:**	Danielle Oum Chair
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	It's fundamental that staff at the Trust are transparent and adhere to both our local policy and guidance set out by NHS England and declare any appropriate conflicts of interest against the clearly defined rules.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Register of Directors Interests at June 2019

Name	Position held in Trust	Description of Interest
Ms Danielle Oum	Chair	Chair: Healthwatch Birmingham
		Committee Member: Healthwatch England
		Chair: Midlands Landlord whg
		Co - Chair, Centre for Health and Social Care, University of Birmingham from 10 Dec 2018
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
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
Mrs Sally Rowe	Associate Non-executive Director	Executive Director Children's Services, Walsall MBC
		Trustee – Grandparents Plus, registered charity
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 Improvement	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/Deputy CEO	No Interests to declare.
Ms Jenna Davies	Director of Governance	No Interests to declare.
Miss Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy ltd
		Chattered Institute of Personnel (CIPD)
Mr Ned Hobbs	Chief Operating Officer	Father – Governor Oxford Health FT Sister in Law – Head of Specialist Services St Giles Hospice
Mrs Jackie White	Interim Trust Secretary	Director - Applied Interim Management Solutions
		Specialist Governance Advisor - CQC
		Clerk & Governance Advisor - employment - The Northern School Of Art
		Director - Dev Co (Subsidiary company - The Northern School of Art)

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

RECOMMENDATIONS

The Board are asked to note the report

Walsall Healthcare NHS Trust

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 6TH JUNE 2019 AT 2:00 p.m. IN THE LECTURE SUITE, MANOR LEARNING & CONFERENCE CENTRE, MANOR HOSPITAL, WALSALL

Present:

Ms D Oum	Chair of the Board of Directors
Mr S Heer	Non-Executive Director
Mr P Gayle	Non-Executive Director
Mrs A Baines	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:

Ms S Rowe	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 0
Members of Staff 3
Members of the Press / Media
Observers 2

021/19 Patient Story

The Patient Experience team presented a video depicting the story of patient Mrs Ursula Phillips and the birth of her son at the hospital.

Mrs Phillips informed that at her 20 week scan she was advised that her son was small and further monitoring was required. The staff were helpful and professional.

During her labour, Mrs Phillips felt that the communication between the staff and herself was poor and she did not feel informed or consulted about her labour and eventual delivery.

Following the birth, Mrs Phillips was happy that her son received regular checks, though she advised that during the 3 days as an inpatient, only 1 person asked her how she was.

4 months after the birth, Mrs Phillips attended Baby-Fest at Walsall Art Gallery and established that she had not realised how traumatic her labour experience was and the need to talk about

what she went through. She was referred to the Trust and had received help from the maternity service for 12 months.

Ms Oum gave thanks to Mrs Phillips for sharing her very powerful story. There had been a number of improvements made within maternity services over recent years and Ms Oum questioned whether this incident was a common occurrence or an unfortunate circumstance. Ms Oum stressed the importance of understanding the lessons to be learnt from her experience.

Dr Dunderdale agreed that small things did make a difference to patients. The WREN Midwifery Team work in providing support to patients had been proving beneficial and were looking to proactively provide support for mothers postnatally and following traumatic births. The Trust had appointed 3 midwives into the team to date. Dr Dunderdale invited Mrs Phillips to share her story in order to support with training.

Dr Lewis stated that it was apparent it's not just what we do, it's how we do it, that leaves a lasting impression. It was important to remind clinicians of the patient's experience and giving them that feedback. Dr Lewis extended his thanks to Mrs Philips.

Mrs Baines observed a number of learning points from the story. Communication needed to be key throughout the patient's journey and asked for assurance that it had improved.

Ms Oum agreed and requested Dr Dunderdale seek assurance of improved communication with patients and to provide feedback to the Quality, Patient Experience and Safety Committee. Dr Dunderdale informed that CNST would also be discussed at the next committee. **Dr Dunderdale**

022/19 Apologies for Absence

Apologies were received from:

- Mr J Dunn, Non-Executive Director
- Mrs P Bradbury, Non-Executive Director
- Dr E England, Associate Non-Executive Director
- Mr A Yates, Associate Non-Executive Director

Ms Oum welcomed partner Mr D Loughton from the Royal Wolverhampton NHS Trust and Ms K Blackwell, Deputy Director of Nursing who were observing the meeting.

023/19 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.

024/19 Minutes of the Board Meeting Held in Public on 2nd May 2019

28/19 Monthly Nursing and Safer Staffing Report – sealing to be amended to ceiling.

Dr Lewis informed that the last paragraph of page should read 'move of Histology'.

The minutes of the meeting held on 2nd May 2019 were approved as a correct record with the above amendments.

025/19 Matters Arising and Action Sheet

Ms Oum noted a number of actions due for completion at the May Quality, Patient Experience and Safety Committee had been deferred and asked that they are reviewed at the next committee. Mrs Baines informed that the items were deferred due to the number of priority agenda items following the cancellation of the April Committee.

Ms Oum noted that there was no update paper received in relation to breast referrals. Mr Beeken advised the paper would be shared at the Performance, Finance and Investment Committee in July. There were also quality concerns that would be reviewed at the July Quality, Patient Experience and Safety Committee. Mr Beeken added that performance had improved since the Board last met and the service had become more stable.
Ms Oum acknowledged that it was a Black Country wide issue but required assurance that the Trust was doing everything it could do to manage the issue in the best interests of patients safety.

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

026/19 Chair's Report

Ms Oum presented the report which was taken as read.

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

027/19 Chief Executive's Report

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

- April 2019 A&E attendance in comparison to April 2018 showed a 14% increase. Discussion at the A&E Delivery Board meeting indicated evidence that the Trust was not unique. Between a 9-16% increase had been reported across acute Trusts. This may impact upon attempts to close additional capacity.
  Ms Oum asked if it was understood why there had been an

increase. Mr Beeken replied that there had been an increase of walk-ins and 111 provision was high. Ms Oum reiterated the need to undertake a root cause and to deal with elements within Trust control. Ms Oum added that clarity in the cause needed to be sought and a plan created including mitigations. **Chief Operating Officer**

- The draft CQC report had not yet been received.
- CIP performance and run rate gains had seen some improvement.
- In terms of Walsall Together and acute hospital collaboration, the long term financial model and an outline of strategical work would be presented to the Board between now and the end of September with Committees having sight of the papers prior to Trust Board. Mrs Baines urged that the assumptions in the plan were evidence based and worked up jointly where appropriate. The CCG had issued a number of contract performance notices and the Trust was seeking to get early resolution.
- Mr Beeken along with Ms Griffiths had been leading mandatory training sessions regarding the new approach to attendance at work. Focus was on early intervention and resolution and a more simple attendance at work policy.

Mr Heer cautioned that he did not share the optimistic view of finance and queried whether the risks could derail the Trust from the financial plan, if so how was reprioritising and mitigation being dealt with. Mr Beeken replied there had been caution applied with assumptions made within the financial plan. Ms Oum requested an early view at a Financial Cabinet meeting.

Mr Gayle asked when a Walsall Together detailed project plan would be available. Mr Beeken responded that a first cut plan would be shared at the July Trust Board meeting, following a review at the Integrated Care Partnership Board meeting.

Mr Heer referring to the update on sickness cautioned that some of the timelines appeared to be a little too late Dr Dunderdale reported that the Trust had seen a 50% reduction in sickness levels within surgery. A performance review was scheduled fortnightly and benefits were being seen. Additional support had been offered to managers and some staff had departed. Ms Griffiths informed that there were some pockets of really good practice, aligned to Trust values and staff side had been supportive. 156 managers had attended the sickness briefings lead by Mr Beeken and Ms Griffiths. Though it would take time to turn around, there was a clear target to reach the national median by March 2020.
Ms Oum was pleased with the actions underway to address sickness.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Noted that the draft Walsall Together Project Plan would be reviewed at the July Trust Board.**
- **Noted that a report would be reviewed by the Board regarding the causes of increases in A&E attendance, mitigations and any anticipated impact.**

028/19 Monthly Nursing and Midwifery Safer Staffing Report

Dr Dunderdale introduced the report which had been reviewed at the Quality, Patient Experience and Safety Committee. The following key points were highlighted:

- There had been a decrease in temporary staffing usage due to the closure of extra capacity and unfunded beds, though there had been a slight rise due to the norovirus, staff sickness and patient flow difficulties over the bank holiday period.
- Fill rates were satisfactory, including ward 2 which had previously been a concern.
- Ward 29 had received further oversight and it was clear that staffing was not a route cause of a number of falls.
- Temporary usage had been reported as slightly higher which reflected an increase in bank which was between 72-77%.
- The ED establishment review was nearing completion and would be presented at the Performance, Finance and Investment Committee next month.
- The establishment gap was reducing and stood at 7.86%. There was a detailed plan in place.
- The reduction in sickness was having a positive impact on temporary staffing.

Mr Heer noted the report and advised that it needed to include benchmarking data and trends to provide more evidence of impact.
Dr Dunderdale drew members attention to table 14 which did provide this information and
Ms Oum requested that the table was changed for the next report.
Dr Dunderdale informed that the paper was now reviewed at the Performance, Finance and Investment Committee, People and Organisational Development Committee and the Quality, Patient Experience and Safety Committee.

Ms Oum queried the timescales for a collaborative bank implementation and Ms Griffiths stated that there had been lots of discussions taking place. The Royal Wolverhampton NHS Trust were keen to collaborate. Not having a shared system such as Allocate did stall progress in terms of implementation. **Ms Griffiths**
Ms Oum requested a plan to be presented and a date on implementation by the next Board meeting.

Mr Gayle asked whether the evaluating care hours training had taken place during May. Dr Dunderdale replied that it was ongoing with model hospital work.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Noted that a collaborative bank plan would be presented at the next meeting.**

029/19 End of Life Strategy

Dr E Waterhouse, Consultant in Palliative Medicine joined the meeting to present the End of Life Strategy.

Dr Dunderdale introduced the paper which had been reviewed twice at the Quality, Patient Experience and Safety Committee who had recommended approval by the Trust Board. The Integrated Care Partnership Board would be reviewing the Strategy at the next meeting.

Dr Waterhouse explained that the strategy had had been refreshed with engagement and collaboration across the borough and the assistance of the public. The strategy was based upon the 6 ambitions of the national end of life care and the 5 priorities of care of the dying person.
Workshops were arranged for the public to attend, many of whom had had bereavements at the Trust.

Dr Waterhouse added that Walsall Together were to take forward the strategy as a key work stream.

Mr Heer observed that there were no outcomes contained within the strategy and questioned how it would be known if it had been successful. Dr Waterhouse replied that it would be a challenge, though there were some outcomes documented on page 16, further work was needed.
Mr Heer thanked Dr Waterhouse for the great effort that had been put into the strategy and requested an update on progress as an appropriate time.

Ms Rowe asked if there had been any discussions with other hospitals about crossed care and dealing with community patients and Dr Waterhouse replied that this was on-going and there was now an STP End of Life Group established.

Mr Fradgley informed that the Integrated Care Partnership Board taking place the following week and the strategy would be presented for adoption. All partners were required to commit and was linking as one of the priorities with EPR and the shared care records.

Mrs Baines added that benefits realisation was being reviewed and reviews were commencing the following week.

Dr Waterhouse requested that the Board consider appointing a Non-Executive Director of end of Life care. Ms Oum stated that consideration would be given to the points raised and asked Dr Waterhouse to pass on her thanks to the teams involved in the creation of the strategy. **Chair/Non-Executive Directors**

The End of Life Strategy was approved.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Approved the End of Life Strategy.**

030/19 Integrated Care Partnership Progress Report

Mr Fradgley presented the progress report and highlighted the following key points:

- The Senior Management Team had been established and were meeting weekly as a Sub-committee of the Integrated Care Partnership Board.
- Work was progressing with estates issues.
- A series of workshops had been arranged over 8 weeks to draft the alliance agreement.
- The Board had committed the remainder of the year to plan the Section 75 agreement.

Mr Heer requested a detailed report quarterly to flag compliance issues. Mrs Baines replied that the Integrated Care Partnership Board was a sub-committee of this Board, which would receive monthly update highlight reports.

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

031/19 Freedom to Speak up

Ms V Ferguson and Ms K Sterling, Freedom to Speak Up Guardians joined the meeting.

Ms Griffiths introduced the Guardian's quarterly report and welcomed Ms Ferguson and Ms Sterling to the meeting.

Ms Sterling informed that the Guardian's continued to have input on the Trust induction to introduce the work they do. The Safeguarding reporting system had been implemented for staff to report issues electronically. Raising awareness continued to take place and the Guardians were attending nurse training days.
A survey had been launched but further work with Tom Johnson, Listening into Action Lead was underway in order to improve response rates.

Ms Ferguson raised that staff within the organisation were still dubious about raising concerns. There was a lot of work to do in order to improve. Staff tended to raise concerns on a one to one basis rather than other platforms. Ms Oum asked if feedback loops were improving. Ms Ferguson replied that it was improving though responses did occasionally require chasing and there were delays. Ms Oum advised that there must be some agreed protocols put in place about reasonable timeframes that should be adopted and upheld.

Mr Heer cautioned that delays after escalation and awaiting feedback needed to be resolved before it undermined the concept. Mrs Baines stated that as the lead Non-Executive Director for the Guardians, the amount of work they did was impressive. Mrs Baines also expressed concern around response times and observed that there was a consistent message raised in relation to staffing levels.

Mr Beeken questioned whether Executive Directors were utilised enough and referenced the Board pledge.

Ms Ferguson suggested attending key meetings to reinforce the work of the Guardians. Ms Griffiths and Mr Beeken agreed to work with the Guardians in order to support.

Dr Dunderdale reflected on the comments raised and agreed that the Guardians attend key meetings. Dr Dunderdale offered to meet with the Guardians to discuss how they could work together to deal with some of the issues.

Ms Oum expressed concern that staff felt nervous about being seen raising a concern. The Guardians needed a room as a priority where they could meet with staff. Mr Fradgley informed that this was in progress with the Space Utilisation Group was reviewing options in order to accommodate.

Ms Griffiths highlighted the increased amount of caseload the Guardians were undertaking and that resourcing was now becoming an issue.

Dr Dunderdale informed that the senior nursing teams were having regular conversations with the Guardians upfront prior to work streams being introduced to keep them abreast of changes.

Ms Oum observed that the ability to be freed from other duties had not been addressed.

Ms Oum referred to the front sheet of the report and stated that there was an equality and diversity implication throughout and that this should be considered for the next update

Dr Lewis queried whether the Guardians were getting as much contact from the medical workforce as they would expect as there

appeared to be reluctance within those teams.
Ms Ferguson replied that there were concerns raised but they tended to be raised with one particular Guardian This needed to be spread across the team.
Dr Lewis replied that he would have conversations with newly recruited doctors and would pick up separately with the Guardians. **Dr Lewis**

Ms Oum thanked the team for the effort they put in to the Guardian role.

Ms Sterling thanked Mrs Baines for the good relationship and support received.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Committed to the recommended actions:**
  - **Ring fenced time to meet the demands of the role.**
  - **Engagement with middle managers.**
  - **Secure an office space.**

032/19 Guardian of Safe Working Annual Report

Dr Lewis presented the report and advised that apologies had been received from Dr Bavakunji. Dr Lewis thanked Dr Bavakunji for the work he had done as this would be his last report prior to stepping down from the role. Dr Lewis added that the number of exceptions had fallen and Dr Bavakunji had developed very good relationships with the doctors and strived to resolve issues quickly.

Dr Lewis reported that the document is an annual report on rota gaps and vacancies within the Trust. It highlights specific issues and actions taken to resolve them. Recruitment continues to be a challenge in some areas especially medicine and anaesthetics.

The process of implementing Allocate was underway and should be in place by August.

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

033/19 Staff Survey Action Plan

Ms Griffiths informed that the staff survey results had been reviewed previously and the resulting action plan was a work in progress. The second phase was cultural and engagement work. The following key points were highlighted;

- The intention to leave the Trust rate was much higher than the national average.
- BME staff experiencing the Trust in different less favourable ways needed to be addressed but noted that this was a

national issue.

- Staff wellbeing had not improved as much as anticipated.
- Staff survey results were overall better than previous years. The plan was a work in progress.
- The Trust had been selected to be part of the Employers Partners Programme

Ms Griffiths gave thanks to Ms Karim for the work that she had done within equality and inclusion. Mr Simon Johnson had worked with the Trust previously undertaking engagement work and would be re-joining the Trust in early July to review what has worked, what hadn't and the next steps.

Mr Heer accepted that it was difficult to make changes on such a topic quickly and asked whether focus could be targeted in specific areas to show some visible tangible differences. Ms Griffiths replied that improving leadership culture was a priority area.

Mrs Baines observed that it was still being reported that Trust staff wouldn't use or recommend its services and it was unknown why that was the case. Mrs Baines queried if intelligence was utilised effectively. Ms Oum asked to ensure that Mr Johnson asked the questions that enabled the understanding behind it.

Mr Gayle stated that the work that Mr Johnson completed did make a difference and staff did feel that they were being listened to. Mr Gayle suggested the creation of a value statement for the Board to view evidence of how the values were making a difference and how they could be measured.

Dr Dunderdale informed that the Pathway to Excellence work would pull together some of the aspects outlined.

Ms Oum passed on her thanks to Ms Karim, Equality, Diversity and Inclusion Manager on leading the equality work.

Ms Oum looked forward to seeing the outcomes of all the work upcoming and already underway.

Resolution

The Board received and noted the content of the report.

034/19 Performance Report

Quality, Patient Experience and Safety Committee

Dr Dunderdale reported sustained improvement in mixed sex breaches. There had been no cases of MRSA reported for the last 6 months. Mental capacity stage 2 training had seen a month on month improvement in compliance. KPIs monitoring of complaints was underway in order to improve response timescales. The focus of the committee over the coming month would be on falls.

Mr Gayle asked for an update in relation to VTE. Dr Lewis acknowledged that the current performance was unacceptable. There hadn't been any thrombosis cases reported in recent months though there was a risk. Discussions were taking place with teams reiterating the responsibilities. A detailed action plan had been created in discussion with the CCG which included a trajectory to bring performance back to 95% by August. The Trust was working with the QI Academy and there would be a long term review of performance metrics through performance reviews.

Ms Oum stated that the approach sounded like it was more sustainable but asked Mr Lewis to ensure that focus remained. Achieving the target date agreed with the CCG was important. **Dr Lewis**

Mr Heer asked for sight of the action plan. Dr Lewis replied that the plan was changing day by day as it was still currently being built, however a version would be uploaded to the reading room.

Dr Dunderdale reported 5 cases of C. diff during May. The total for the year to date stood at 8. Of the 8, 1 could have been avoided. Dr Dunderdale added that she chaired all Root Cause Analysis meetings. Lessons learnt were drawn from the RCAs An external observation had taken place by an NHSI Lead nurse who was satisfied with the governance arrangements in place.

Integration

Mr Fradgley informed that the single point of access pilot had started. Rapid response referrals had increased. Medically fit work was underway. Length of stays were reducing. The Social care numbers of medically fit patients had halved from an average of 40 delays per day down to 20.

Ms Oum stated it was satisfying to see the model working.

Mr Heer asked what it meant for service users and if there was a financial saving. Mr Fradgley informed that community based treatment deflected resources. Mr Beeken informed that there was lower hospital bed occupancy and fewer community beds in use than would be expected. Mr Fradgley informed that length of stay of complex patients was increasing which required remedial action.

People and Organisational Development Committee

Ms Griffiths updated that improvement had been seen within Level 2 Children's safeguarding training though work was still underway.

Ms Oum cautioned to not underestimate how important the safeguarding training was and that something different needed to be done.

Performance, Finance and Investment Committee
Mr Caldicott reported that the Trust ended month 1 with a £500k deficit. A financial cabinet met regularly and mitigations put in place. Obstetric activity was low. The MLTC were putting together a number of measures. CIP attainment had been good and was above plan.

Mrs Barnaby informed that ASU beds for medical outliers and additional beds on ward 4 had now closed. All were open during April. Mr Beeken clarified that the ward 4 beds opened before the last winter and had never closed.

Mrs Baines stated that she would value more detail in relation to CIP schemes. Mrs Barnaby responded that the Performance, Finance and Investment Committee received a very detailed CIP report, which could be shared.

Mr Heer welcomed a review at Board level.

Mrs Barnaby informed that the Performance, Finance and Investment Committee had requested an A&E performance deep dive as overall, it was standing still. The anticipation would be to have seen some improvements in this quarter. Models of care and flow needed to be reviewed.

Ms Oum clarified that the Financial Cabinet objective was to brainstorm and test ideas and would not be held accountable for Executive under performance.

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

035/19 Impairment Update Report
Mr Caldicott confirmed that the Trust ensured value for money for the charges received through engagement of an independent tester who valued the works compared to the invoices received.

The Trust has secured value for money from engagement with an independent tester, though incurred a significant impairment that is largely associated with application of an approved valuation methodology and fees.

Mr Heer drew awareness that the value of the balance sheet differed and that a 6 monthly review would be helpful.

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

036/19 Audit Committee Highlight Report
The report was taken as read.

Mr Heer gave thanks to the finance team. The auditors were complementary of the papers and made no adjustments.

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

037/19 Quality, Patient Experience and Safety Committee Highlight Report
The report was taken as read.

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

038/19 Performance, Finance & Investment Committee Highlight Report
The report was taken as read.

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

039/19 POD Highlight Report
Mr Gayle updated that the committee had received a presentation from Dr Selzer in relation to workforce risk. There was a nationwide issue which needed to be flagged and registered with regard to Tax. Consultants were looking at reducing their PAs and action need to be taken in order to mitigate.
Ms Oum informed that there has been a recent update nationally with regard to this issue.

Dr Lewis advised that the issue had been added to the risk register. There was a national consultation to mitigate the risk, therefore the Trust had not looked at local measures.
Mr Gayle asked for reassurance to be given to staff.
Mr Beeken replied that the Trust could reassure that the issue was being looked at nationally.

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

040/19 Questions from the Public

Ms Karim advised that the Board pledge and values on the intranet site did not have all Board members signatures.

Mr Loughton advised that there was unlikely to be a speedy resolution to the PAs.

041/18 Date of Next Meeting

The next meeting of the Trust Board held in public would be on Thursday 4th July 2019 at 2:00p.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

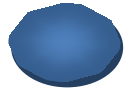
Resolution:

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
205/18 Matters Arising	There were a number of actions from the winter plan to be discussed at the Quality, Safety and Patient Experience Committee. Mrs Barnaby to share the actions with Board members prior to the next meeting.	Chief Operating Officer	06/06/19	Update – the review of the winter plan for 18/19 has been considered by POD and QPES. It is due to be considered at the next PFIC meeting and then Board in July	
226/18 Patient Story	Consideration of drafting a letter to Commissioners flagging the issues of treatment for patients who had consumed alcohol. Quality, Patient Experience and Safety Committee to review the issue.	Director of Nursing/Medical Director	~~02/05/2019~~ 04/009/19	On the agenda for QPES in May. This has been deferred to the July Committee	
234/18 Improvement Update	Dr Lewis to review the underlying evidence in relation to CPR compliance. Feedback to be reviewed at the Quality, Patient Experience and Safety Committee.	Medical Director/ QPES	~~02/05/2019~~ 04/09/19	On the agenda for QPES in May. This has been deferred to July	
001/19 Patient Story	Mr Fradgley would take the learning from the story and deliver to the place based teams for referrals.	Director of Strategy & Transformation	06/06/2019	Completed and discussed with the teams	
001/19 Patient Story	Mrs Barnaby agreed to review the pre assessment information given to patients, including post-operative care, discharge information and links to the correct care pathway	Chief Operating Officer	06/06/2019	Action handed over to the new Chief Operating Officer	
008/19 Nursing and Midwifery Safer Staffing Report	Dr Dunderdale would include benchmarking data for temporary staffing in the next report	Director of Nursing	~~02/05/2019~~ 06.06.2019	Work ongoing to complete this	
010/19 Learning from Deaths Report	Dr Richard Wilson, NHSI, to be invited to the Trust to undertake a board development session on Mortality.	Trust Secretary	02/05/2019	Currently arranging a date	

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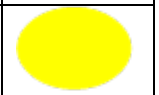
Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
032/19 Performance Report	Mr Fradgley would review to see if there were any options with IT in preventing users from proceeding until VTE was complete.	Director of Strategy & Transformation	04/07/2019	Investigated. Not possible in current configuration but planned in new EPR deployment	
027/19 Chief Executives Report	Mr Fradgley to present a market share dashboard at Private Trust Board.	Director of Strategy & Improvement	07/07/2019	Completed on the agenda	
027/19 Chief Executive's Report	Mid-year review of Strategy and Board Assurance Framework	Director of Strategy & Improvement	07/09/2019	Progressing not due	
032/19 Performance Report	Breast referrals paper to be reviewed.	Chief Operating Officer	06/06/2019	This action is currently being picked up by Committees and is on the agenda for July	
021/19 Patient Story	Dr Dunderdale to seek assurance of improved communication with patients and to provide feedback to the Quality, Patient Experience and Safety Committee.	Director of Nursing	04/07/2019	This is on the Agenda for QPES in July	
027/19 Chief Executive's Report	Clarity in the cause of high A&E attendance needed to be sought and a plan created including mitigations.	Chief Operating Officer	04/07/2019	Detailed report scheduled August	
028/19 Nursing & Safer Staffing Report	Bank implementation plan to be presented at the next Trust Board meeting.	Director of Culture & People	07/09/2019	On the agenda for POD in August	
029/19 End of Life Strategy	Consideration to be given to appointing a Non-Executive Director to end of life care.	Chair	04/07/2019	Pamela Bradbury has been appointed as the NED champion for End of Life Care	

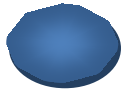
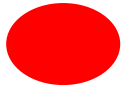
ENC 3

Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
031/19 Freedom to Speak Up	Room to be sourced for use by the Freedom to Speak Up Guardians.	Director of Strategy	07/09/2019	Planning through space utilisation group	
	Dr Lewis would have conversations with newly appointed doctors and would pick up separately with the Guardians.	Medical Director	04/07/2019	Meetings with newly appointed doctors and Guardians arranged	
034/19 Performance Report	Dr Lewis to share the VTE action plan.	Medical Director	04/07/2019	VTE action plan provided to Trust Chair and available in Diligent Reading Room	

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 4th July 2019			
Chair's Report			**AGENDA ITEM: 7**
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 am continuing my 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 2019/2020

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

   I was pleased to participate in the Trust Strategy Day. I attended the sessions focusing upon Partners and Valuing Colleagues and it was good to see the sharing of ideas for improvement.

2. **Improve our financial health through our robust improvement programme**

   I attended the Performance, Finance and Investment committee and noted several areas for concern in relation to financial performance, sickness absence and the Urgent Care Centre.

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

   Together with the Chief Executive, I met with Healthwatch Walsall for a quarterly update meeting.

   I met with the Black Country Chairs to discuss collaborative working.

   I participated in the interview panel for the recruitment of a Non-Executive Director and two Associate Non-Executive Directors at Wye Valley NHS Trust.

   I chaired a session at NHS Confed regarding BME Leaders.

   I chaired the first meeting of the University of Birmingham Centre for Leadership and attended a lecture by Chris Ham on Systems Leadership

   I attended a regional NHSI/E Chairs' Development network event

Meetings attended / services visited

One to one meetings with: Executive Directors
Equality & Diversity Lead
New Chair of Dudley Group of Hospitals FT
ENT Board Walk
Volunteers' Celebration event

RECOMMENDATIONS

The Board are asked to note the report

Danielle Oum, June 2019

MEETING OF THE PUBLIC TRUST BOARD – Thursday 4th July 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 provide the Board with my appraisal of the high level, critical activities which the organisation has been engaged in during the past month, set against the organisation's strategic objectives. This month, I focus on the threat of sustained increases in ED attendances to our quality and financial delivery, update on progress being made with organisational engagement in our Improvement Programme development and brief colleagues on how our wider, social responsibility as the town's largest employer, are being managed. I also share concerns that are emerging about the STP being asked to reduce the capital loan requirement for NHS providers by potentially, 20% and the impact this may have for the Trust this year. The report also sets out to the Board, the significant level of guidance, instruction and best practice adoption we received during May 2019 and assures the Board through an allocation of the actions required, to the relevant executive director.		
Recommendation	Members of the Trust Board are asked to: Note the report and discuss the content		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report outlines the activities undertaken by the Chief Executive officer aligned to each of the organisation's strategic objectives. This report provides assurance around the mitigation of a number of our strategic risks and also provides context in which the Board can triangulate information.		

Resource implications	There are no resource implications associated with this report as such, however there are resource implications, both short and medium term, regarding our operational resilience and urgent care pressures, which will need discussion and agreement within the Board over the next few months.	
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 provide the Board with my appraisal of the high level, critical activities which the organisation has been engaged in during the past month, set against the organisation's strategic objectives.

The report also sets out to the Board the significant level of guidance, instruction and best practice adoption we received during June 2019 and assures the Board through an allocation of the actions required, to the relevant executive director.

2. BACKGROUND

The Trust has, through its sign off of the 2019/20 Annual Plan, reaffirmed its strategic objectives. These will drive the bulk of our action as a wider leadership team and organisation:

- Provide safe, high quality care across all our services
- Use resources well to ensure we are sustainable
- Care for patients at home wherever we can
- Work closely with partners in Walsall and surrounding areas
- Value our colleagues so they recommend us as a place to work

3. DETAILS

3.1. Provide safe, high quality care across all our services

During April, May and June we have seen huge strain placed upon our urgent care services. Initial ED activity reports comparing April 2019 with April 2018, showed an increase in attendances of 14%. In May, that year on year increase was >6%. On 24th June, we treated a record number of ED attendances (311 in a 24 hour period, some 18 higher than our previous record). I signalled last month that if this was sustained, this would be an unprecedented shift and will have consequent effects on our ability to provide a good experience for patients, our ability to deliver improved ED 4 hour target performance. It has also led to a greater number of referrals for admission than we have been able to cope with within our core bed base and therefore, during the last few days, our staffing resilience (AEC, acute medicine cover and contingency beds last opened in winter) has had to increase. NHSI have been informed of these actions and their possible consequences.

We will quantify the financial implications of this and share with PFIC for consideration at the earliest opportunity. QPES Committee will also have to determine how it wishes to gain assurance regarding patient experience and safety, particularly within an ED that has been overcrowded on occasion. Staff morale is also being affected, if my conversations with the ED team are anything to go by. PODC may also want to assess this impact if this activity impact is sustained.

At the A&E Delivery Board, we have been scrutinising the possible explanations for this increase in ED attendance. Evidence suggests that a combination of town centre walk in centre consolidation and NHS 111 dispositions to ED, are the root cause. The AEDB did helpfully get chance to scrutinise how Care UK, NHS 111 provider for the West Midlands, is planning to ensure that more clinical triage of calls is established to reduce the propensity to refer to ED. I will update colleagues on progress next month.

At the time of writing my report, the Trust had received our draft inspection report (core services inspection, use of resources assessment and well-led inspection). By the time the Board meets on 4th July, we will have submitted any proposed factual accuracy changes. This may or may not affect the ratings grid so we cannot predict at this stage when the final, published report will come out.

As I highlighted at the last Board meeting, we are now looking "beyond special measures" as a Trust and have started to engage the organisation in the development of our Improvement Programme – the vehicle for achieving outstanding rated services in Walsall by 2022. We have held a Board workshop on the programme and its development. We have also held a programme development day ("Shaping Our Future") with our top 100 leaders, engagents and patient representatives, on 18th June. This superbly attended and enthusiastically delivered event, has started the process of determining what of our current improvement work is "business as usual" and which should be aligned to the Programme overall.

3.2 Valuing our colleagues

We are the largest employer in the borough and as such, need to be more aware of our wider social and civic responsibilities, reflecting this in demonstrably leading on actions which reflect the health, wellbeing and cultural diversity needs of the borough and our staff.

Colleagues may recall that the Walsall Plan, which previously had over 30 different priorities and had lost impact as a result, has now 3 key priorities only:

- Reduction of youth violence
- "Getting Walsall on the move", including delivering on smoke-free environments
- Regeneration of the town centre

At the June Health & Wellbeing Board, I committed Walsall Healthcare NHS Trust to being the lead and coordinating partner for delivering on the second of these three priorities. Catherine Griffiths, Director of People & Culture, will be the executive lead for this, supported by Jane Longden, Divisional Director (Estates & Facilities). The likely actions will include:

- A review of public transport and cycling/walking promotion amongst the larger public and private sector employers
- A review of health and wellbeing offers by those employers to their staff
- Walsall Healthcare NHS Trust buildings and sites going smoke free by March 2020

3.3 Partners

An encouraging session was attended by myself and the Director of Strategy, with colleagues from the West Midlands Combined Authority and other statutory bodies in Walsall, regarding the "One Public Estate" agenda. Funding has been received for a feasibility study into the consolidation and improvement of health and social care estate in our community settings. This should deliver a coherent proposal for our Walsall Together needs, that will facilitate integrated working between different organisation's teams. A Business Case for change should be produced by June 2020 and the changes should be complete by December 2022.

Following the commitment made at our last public Board meeting, I am meeting colleagues from The Royal Wolverhampton NHS Trust next week, to initiate the process for establishing a joint group between the two Trusts for the Board oversight of clinical and back office collaboration. I remain hopeful of persuading the Dudley Group NHS FT to participate also. The STP health leaders forum continues to scrutinise this work, in the context of our collective responsibility to manage these issues radically differently, under the umbrella of the roll out of the Long Term NHS Plan.

3.3 Resources

We already have discussed as a Board that capital and revenue resources in the NHS remain extremely tight, even allowing for the release of the PSF and FRF to aid the elimination of provider side deficits. Two recent developments in this field are of particular concern and are being discussed at the STP health partnership forum on 27/6/19. I will be able to provide an update at the Board meeting with regard to each:

- A national request is imminent in which STPs will be expected to, by consensus, reduce the size of the capital 'ask' nationally, by circa 20%. For WHT, we have only submitted a capital loan request which is the bare minimum requirement for the resolution of overdue and high risk backlog maintenance, essential and high risk medical equipment needs and to complete the ICCU development (support accommodation). Any further reductions in our capital allocation will lead to revisions to the capital plan, the implications of which may need risk assessing by both QPES and PFIC in due course
- To achieve financial balance across the Midlands NHS, CCGs in the Black Country have been asked to find a further £8 million of savings in 2019/20. This will have obvious consequences for providers, from whom the CCGs will almost certainly need to claw back previously planned commitments

4. RECOMMENDATIONS

Board members are asked to note the report and discuss the content.

Richard Beeken
Chief Executive
24/6/19

NEW NATIONAL GUIDANCE, REPORTS AND CONSULTATIONS

The following guidance and policy actions, which have been received from the wider regulatory and policy system during June 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
	Improving staff retention — new resources Retention of staff is a key theme of the interim NHS People Plan and is a crucial factor in securing a skilled and sustainable workforce for the future. In addition to NHSIs retention support programme, they regularly publish retention improvement guides and case studies from organisations across the country to help spread successful initiatives and ideas. Recent additions to the collection include: • New starters questionnaire from Pennine Care NHS Foundation Trust • Promoting your preceptorship offer from Royal Berkshire NHS Foundation Trust • Improving midwifery preceptorship with a midwifery development pathway from University Hospitals Birmingham NHS Foundation Trust	**Information**	**Director of People & Culture**
	Primary care networks: a briefing for pharmacy teams This briefing is for pharmacists and pharmacy technicians across the NHS, including those working in acute, mental health and community services. It outlines how the primary care network (PCN) model allows secondary care pharmacists to work across primary and secondary care — encouraging a system-wide approach to pharmacy service provision.	**Information**	**Medical Director**
	Homes for NHS staff guidance The Secretary of State for Health and Social Care announced in October 2017 that NHS staff would be offered first refusal on affordable homes built on surplus land disposed of by NHS estate owners, with an ambition to benefit up to 3,000 staff. This policy aims to increase access to affordable	**Information**	**Director of Strategy & Improvement**

	housing for NHS staff and relates to NHS estate owners disposing of surplus land, where residential development is planned.		
	Amendment to national safety standards for invasive procedures (NatSSIPs) Following work with clinicians and recommendations from the Healthcare Safety Investigation Branch's June 2018 report: Investigation into the implantation of wrong prostheses during joint replacement surgery NHSI have amended the NatSSIPs prosthesis verification standard. This change will help prevent further incidents involving the wrong selection of a prosthesis for implant.	**Action**	**Director of Governance**
	Share your views on maximising the success of new-in-post executive and non-executive directors The themes in this survey have been drawn from interviews with system leaders and key reports such as the Kerr review and the Smith review. Your feedback will support NHSIs aims to improve leadership culture and make the NHS the best place to work two key focuses of the Interim NHS People Plan.	**Action**	**Director of Governance, Chair and CEO**
	Proposed changes to agency rules — consultation response NHSI have published their response to the consultation on proposed changes to agency rules, which will restrict the use of off-framework agency staff for certain clinical and non-clinical roles. NHSI are supporting trusts ahead of the changes to move affected workers to approved agencies, where possible. Changes will take effect from Monday 16 September.	**Information**	**Director of People & Culture**
	What is a biosimilar medicine? - an updated guide This updated guide to biosimilar medicine has been developed to support the Trust in the safe, effective and consistent use of biological medicines — in line with the principles of shared decision-making between healthcare professionals and patients. Increased competition in the biological medicines market has the potential to deliver	**information**	**Medical Director**

	significant savings for the NHS — of at least £400 million to £500 million per year by 2020/21 — which can be reinvested in treatments and improving patient care.		
	Frailty toolkit: providing the best care for people living with frailty The NHS Long Term Plan sets out the ambition of 'supporting people to age well'. There are increasing numbers of people at risk of developing frailty, and the opportunities to improve their care with the new RightCare frailty toolkit are considerable. Trusts can use this resource as a framework for local improvement discussions supported by your local delivery partner.	**Information**	**COO**
	Aspire Together Talent Pools — nominations and applications The Aspire Together Talent Pools help support current and aspiring senior leaders in the NHS. They aim to create a pool of talented people who are ready to be shortlisted for director (provider) and governing body (CCG) positions in the Midlands and East of England. The Regional Talent Boards are now inviting nominations and applications for aspiring and existing directors in the: • North West • North East and Yorkshire • Midlands • East of England	**Action**	**Director of People & Culture**
	Learning lessons to improve our people practices NHSIs chair Dido Harding has written to trust chairs and chief executives detailing the findings of an independent analysis by an advisory group following the very tragic death of Amin Abdullah in 2016. The letter includes guidance relating to the management and oversight of local investigation and disciplinary procedures, prepared based on the advisory group's recommendations.	**Action**	**Director of People & Culture**
	Share your views on proposed guidance relating to those detained under the Mental Health Act within prisons and immigration removal centres (IRCs) This consultation relates to individuals held	**Information**	**Director of Nursing**

	within prisons and IRCs detained for assessment and treatment within mental health inpatient services. It will help to inform final versions of two proposed guidance documents — with a focus on the times for transfer and remission, and the dispute resolution process. The two proposed documents are: • updates to 'The transfer and remission of adult prisoners under the Mental Health Act 1983 good practice guidance 2019' • introduction of 'The transfer and remission of immigration removal centre detainees under the Mental Health Act 1983 good practice guidance 2019'		
	Interim NHS People Plan Developed collaboratively with national leaders and partners, the Interim NHS People Plan sets a vision for how you will be supported to deliver the personalised and patient-centred care required to deliver the NHS Long Term Plan, and identifies the actions NHSI will take to help you do this effectively. Some actions will make a rapid difference in 2019/20, and some will lay the groundwork to grow our workforce, support and develop you, and make our NHS the best place to work.	**Information**	**Director of People & Culture**
	This year's new healthcare workers vaccination campaign Following seven successful years of Flu Fighters this July a new campaign will be launched to help Trusts communicate the importance of staff vaccination. Developed with Public Health England, the campaign will include a toolkit consisting of social media, video and other digital resources plus a selection of printed items available for pre-order from July. Keep up todate with the new campaignopens in a new window, or send your questions to partnerships@phe.gov.uk.	**Information**	**Director of People & Culture**
	Host an NHS Big Tea party The NHS will be turning 71 on Friday 5 July, and staff across the country are celebrating by hosting their own NHS Big Tea parties. This is a great opportunity for you to recognise the hard work and commitment of staff past and present	**Information**	**Director of Nursing**

	and come together to raise money for 250 NHS charities from across the country. Find out how to get involved and plan your Big Tea party.		
	Levels of attainment and meaningful use standards now available for e-rostering and e-job planning NHSI have developed these guides to help you make sure the right staff are in the right place at the right time, by applying e-rostering and e-job planning software to its fullest potential. The documents outline the systems and standards you need to meet to reach milestones, known as levels of attainment, and provide support on how to do so.	**Information**	**Medical Director**

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD – 4th July 2019			
Monthly Nurse Staffing Report – May 2019 Data			**AGENDA ITEM: 9**
Report Author and Job Title:	Angie Davies Deputy Director of Nursing – Workforce & Education	**Responsible Director:**	Dr Karen Dunderdale Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	May continued to see the opening of some additional capacity beds which resulted in the continued use of additional temporary staffing.Ward 14 continues to be an unfunded ward with all ward staffing reflected as additional capacity. The overall fill rate position for days was 91.43% during May, a reduction from 93.91% last month and 97.66% across nights compared to 91.95% in April. Bank use and Agency use followed a normal trend in month. A number of actions have been enacted to ensure grip and control remains around request of temporary staffing. There was one shift of off framework agency nurses during the month. 6 Wards had a < 90% RN overall fill rate. 4 wards had a <80% CSW overall fill rate. An immediate plan to address Roster KPI compliance has been agreed to improve current roster performance. The Director of Nursing continues to give assurance that staffing levels have not compromised patient safety. This paper has been considered by the Quality, Paitent Experince and Safety Committee		
Recommendation	The Committee is requested to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Objective No 6: BAF Objective No 6: National staff shortages amongst a number professions impacts on the Trusts ability to deliver safe and high quality care, and impacts on the morale and robustness of the Trusts current workforce Corporate Risk No 11: Failure to assure safe nurse staffing levels.		
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.

This paper should be considered alongside the monthly paper for nursing quality indicators which are reported in detail to ensure a comprehensive and integrated approach to safe staffing and quality.

2. PROGRESS UPDATE

Temporary Staffing

The total Agency nurse usage for May 2019 followed a similar trend seen in May 2018 but still finished the month using less than the same period last year (table 1).

Bank usage also remains consistent, following a similar trend to this month last year (table 2).

Table 1

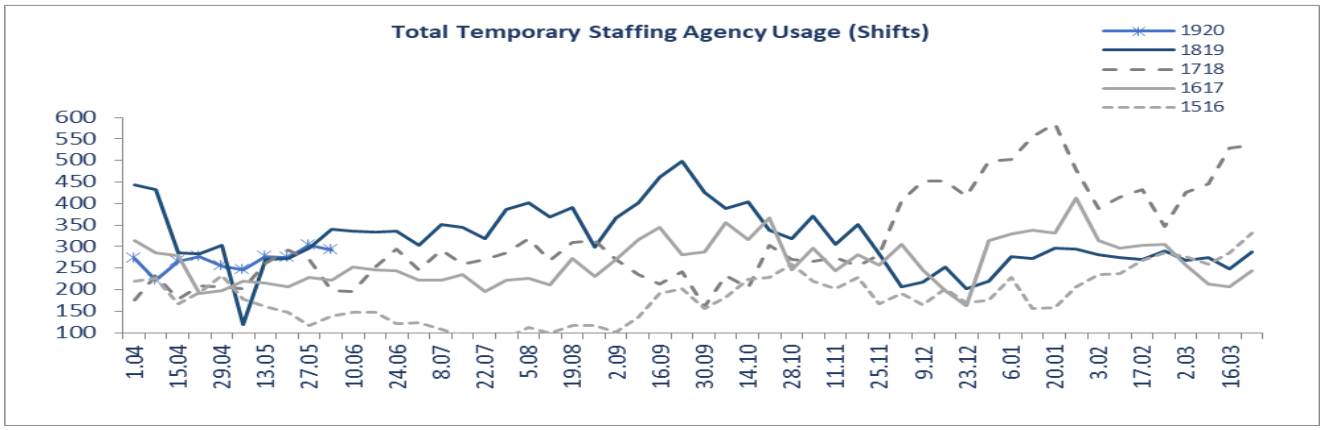


Table 2

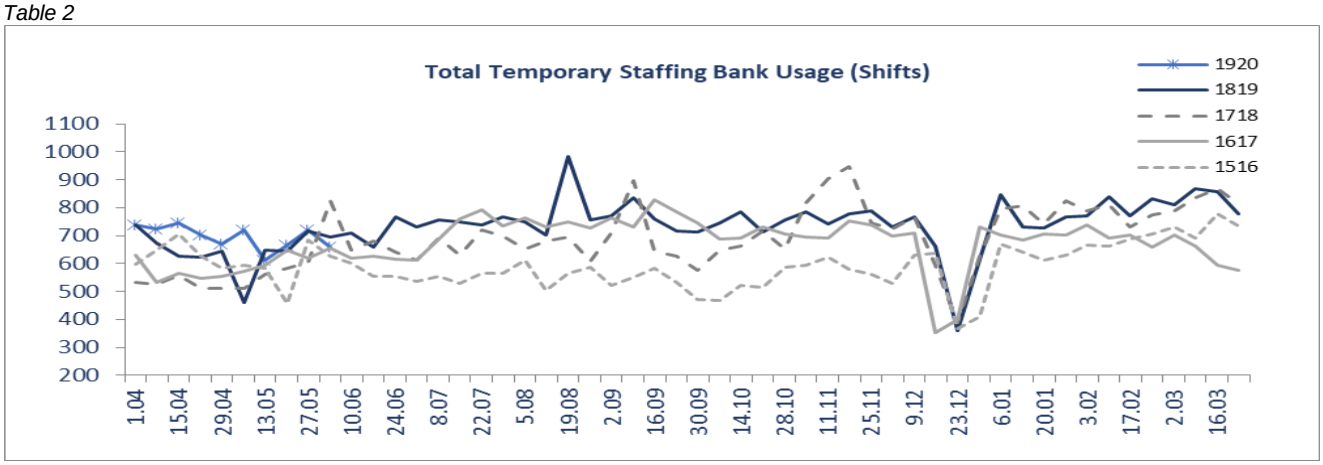
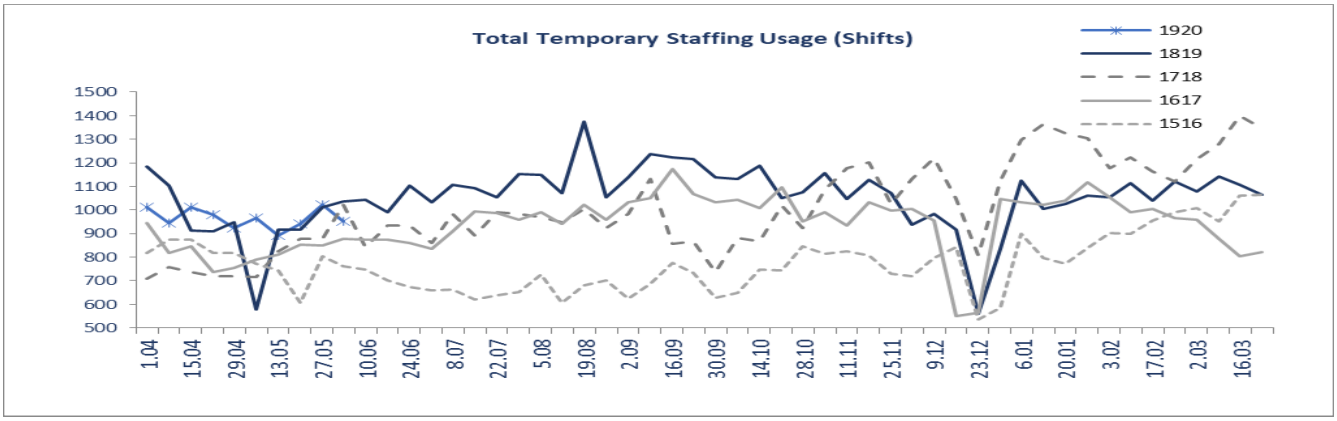


Table 3



The top four reasons for temporary staffing usage during May 2019 are listed below in order of booking request: (Tables 5 & 6)

- Vacancies
- Sickness
- Additional capacity
- Maternity Leave

'Vacancy' as a reason for temporary staffing request is currently subject to a number of actions including robust check and challenge as part of the daily staffing request for shift fill, the ability to align these requests to the actual vacancy positon at roster creation occurs but limitations of the current e-roster sysem mean this is not robustly supported.

The Workforce Transformation meetings are undertaking a weekly appraisal of vacancy figures by ward to facilitate easier cross referencing of current vacancies and Matrons are expected to align all requests to their current vacancy position.

Table 5

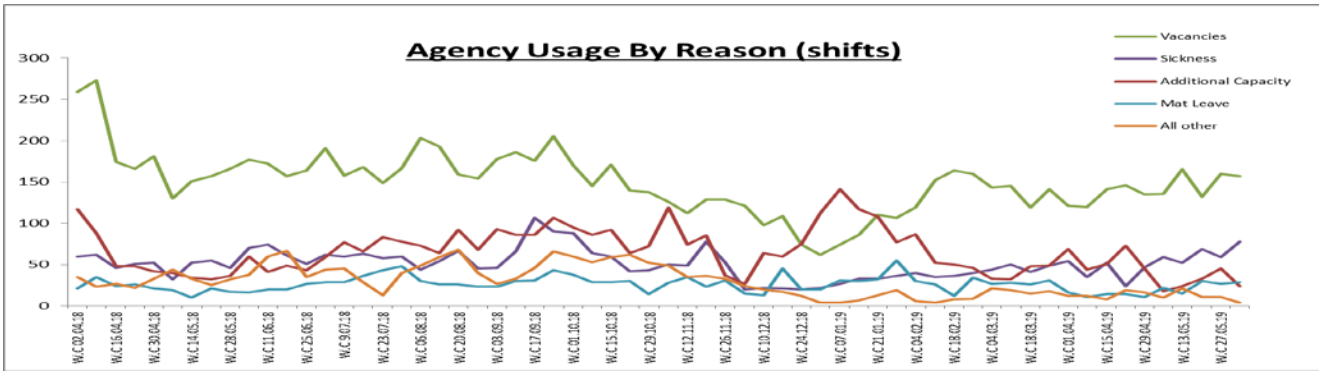
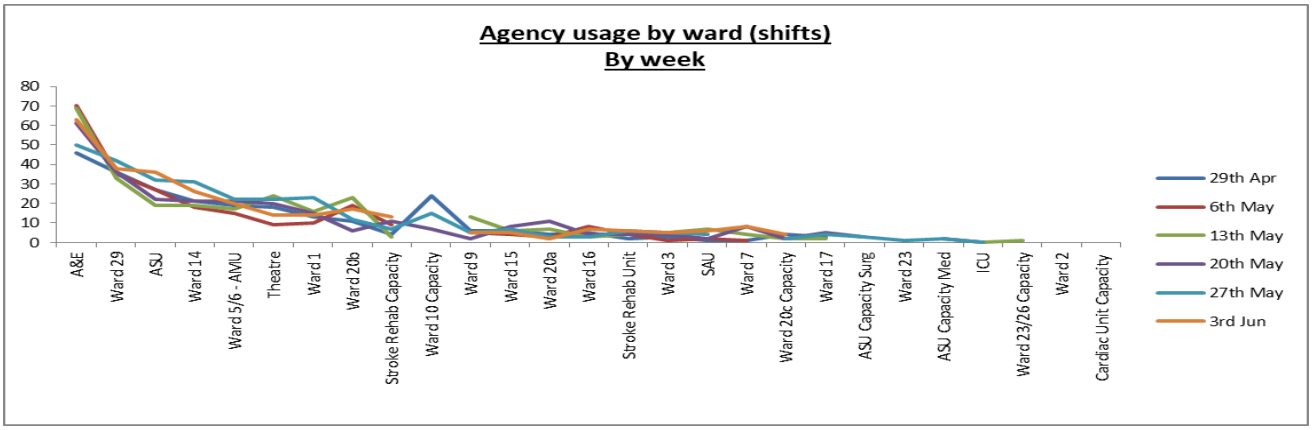


Table 6

	Vacancies	Sickness	Additional Capacity	Mat Leave	All other
W.C 29.04.19	135	47	45	11	16
W.C 06.05.19	136	59	18	22	10
W.C 13.05.19	165	52	24	15	21
W.C 20.05.19	132	69	33	30	11
W.C 27.05.19	160	59	45	27	11
W.C 03.06.19	157	78	24	29	4

The ward areas with the highest volume of temporary staffing usage during May 2019 are captured below (table 7) with a mix of reasons for use as highlighted in the top 4 reasons above. ED remains a consistent highest user of Agency nurses and has a vacancy gap of 10.71 wte (15.8%), the second highest users are Ward 29 and ASU with a vacancy gap of 2.8 wte and 6.0wte (16% and 18% respectively) .

Table 7



The increase in Tier 2 agency nurse use is part of the short notice shift fill cover. Tier 1 shifts are mostly used as night cover which also accounts for the cost of day cover at Tier 2 (tables 8 & 9). ED shifts are filled at Tier 2 and above due to the specialist skill set required for that area and the current vacancy position that includes the paediatric nurse posts, which are required in the 24 hour establishment cover.

Ward 14 remains an unfunded ward so all temporary staffing usage is additional capacity.

Table 8

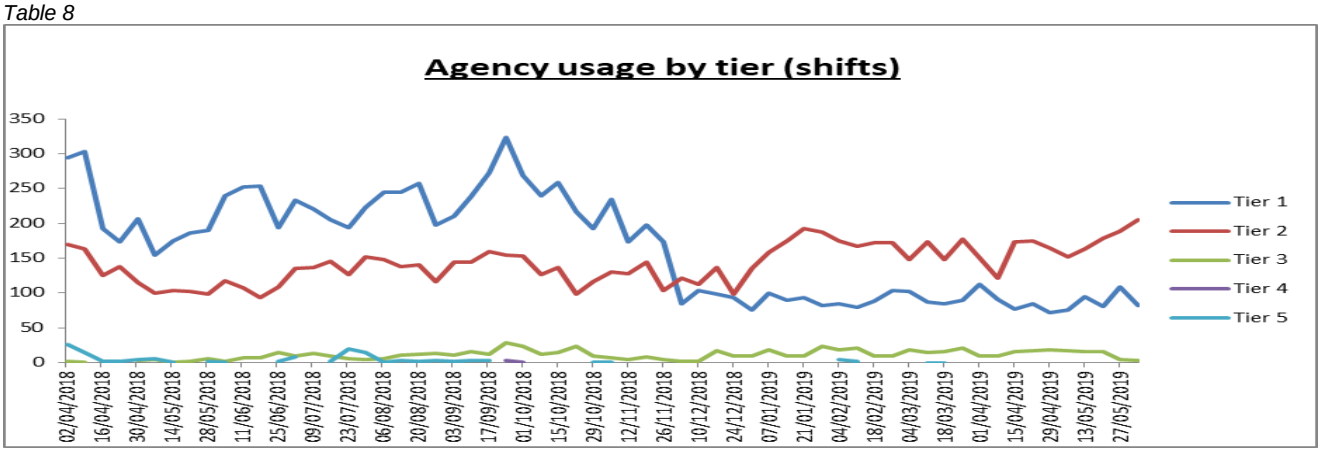
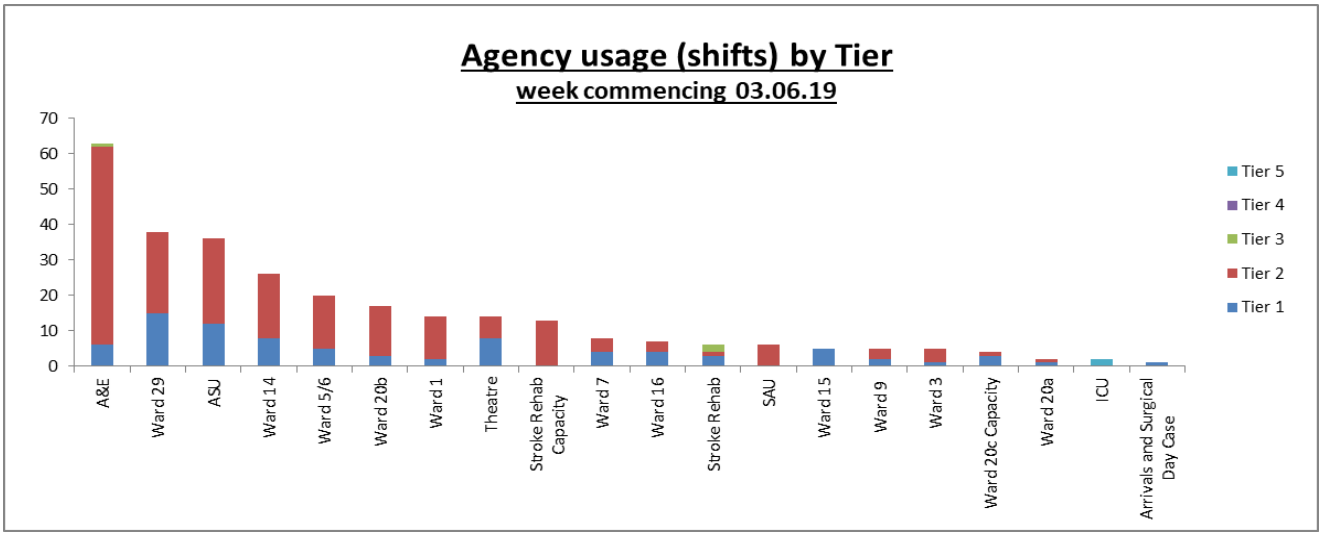


Table 9



Tier 2 agencies were used to cover short notice shifts for additional bed capacity, sickness and shifts that were not filled by bank.

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 after risk assessment and acuity consideration.

All rates were within temporary staffing framework capped levels.

1 shift was filled with off framework agency nurses in month during a weekend shift in the ED (table10).

Table 10

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Total breaches of Frameworks (Thornbury)	26 shifts	5 shifts	3 shifts	22 shifts	9 shifts	8 shifts	4 shifts	3 shifts	1 shift	0 shifts	6 shifts	0 shifts	0 shifts	1 shift

The target of 75% temporary staff shift fill using bank cover (tables 11 & 12) was harder to achieve during May ranging between 69% – 75% during the month, which contributes to the use of agency nurses in month.

Table 11

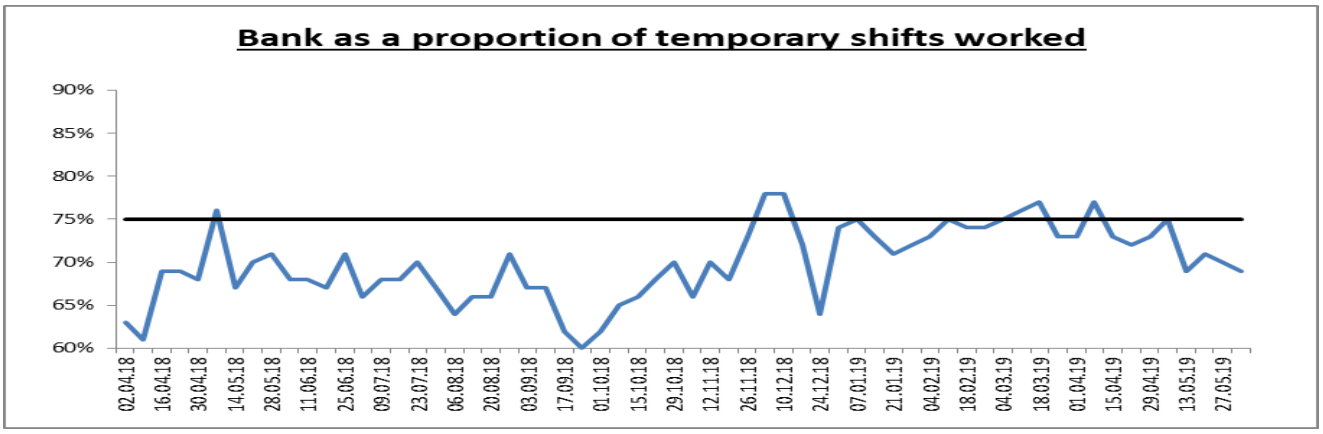
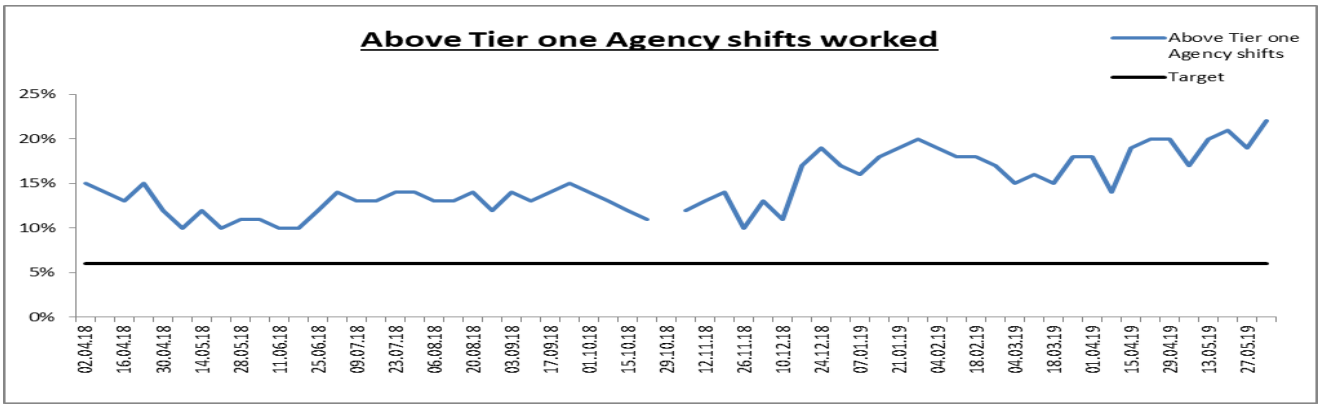


Table 12

	Shifts		Hours		%	
Week commencing	Bank	Agency	Bank	Agency	Bank	Agency
29-Apr	670	254	5290	2042	73%	27%
06-May	722	245	5610	1844	75%	25%
13-May	614	277	4845	2223	69%	31%
20-May	665	275	5440	2118	71%	29%
27-May	720	302	5728	2412	70%	30%
03-Jun	659	292	5279	2230	69%	31%

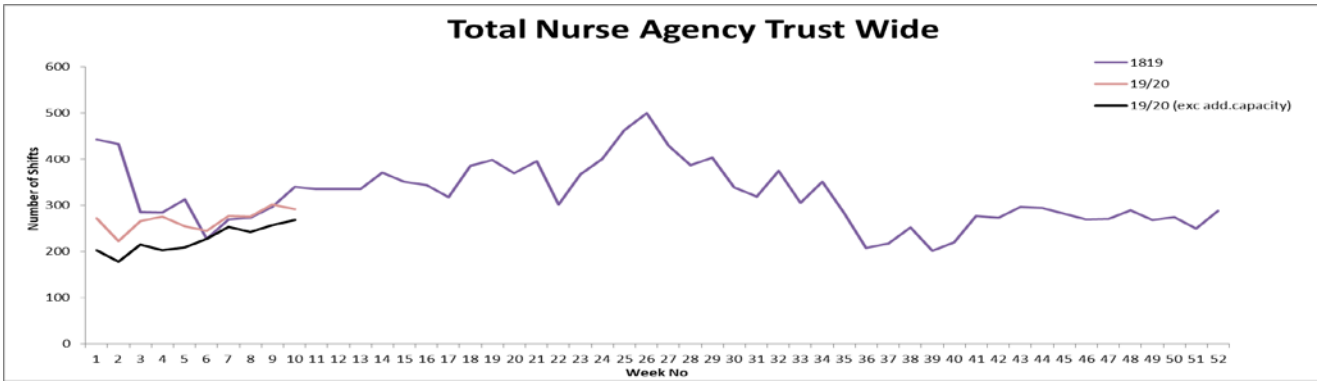
The target of 6% shift fill for use of temporary staffing above Tier 1 (table 13) remains very challenging to achieve and requires robust rostering to support a realistic reduction from current performance. This target has been explored with NHSI who offer no reason for its continued use as this is not a recognised target ouside of this Trust. The Committee are asked to support a recommendation to remove this target.

Table 13



The continued efforts to sustain a level of grip and control that is now being embedded into practice and key messages reinforced regularly is reflected in table 14 below. The impact of extra capacity on Agency use is also shown.

Table 14



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 only.

Appendix 1 shows the combined day/night overall monthly fill rate percentage for the last year for both Registered Nurses (RN) and Clinical Support Workers (CSW).

The overall monthly average fill rate for RN and CSW split by days and nights is shown below in table 15.

Table 15

		Apr-18	May 18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Day	RN	97.50%	99.73%	97.02%	95.84%	95.10%	95.22%	97.33%	95.09%	92.15%	90.60%	91.00%	89.16%
	CSW	98.52%	96.14%	91.85%	91.10%	92.40%	91.33%	94.64%	94.47%	92.80%	93.3%%	91.20%	92.43%
Night	RN	98.35%	95.17%	97.44%	96.22%	94.57%	95.19%	97.35%	97.81%	96.82%	96.60%	98.30%	98.80%
	CSW	107.49%	98.33%	102.08%	97.46%	97.72%	96.59%	99.19%	99.68%	99.36%	99.30%	101.20%	99.44%

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Day	RN	92.00%	92.59%										

	CSW	89.43%	89.96%										
Night	RN	96.50%	97.65%										
	CSW	95.48%	97.67%										

May 2019 the overall average for RN fill rate is:

- 92.59% for day shifts
- 97.65% for night shifts

Of the 23 areas reported on during May 2019, a number of areas worked with fill rates of 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 across Division and across site.

- 7 areas recorded less than 90% shift fill rate on days for RN
  - Wards 1 / 2 / 3 / 7 / 20a / 29/ AMU

- 6 areas recorded less than 80% shift fill rate on days for CSW
  - Wards 4 / 23 / 24&25 / ASU / ICU / SAU
- 1 areas recorded less than 80% shift fill rate on nights for CSW
  - ICU

RN shift

		Number of areas with <90% shift fill											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Days	RN	2	1	2	4	2	3	0	4	6	10	9	9
Night	RN	0	4	2	2	4	3	1	1	3	1	0	1

		Number of areas with <90% shift fill											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Days	RN	8	7										
Night	RN	1	0										

CSW shift

		Number of areas with <80% shift fill											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Days	CSW	2	2	1	3	1	3	3	8	2	1	4	2
Night	CSW	1	2	1	1	1	1	2	2	1	1	0	2

		Number of areas with <80% shift fill											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Days	CSW	4	6										
Night	CSW	1	1										

Ward 2 continued to have a lower RN day fill rate at 77.2% which was an improvement on last month of 5% which shows a continued improved fill rate position over the last two months.

Ward 29 also experienced a low RN fill rate on days at 83%, an improvement of 4% on last month but still lower than a desired fill rate.

Ward 9 RN day and night fill rate has achieved their best fill rate for five months at around 96%.

The Ward Managers and Matrons reviewed the position daily and risk assessed according to patient need and acuity as well as considering staff experience and maturity to ensure patient care was safe. Where necessary staff were utilised from other areas across the Trust. No escalations or concerns were raised about patient safety issues.

2.1.3 CHPPD

The CHPPD data continues to show unwarranted variation. Inconsistency in data recording and data entry appears to be part of the issue and is being addressed as part of the ongoing work around the nurse staffing transformation programme.

Data validation from the Divisional Directors of Nursing and Matrons has commenced from the January 2019 data and will continue every month but the process is not yet embedded.

The process for data collection and data submission is still 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.

Internal training has been arranged for June 2019 to look at the ways in which CHPPD can inform the safe staffing conversation on a daily basis and how it can contribute to establishment reviews going forward.

Training support from NHSI has been arranged to deliver SNCT Acuity tool and safe staffing data input and validation process for July 2019. The SNCT data collection commenced on June 3rd 2019.

The full NHS Digital upload is provided in Appendix 2.

2.1.4 Reported incidents

Safe staffing levels have a direct impact on outcomes for patients. For all wards with an average RN fill rate of 90% or less, it is essential to identify correlating harm to patients through reported incidents and poor patient experience.

The quality KPIs for the wards where the overall RN fill rate was below 90% have been analysed and compared with the previous months reported incidence to determine if staffing levels may have impacted on these aspects of patient care.

Table 16

	Pressure Ulcers Category 2		Pressure Ulcers Category 3,4 & Unstageable		Total Pressure Ulcers	
	Apr 2019	May 2019	Apr 2019	May 2019	Apr 2019	May 2019
Ward 1	0	1	0	0	0	1
Ward 2	0	1	0	0	0	1
Ward 3	0	0	0	0	0	0
Ward 4	0	0	0	0	0	0
Ward 7	0	0	0	0	0	0
Ward 29	0	1	0	0	0	1
AMU	1	0	0	1	1	1
Overall Total	1	3	0	1	1	4

Table 16 shows the numbers of patients who acquired a pressure ulcer in month compared to the previous month.(Red = an increase).

The correlation between RN staffing levels and patient harm is well evidenced and consideration if this was a contributory factor in terms of the knowledge and skills that a registered nurse would apply to patient assessment, treatment and evaluation of care in those areas with a lower than desired RN fill rate, needs to be applied and will be borne out in the RCA.

Table 17

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 7	Ward 29	AMU	Falls Total
Number of Falls Apr 2019	9	5	6	5	2	11	5	41
Number of Falls May 2019	8	1	11	6	5	5	7	38

Table 17 shows the 7 wards with a <90% RN day fill rate which had patient falls over the last two months (Red = an increase).

Three of the 7 wards with a RN day fill rate of <90% in May had the same number or less falls than the previous month, of the remaining four wards, Ward 3 falls review showed that on 2 occasions it was noted that there was a staffing shortfall of CSW's. Correlation between staffing levels and patient harm must be considered for any occasion where a patient fall occurs. On these occasions there is no evidence to show that patient harm experienced on any of the above patient falls was due to staffing issues.

Any correlation between staffing and a patient fall on a particular day or night shift is not always easy to identify as historically patient falls incidents have not also specificed the staffing on duty at the time and if there is a reduction in planned staffing; the falls incidents reported that result in no harm are managed locally by the ward manager unlike the moderate/severe which have a full RCA in which staffing implications can be examined. Further work around reduction of falls is ongoing.

The triangulation of staffing levels and the incidence of falls and pressure ulcers continues to be monitored month on month for any trends relating to gaps in staffing and correlation with increased levels of harm.

Rostering

The quality of rosters at creation is still variable across the Divisions at ward level and contributes to the staffing shortfalls and roster inefficiencies. Detailed reports including the information in table 18 are now being shared with the Divisions through the Nursing and Midwifery Advisory Forum. Training and support is offered to individual Ward Manager and Matrons who may require this. Action plans are created where necessary.

Table 18 reflects the roster KPI performance for the roster period 22nd April - 19th May 2019 (signed off 25th February 2019)

Table 18

Roster KPIs 22nd April Roster	Target	Tolerance	MLTC Summary of compliance with target	D of Surgery Summary of compliance with target	WCCSS Summary of compliance with target	Overall Count of wards compliant
Compliance with sign off on correct date	100%		75% of areas	33% of areas	67% of areas	15 out of 24 areas
Shifts to BANK at Sign-Off compliance	100%		58% of areas	20% of areas	N/A	8 out of 17 areas
Planned number of shifts without NIC cover	0	0	17.5 shifts on 12 wards	1 shift on 6 wards	All wards had NIC covered	18 out of 24 wards had all NIC covered
Actual number of shifts without NIC cover	0	0	22.5 shifts on 12 wards	46 shifts on 6 wards	66.5 shifts on 6 wards	6 out of 24 wards had all NIC covered
Planned sickness headroom (not ESR data)	Not exceeding 3.3%		100% of areas	100% of areas	100% of areas	24 out of 24 areas
Actual sickness headroom (not ESR data)	Not exceeding 3.3%		0% of areas	0% of areas	17% of areas	1 out of 24 areas
Planned study leave headroom (not within tolerance)	3%	+/-1 %	8% of areas	50% of areas	50% of areas	4 out of 24 areas
Actual study leave headroom (not within tolerance)	3%	+/-1 %	58% of areas	83% of areas	50% of areas	9 out of 24 areas
Planned annual leave headroom (not within tolerance)	14%	+/-3 %	75% of areas	50% of areas	50% of areas	9 out of 24 areas
Actual annual leave headroom (not within tolerance)	14%	+/-3 %	50% of areas	67% of areas	50% of areas	11 out of 24 areas

Sign Off of rosters on time continues to be an issue with areas with some Matrons choosing to delay roster sign off because roster was of a poor quality. Whilst this indicator demonstrates a lower level of compliance, Matrons and Divisional Directors of Nursing have already put in place tighter controls and additional roster checks to improve on this situation. Matrons who have experienced issues with roster quality are asked to plan in a review ahead of sign off to allow for expected adjustments to be made.

Compliance across all KPI areas continues to be an issue partly due to the poor controls that the exisiting roster system allows.

Sickness absence continues to be actively managed and monitored and is an improving picture across most areas.

Unpaid leave is still being addressed on an ongoing basis, with the majority of these hours taken as a legitimate use of the policy, where individual behaviour needs to be addressed this is being actioned with the support of HR. Table 19 shows an increase in unpaid leave hours for May, this was mostly due to one individual staff member which has been addressed and was a managed situation. Exclusing that individuals' hours would give a position of 129 hours. Positive progress is being made but continued sustained efforts to reinforce the key messages is still required.

Table 19

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 19	Jan 19	Feb 19	Mar 19
Unpaid Leave (hours)	46	144	249	716.5	716.5	465.5	240	225	135	202	190	63

	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Unpaid Leave (hours)	184	299 (129)										

Establishments

The current overall establishment gaps from ESR as mid April 2019 (excluding theatres) are shown below in table 20 and includes numbers of pipeline recruits over May-July 2019.

The establishment gap is positively reducing due to new recruits and vacancy management and this contributes to enhance the staffing levels and reducing agency useage. All new RN and CSW starters are offered a bank contract on appointment to the Trust.

Table 20

Division	Vacancy Gap – RN (FTE)	Long Term Sickness Gap (FTE)	Maternity & Adoption Leave (FTE)	Total Gap – FTE	Vacancy Gap Rate %	Pipeline – May	Pipeline –June	Pipeline – July	Total
SURGERY	21.58	8.43	3.84	33.85	7.51%	0	0	1	1
MLTC	28.35	14.89	8.74	51.98	8.28%	2	3	4	9
WCCSS	34.20	7.34	8.66	50.20	8.82%	1	2	0	3
COMMUNITY	6.57	3.40	11.64	21.61	3.67%	0	0	0	0
	90.19	34.06	32.87	157.12	7.54%	3	5	5	13

Table 21 below reflects the ongoing recruitment of RN and CSW to the nurse bank, since the proactive approach of offering a bank contract at Trust Induction started in November 2018 and the active recruitment of CSW's to the bank.

Table 21

	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19

Total RN to join during the month	17	10	14	15	15	10	12
Total CSW to join during the month	8	13	8	16	15	11	13

ED establishment review work has been undertaken, applying a model used for urgent and emergency care staffing.The nursing shift pattern is being aligned to departmental activity and will be different to the current shift pattern of long days and long nights, a variety of shifts is part of the final establishment model.

3.0 RECOMMENDATIONS

The Committee is requested to:

- note the report and make recommendations as necessary
- support the recommendation to remove the 6% target of above tier 1 agency use (as per table 13).

4.0 CONCLUSIONS

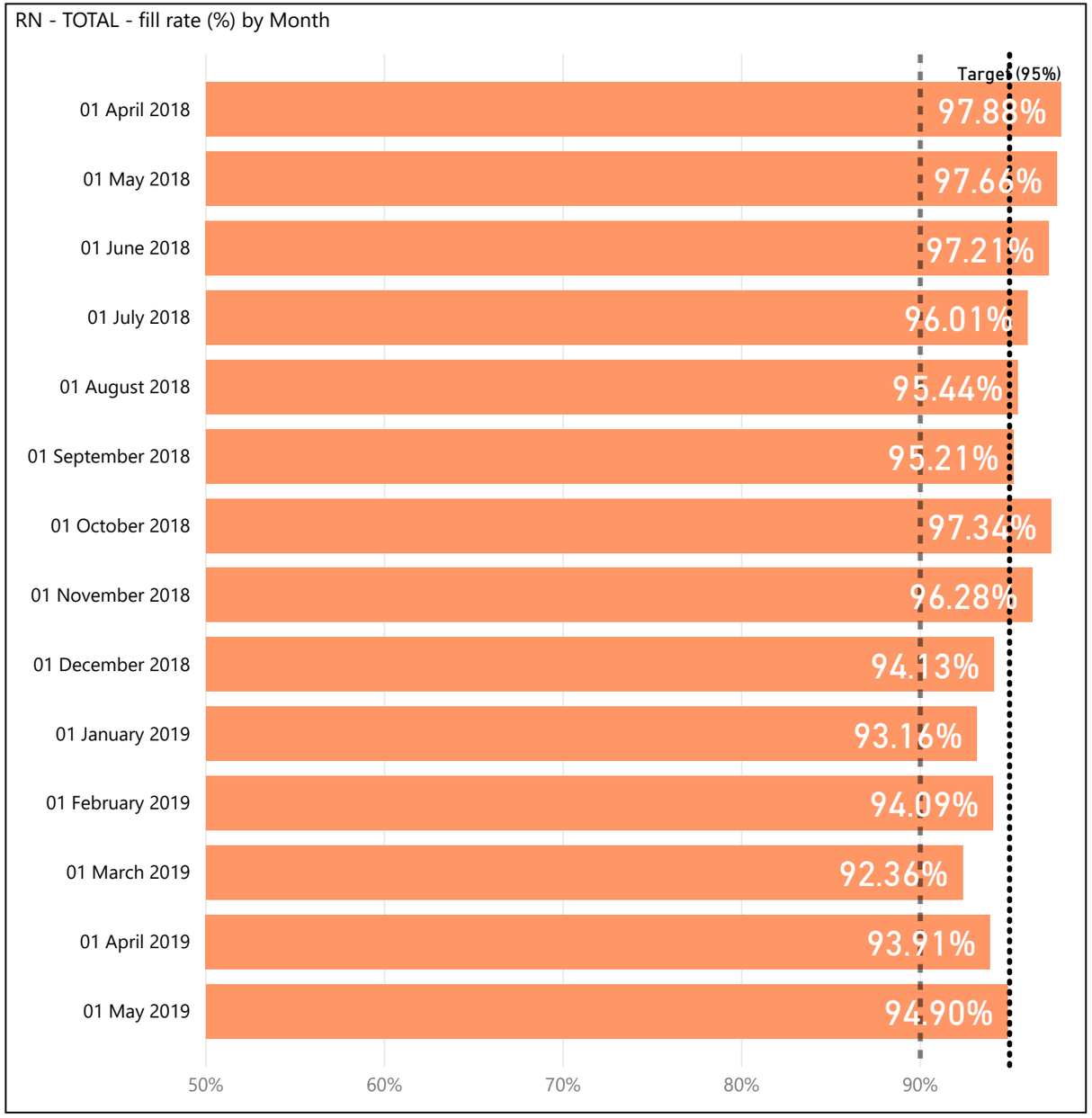
The report is presented to reflect the on-going nursing workforce transformation and will continue to reflect the progress being made and the improvements in grip and control across temporary staffing and rosters in particular but enhanced by workforce developments and agreed safe establishments according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

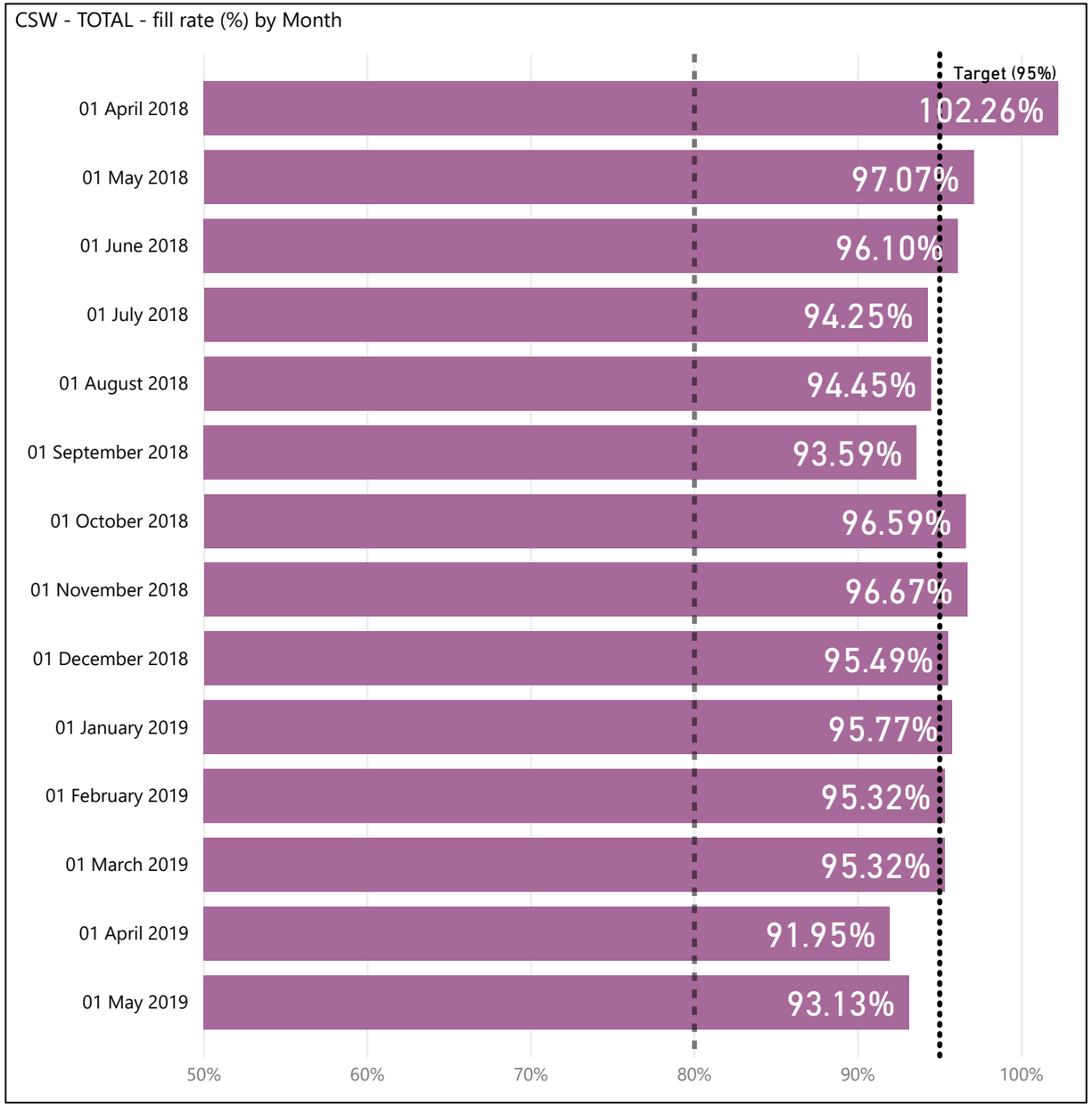
Appendix 1: Monthly overall fill rate data for RN/CSW
Appendix 2: NHS Digital Upload

0701 Safe Staffing Return - Overall Fill Rate

Split between RN & CSW

Walsall Healthcare NHS Trust





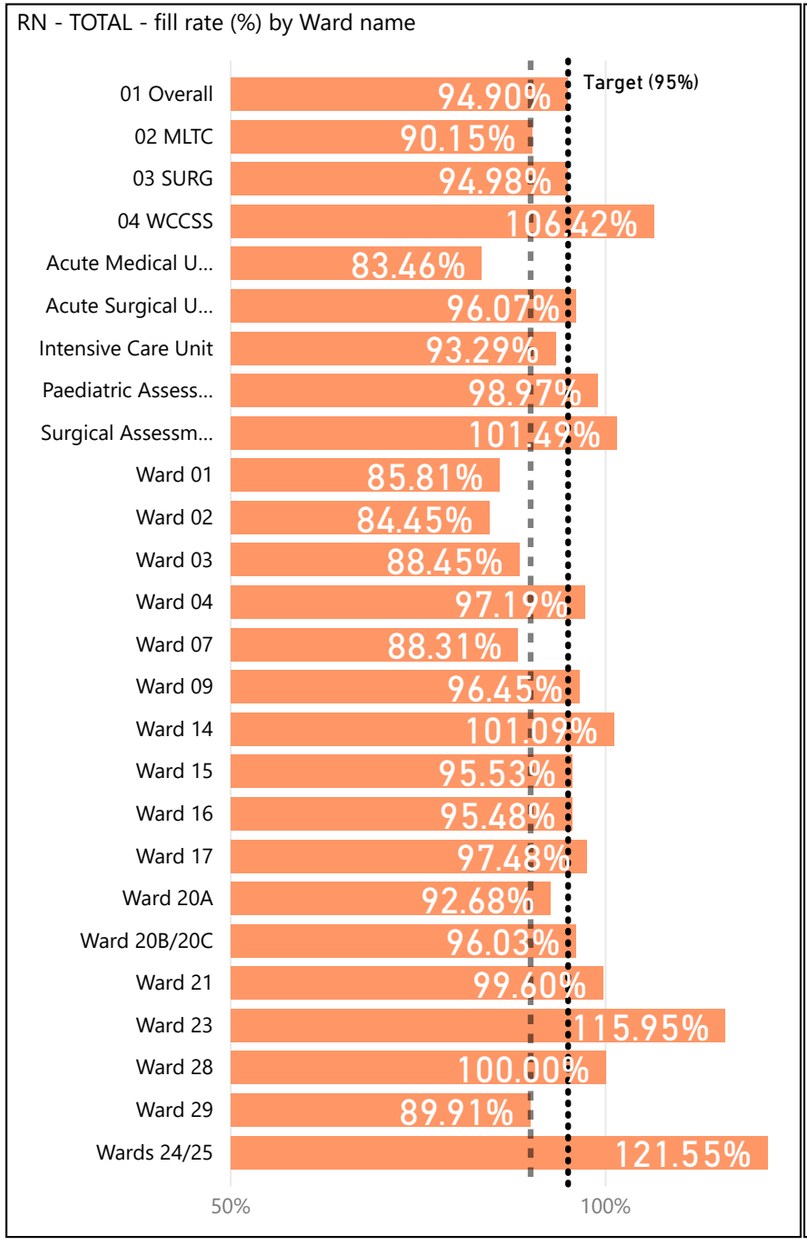
0701 Safe Staffing Return - Overall Fill Rate

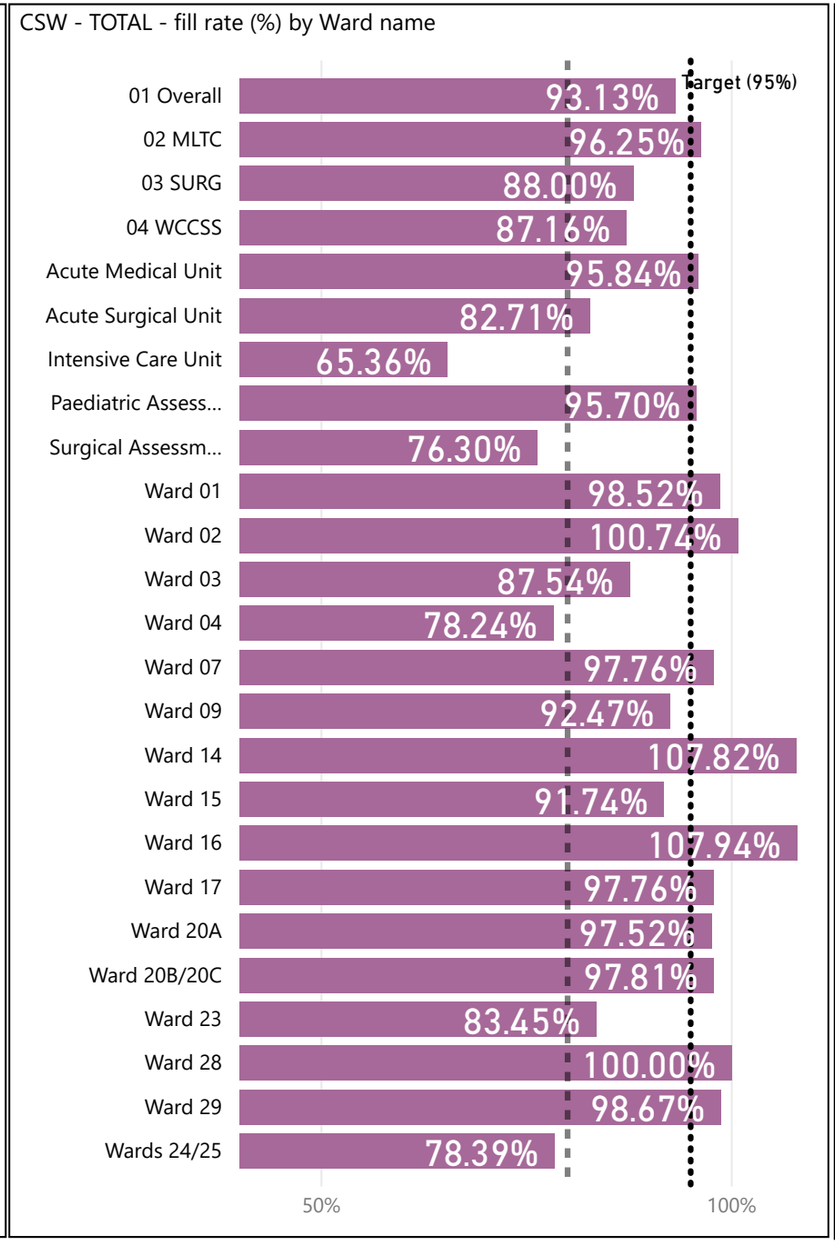
By Ward split between RN & CSW

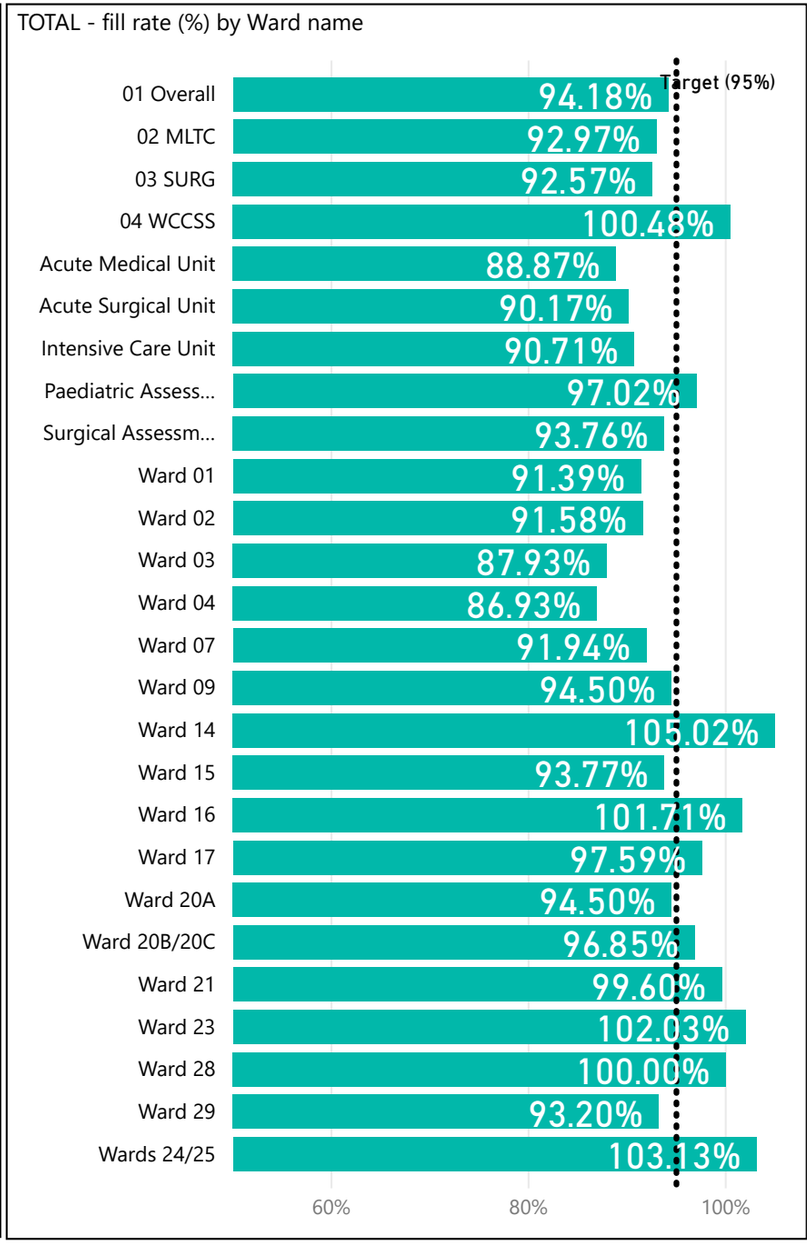
Month

01 May 2019

Walsall Healthcare NHS Trust







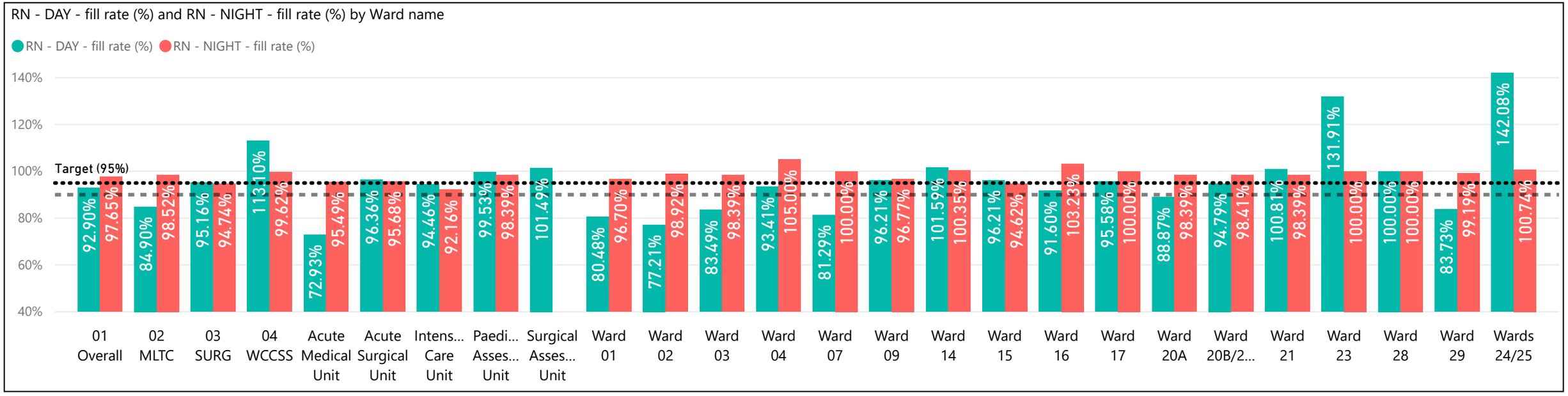
0701 Safe Staffing Return - Fill Rate for RN & CSW

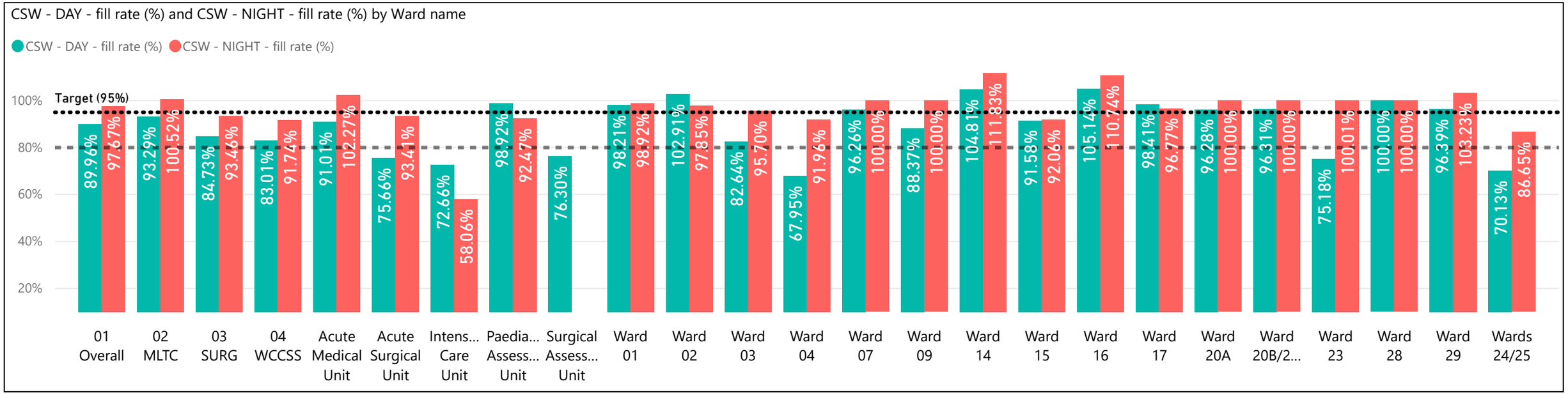
By Ward split between Day & Night

Month

01 May 2019

Walsall Healthcare NHS Trust





Safe Staffing (Rota Fil CHPPD) Collection

For any techincal queries or additional clarification relating to the collection ple

For any queries or additional clarification relating to submissions please conta

l Rates and

ease contact: NHSI.Returns@nhs.net

ct: data.collections@nhs.net

Safe Staffi

Please check that the data on this upload ter
is the responsibility of your organisation th
checks on these

RBK

Please correct all issues listed within

ng (Rota Fill Rates and CHPPD) Collection

nplate is accurate before being submitted to SDCS. You are reminded that these figures will b
ıat these submitted figures are accurate and in line with national guidance. We will undertak
figures post submission, and may come back to you with any queries we may have.

Walsall Healthcare NHS Trust

Validations

the tables below. If the issues are not corrected then the pro forma will fail the validation sta

Control Panel

Trust - Frontsheet

be published, and it
e basic validation

ge in SDCS.

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation: RBK Walsall Healthcare NHS Trust

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

Only complete sites your organisation is accountable for					Day				Night				Allied Health Professionals				Care Hours Per Patient Day (CHPPD)						Day		Night		Allied Health Professionals	
Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Registered allied healtH professionals		Non-registered allied health professionals		Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP) (%)
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
RBK02	MANOR HOSPITAL	Acute Surgical Unit	100 - GENERAL SURGERY		2530	2438	2093	1583.5	1863	1782.5	1380	1289					1210	3.5	2.4	0.0	0.0	5.9	96.4%	75.7%	95.7%	93.4%		
RBK02	MANOR HOSPITAL	Paediatric Assessment Unit	420 - PAEDIATRICS	171 - PAEDIATRIC SURGERY	743	739.5	1069.5	1058	713	701.5	1069.5	989					22	65.5	93.0	0.0	0.0	158.5	99.5%	98.9%	98.4%	92.5%		
RBK02	MANOR HOSPITAL	Ward 01	400 - NEUROLOGY	300 - GENERAL MEDICINE	2139	1721.5	1426	1400.5	1046.5	1012	1069.5	1058					987	2.8	2.5	0.0	0.0	5.3	80.5%	98.2%	96.7%	98.9%		
RBK02	MANOR HOSPITAL	Ward 02	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2139	1651.5	1426	1467.5	1069.5	1058	1069.5	1046.5					1039	2.6	2.4	0.0	0.0	5.0	77.2%	102.9%	98.9%	97.8%		
RBK02	MANOR HOSPITAL	Ward 03	300 - GENERAL MEDICINE		1426	1190.5	1782.5	1473	713	701.5	1069.5	1023.5					1033	1.8	2.4	0.0	0.0	4.2	83.5%	82.6%	98.4%	95.7%		
RBK02	MANOR HOSPITAL	Ward 04	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1426	1332	1426	969	690	724.5	1069.5	983.5					725	2.8	2.7	0.0	0.0	5.5	93.4%	68.0%	105.0%	92.0%		
RBK02	MANOR HOSPITAL	Acute Medical Unit	326 - ACUTE INTERNAL MEDICINE		2852	2080	2371.5	2158.4	2495.5	2382.9	1782.5	1823					1221	3.7	3.3	0.0	0.0	6.9	72.9%	91.0%	95.5%	102.3%		
RBK02	MANOR HOSPITAL	Ward 07	320 - CARDIOLOGY		1782.5	1449	1069.5	1029.5	1069.5	1069.5	713	713					676	3.7	2.6	0.0	0.0	6.3	81.3%	96.3%	100.0%	100.0%		
RBK02	MANOR HOSPITAL	Surgical Assessment Unit	100 - GENERAL SURGERY		806	818	356.5	272	0	0	0	0					10	81.8	27.2	0.0	0.0	109.0	101.5%	76.3%	-	-		
RBK02	MANOR HOSPITAL	Ward 09	110 - TRAUMA & ORTHOPAEDICS		1426	1372	1560	1378.5	1069.5	1035	851	851					777	3.1	2.9	0.0	0.0	6.0	96.2%	88.4%	96.8%	100.0%		
RBK02	MANOR HOSPITAL	Ward 14	300 - GENERAL MEDICINE		1069.5	1086.5	1426	1494.6	713	715.5	1069.5	1196					799	2.3	3.4	0.0	0.0	5.6	101.6%	104.8%	100.4%	111.8%		
RBK02	MANOR HOSPITAL	Ward 15	302 - ENDOCRINOLOGY	300 - GENERAL MEDICINE	1426	1372	1437.5	1316.5	1069.5	1012	724.5	667					768	3.1	2.6	0.0	0.0	5.7	96.2%	91.6%	94.6%	92.1%		
RBK02	MANOR HOSPITAL	Ward 16	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1426	1306.25	1069.5	1124.5	713	736	1069.5	1184.4					752	2.7	3.1	0.0	0.0	5.8	91.6%	105.1%	103.2%	110.7%		
RBK02	MANOR HOSPITAL	Ward 17	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1426	1363	1069.5	1052.5	1069.5	1069.5	713	690					750	3.2	2.3	0.0	0.0	5.6	95.6%	98.4%	100.0%	96.8%		
RBK02	MANOR HOSPITAL	Intensive Care Unit	100 - GENERAL SURGERY	192 - CRITICAL CARE MEDICINE	3438.5	3248	356.5	259.05	3553.5	3275	356.5	207					313	20.8	1.5	0.0	0.0	22.3	94.5%	72.7%	92.2%	58.1%		
RBK02	MANOR HOSPITAL	Ward 20A	110 - TRAUMA & ORTHOPAEDICS		1069.5	950.5	713	686.5	713	701.5	356.5	356.5					377	4.4	2.8	0.0	0.0	7.1	88.9%	96.3%	98.4%	100.0%		
RBK02	MANOR HOSPITAL	Ward 20B/20C	100 - GENERAL SURGERY		1391.5	1319	1069.5	1030	724.5	713	736	736					701	2.9	2.5	0.0	0.0	5.4	94.8%	96.3%	98.4%	100.0%		
RBK02	MANOR HOSPITAL	Ward 21	420 - PAEDIATRICS	171 - PAEDIATRIC SURGERY	1426	1437.5	0	0	1426	1403	0	0					400	7.1	0.0	0.0	0.0	7.1	100.8%	-	98.4%	-		
RBK02	MANOR HOSPITAL	Ward 23	502 - GYNAECOLOGY	100 - GENERAL SURGERY	713	940.5	713	536	713	713	356.5	356.55					291	5.7	3.1	0.0	0.0	8.7	131.9%	75.2%	100.0%	100.0%		
RBK02	MANOR HOSPITAL	Wards 24/25	501 - OBSTETRICS		1446	2054.5	1069.5	750	1426	1436.5	1069.5	926.75					776	4.5	2.2	0.0	0.0	6.7	142.1%	70.1%	100.7%	86.7%		
RBK02	MANOR HOSPITAL	Ward 28	501 - OBSTETRICS		2116	2116	138	138	2047	2047	207	207					357	11.7	1.0	0.0	0.0	12.6	100.0%	100.0%	100.0%	100.0%		
RBK02	MANOR HOSPITAL	Ward 29	300 - GENERAL MEDICINE		2139	1790.9	1426	1374.5	1426	1414.5	713	736					1024	3.1	2.1	0.0	0.0	5.2	83.7%	96.4%	99.2%	103.2%		

MEETING OF THE PUBLIC TRUST BOARD – JULY 2019			
Nursing Establishment Review: Emergency Department			**AGENDA ITEM: 10**
Report Author and Job Title:	Angie Davies Deputy Director of Nursing	**Responsible Director:**	Dr Karen Dunderdale, Director of Nursing
Action Required	Approve ☒ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	There is a significant body of evidence to highlight the relationship between registered nurse staffing levels and the resulting impact on care delivery and patient experience. The Trust remains committed to ensuring that the levels of nursing staff, which includes registered nurses, midwives and healthcare assistants are correct to meet the care requirements of our patients across the Trust. The base ward reviews were completed in September 2018 and reported to the Board in October 2018. The review has been conducted using best practice methodology, comparison against model hospital data. A range of establishment options were developed and discussed as part of the review process. The proposed establishment includes additional training time of 5 days per RN due to the requirement for additional and essential knowledge and skill set to safely practice as an ED nurse, for example trauma training; PALS (paediatric advanced life support) etc., which would otherwise be covered by temporary staffing. The anticipated start date for the new roster pattern is December 2019.		
Recommendation	The Board are asked approve the proposed establishment and approve the next steps		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Objective No 6: National staff shortages amongst a number professions impacts on the Trusts ability to deliver safe and high quality care, and impacts on the morale and robustness of the Trusts current workforce Corporate Risk No 11: Failure to assure safe nurse staffing levels.		

Resource implications	Resource implications are identified within the paper.	
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 ☒	

Nurse Establishment Review:

Emergency Department

1: Nursing Review Process:

The Nurse Establishment Review set out in September 2018 to take forward a comprehensive review of nursing establishments based on:

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

This paper sets out a revision for the Emergency Department.

2. Emergency Department – Review:

This review element covers all distinct areas and nursing elements within the Emergency Department including 24 hour adult and paediatric service provision.

Establishments have been reviewed using the Department activity and application of the urgent and emergency care establishment tool and ECIST modelling tool, incorporating a range of shifts matched to Departmental activity and an emergency care Nursing Ratio model to provide added objectivity. The model has taken into account patient acuity and complexity of care in order to ensure the nursing levels are optimised for workloads in each discreet area of the Department. Shift patterns with appropriate staff numbers have been collated using an establishment-setting tool, which is configured to create both an establishment and budget for any given shift pattern. A range of establishment options were developed and discussed as part of the review process. The model uses the following assumptions:

- Shift patterns as identified, according to Departmental activity and skill mix need.
- Leave cover arrangements based upon standard leave entitlements but pitched at a lower level due to current banding points average for the Department (30.1days + 8 B/H)
- Training cover set to 5 days per WTE per year with an additional 5 days per RN for essential Emergency Care role training
- Sickness absence cover set at 3.39% sickness rate (bank cover)
- Resulting in a headroom allowance of 21.83% - noting if annual leave increases to 33 days then headroom allowance would need to increase to 23% (additional cost of £32k). This would be reviewed annually at budget setting.

The calculated establishment includes all nursing, but excludes support functions and administration. It does include supernumerary nurse management linked directly to the

Department establishment. In addition the review assumed a default position of a shift co-ordinator per shift supernumerary to the patient centred establishment.

A review of last years' (2018/19) service costs showed an overspend of around £752k. There were a number of reasons for the overspend namely;

- provision of 24 hour paediatric nursing cover of 2 Paediatric RN's where establishment gaps existed,
- covering shifts that are in the current establishment but have since been changed in the proposed establishment,
- adjustment to a 95% fill rate where safe and possible to do so,
- support additional capacity and flow issues in the Department especially when 'boarding' admitted patients,
- vacancy position and
- sickness position

The proposed establishment includes additional training time of 5 days per RN due to the requirement for additional and essential knowledge and skill set to safely practice as an ED nurse, for example trauma training; PALS (paediatric advanced life support) etc, which would otherwise be covered by temporary staffing.

This proposal also assumes that the £200k Business case for paediatric nursing is approved

3. Immediate Actions

Following the establishment review the current roster template has been adjusted to reflect a reduction in the numbers of nurses on the early part of the long day shift. This supports the move towards the proposed numbers aligned to activity at this part of the day, supports the current vacancy gap and thus reduces the temporary staffing request for RN's by 3 per day.

The Practice Development Nurse role which supports the Department is to be a 50 / 50 split of clinical and training time, with the clinical time to be rostered into the department roster. This furthers supports the nursing establishment at the clinical level.

4. Outcome of the Review:

Appendix 1 identifies the movement for the Department based on the current establishment and the proposed establishment.

The proposed establishment is Option B (future-NA).

Detailed analysis around the current staffing model and further changes to the proposed model are also identified within the analysis. The proposed establishment acknowledges that this is a recurrent model with a period of non-recurrent funding allocation to support the phasing of the model, due to the three Nursing Associates in training, with completion dates of March and September 2020 and March 2021.

Once qualified as a Nursing Associate and established into the roster proper, this then reduces the establishment cost to a cost neutral model.

Noting that appendix 1 does not cover the supernumerary posts when comparing the direct care staffing numbers.

Roster plan appendices, with the detailed calculations for the Department, including the activity levels underlying the establishment calculations, is available separately.

8. Workforce Changes:

The establishment requirement set by this review process will be compared to the current staffing in post with the following actions to take place to re-align/recruit staffing where there are gaps following the skill mix review.

Recruitment actions will include:

- Implement recruitment in accordance with the Trust Recruitment Strategy
- Cohort recruitment and establishment of talent pools
- Support our CSW's to nurse training and backfill with an apprentice provision
- Continue to recruit to Nursing Associate role and to the trainee NA role
- Support placement of Return to Practice Nursing provision
- Continue to actively recruit through local and national recruitment drives
- Develop a Nursing Workforce strategy in line with new roles
- Potential to develop a response team to support ED activity (this may be a future operational flow model that supports ED and urgent care, if required)

9. Implementation Plan:

The implementation plan will include the following elements:

Action 1: management of change paper and consultation exercise with affected nursing staff to run for 3 months as per Trust Policy with following notice period of 1 month prior to agreed changes.
Date: July 2019
Manager Responsible: Claire Hubbard

Action 2: Implement proposed roster plan changes within e-rostering system
Date: November 2019
Manager Responsible: Gaynor Farmer

The revised shift patterns and establishments will go live from the following E-Rostering cycle start date: December 2019

10. Detailed Shift Analyses:

Shift details for the department, and the resulting establishment and cost calculations, are shown in Appendix 1

11. Next steps:

- Management of change process to be undertaken with affected nursing staff in the Department.
- Implementation of the establishments as per the implementation plan following agreement in the consultation process.

- Feed the output of the establishment review into the nursing workforce transformation programme to ensure agency controls are in place.
- Clear competency framework for the Nursing Associate role in the Department.
- Plan for the introduction of Nursing Associates into the establishments going forward

DRAFT for REVIEW

Summary (Financial / MPE) between options			
	ED Recurrent Budget	**Option A**	**Option B (Future NA)**
MPE	101.30	96.88	96.20
£'s	3,983,173	4,039,491	3,957,634
Variance (MPE)		(4.42)	(5.10)
Variance (£ Saving)		56,318	(25,539)

Notes

1 Option A includes twilight shift (16:00 to 03:00) x 2 head count
2 Option B - removes twilight shift and re-balances workload, with a future move to 24/7 NA cover
3 Based on current pay scales and enhancements (year 2 of 3 yr pay deal - average salary of existing sta

Assumptions on relief

Based on 30.1 days A/L allowance (average for the department) plus bank holidays
Based on 10 days study (per training estimates)
3.39% sickness relief built into bank
Results in relief of 21.83% - noting if A/L increases to 33 days relief would need to increase to 23% (a

aff by band)

dditional cost of £32k)

Assumptions

Nursing WTE Week (Hrs)		**37.5**			
Weekday Bank Holiday Adjustment:					
Total Available Days:		261			
Bank Holidays		**8**	**3.07%**		
Residual		**253**	**96.93%**		
Establishment Uplift For Annual Leave & Training:					
		Reg		**HCA**	
Total Available Days:		261		261	
Annual Leave Entitlement:		30		30	
Statutory Holidays:		8		8	
Training/Non Clinical:		10		5	
Total		**48**	**18.44%**	**43**	**16.52%**
Establishment Bank Allowance For Sickness and Absence:					
Total Available Days:		261			
Sickness Absence:	3.4%	9			
Other Absence:	0.0%	0			
Total		**9**	**3.39%**		**3.39%**
NOTE SNCT recomends 22% total relief.			**21.83%**		**19.91%**
Night Rate Paid From:		**20:00**			
Night Rate Paid To:		**06:00**			

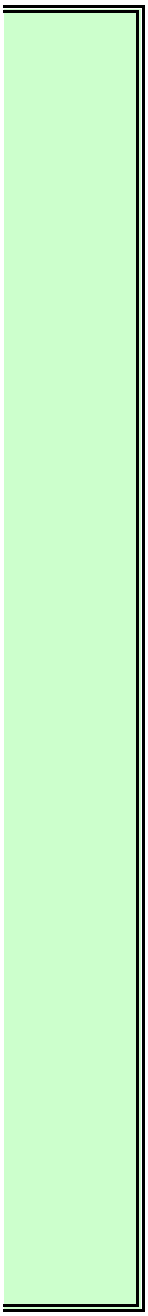
Consultation period < 100 staff = 30 days
Consultation period >= 100 staff = 90 days
Notice period = 90 days
Breaks: 6 hours requires a break (min 20 mins); < 6 hours no break except by discretion; 10+ hrs will get

Rules

Enhancement Percentage Rates Applicable Under A4C - 2019/20

Band		Night Enhance %	Saturday Enhance %	Sun/BH Enhance %
1		48%	48%	95%
2		42%	42%	84%
3		35%	35%	70%
4plus		30%	30%	60%

Night Rate Paid From:	**20:00**
Night Rate Paid To:	**06:00**
Night Rate Applies to Full Shift If >50% of Shift Is at Night Rate	



225.75

38 60 285.75

14.6%

3.8%

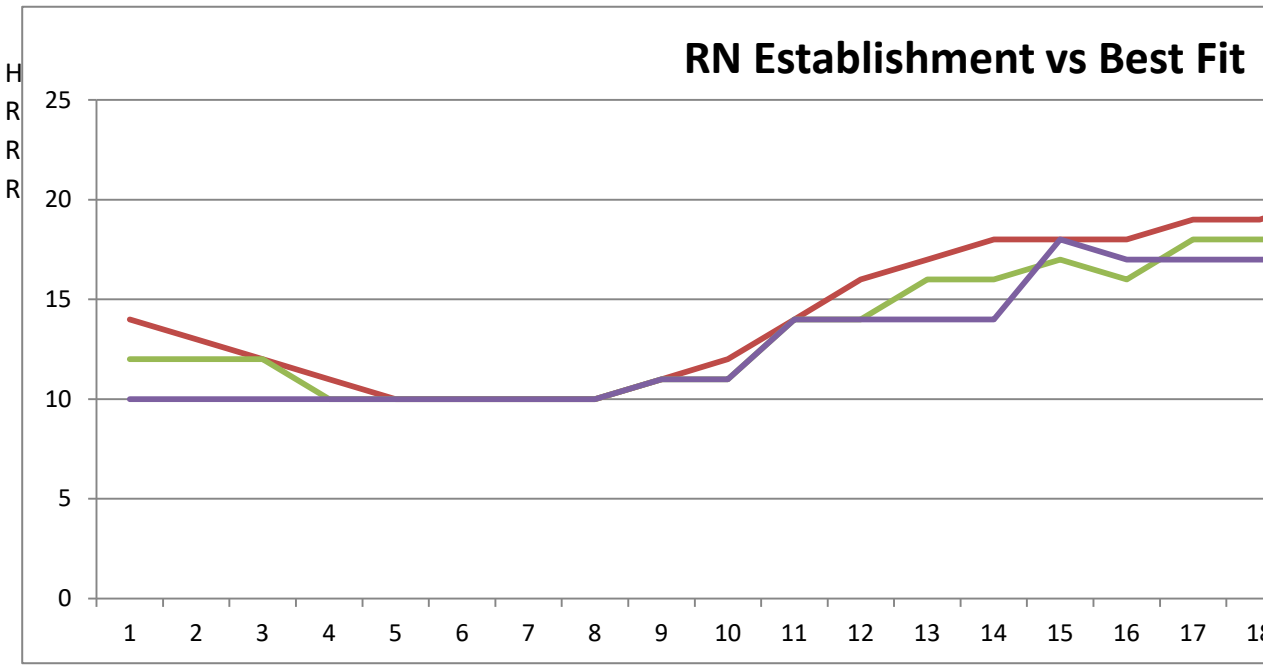
3.39%

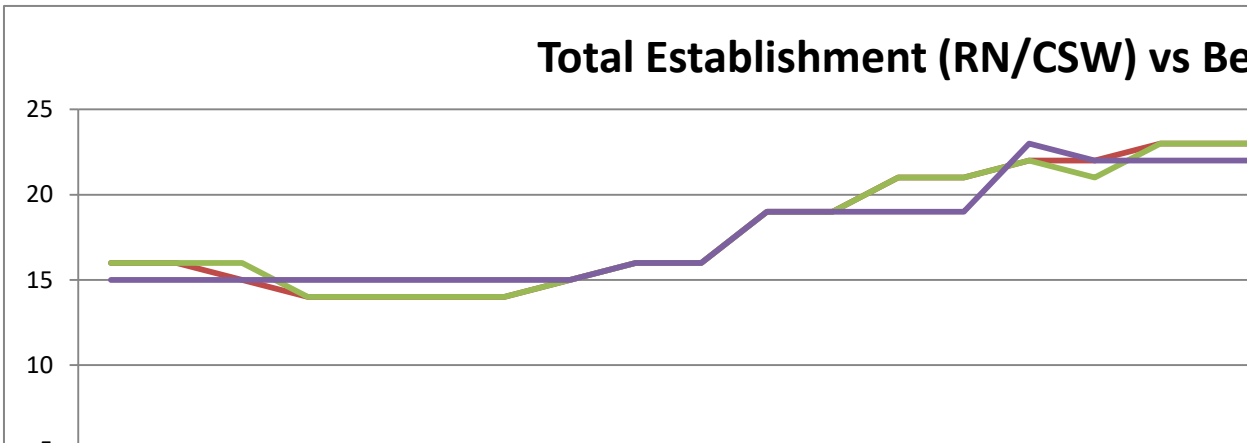
60 min break

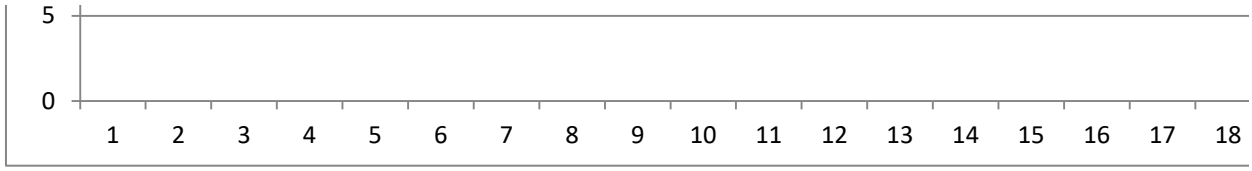
DRAFT for REVIEW

Desc	Hour of the Day														
Hour	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Best fit (head count)	16	16	15	14	14	14	14	15	16	16	19	19	21	21	22
Option A	16	16	16	14	14	14	14	15	16	16	19	19	21	21	22
Variance to best fit	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Option B (current NA)	15	15	15	15	15	15	15	15	16	16	19	19	19	19	23
Variance to best fit	**(1)**	**(1)**	**0**	**1**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**(2)**	**(2)**	**1**
Option B (future NA)	15	15	15	15	15	15	15	15	16	16	19	19	19	19	23
Variance to best fit	**(1)**	**(1)**	**0**	**1**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**(2)**	**(2)**	**1**

Hand over (30 mins)



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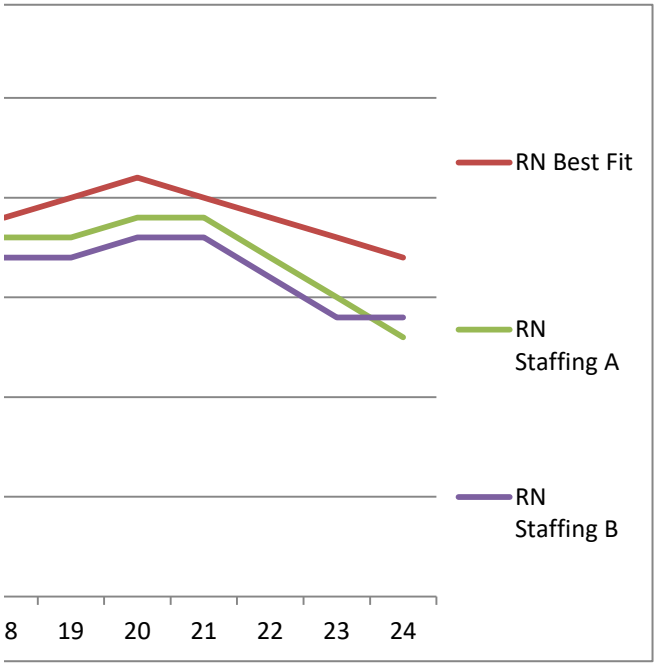
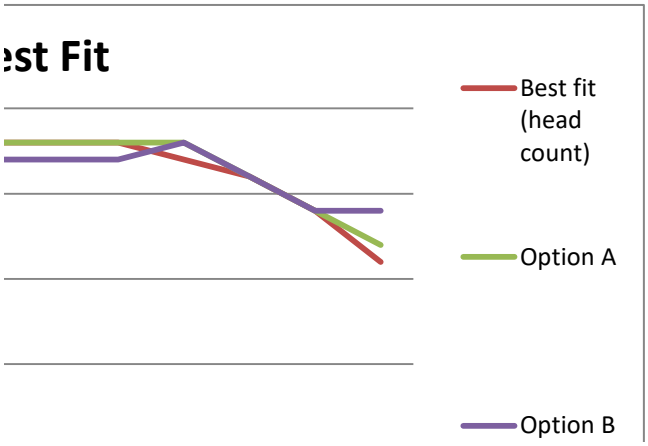
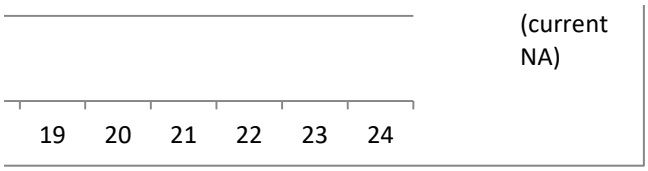
15	16	17	18	19	20	21	22	23
22	23	23	23	23	22	21	19	16
21	23	23	23	23	23	21	19	17
(1)	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**
22	22	22	22	22	23	21	19	19
0	**(1)**	**(1)**	**(1)**	**(1)**	**1**	**0**	**0**	**3**
22	22	22	22	22	23	21	19	19
0	**(1)**	**(1)**	**(1)**	**(1)**	**1**	**0**	**0**	**3**

Hand over (30 mins)







(current
NA)

Rota Model | **Enhancements** | **Shift Rota Pattern (head count)**

Description	Shift Detail (Free text)	Backfill Required (Y/N)	Start Time	Finish Time	Duration Hrs/Mins	Duration Minutes	Breaks Minutes i.e. (30)	Paid Hours	Hours at Sun/BH Rate	Hours at Sat/Night Rate	Hours at Standard Rate	Total Hours	Night Rate Override	Enhancement % Enhance% Reg/Band4	Enhance% Band3	Enhance% Band2	Enhance% Band1	Mon Reg	Mon HCA	Tue Reg	Tue HCA	Wed Reg	Wed HCA	Thu Reg	Thu HCA	Fri Reg	Fri HCA	Sat Reg	Sat HCA	Sun Reg	Sun HCA
PDN	Weekday	N	09:00	17:00	08:00	480	(30)	7.50		00:00	08:00	08:00	N	0.00%	0.00%	0.00%	0.00%	1		1											
PDN	Weekday	N	09:00	20:00	11:00	660	(30)	10.50		00:00	11:00	11:00	N	0.00%	0.00%	0.00%	0.00%	1													
	Ward Manager	N	09:00	17:00	08:00	480	(30)	7.50		00:00	08:00	08:00	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday	RN Long Day (PB 7)	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday	RN Long Day (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%	3		3		3		3		3					
Weekday	RN Long Day (PB 5)	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%	3		3		3		3		3					
Weekday	RN Early	Y	07:00	15:00	08:00	480	(30)	7.50		00:00	08:00	08:00	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday	RN 10am 9pm	Y	10:00	21:00	11:00	660	(60)	10.00		01:00	10:00	11:00	N	2.73%	3.18%	3.82%	4.36%	2		2		2		2		2					
Weekday	Band 4 10 till 10	Y	10:00	22:00	12:00	720	(60)	11.00		02:00	10:00	12:00	N	5.00%	5.83%	7.00%	8.00%		1		1		1		1		1				
Weekday	Band 4 2 till midnight	Y	14:00	00:00	10:00	600	(60)	9.00		04:00	06:00	10:00	N	12.00%	14.00%	16.80%	19.20%		1		1		1		1		1				
Weekday	Paeds RN LD (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday	Paeds RN LD (PB 5)	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday	ENP E (BP6)	Y	08:00	15:00	07:00	420	(30)	6.50		00:00	07:00	07:00	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday	ENP L (PB 6)	Y	15:00	22:00	07:00	420	(30)	6.50		02:00	05:00	07:00	N	8.57%	10.00%	12.00%	13.71%	1		1		1		1		1					
Weekday	CSW LD	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%		5		5		5		5		5				
Weekday	RN 12 till 2300	Y	12:00	23:00	11:00	660	(60)	10.00		03:00	08:00	11:00	N	8.18%	9.55%	11.45%	13.09%	2		2		2		2		2					
Weekday	**Night**	Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday	RN night (PB 7)	Y	19:00	07:30	12:30	750	(60)	11.50		10:00	02:30	12:30	Y	30.00%	35.00%	42.00%	48.00%	1		1		1		1		1					
Weekday	RN night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50		10:00	02:30	12:30	Y	30.00%	35.00%	42.00%	48.00%	3		3		3		3		3					
Weekday	RN night (PB 5)	Y	19:00	07:30	12:30	750	(60)	11.50		10:00	02:30	12:30	Y	30.00%	35.00%	42.00%	48.00%	4		4		4		4		4					
Weekday	RN Paeds night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50		10:00	02:30	12:30	Y	30.00%	35.00%	42.00%	48.00%	1		1		1		1		1					
Weekday	RN Paeds night (PB 5)	Y	19:00	07:30	12:30	750	(60)	11.50		10:00	02:30	12:30	Y	30.00%	35.00%	42.00%	48.00%	1		1		1		1		1					
Weekday	CSW Band 2 night	Y	20:00	07:00	11:00	660	(60)	10.00		10:00	01:00	11:00	Y	30.00%	35.00%	42.00%	48.00%		4		4		4		4		4				
Weekday	RN twilight	Y	16:00	03:00	11:00	660	(60)	10.00		07:00	04:00	11:00	Y	30.00%	35.00%	42.00%	48.00%	2		2		2		2		2					
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Saturday	RN Long Day (PB 7)	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%											1			
Saturday	RN Long Day (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%											3			
Saturday	RN Long Day (PB 5)	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%											3			
Saturday	RN Early	Y	07:00	15:00	08:00	480	(30)	7.50	00:00	08:00		08:00		30.00%	35.00%	42.00%	48.00%											1			
Saturday	RN 10am 9pm	Y	10:00	21:00	11:00	660	(60)	10.00	00:00	11:00		11:00		30.00%	35.00%	42.00%	48.00%											2			
Saturday	Band 4 10 till 10	Y	10:00	22:00	12:00	720	(60)	11.00	00:00	12:00		12:00		30.00%	35.00%	42.00%	48.00%												1		
Saturday	Band 4 2 till midnight	Y	14:00	00:00	10:00	600	(60)	9.00	00:00	10:00		10:00		30.00%	35.00%	42.00%	48.00%												1		
Saturday	Paeds RN LD (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%											1			
Saturday	Paeds RN LD (PB 5)	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%											1			
Saturday	ENP E (BP6)	Y	08:00	15:00	07:00	420	(30)	6.50	00:00	07:00		07:00		30.00%	35.00%	42.00%	48.00%											1			
Saturday	ENP L (PB 6)	Y	15:00	22:00	07:00	420	(30)	6.50	00:00	07:00		07:00		30.00%	35.00%	42.00%	48.00%											1			
Saturday	CSW LD	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%												5		
Saturday	RN 12 till 2300	Y	12:00	23:00	11:00	660	(60)	10.00	00:00	11:00		11:00		30.00%	35.00%	42.00%	48.00%											2			
Saturday	Night	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	RN night (PB 7)	Y	19:00	07:30	12:30	750	(60)	11.50	07:30	05:00		12:30		48.00%	56.00%	67.20%	76.20%											1			
Saturday	RN night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50	07:30	05:00		12:30		48.00%	56.00%	67.20%	76.20%											3			
Saturday	RN night (PB 5)	Y	19:00	07:30	12:30	750	(60)	11.50	07:30	05:00		12:30		48.00%	56.00%	67.20%	76.20%											4			
Saturday	RN Paeds night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50	07:30	05:00		12:30		48.00%	56.00%	67.20%	76.20%											1			
Saturday	RN Paeds night (PB 5)	Y	19:00	07:30	12:30	750	(60)	11.50	07:30	05:00		12:30		48.00%	56.00%	67.20%	76.20%											1			
Saturday	CSW Band 2 night	Y	20:00	07:00	11:00	660	(60)	10.00	07:00	04:00		11:00		49.09%	57.27%	68.73%	77.91%												4		
Saturday	RN twilight	Y	16:00	03:00	11:00	660	(60)	10.00	03:00	08:00		11:00		38.18%	44.55%	53.45%	60.82%											2			
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Sunday	RN Long Day (PB 7)	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%													1	
Sunday	RN Long Day (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%													3	
Sunday	RN Long Day (PB 5)	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%													3	
Sunday	RN Early	Y	07:00	15:00	08:00	480	(30)	7.50	08:00	00:00		08:00		60.00%	70.00%	84.00%	95.00%													1	
Sunday	RN 10am 9pm	Y	10:00	21:00	11:00	660	(60)	10.00	11:00	00:00		11:00		60.00%	70.00%	84.00%	95.00%													2	
Sunday	Band 4 10 till 10	Y	10:00	22:00	12:00	720	(60)	11.00	12:00	00:00		12:00		60.00%	70.00%	84.00%	95.00%														1
Sunday	Band 4 2 till midnight	Y	14:00	00:00	10:00	600	(60)	9.00	10:00	00:00		10:00		60.00%	70.00%	84.00%	95.00%														1
Sunday	Paeds RN LD (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%													1	
Sunday	Paeds RN LD (PB 5)	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%													1	
Sunday	ENP E (BP6)	Y	08:00	15:00	07:00	420	(30)	6.50	07:00	00:00		07:00		60.00%	70.00%	84.00%	95.00%													1	
Sunday	ENP L (PB 6)	Y	15:00	22:00	07:00	420	(30)	6.50	07:00	00:00		07:00		60.00%	70.00%	84.00%	95.00%													1	
Sunday	CSW LD	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%														5
Sunday	RN 12 till 2300	Y	12:00	23:00	11:00	660	(60)	10.00	11:00	00:00		11:00		60.00%	70.00%	84.00%	95.00%													2	
Sunday	Night	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	RN night (PB 7)	Y	19:00	07:30	12:30	750	(60)	11.50	05:00	07:30		12:30		42.00%	49.00%	58.80%	66.80%													1	
Sunday	RN night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50	05:00	07:30		12:30		42.00%	49.00%	58.80%	66.80%													3	
Sunday	RN night (PB 5)	Y	19:00	07:30	12:30	750	(60)	11.50	05:00	07:30		12:30		42.00%	49.00%	58.80%	66.80%													4	
Sunday	RN Paeds night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50	05:00	07:30		12:30		42.00%	49.00%	58.80%	66.80%													1	
Sunday	RN Paeds night (PB 5)	Y	19:00	07:30	12:30	750	(60)	11.50	05:00	07:30		12:30		42.00%	49.00%	58.80%	66.80%													1	
Sunday	CSW Band 2 night	Y	20:00	07:00	11:00	660	(60)	10.00	04:00	07:00		11:00		40.91%	47.73%	57.27%	65.09%														4
Sunday	RN twilight	Y	16:00	03:00	11:00	660	(60)	10.00	08:00	03:00		11:00		51.82%	60.45%	72.55%	82.18%													2	
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														

Rota Model

Enhancements

Shift Rota Pattern (head count)

Description	Shift Detail (Free text)	Backfill Required (Y/N)	Start Time	Finish Time	Duration Hrs/Mins	Duration Minutes	Breaks Minutes i.e. (30)	Paid Hours	Hours at Sun/BH Rate	Hours at Sat/Night Rate	Hours at Standard Rate	Total Hours	Enhancement % Night Rate Override	Enhance% Reg/Band4	Enhance% Band3	Enhance% Band2	Enhance% Band1	Mon Reg	Mon HCA	Tue Reg	Tue HCA	Wed Reg	Wed HCA	Thu Reg	Thu HCA	Fri Reg	Fri HCA	Sat Reg	Sat HCA	Sun Reg	Sun HCA
PDN	Weekday	N	09:00	17:00	08:00	480	(30)	7.50		00:00	08:00	08:00	N	0.00%	0.00%	0.00%	0.00%	1		1											
PDN	Weekday	N	09:00	20:00	11:00	660	(30)	10.50		00:00	11:00	11:00	N	0.00%	0.00%	0.00%	0.00%	1													
	Ward Manager	N	09:00	17:00	08:00	480	(30)	7.50		00:00	08:00	08:00	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday (No B/H)					00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday	RN Long Day (PB 7)	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday	RN Long Day (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%	3		3		3		3		3					
Weekday	RN Long Day (PB 5) 1 band 4	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%	2	1	2	1	2	1	2	1	2	1				
Weekday	RN Early	Y	07:00	15:00	08:00	480	(30)	7.50		00:00	08:00	08:00	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday	RN 10am 9pm	Y	10:00	21:00	11:00	660	(60)	10.00		01:00	10:00	11:00	N	2.73%	3.18%	3.82%	4.36%	2		2		2		2		2					
Weekday	Band 4 10 till 10	Y	10:00	22:00	12:00	720	(60)	11.00		02:00	10:00	12:00	N	5.00%	5.83%	7.00%	8.00%		1		1		1		1		1				
Weekday	Band 5 2 till midnight	Y	14:00	00:00	10:00	600	(60)	9.00		04:00	06:00	10:00	N	12.00%	14.00%	16.80%	19.20%	1	0	1	0	1	0	1	0	1	0				
Weekday	Paeds RN LD (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday	Paeds RN LD (PB 5)	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday	ENP E (BP6)	Y	08:00	15:00	07:00	420	(30)	6.50		00:00	07:00	07:00	N	0.00%	0.00%	0.00%	0.00%	1		1		1		1		1					
Weekday	ENP L (PB 6)	Y	15:00	22:00	07:00	420	(30)	6.50		02:00	05:00	07:00	N	8.57%	10.00%	12.00%	13.71%	1		1		1		1		1					
Weekday	CSW LD	Y	07:00	19:30	12:30	750	(60)	11.50		00:00	12:30	12:30	N	0.00%	0.00%	0.00%	0.00%		5		5		5		5		5				
Weekday	RN 14 till 0:00	Y	14:00	00:00	10:00	600	(60)	9.00		04:00	06:00	10:00	N	12.00%	14.00%	16.80%	19.20%	3		3		3		3		3					
Weekday	**Night**	Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday	RN night (PB 7)	Y	19:00	07:30	12:30	750	(60)	11.50		10:00	02:30	12:30	Y	30.00%	35.00%	42.00%	48.00%	1		1		1		1		1					
Weekday	RN night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50		10:00	02:30	12:30	Y	30.00%	35.00%	42.00%	48.00%	3		3		3		3		3					
Weekday	RN night (PB 5) 1 band 4	Y	19:00	07:30	12:30	750	(60)	11.50		10:00	02:30	12:30	Y	30.00%	35.00%	42.00%	48.00%	3	1	3	1	3	1	3	1	3	1				
Weekday	RN Paeds night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50		10:00	02:30	12:30	Y	30.00%	35.00%	42.00%	48.00%	1		1		1		1		1					
Weekday	RN Paeds night (PB 5)	Y	19:00	07:30	12:30	750	(60)	11.50		10:00	02:30	12:30	Y	30.00%	35.00%	42.00%	48.00%	1		1		1		1		1					
Weekday	CSW Band 2 night	Y	20:00	07:00	11:00	660	(60)	10.00		10:00	01:00	11:00	Y	30.00%	35.00%	42.00%	48.00%		5		5		5		5		5				
Weekday	~~RN twilight~~	Y	~~16:00~~	~~03:00~~	11:00	660	(60)	10.00		07:00	04:00	11:00	Y	30.00%	35.00%	42.00%	48.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Weekday		Y			00:00	0		0.00		04:00	20:00	00:00	N	5.00%	5.83%	7.00%	8.00%														
Saturday	RN Long Day (PB 7)	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%											1			
Saturday	RN Long Day (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%											3			
Saturday	RN Long Day (PB 5) 1 band 4	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%											2	1		
Saturday	RN Early	Y	07:00	15:00	08:00	480	(30)	7.50	00:00	08:00		08:00		30.00%	35.00%	42.00%	48.00%											1			
Saturday	RN 10am 9pm	Y	10:00	21:00	11:00	660	(60)	10.00	00:00	11:00		11:00		30.00%	35.00%	42.00%	48.00%											2			
Saturday	Band 4 10 till 10	Y	10:00	22:00	12:00	720	(60)	11.00	00:00	12:00		12:00		30.00%	35.00%	42.00%	48.00%												1		
Saturday	Band 5 2 till midnight	Y	14:00	00:00	10:00	600	(60)	9.00	00:00	10:00		10:00		30.00%	35.00%	42.00%	48.00%											1	0		
Saturday	Paeds RN LD (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%											1			
Saturday	Paeds RN LD (PB 5)	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%											1			
Saturday	ENP E (BP6)	Y	08:00	15:00	07:00	420	(30)	6.50	00:00	07:00		07:00		30.00%	35.00%	42.00%	48.00%											1			
Saturday	ENP L (PB 6)	Y	15:00	22:00	07:00	420	(30)	6.50	00:00	07:00		07:00		30.00%	35.00%	42.00%	48.00%											1			
Saturday	CSW LD	Y	07:00	19:30	12:30	750	(60)	11.50	00:00	12:30		12:30		30.00%	35.00%	42.00%	48.00%												5		
Saturday	RN 14 till 0:00	Y	14:00	00:00	10:00	600	(60)	9.00	00:00	10:00		10:00		30.00%	35.00%	42.00%	48.00%											3			
Saturday	Night	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	RN night (PB 7)	Y	19:00	07:30	12:30	750	(60)	11.50	07:30	05:00		12:30		48.00%	56.00%	67.20%	76.20%											1			
Saturday	RN night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50	07:30	05:00		12:30		48.00%	56.00%	67.20%	76.20%											3			
Saturday	RN night (PB 5) 1 band 4	Y	19:00	07:30	12:30	750	(60)	11.50	07:30	05:00		12:30		48.00%	56.00%	67.20%	76.20%											3	1		
Saturday	RN Paeds night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50	07:30	05:00		12:30		48.00%	56.00%	67.20%	76.20%											1			
Saturday	RN Paeds night (PB 5)	Y	19:00	07:30	12:30	750	(60)	11.50	07:30	05:00		12:30		48.00%	56.00%	67.20%	76.20%											1			
Saturday	CSW Band 2 night	Y	20:00	07:00	11:00	660	(60)	10.00	07:00	04:00		11:00		49.09%	57.27%	68.73%	77.91%												5		
Saturday	~~RN twilight~~	Y	~~16:00~~	~~03:00~~	11:00	660	(60)	10.00	03:00	08:00		11:00		38.18%	44.55%	53.45%	60.82%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Saturday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		30.00%	35.00%	42.00%	48.00%														
Sunday	RN Long Day (PB 7)	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%													1	
Sunday	RN Long Day (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%													3	
Sunday	RN Long Day (PB 5) 1 band 4	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%													2	1
Sunday	RN Early	Y	07:00	15:00	08:00	480	(30)	7.50	08:00	00:00		08:00		60.00%	70.00%	84.00%	95.00%													1	
Sunday	RN 10am 9pm	Y	10:00	21:00	11:00	660	(60)	10.00	11:00	00:00		11:00		60.00%	70.00%	84.00%	95.00%													2	
Sunday	Band 4 10 till 10	Y	10:00	22:00	12:00	720	(60)	11.00	12:00	00:00		12:00		60.00%	70.00%	84.00%	95.00%														1
Sunday	Band 5 2 till midnight	Y	14:00	00:00	10:00	600	(60)	9.00	10:00	00:00		10:00		60.00%	70.00%	84.00%	95.00%													1	0
Sunday	Paeds RN LD (PB 6)	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%													1	
Sunday	Paeds RN LD (PB 5)	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%													1	
Sunday	ENP E (BP6)	Y	08:00	15:00	07:00	420	(30)	6.50	07:00	00:00		07:00		60.00%	70.00%	84.00%	95.00%													1	
Sunday	ENP L (PB 6)	Y	15:00	22:00	07:00	420	(30)	6.50	07:00	00:00		07:00		60.00%	70.00%	84.00%	95.00%													1	
Sunday	CSW LD	Y	07:00	19:30	12:30	750	(60)	11.50	12:30	00:00		12:30		60.00%	70.00%	84.00%	95.00%														5
Sunday	RN 14 till 0:00	Y	14:00	00:00	10:00	600	(60)	9.00	10:00	00:00		10:00		60.00%	70.00%	84.00%	95.00%													3	
Sunday	Night	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	RN night (PB 7)	Y	19:00	07:30	12:30	750	(60)	11.50	05:00	07:30		12:30		42.00%	49.00%	58.80%	66.80%													1	
Sunday	RN night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50	05:00	07:30		12:30		42.00%	49.00%	58.80%	66.80%													3	
Sunday	RN night (PB 5) 1 band 4	Y	19:00	07:30	12:30	750	(60)	11.50	05:00	07:30		12:30		42.00%	49.00%	58.80%	66.80%													3	1
Sunday	RN Paeds night (PB 6)	Y	19:00	07:30	12:30	750	(60)	11.50	05:00	07:30		12:30		42.00%	49.00%	58.80%	66.80%													1	
Sunday	RN Paeds night (PB 5)	Y	19:00	07:30	12:30	750	(60)	11.50	05:00	07:30		12:30		42.00%	49.00%	58.80%	66.80%													1	
Sunday	CSW Band 2 night	Y	20:00	07:00	11:00	660	(60)	10.00	04:00	07:00		11:00		40.91%	47.73%	57.27%	65.09%														5
Sunday	~~RN twilight~~	Y	~~16:00~~	~~03:00~~	11:00	660	(60)	10.00	08:00	03:00		11:00		51.82%	60.45%	72.55%	82.18%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														
Sunday	0	Y	00:00	00:00	00:00	0	0	0.00	00:00	00:00		00:00		60.00%	70.00%	84.00%	95.00%														

Hour
Band 7 RN
Band 6 RN
Band 5 RN
Band 4 TNA
Band 6 Paeds RN
Band 5 Paeds RN
ENP B6
CSW B2
TOTAL WTE

Shift	Time	Band 7 RN	Band 6 RN	Band 5 RN	Band 4 TNA	Band 6 Paed
DAY SHIFTS						
RN LD	0700-1930	1	3	3		
RN E	0700-1500			1		
RN 10 till 2100	10 till 2100			2		
Band 4 10 till 10	10 till 10				1	
Band 4 2 till midnight	2 till 24				1	
Paeds RN LD	0700-1930					1
ENP E	0800-1500					
ENP L	1500-2200					
CSW LD	0700-1930					
RN 12 till 2300	12 till 2300			2		
NIGHT SHIFTS						
RN night	1900-0730	1	3	4		
RN Paeds night	1900 till 0730					1
CSW Band 2 night	2000 till 0700					
RN twilight	1600-0300			2		

0	1	2	3	4	5
1	1	1	1	1	1
3	3	3	3	3	3
6	6	5	4	4	4
0	0	0	0	0	0
1	1	1	1	1	1
1	1	1	1	1	1
0	0	0	0	0	0
4	4	4	4	4	4
16	16	15	14	14	14

Band 5 Paed	Band 6 ENP	Band 2 CSW					
1							
	1						
	1						
		5					
			8	8	8	8	8	8
1			2	2	2	2	2	2
		4	4	4	4	4	4	4
			2	2	2			
			16	16	16	14	14	14
			0	0	1	0	0	0

6	7	8	9	10	11	12	13	14
1	1	1	1	1	1	1	1	1
3	3	3	3	3	3	3	3	3
4	4	4	4	6	6	8	8	8
0	0	0	0	1	1	1	1	2
1	1	1	1	1	1	1	1	1
1	1	1	1	1	1	1	1	1
0	0	1	1	1	1	1	1	1
4	5	5	5	5	5	5	5	5
14	15	16	16	19	19	21	21	22

	7	7	7	7	7	7	7	7
	1	1	1	1	1	1	1	1
				2	2	2	2	2
				1	1	1	1	1
								1
	2	2	2	2	2	2	2	2
		1	1	1	1	1	1	1
	5	5	5	5	5	5	5	5
						2	2	2
8	8							
2	2							
4								
14	25	16	16	19	19	21	21	22
0	10	0	0	0	0	0	0	0

H/O

15	16	17	18	19	20	21	22	23
1	1	1	1	1	1	1	1	1
3	3	3	3	3	3	3	3	3
8	9	9	9	9	9	8	8	5
2	2	2	2	2	2	2	1	1
1	1	1	1	1	1	1	1	1
1	1	1	1	1	1	1	1	1
1	1	1	1	1	1	1	0	0
5	5	5	5	5	4	4	4	4
22	23	23	23	23	22	21	19	16

7	7	7	7	7				
2	2	2	2	2	2			
1	1	1	1	1	1	1		
1	1	1	1	1	1	1	1	1
2	2	2	2	2				
1	1	1	1	1	1	1		
5	5	5	5	5				
2	2	2	2	2	2	2	2	
				8	8	8	8	8
				2	2	2	2	2
					4	4	4	4
	2	2	2	2	2	2	2	2
21	23	23	23	33	23	21	19	17
-1	0	0	0	10	1	0	0	1

H/O

24	Band 7 RN
72	Band 6 RN
155	Band 5 RN
22	Band 4 TNA
24	Band 6 Paeds RN
24	Band 5 Paeds RN
14	ENP B6
109	CSW B2
444	

Hour
Band 7 RN
Band 6 RN
Band 5 RN
Band 4 TNA
Band 6 Paeds RN
Band 5 Paeds RN
ENP B6
CSW B2
TOTAL WTE

Shift	Time	Band 7 RN	Band 6 RN	Band 5 RN	Band 4 NA	Band 6 Paed
DAY SHIFTS						
RN LD	0700-1930	1	3	2	1	
RN E	0700-1500			1		
RN 10 till 2100	10 till 2100			2		
Band 4 10 till 10	10 till 10				1	
Band 4 2 till midnight	2 till 24			1		
Paeds RN LD	0700-1930					1
ENP E	0800-1500					
ENP L	1500-2200					
CSW LD	0700-1930					
RN 14 till 2400	14 till 2400			3		
NIGHT SHIFTS						
RN night	1900-0730	1	3	3	1	
RN Paeds night	1900 till 0730					1
CSW Band 2 night	2000 till 0700					
RN twilight	1600-0300					

0	1	2	3	4	5
1	1	1	1	1	1
3	3	3	3	3	3
6	6	5	4	4	4
0	0	0	0	0	0
1	1	1	1	1	1
1	1	1	1	1	1
0	0	0	0	0	0
4	4	4	4	4	4
16	16	15	14	14	14

Band 5 Paed	Band 6 ENP	Band 2 CSW					
1							
	1						
	1						
		5					
			8	8	8	8	8	8
1			2	2	2	2	2	2
		5	5	5	5	5	5	5
			15	15	15	15	15	15
			-1	-1	0	1	1	1

6	7	8	9	10	11	12	13	14
1	1	1	1	1	1	1	1	1
3	3	3	3	3	3	3	3	3
4	4	4	4	6	6	8	8	8
0	0	0	0	1	1	1	1	2
1	1	1	1	1	1	1	1	1
1	1	1	1	1	1	1	1	1
0	0	1	1	1	1	1	1	1
4	5	5	5	5	5	5	5	5
14	15	16	16	19	19	21	21	22

	7	7	7	7	7	7	7	7
	1	1	1	1	1	1	1	1
				2	2	2	2	2
				1	1	1	1	1
								1
	2	2	2	2	2	2	2	2
		1	1	1	1	1	1	1
	5	5	5	5	5	5	5	5
								3
8	8							
2	2							
5								
15	25	16	16	19	19	19	19	23
1	10	0	0	0	0	-2	-2	1

H/O

15	16	17	18	19	20	21	22	23
1	1	1	1	1	1	1	1	1
3	3	3	3	3	3	3	3	3
8	9	9	9	9	9	8	8	5
2	2	2	2	2	2	2	1	1
1	1	1	1	1	1	1	1	1
1	1	1	1	1	1	1	1	1
1	1	1	1	1	1	1	0	0
5	5	5	5	5	4	4	4	4
22	23	23	23	23	22	21	19	16

7	7	7	7	7				
2	2	2	2	2	2			
1	1	1	1	1	1	1		
1	1	1	1	1	1	1	1	1
2	2	2	2	2				
1	1	1	1	1	1	1		
5	5	5	5	5				
3	3	3	3	3	3	3	3	3
				8	8	8	8	8
				2	2	2	2	2
					5	5	5	5
22	22	22	22	32	23	21	19	19
0	-1	-1	-1	9	1	0	0	3

H/O

24	Band 7 RN
72	Band 6 RN
155	Band 5 RN
22	Band 4 TNA
24	Band 6 Paeds RN
24	Band 5 Paeds RN
14	ENP B6
109	CSW B2
444	

MEETING OF THE TRUST BOARD - 4th July 2019			
Hospital Mortality			**AGENDA ITEM: 12** **Enc 9**
Report Author and Job Title:	Uzo Ibechukwu Project Manager – Medical Directorate	**Responsible Director:**	Dr Matthew Lewis Medical Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report details the performance against the hospital mortality indicators. Deaths in hospital have fallen compared to the last two years and Crude mortality has started to reduce. We have received a CuSum (Cumulative SUM of outcomes) alert for January and February 2019 (acute and unspecified renal failure) is under investigation by the Coding Department. Although the statutory requirement for Medical Examiners has been deferred to April 2020, the Medical Examiner strategy is being implemented in the Trust, starting from September 2019. A major review of the Learning from Death Policy is underway to respond to: • NHSI recommendations following local observations • CQC risk identified during their inspection • Internal audit recommendations • Commissioner's contract performance notice (CPN015) In future, monthly reporting will align to the NHSI framework for number of deaths, Learning Disability deaths, reviews and quality of care identified; plus those reviews that trigger an incident report where care has been determined as inadequate.		
Recommendations	Members of the Committee are asked to note: • Key mortality indices are comparable with similar trusts • Improvements in the mortality review process are continuing • Implementation of the Medical Examiner statutory requirements		
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 Performance against SHMI is recorded as a risk on the risk register for the trust.		

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. Not all of the business case is required to ensure statutory compliance.	
Legal and Equality and Diversity implications	The equality and diversity implications to the trust for patients with learning disabilities are managed as per the trust policy and LeDeR recommendations. The policy must assure that all patient care within the organisation is equitable.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Hospital Mortality

Introduction

This report details:

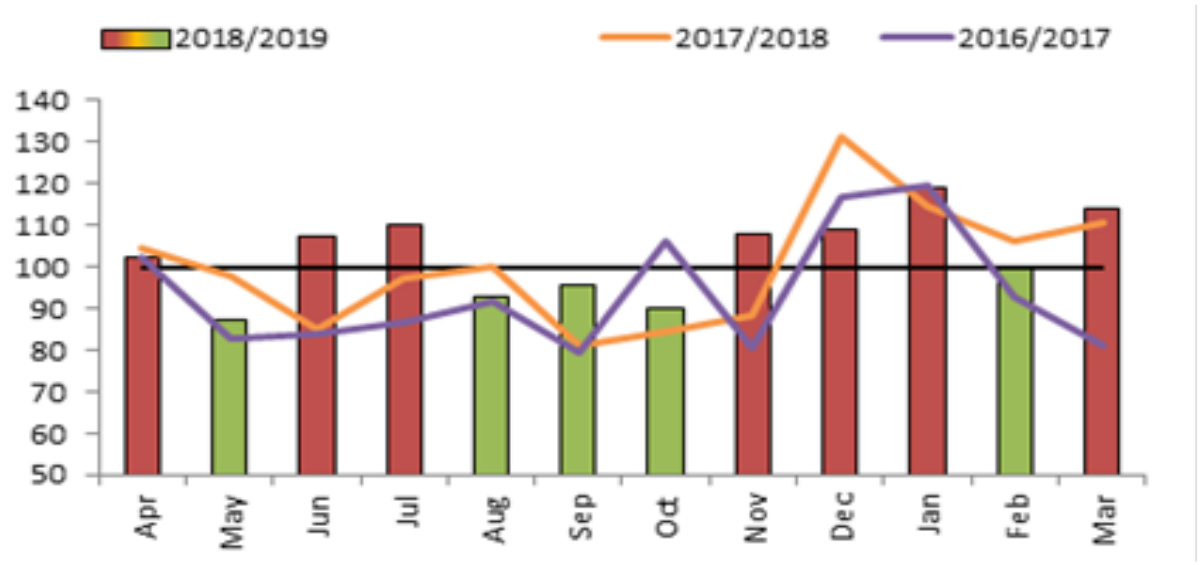
1. **Performance** data relevant to the trust, compared with regional and national comparator sites, where appropriate
2. **Key areas for attention**, together with analysis, actions and outcomes
3. **Future actions** and developments in understanding mortality data

1. PERFORMANCE

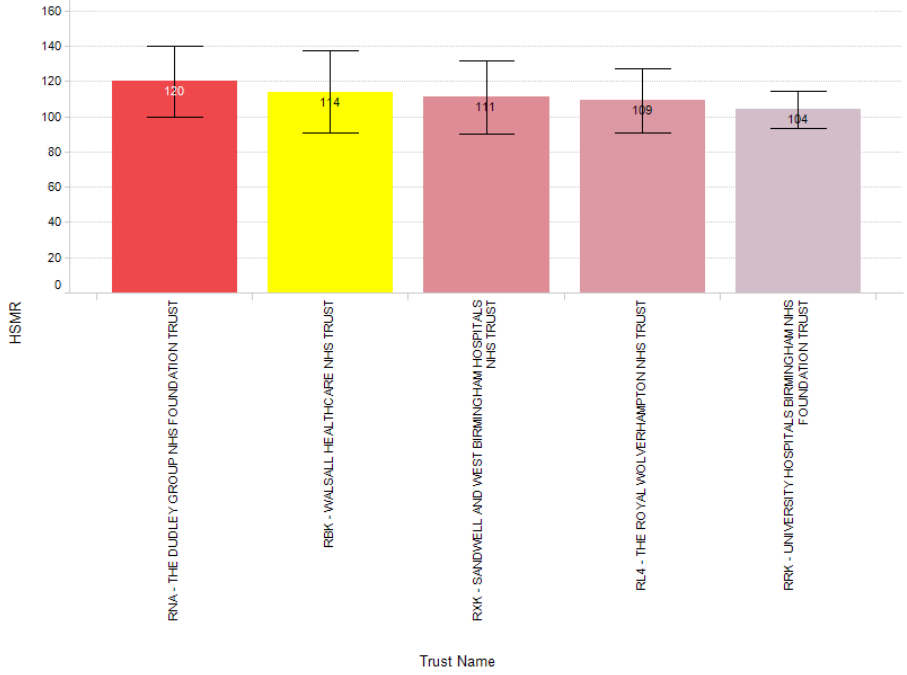
National Benchmarks

The Trust uses two national benchmarks as primary indicators for mortality, Hospital Standard Mortality rate (HSMR) and Standard Hospital Mortality Index (SHMI). Delays in reporting SHMI are due to data issues with NHS Digital and HED.

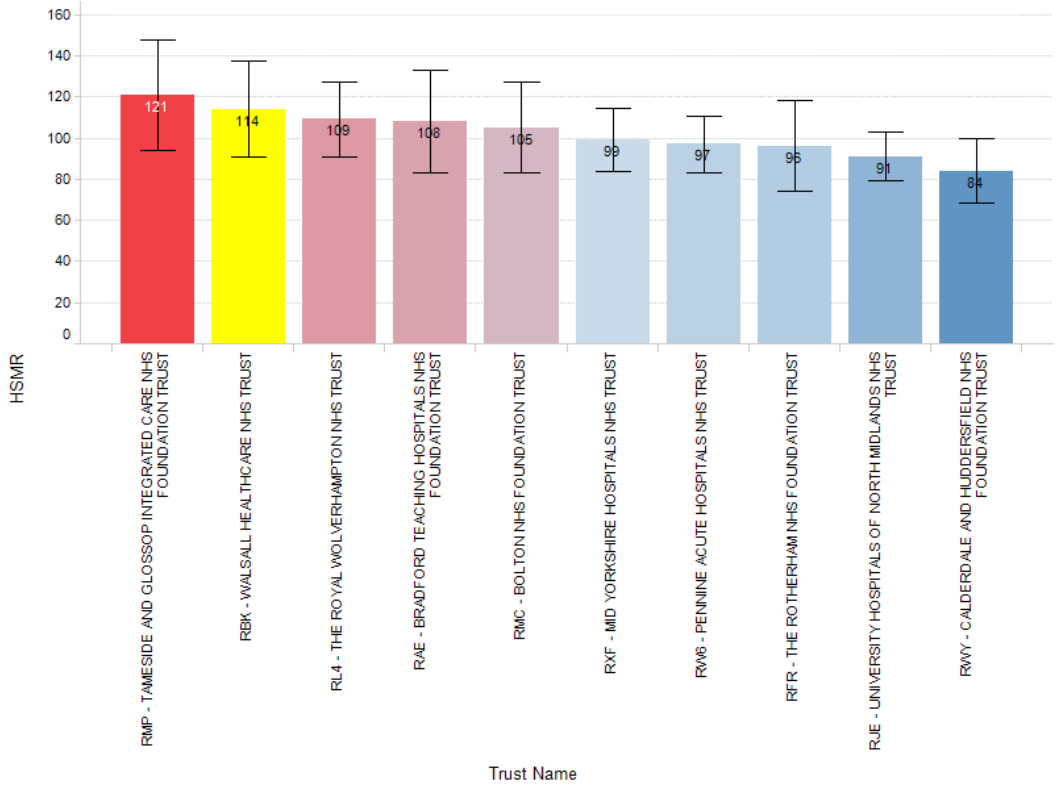
HSMR 2018/19 v. previous 2 years



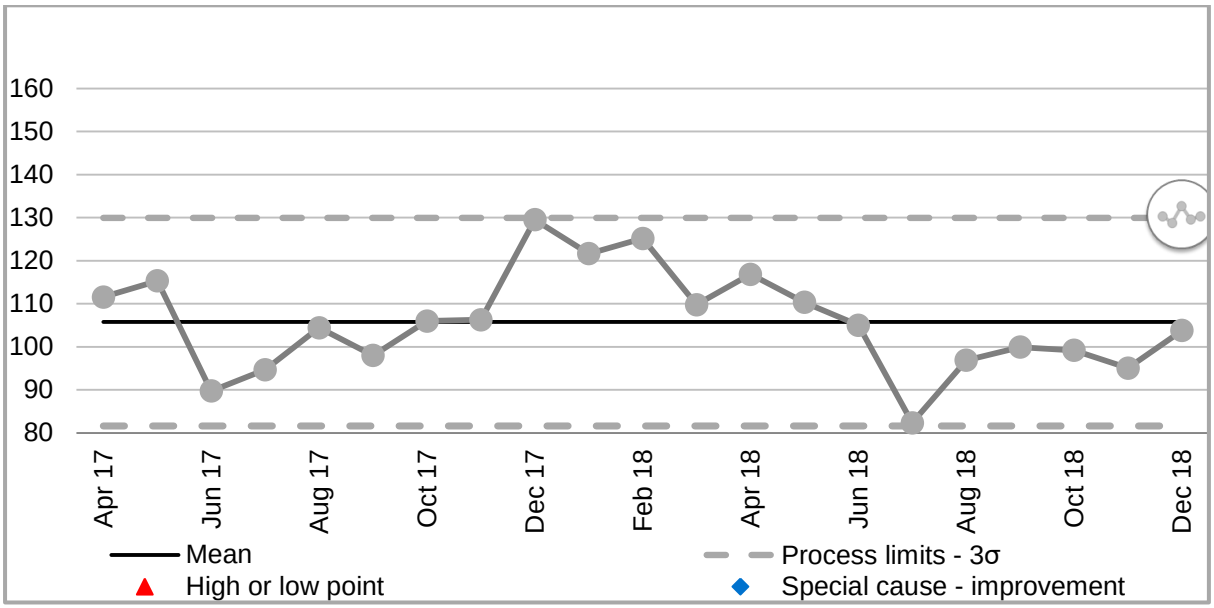
HSMR performance 2018/19 v. regional comparators



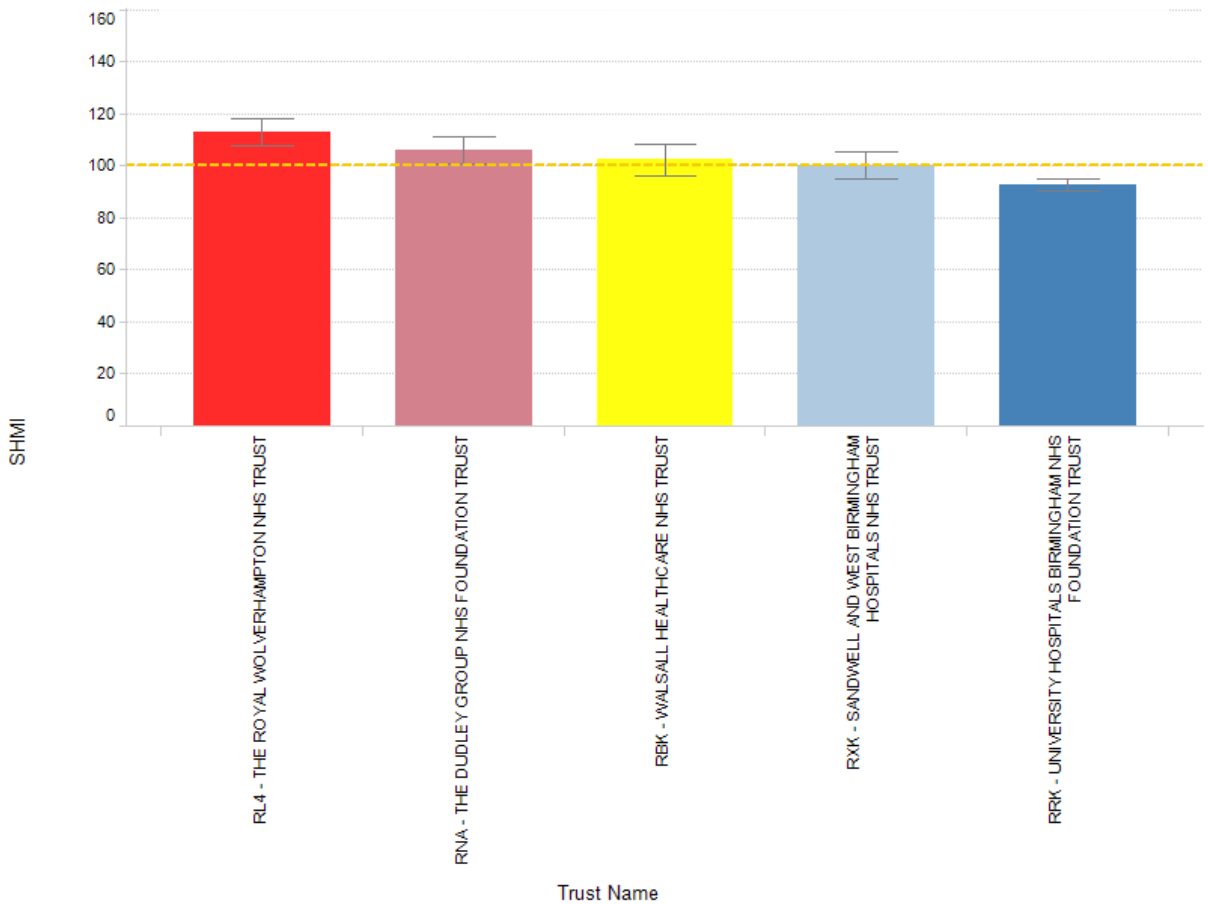
HSMR performance v. national comparators



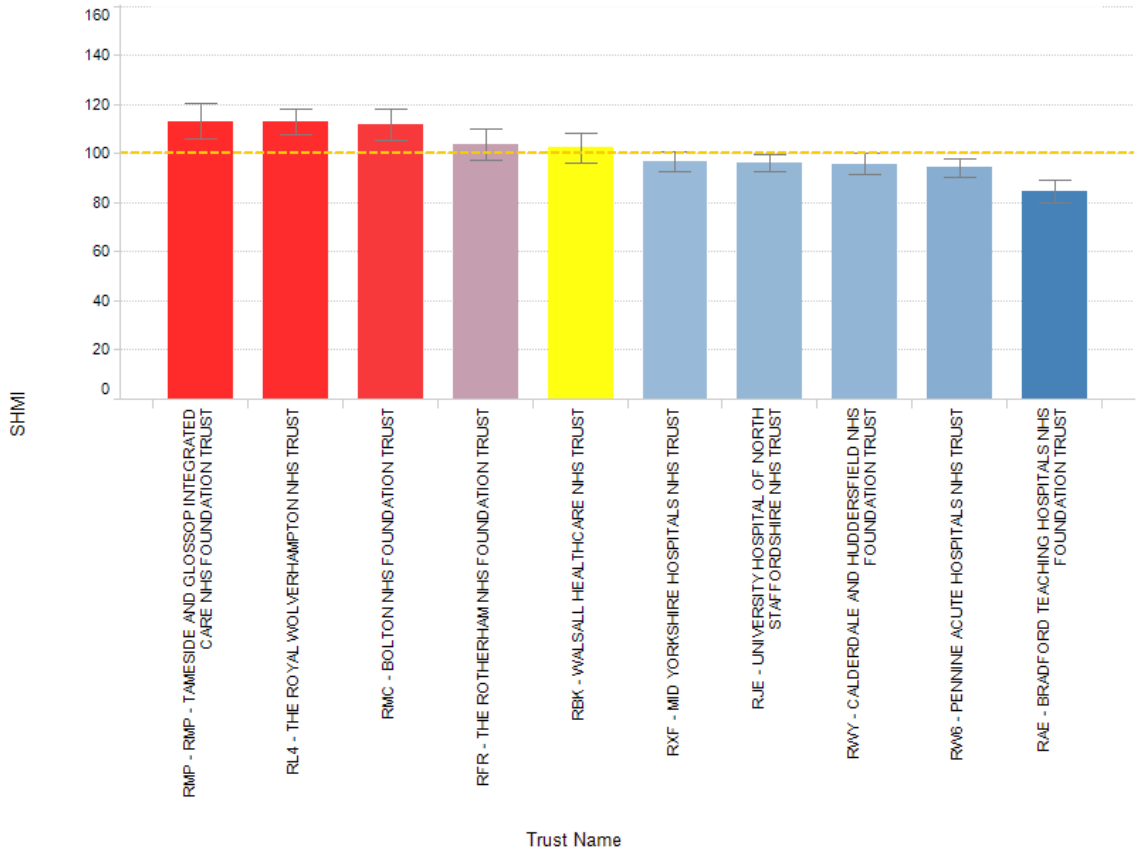
SHMI 2017 – 2018



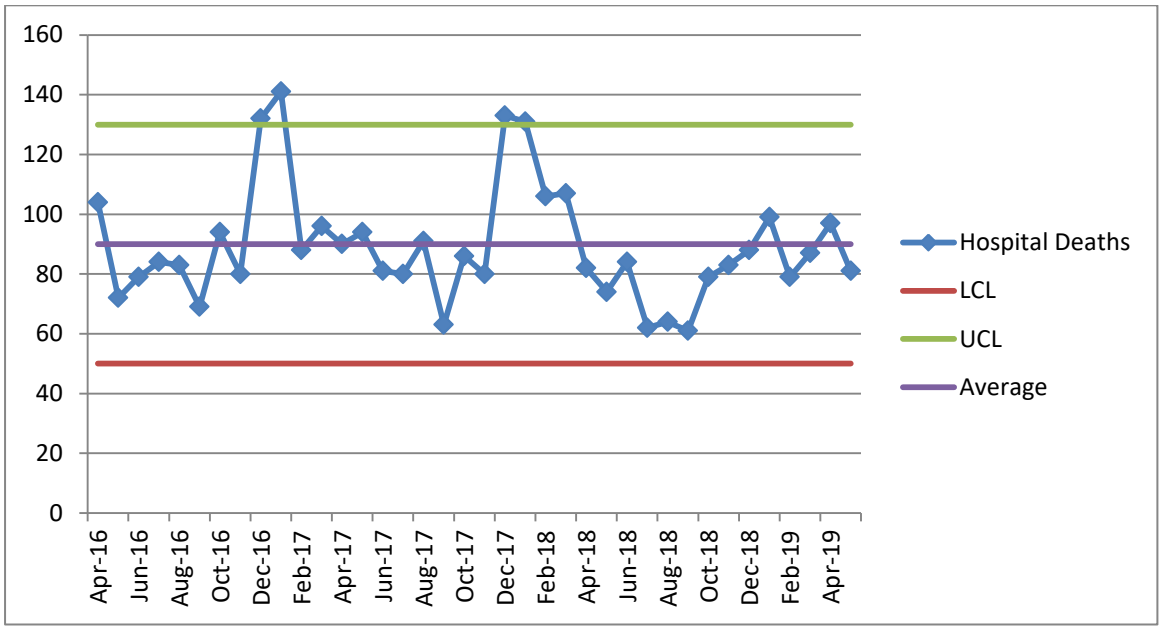
SHMI performance 2018/19 v. regional comparators



SHMI performance 2018/19 v. national comparators



In hospital deaths 2016 – 2019
Total numbers of deaths in hospital have been stable for the past 12 months.



Process for reviewing deaths in hospital
The Trust has aspired 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 and using the SJR tool.

The trust has historically required up to 75% of deaths to undergo formal SJR review, based on pre-determined triggers. This process will be reviewed to align to the developments for implementing the role of the Medical Examiner and to the learning from death strategy. It is expected that fewer deaths will receive formal SJR in future, in keeping with the national guidance (pilot sites have determined that approximately 50% of deaths progress to a formal SJR review).

A number of reviews as referenced in the NQB guidelines as a minimal requirement will undergo formal SJR:

- All deaths where a bereaved family, carer or staff have raised a concern
- Patient deaths of those with a learning disability
- Patient deaths of those with a mental illness
- Unexpected deaths, such as following an elective procedure
- Particular groups where an alarm has been raised for example via HSMR, SHMI or CQC
- Deaths occurring where a patient has been readmitted to the trust within 30 days of a previous discharge
- All maternal deaths
- All child deaths, over 16 years of age
- All perinatal and still birth deaths.

Top 10 causes of death derived from HSMR

Diagnostic Group		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
55 - Fluid and electrolyte disorders	Deaths	3	1	0	1	2	0	1	0	2	0	0	2	12
	HSMR	385.69	222.5	0	135.84	337.49	0	168.28	0	224.75	0	0	236.66	
131 - Respiratory failure; insufficiency; arrest (adult)	Deaths	5	1	0	1	3	3	3	3	6	5	2	3	35
	HSMR	301.07	675.43	0	96.62	126.77	246.48	136.78	150.54	329.37	323.12	123.96	343.17	
108 - Congestive heart failure; nonhypertensive	Deaths	7	3	3	5	5	6	3	4	4	5	5	3	53
	HSMR	182.24	82.15	91.22	194.31	111.13	144.05	76.24	85.41	143.46	165.62	106.89	72.83	
109 - Acute cerebrovascular disease	Deaths	6	1	3	0	1	2	2	0	1	1	2	2	21
	HSMR	154.45	103.85	122.66	0	183.56	225.79	658.9	0	591.45	90.04	205.07	264.31	
157 - Acute and unspecified renal failure	Deaths	5	4	4	6	7	4	3	6	6	9	9	4	67
	HSMR	143.25	82.98	113	133	218.83	159.98	145.59	162.39	108.02	205.02	218.45	123.55	
226 - Fracture of neck of femur (hip)	Deaths	4	1	6	2	0	1	2	2	4	5	6	4	37
	HSMR	138.27	96.91	268.98	151.03	0	132.53	129.67	122.42	210.14	151.22	384.23	129.03	
149 - Biliary tract disease	Deaths	1	1	1	0	1	1	1	2	0	4	1	0	13
	HSMR	136.64	112.87	238.28	0	93.61	114.11	153.42	338.97	0	434.68	302.94	0	
159 - Urinary tract infections	Deaths	2	5	4	1	3	0	0	5	4	1	2	3	30
	HSMR	131.29	217.47	318.59	73.72	140.08	0	0	184.35	246.69	58.96	137.77	146.62	
127 - Chronic obstructive pulmonary disease and bronchiectasis	Deaths	4	3	4	1	3	2	3	1	8	2	3	4	38
	HSMR	126.65	113.2	134.87	55.53	81.97	122.74	117.48	52.02	300.15	47.78	97.55	149.72	
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	Deaths	10	18	18	14	10	9	18	19	21	21	16	19	193
	HSMR	76.12	119.5	114.99	126.94	101.22	102.32	105.16	132.17	115.59	103.34	104.01	135.41	

From April 2018 to March 2019, HSMR has reported 26 diagnostic groups with a HSMR above 100. 7 of these groups have recorded greater than 30 deaths in the year to date (highlighted in yellow).

Diagnostic Group (CCS)	Expected number of deaths	Number of deaths	HSMR	Average comorbidities per spell	Obs. - Exp.
157 - Acute and unspecified renal failure	45.12	67	148.5	15.15	22
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	172.96	193	111.59	10.94	20
131 - Respiratory failure; insufficiency; arrest (adult)	17.06	35	205.14	11.01	18
226 - Fracture of neck of femur (hip)	22.63	37	163.53	9.36	14
159 - Urinary tract infections	22.49	30	133.41	8.17	8
108 - Congestive heart failure; non-hypertensive	45.24	53	117.15	9.79	8
149 - Biliary tract disease	7.34	13	177.14	3.43	6
109 - Acute cerebrovascular disease	14.5	21	144.8	8.71	6
43 - Malignant neoplasm without specification of site	5.78	11	190.18	17.23	5
127 - Chronic obstructive pulmonary disease and bronchiectasis	32.94	38	115.37	7.67	5
151 - Other liver diseases	6.88	11	160	8.54	4
55 - Fluid and electrolyte disorders	7.95	12	150.9	10.28	4
237 - Complication of device; implant or graft	3.19	6	187.89	6.04	3
197 - Skin and subcutaneous tissue infections	6.78	10	147.53	3.24	3
251 - Abdominal pain	0.8	3	377.29	1.83	2
29 - Cancer of prostate	2.18	4	183.91	5.15	2
59 - Deficiency and other anemia	4.06	6	147.87	5.04	2
125 - Acute bronchitis	20.98	23	109.63	5.65	2
13 - Cancer of stomach	1.7	3	176.94	6.92	1
115 - Aortic; peripheral; and visceral artery aneurysms	2.27	3	131.9	4.54	1
15 - Cancer of rectum and anus	3.87	5	129.16	6.66	1
133 - Other lower respiratory disease	5.51	7	127.15	4.24	1
117 - Other circulatory disease	2.38	3	126.29	8.86	1
224 - Other perinatal conditions	10.41	11	105.68	0.02	1
155 - Other gastrointestinal disorders	12.32	13	105.48	3.57	1
245 - Syncope	0.71	1	141.84	3.61	0

2. KEY AREAS FOR ATTENTION

Deaths of patients with a learning disability
During the period January to May 2019 the Trust has noted 5 deaths of patients with a learning disability. As per the national requirements all the deaths have been reported to LeDeR. All LD deaths will be subject to a formal Structured Judgement Review (SJR), discussion at divisional safety huddle and escalation to the weekly Serious Incident Meeting, as appropriate.

- 2 of the deaths, occurring during February 2019, have undergone an SJR with no concerns in care noted.
- 3 deaths are currently undergoing SJR and review by the Corporate Senior Nurse for Quality and Adult Safeguarding and the lead nurse for Learning Disability.

Deaths where there may have been an issue in care, system or process
During the period January to April, 4 deaths have been recorded as an overall care score of 2 (poor care).

- 1 has undergone a second review identifying adequate care,
- 3 are currently undergoing a secondary review.

CuSum, Cumulative Sum Control Chart, identifies significant changes and persistent deviation from the expected.

a) During January and February 2019 the Trust recorded a CuSum alert for **Acute and unspecified renal failure**. An initial review of this group of patients has identified 17 patients:
   7 reviews scored 3 or above (adequate to excellent care),
   6 are pending review,
   4 did not trigger for a review.

b) In March 2019 a further alert was recorded relating to **Respiratory failure.** Since August 2018, 25 deaths have been recorded versus 11 expected. Due to the low number of deaths in this diagnostic group this score is particularly volatile. This is under investigation following discussion by the Mortality Surveillance Group.

New **fracture neck of femur** pathways have been implemented over the past 6 months, with the aim of reducing the interval between presentation and surgery. Ongoing discussions are taking place involving the Trauma, Anaesthetic and Elderly Care teams to improve pre-operative patient optimisation.

The process for **verifying death** has been amended and the revised procedure is being implemented in July.

3. FUTURE ACTIONS

Medical Examiner
A revised reporting tool will be implemented to report national requirements, with a monthly summary commencing June 2019. This tool will be amended to align with the Medical Examiner process (requiring scrutiny of all deaths, with SJR based on the review or reference to the National Quality Board minimum criteria).

The Medical Examiner will identify additional SJR applicable deaths where learning and improvement has been identified, issues in care, system or process has been noted. Substandard care will be recorded on Safeguarding and will be discussed through Safety Huddles, Care Group governance meetings and the Mortality Surveillance Groups where appropriate actions and follow-up will be identified.

In order to engage the mortality leads, the following actions have taken place:

- Defined criteria for incident reporting following mortality reviews
- Revised review proforma
- Specialty rolling programme for presentations at the monthly Mortality Surveillance Group MSG to capture lessons learnt and action plans
- Shared drive has been created with access for all stakeholders
- Terms of reference of the MSG have been revised for ratification at ratified at QPES in May 2019 (Appendix 1)
- An action plan following specialty presentations at MSG identifying learning points and actions will be shared on a monthly basis through the mortality report at QPES and Board (Appendix 3)

Three MEs have been recruited so far. Recruits are currently in the process of undertaking the mandatory e-learning and face to face training delivered by the Royal College of Pathologists. Recruitment to Medical Examiner Officers and administrative support will commence this month. The ME scrutiny process will commence in September 2019.

The update of the **Trust Learning from Death Policy** will be completed in July to encompass the revised processes, governance, reporting and auditing.

Report on recent changes to mortality process
In recent months, the mortality team have taken advice from a number of sources:

- NHSI observation of Mortality Surveillance Group
- Visit by Medical Director to Kettering General Hospital to discuss mortality processes with MD and Deputy MDs
- Discussion with mortality lead at Coventry and Warwick
- Meetings with Regional MD and deputy
- Discussions with Richard Wilson from NHSI, who has offered to attend Trust Board Development session and to train CDs/mortality leads in the trust
- Discussions with CCG through Contract Performance Notice

A **report** summarising changes in our process for monitoring and acting on deaths in the trust will be completed in August 2019.

Quality Improvements Presentations and Action Log

Date	Specialty	Presenter	Summary/ Learning Points	Actions	Progress	Owner	Target Date	RAG
April 2019	All specialties	Miss R Joshi (retrospective)	A review of 7 patients was undertaken as part of the Well Led CQC inspection Key Learning Points 1.Poor documentation using the sepsis tool 2.Innaccurate cause of death recorded on medical certification 3.Improved use of a ceiling of care and advanced care pathway	To be presented at the June MSG	TBC	TBC	July 2019	
10 May 2019	All specialties		Following a CuSuM alert in April 2018 and a subsequent CQC request to review a group of patients whose cause of death was recorded as fluid and electrolyte imbalance management of hyperkalaemia was noted as an issue but not contributory to the death of patients. An action point was allocated to the clinical lead in ED.A subsequent NPSSA alert was received relating to an update of clinical guidelines in the management of hyperkalaemia	1. The CD for ED is to undertake communication and awareness sessions with her team. 2. The hyperkalaemia guideline is to be updated and training and awareness session to be delivered through junior doctor training, grand round and clinical team meetings.	The CD for ED have discussed the issues at departmental board rounds and team meetings. The hyperkalaemia guideline has been updated as per the national guidance and is currently in the awareness and training phase. The guideline will be presented at DQB week commencing 27 May and during junior doctor training and grand round during June. UPDATE: 13/6/19 – awaiting confirmation from Emergency & Acute Medicine Care Groups of internal dissemination	UI	30 June 2019	
10 May 2019	Acute Medicine	Dr Ali	A review of 20 patients was presented. Key Learning Points 17 out of 20 patients DNAR was put in place Incomplete MCA documentation Poor documentation in the patient record A medication error was noted	1.To review the 17 patients with a DNAR put in place and represent at the June MSG to identify any pathway themes 2. General documentation and MCA completeness to be discussed at team meetings. 3.Performance relating to DNAR and MCA to be		MA/SR	30 June 2019	

				addressed through the deteriorating patient and sepsis group chaired by the DDDN 4. Medication error to be reported through the safeguarding framework				
10 May 2019	Anaesthetics	Dr Garg	A retrospective review of the quality of verification of death and associated documentation was undertaken Key learning points Poor documentation Varied degrees of application of the national standards Disparity in time of death and verification leading to anomalies in subsequent death certification alignment QIP Death Verification Garg.pdf	1.Review of the Trust Verification of death Policy 2.implementation of a standard verification proforma		AG/DR		July 2019

Appendix 1: Clinical Mortality Leads Key Responsibilities

Clinical Mortality Leads Key Responsibi

Appendix 2: Proposed Closure of Acorns Children's Hospice in Walsall

Acorns Closure Letter.pdf

Appendix 3: March 2019 Re-audit of Mortality Review Turnaround Times

MAC Mortality Review Turnaround F

MEETING OF THE PUBLIC TRUST BOARD – 4th July 2019			
Walsall Together Business Case and Integrated Care Partnership (ICP) Board Terms of Reference			**AGENDA ITEM: 13**
Report Author and Job Title:	Walsall Together Partnership	**Responsible Director:**	Daren Fradgley Interim Director of Walsall Together
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The Walsall Together Business Case has been produced following the approval of the Case for Change document in March 2018. The business case outlines the following; • The way in which the 'Walsall Together' partners will improve the way specialist support is delivered in the community. • New integrated ways of working will be developed to improve the health and wellbeing outcomes for the citizens of Walsall. • An Increase in the quality of care provided. • Long term financial sustainability for the system. Walsall Together supports the wider Black Country Sustainability and Transformation Plans (STP) by enabling place-based, partnership working to improve the health and welling of a population.		
Recommendation	Members of the Trust Board are asked to: • To approve the model of operating in principle for services as described, with more detailed plans and Board approvals to be sought in due course. • To approve the establishment of the Walsall Together ICP Board • To approve the Terms of reference for the Integrated Care Partnership (ICP) Board (Appendix 1). • To support the development of an s75 NHS Act contract during 2019/20 and for the ICP board to present a proposal back to the Trust Board and Council Cabinet for consideration.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This paper provides assurance and approval of the Business case and the TOR provides mitigation against BAF 003 '*Failure to develop effective partnerships within the Walsall Together Partnership may result in the Trust being able to deliver integrated care and Population Health Management*'		

Resource implications	The resources required to deliver the business case are explained throughout. These include the leadership team and also the Trust Services that are considered in scope in each of the Horizons	
Legal and Equality and Diversity implications	The principles of the case have been tested against the NHS transactions principles through two confirm and challenge sessions with NHS England and NHS Improvement. Legal and Commercial advice has been sought through the Governance workstream. Additional legal advice will be required in Horizon 1 when the Section 75 arrangements are considered.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Walsall Together Business Case

The Proposal

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.

The partners are: Walsall Healthcare NHS Trust; Walsall Council – Adults Social Care, Public Health and Children's Services; Dudley and Walsall Mental Health Trust; Walsall CCG; all Walsall GP's; and One Walsall.

The model: an operating model has been developed with clinicians, practitioners and managers taking the best examples from around the world to inform our thinking. In summary this includes:

- Resilient communities; building the capacity and understanding of what communities can do together, and for each other to keep people healthy, engaged and active.
- Integrated primary, long term management and community services, where local access to support is coordinated around that community and health centres.
- A single point of access where the whole population's health is understood and the best and most effective responses are directed to them in a coordinated manner.
- Specialist community outpatient and diagnostic services that are available in local health and wellbeing hubs. Intermediate and social care and unplanned care services, which step in during a crisis and prevent unnecessary access to A&E and hospital.
- Acute hospital services, most of which are local and some others which are designed on a larger footprint due to their lower volumes / increases specialist.

Financial Case: At present without both efficiency savings and meaningful service change the baseline position all these organisations show is a financial gap of £174m by 2022/23. Based on the current planned efficiency savings the gap would reduce to £61m, but this is based on all plans being delivered and no other (unforeseeable) factors coming into play.

Without sustainable system wide transformation for the delivery of care, the system continues to operate in an ever increasing deficit position for the foreseeable future. What we also know is that we can use our resources better, and citizens want improved coordination and access.

It is important to note that the financial modelling and dependencies described in the Walsall Together business case are indicative and based on a number of assumptions and financial ranges, all of which will be tested and moderated over the coming months and years as the programme develops, progresses and is finalised.

The financial analysis is for indicative purposes only and is subject to further due diligence and review.

Cases for change will be passed through the constituent governing bodies and Trust Board on a case by case basis**.**

Governance:

The partner organisations have participated in an evaluation against established criteria to determine the best fit for the "Host" organisation to take the lead for the outcome improvements we seek in the future. WHT was evaluated as the host and that is recommended within the business case. The in early stages, Horizon 1, The Host will be accountable to commissioners (CCG and WMBC) for the delivery of service redesign leading to the outputs demanded of us.

We wish to establish an Integrated Care Partnership Board that will be responsible for the delivery of the business plan and for achieving improvements in wellbeing and health outcomes. This is the first time such a board will have existed in Walsall, which will be able to make commissioning and service delivery recommendations in an aligned and inter-connected way.

This ICP Board will have senior representatives from each constituent member and will be responsible for the oversight of the services which are contractually in scope and for wider system integration and transformation. The purpose and responsibilities of the ICP Board are set out in the Terms of Reference (Appendix 1), which we are asking the Board to approve.

The Trust's representatives are: Chief Executive, Walsall Together Director (New Executive appointment) and a new Non Executive Chair.

Following the formal establishment of the ICP Board and approval of the Terms of Reference (appendix 1), an alliance agreement will be produced which will formalise the agreement with partners.

The business case proposes an alliance model, following further engagement with partners an amendment has been made to how the ICP Board will be established; rationale for this is described by the CCG as follows:

"We revisited the question of what type of alliance would best deliver the ambitions set out in the business case. Our conclusion was that it would be better for the ICP to be set up as a

provider alliance and not as a commissioner-provider alliance as proposed in the business case. The rationale for this view was two-fold: first, it provides clarity of governance and accountability in terms of the CCG's relationship with the ICP Alliance and its member organisations; and second, it provides – through the ICP – a vehicle through which provider (including – importantly - general practice) will develop partnership relationships at place level which is separate to their relationship with the CCG as commissioner of their services. Whilst we would propose, therefore, that the CCG is not represented as a member of the ICP Board we would wish to have the right to receive papers and to attend meetings of the ICP Board as a Participating Attendee".

Senior Management Team: in order to oversee a transformation of this scale, there will be various existing roles that will start to work as a virtual senior team. WHT will appoint to a Executive Director of Walsall Together role who will be responsible for delivering the transformation plans and deepening of the integrated relationships between teams and services. For Adult Social Care, the Head of Community Care and Partnerships will operate within that senior team but retain all accountability for performance, staff and finances to the Director of Adult Social Care.

Success: we will measure success in 3 ways. A new Outcomes Framework has been developed by the CCG and Council to measure the quality of life improvements that we seek for the whole population. Each of these have detailed perform indicators and will be tracked on a regular basis.

Service quality and the experiences of our patients and citizens need to rise. These are already measured by Regulators (and data collated by each organisation but there is a requirement to join this data up and understand how a patient and citizen may enjoy a good response from all services not just individual teams/services. Finally we have set ambitious plans for financial sustainability. WHT as the host will be fully supported by the partner organisations to ensure we are making decisions which demonstrate value for money for all

Recommendations

1. To approve the model of operating in principle for services as described, with more detailed plans and Board approvals to be sought in due course.
2. To approve the establishment of the Walsall Together ICP Board
3. To approve the Terms of reference for the Integrated Care Partnership (ICP) Board (Appendix 1).
4. To support the development of an s75 NHS Act contract during 2019/20 and for the ICP board to present a proposal back to the Trust Board and Council Cabinet for consideration.

Daren Fradgley
26th June 2019

Appendix 1

INTERGRATED CARE PARTNERSHIP BOARD

TERMS OF REFERENCE: Version 0.8

RATIFIED BY THE TRUST BOARD ON:

NEXT REVIEW DUE: May 2020

1. CONSTITUTION

1.1 The Board of Directors with support from Walsall Together Partners, hereby resolves to establish a Committee of the Board of Directors to be known as the Integrated Care Partnership Board (ICP Board). The ICP Board has no executive powers, other than those specifically delegated in these Terms of Reference.

2. PURPOSE

2.1 The ICP Board will be responsible for decision making by consensus of all partners in developing the strategic direction, including responsibility for the delivery of the Walsall Together Business Plan.

2.2 This ICP Board will have responsibility for the oversight of services contractually in scope for the system integration and transformation.

2.3 The ICP Board is authorised by the Board of Walsall Healthcare NHS Trust and Partner Organisations to investigate any activity within its terms of reference. The ICP Board is authorised to obtain outside legal or independent advice and to see the attendance of outsiders with relevant experience and expertise if it considers necessary.

3. MEMBERSHIP

3.1 As the ICP Board is one focused on partnership working across the borough of Walsall, the ICP Board will include members of Partner organisations.

The membership of the Committee from the Host Partner shall consist of;

- A Non-Executive Director to be appointed by the Chairman to Chair the Committee
- One Non-Executive Director
- Chief Executive Officer
- Director of Walsall Together
- Director of Governance

3.2 The membership from Partner Organisations of the Committee shall consist of:

- Chief Executive, Dudley and Walsall Mental Health Partnership Trust
- Non-Executive Director Dudley and Walsall Mental Health Partnership Trust
- Director of Adult Social Care, Walsall MBC
- Director of Public Health, Walsall MBC.
- Director of Children's Services, Walsall MBC
- Chief Executive, One Walsall.
- Primary Care Networks leads

3.3 Professional Representation as required.

- Clinical lead for in-scope hospital services.
- Clinical lead for Mental Health.
- Professional lead for Nursing and AHPs.
- Professional lead for Adult Social Care
- Professional lead for Children's Services.

4. ATTENDEES

4.1 Walsall CCG has the right to attend as a participating attendee Other executive directors/managers from across the partnership should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

5. ATTENDANCE

5.1 It is expected that each host member and partner attends a minimum of 75% of meetings and performance will be reported to the ICP Board and Walsall Healthcare NHS Trust Board for each host member only in terms of attendance at the end of each financial year.

6. QUORUM

6.1 A quorum shall be 2 Non-Executive Directors and 2 Executive Directors.

6.2 No decision will be taken about a Partner organisations who are not represented at the time of the decision.

7. FREQUENCY OF MEETINGS

7.1 The Committee will meet 10 times a year additional meetings may be arranged as required.

8. CHANGES TO TERMS OF REFERENCE

8.1 Changes to the terms of reference including changes to the Chair or membership of the Committee are a matter for discussion at partners organisations but reserved to the Walsall Healthcare Trust Board.

9. ADMINISTRATIVE ARRANGEMENTS

9.1 The Chair of the Committee will agree the agenda for each meeting with the Director of Walsall Together who will coordinate the requirements of all partners. The Committee shall be supported administratively by the Executive PA who's duties in this respect will include:

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

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

10. ANNUAL CYCLE OF BUSINESS

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

11. REPORTING TO THE PARTNER ORGANISATIONS

11.1 The Chair of the ICP board will on behalf of the ICP Board provide a highlight report monthly to each of the partner organisations outlining key actions taken with regard to the issues, key risks identified and key levels of assurance given.

12. STATUS OF THE MEETING

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

13. MONITORING

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

14. DUTIES

14.1 The primary responsibility of the ICP Board will be the integration of services deemed to be “in scope” and not for the delivery of those services.

14.2 The functions of the ICP Board would be to:

- Provide strategic leadership and oversight of service delivery for in-scope services and for ICP programme work streams;
- Promote and encourage commitment to the Alliance Principles and Alliance Objectives amongst all Alliance Participants

- Monitoring and review of key interdependencies between Partners to ensure that benefits of the new Services model is fully realised for the benefit of patients, carers and their families;

- Oversee the development of, and transition to, new models of care in priority areas/in scope services;
- Make decisions in the context of the shared vision for the Walsall Together Partnership, and as detailed in the Alliance Agreement;
- Consider investment and any disinvestment decisions across the partnership;
- Collectively hold ICP partners to account for upholding the commitments made in the Business case, and the Alliance contract.
- To provide assurance that needs of the community and patients are best serviced by the proposed partnering arrangements

14.3 To review the risk implications of the partnership arrangements

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

14.5 To contribute to improving the health and wellbeing of the population.

Walsall Together

Joining up your health and social care

Walsall Together

Moving towards an Integrated Care Partnership (ICP)

January 2019

Supported by:

Walsall Council

NHS Walsall Clinical Commissioning Group

NHS Dudley and Walsall Mental Health Partnership NHS Trust

One Walsall

Inspiring and supporting social action

Walsall Healthcare NHS Trust

Disclaimer

The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavour to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act on such information without appropriate professional advice after a thorough examination of the particular situation.

Contents

Version Control

Document Information	
Document Title	Walsall Together: Moving towards an Integrated Care Partnership
Date	January 2019
Owner	Walsall Together Programme Steering Group

Document History			
Version	**Date**	**Change made by**	**Description**
1.1	13/12/2018	Hannah Lewis	Initial draft – Financial section outstanding
1.2	20/12/2018	Hannah Lewis	Additions: Financial section and recommendations
1.3	20/12/2018	Hannah Lewis	Review by Paul Tulley
1.4	21/12/2018	Gareth Richards	Financial section
1.5	21/12/2018	Hannah Lewis	Updated exec summary
1.6	7/1/2019	Hannah Lewis	Amendments as per comments received
1.7	14/1/2019	Hannah Lewis	Amendments as per review on 9/1/2018

2.0	15/01/2019	Gareth Richards	Finance section updated
2.3	21/01/2019	Hannah Lewis	Comments from PH
3.0	18/1/2019	Hannah Lewis	TOR adjustments and others
3.1	21/01/2019	Hannah Lewis	Joshua and Sophie's User Stories adjusted
3.2	25/1/2019	Hannah Lewis	Comments from Steering Group
3.3	28/01/2019	Sarb Basi	Updated investment plan and "Do something" narrative
3.4	29/01/2019	Hannah Lewis	Final amendments, Appendix 7, watermark removed

Abbreviations

ACS	Accountable Care System
API	Application Program Interface
CCG	Clinical Commissioning Group
CIP	Cost Improvement Programme
CQC	Care Quality Commission
DWMH	Dudley and Walsall Mental Health Partnership NHS Trust
EEA	European Economic Area
FYFV	Five Year Forward View
H&W Centre	Health and Wellbeing Centre
HWBB	Health and Wellbeing Board
ICP	Integrated Care Partnership
JCC	Joint Commissioning Committee
KPI	Key Performance Indicators
MBC	Metropolitan Borough Council
MDT	Multi-disciplinary Team
MCP	Multi-speciality Care Provider
NHSI	NHS Improvement
OM	Operating Model
PAS	Patient Administration System
PBT	Place Based Team
QIPP	Quality, Innovation, Productivity and Prevention
SMT	Senior Management Team
STP	Sustainability and Transformation Partnerships
WHT	Walsall Healthcare NHS Trust
WT	Walsall Together
WTPB	Walsall Together Partnership Board
ToR	Terms of Reference

TPO	Transformation Programme Office
VCSE	Voluntary, Community and Social Enterprise

Foreword from Walsall Partners

Building on a strong history of collaboration, Walsall now has a fantastic opportunity to stand out from the crowd with a revolutionary health and care model, rivalling even the most pioneering integrated models across the country. Integrated Care is an approach aimed at recognising the diverse and increasing needs of an ageing population, and responding to the unique needs of a person to improve their health and wellbeing, rather than treating an episode of illness. (The King's Fund, 2018).

As system leaders, we understand the challenges of ensuring citizens receive the right care, in the right place and at the right time and we also recognise that this is not always happening in Walsall. Health and wellbeing outcomes vary vastly across the Borough, due in part to pockets of deprivation and affluence, and in some cases Walsall is falling behind regional peers on measures such as healthy life expectancy.

We believe by addressing the root cause of these issues - known as the wider determinants of health, such as housing, debt, education and employment- that the overall health and wellbeing of Walsall citizens can be greatly improved, alongside delivering greater value for the Walsall pound. This increased focus and associated investment in preventative and early-intervention services, forms the basis of the "Resilient Communities" offering to citizens; a place based, integrated service to connect and develop people within a community to build social capital and increase overall wellbeing.

Resilient Communities provides the foundations upon which all other health and care services are provided in the proposed model outlined here. We believe that this is the right direction for the health and care system and recognise the significant transformation that will be required to move towards a proactive system that supports residents to remain independent and away from using services which do not deliver the best outcomes.

This business case aims to accelerate this change, bringing together colleagues from across Public Health, Primary Care, Community Services, Social Care, Mental Health and Secondary Care to deliver the shared Walsall Together vision of "addressing the changing needs of our population with integrated care solutions that maximise the potential of the individual person, the teams that support them and the wider health and care system." Our future plans will also include Children's Services and Public Health.

We believe that this brings the Walsall Together programme to a significant milestone in the transformation journey, with a clear plan for detailed design, implementation and continual refinement provided over the next three years supported by commissioners and partner providers. Our ambitions and plans are aligned to the recently published NHS Long Term Plan and we look forward to working with our staff, partners and citizens to bring this vision into existence for the current and future generations of Walsall residents.

Paula Furnival, Executive Director of Adult Social Care, Walsall Metropolitan Borough Council

Richard Beeken, CEO, Walsall Healthcare NHS Trust

Mark Axcell, CEO, Dudley and Walsall Mental Health Partnership NHS Trust

Simon Brake, Chief Officer, Walsall Clinical Commissioning Group

Dr Barbara Watt, Director of Public Health

Sally Rowe, Director of Children's Service, Walsall Metropolitan Borough Council

1 Introduction

The Walsall health and care system partners are developing new integrated ways of working to improve the health and wellbeing outcomes of their population, increase the quality of care provided and provide long term financial sustainability for the system. This business case outlines the way in which the "Walsall Together" partners will improve the way specialist support is delivered in the community to meet these objectives through establishing an Integrated Care Partnership (ICP) Board. 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 welling of a population (Kings Fund, 2018).

Overview

This business case 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 in enabling formal, contractual changes that empower the Walsall Together Partnership Board (WTPB) by creating an outcome focused environment in which system partners are incentivised to deliver agreed outcomes.

It builds on the work completed to date as part of the Walsall Together programme and the Case for Change paper, further details below, and seeks to provide the clarity on the future Operating Model, commercial vehicle and governance to a level of detail required to facilitate approval by the Executive Leadership Boards of the WTPB's membership;

- Dudley and Walsall Mental Health Partnership Trust (DWMH);
- One Walsall;
- Walsall Clinical Commissioning Group (Walsall CCG), including Primary Care colleague representation;
- Walsall Metropolitan Borough Council (Walsall MBC);
- Walsall Healthcare NHS Trust (WHT).

Walsall Together and 'The Case for Change' paper

The Walsall Together programme launched in 2016, bringing together the providers and commissioners across Walsall to deliver three key aims:

- Improving health and wellbeing outcomes for the Walsall population;
- Improving care and quality standards in the provision of care;
- Meeting the statutory financial duties of all partner organisations.

The programme saw the establishment of two Boards; the Walsall Together Provider Board, consisting of all service providers in Walsall and the Walsall Together Partnership Board (WTPB) which included the local commissioning bodies; Walsall Metropolitan Borough Council (WMBC) and Walsall Clinical Commissioning Group (CCG) alongside the provider organisations.

Over the course of 2015-2016 the WTPB developed and agreed The Walsall Model of Integrated Care, which details the ambition of providers working to keep the citizen at the heart of the health and care system and ensuring they receive the right level of care, at the right time and in the right place.

The Case for Change paper delivered to the WTPB and member partners' Boards in January 2018, outlined the renewed vision and stated the commitment to agreeing the preferred model for delivering integrated care in Walsall by early 2018/19. This document was approved by the respective partner organisations' boards in February/March 2018, including the recommend next steps, which are outlined below:

1. Establishing a Programme Team with access to dedicated resource to run the development process;
2. Developing a business case for stakeholder sign-off (Including NHS Improvement) within the next six months to include the following priorities:
    - Defining appropriate governance to facilitate collective leadership in transition and end state;
    - The development of a comprehensive, Walsall wide financial model for the system;
    - Developing an Operating Model;
    - Developing an appropriate commercial model.
3. The creation of a budget and resource commitments to support both internal and external inputs to the process over the next 6 months.

This business case sets out to address point 2 above, supported by a system wide activity and cost model, and sits alongside the wider Walsall Together programme work that is currently underway. For example the Walsall Together Outcomes Framework, developed by Walsall CCG and Walsall MBC, is intended to support the move to more integrated delivery and once implemented across Walsall, will provide the framework and metrics against which all providers of health and care services will be measured.

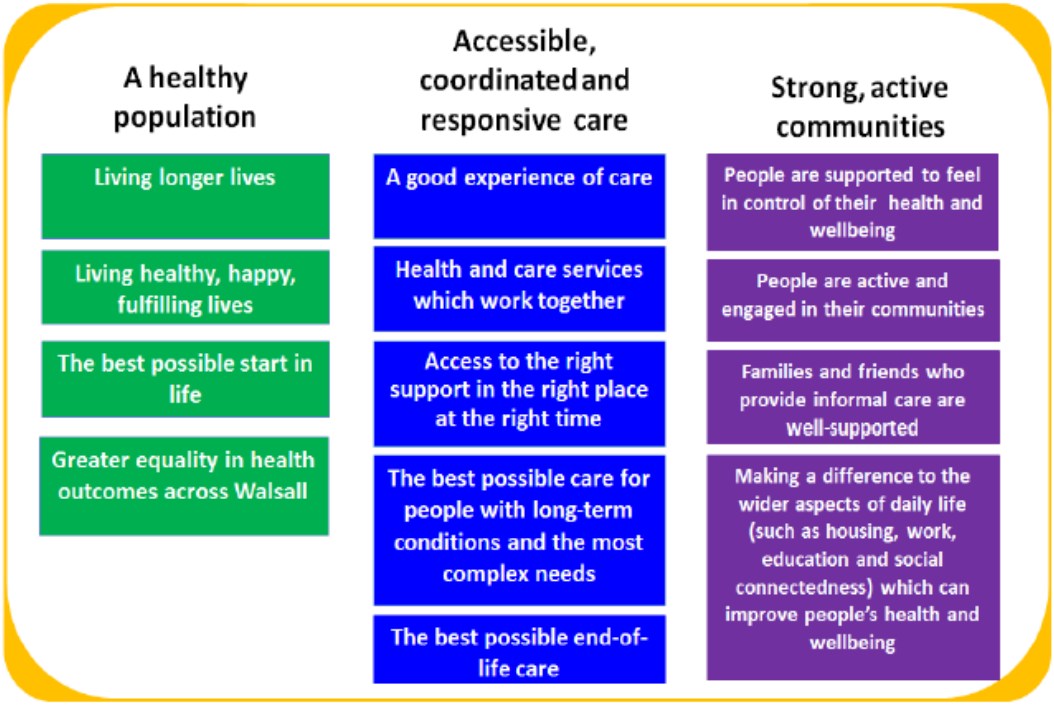


Figure 1Walsall Outcomes Framework (Under consultation)

The three themes; 'A healthy population', 'Accessible coordinated and responsive care' and 'Strong, active communities' demonstrate the shift to a more holistic approach to health and care provision, focused on addressing the wider determinants of health, designing appropriate responses and building community resilience. This new framework and the associated metrics used to measure performance demonstrates the focus of commissioners and system leaders on delivering improved outcomes for citizens and the population health as a whole, rather than units of activity delivered by local services.

Examples of these new metrics against the themes above include:

A healthy population

- Rate of five year old children free from dental decay;
- Self-reported well-being;
- Comparing outcomes achieved in the best and worst performing areas of Walsall.

Accessible, coordinated and responsive care

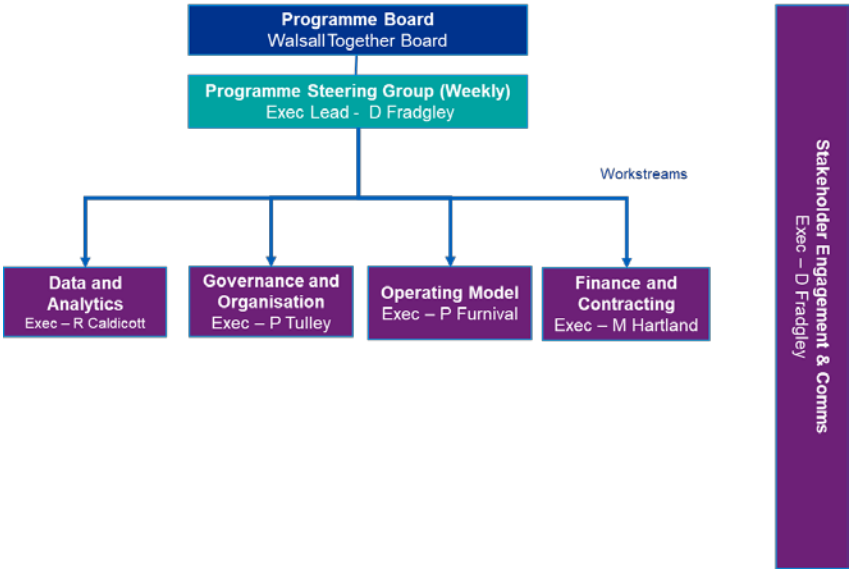
- Patients with Chronic Obstructive Pulmonary Disease (COPD) who have stopped smoking and not smoked for two years;
- Proportion of social care assessments taking place outside of a hospital setting;
- What proportion of people die in their preferred place of death.

Strong, active communities

- How many adults with a learning disability live in their own home or with their family;
- How many people in Walsall are supporting health and care services through formal volunteering;
- How many people who use services and carers report that they have as much social contact as they would like.

Process for Business Case Development

The WTPB appointed KPMG as the external advisors to support the delivery of this business case. As part of the programme mobilisation, WTPB senior leaders established the programme governance; including the creation of a Programme Steering Group, Programme Board and five individual working groups to support development of specific business case content. The programme governance structure and executive sponsor or chair of each group is outlined below, while the full membership of each group can be found in the Appendix (1):



The Programme Steering Group met weekly to review progress, risks and upcoming actions while, a highlight update was provided to the Programme Board on a 6 weekly basis, attended by a range of stakeholders from across the system, further details provided in appendix 1. Additional Board and Cabinet awareness sessions have also been held as part of the development process to allow senior stakeholders visibility and oversight of the process with appropriate opportunities to challenge direction. Following an initial draft prepared in early December 2018, the business case has undergone further review and refinement, including at Board Development sessions to ensure all parties are aligned to the outlined propositions.

Purpose of the Business Case

As detailed above as part of the business case development process, while there has been frequent and consistent engagement with a number of senior leaders and members from across the Walsall Together Partnership, this has remained a small representative group in comparison to the Walsall system. This is particularly true of the clinical and professional workforce, who have had limited involvement due to the time pressures and the largely non-clinical/professional nature of the conversations; outside of the Operating Model workstream.

As such, this business case is designed to enable system leaders to enter into Horizon 1 (April 2019/20) arrangements with the clarity required around infrastructure and governance alongside a high level view of the Operating Model, supported by data to facilitate an extensive co-design process of the Operating Model with professional colleagues. The Operating Model presented herein is intended to provide an outline of a future state health and care system in Walsall, requiring a subsequent detailed design phase to map the care pathways, patient flows and workforce requirements to deliver this. This will be an ongoing, iterative process as services and pathways are refined, in addition to new services rolling into the model over a number of years, detailed further in sections 2 and 7.

The Walsall Together partners intend to develop an Integrated Care Partnership (ICP) through which to plan, manage and deliver integrated care, which will provide the contractual environment to further develop and strengthen the role and responsibility of the Walsall Together ICP as this matures over the coming years. This will be established during the initial transition period from April 2019-

April 2020 (Horizon 1) as part of the broader detailed design phase, including developing contracting and risk sharing arrangements. Where possible, an outline of future Walsall Together objectives and arrangements between system partners are detailed, however it will be the responsibility of the ICP Board and partners to determine and agree these during Horizon 1.

Overview of the Walsall Health and Care System Partners

Dudley and Walsall Mental Health Partnership Trust (DWMH)

Dudley and Walsall Mental Health Partnership Trust (DWMH) provide a full range of integrated mental health services from 26 sites to the people of Dudley and Walsall. This includes community mental health services for children, adults and older people, in addition to inpatient facilities for adult and older people.

DWMH are currently rated as "Good" by the Care Quality Commission (CQC) following their assessment in November 2016, with improvements made in a number of areas including reducing waiting times for specialist community services for children and young people and the caring and responsive attitude staff had towards those in their care. The CQC have recently conducted a full inspection during November 2018, with results due to be published the beginning of 2019.

According to the National Community Mental Health Survey, carried out by the CQC, DWMH scores amongst the top 20% of Trusts for patients knowing who to contact in a crisis out of hours and above the national average for patients stating they got the help they needed when they contacted the team. Furthermore 66% of staff indicted they would be happy with the standard of care for a friend/relative in the 2017 Staff Survey; 3% higher than the average Mental Health Trust score. The Trust is one of the best performing providers in the country for staff engagement and culture through the annual NHS Staff survey. The Trust also achieved or exceeded 19 out of 22 Contractual Key Performance Indicators (KPI) agreed with Walsall CCG in 2017/18.

DWMH's financial performance continues to be strong, reporting a surplus for the 10th consecutive year of £3.3m. This surplus is in addition to the £3.5m of savings also delivered during the period 2017/18 as part of Cost Improvement (CIP) savings requirements. The Trust has also continued to invest in estate and IT infrastructure, with investments of £2.9m spent on capital works in 2017/18.

One Walsall

One Walsall is an independent charity which has been providing infrastructure support, representation and leadership for the Borough's voluntary, community, and social enterprise (VCSE) sector for over 30 years. Previously known as Walsall Voluntary Action, the organisation rebranded as One Walsall in 2016. Following a major organisational development programme in 2017, capacity building and volunteer support services are now delivered within the locality model described in the Clinical Strategy Section of this document. The Charity is supported financially by local statutory agencies, including Walsall Council and Walsall CCG, alongside local and national grant making trusts.

As an umbrella organisation, One Walsall represents the estimated 1500 organisations and groups that make up Walsall's VCSE sector. This diverse body of community groups, charities, faith organisations, amateur sports clubs and social enterprises deliver a broad range of early intervention and prevention activities addressing the wider, social determinants of residents' health, by building individual and community capacity and resilience. The sector spends an estimated £34million on employing 2,600 FTE staff, and is supported by over 26,000 volunteer hours given each year. Many of Walsall's VCSE organisations are already working closely with Walsall's health and care system partners to deliver health and wellbeing outcomes for residents. In the last financial year One Walsall

supported the sector to secure over £1.8million funding external to the borough to sustain these vital community services.

Walsall Clinical Commissioning Group (CCG)

Walsall CCG commissions primary care, community, hospital and mental health services across Walsall and, as a membership organisation, represents 52 GP practices covering approximately 303,000 patients. Each GP practice is mapped to one of the four localities, with each locality having at least one dedicated multidisciplinary Place Based Team (PBT) – in the larger localities, two teams are assigned to serve the population. Further detail of this model is provided in the Strategy section (3).

The CCG is currently in a positive stable financial position having been removed from Special Measures in 2017/18 following the successful implementation of the Financial Recovery Plan. This implementation, alongside the delivery of a QIPP programme of £20.7m, leaves the CCG with a cumulative surplus of £5.7m. The CCG is on target to achieve one of its key financial metrics of achieving break even in 2018/19.

Walsall Healthcare NHS Trust (WHT)

Walsall Healthcare NHS Trust is an integrated Acute and Community services provider. They deliver a full range of acute hospital services including A&E, outpatients, diagnostics, elective and non-elective admissions. In addition they provide a full range of Community services to the Borough.

WHT is currently rated as "Requires Improvement "overall following an unannounced inspection by the Care Quality Commission (CQC) in May 2017. This inspection was prompted by the placing of WHT in special measures by the Secretary of State for Health in February 2016, following significant concerns around the provision of maternity services. Following the 2017 inspection, maternity and gynaecology services retained their rating of "Inadequate", however there were improvements in ratings for all other acute services at the Manor Hospital. The community services provided by WHT have been awarded an "Outstanding" rating, and community end of life care improved from "Good" to "Outstanding" following the last inspection.

Walsall Healthcare Trust are reporting a deficit of £23m for 2017/18; £2m greater than the deficit reported in 2016/17 of £21m and therefore WHT was unable to achieve its financial duty to break even. This overspend was largely due to the high costs incurred during periods of high demand on emergency services, requiring the use of additional capacity areas and an increased reliance on temporary workforce. There has also been a significant investment in buildings and refurbishments, totalling a further £1.2m, bringing the total deficit to £24.4m.

Walsall Metropolitan Borough Council (Walsall MBC)

Walsall Metropolitan Borough Council (Walsall MBC) provide Adult Social Care and Children's Services, and Public Health in their role as health and care commissioner. This includes but is not limited to; safeguarding, supporting those with mental health needs, those with physical or learning disabilities and those acting as a carer. There are statutory responsibilities to safeguard those at risk of abuse, to look after children who cannot live within their own immediate family and to offer early help and support to children in the most need.

While Public Health and Social Care has been significantly underfunded at a national level for a number of years, despite the increasing demand for service, Walsall MBC has managed the Adult and Children and Young People's budgets well, maintaining financial balance alongside increasing savings pressures with a further £12.8m planned over the period 2018/20. For the 2017/18 period, the Adult Social Gross Income totalled £47.767, with gross expenditure of £115.500m. For Children and Young

People Services gross income totalled £181.803m, with a corresponding gross expenditure of £285.389m.

2 Strategic rationale

The momentum and alignment achieved through publication of the *Case for Change* document signifies the system's readiness for formalised processes to enable real integration and transformation. The system leaders from across the provider and commissioning bodies in Walsall have demonstrated their commitment in approving the Case for Change, with the role of this business case being to outline the Operating Model for the future sustainability of the health and care system and the commercial and governance arrangements required to support this. This will be underpinned by a clear understanding on the strategic and financial rationale for these changes.

Baseline financial position

Using 2017/18 as the baseline year, the Walsall system income is £611m, while the expenditure is £633m, leaving a current deficit of £22.1m. Using a combination of national population growth assumptions and NHS activity growth assumptions, shown in further detail in the appendices (2), the system income will rise to £675m and expenditure to £849m by 2023/24. This leaves a funding gap of £174m, taking into account all forecast changes to income and expenditure, and before any assumptions about organisations achieving efficiency targets have been applied. This substantial, but not insurmountable, financial challenge presents the Walsall partners with an opportunity to develop new operating models that provide care at a lower cost, building in long term sustainability and, most importantly, with the aim of improving quality of care.

National, Regional and Local drivers

The necessity to transform the health and care system in Walsall is far from driven purely by the current financial situation and forward forecast. There are a number of national, regional and local challenges and associated strategic plans to address these already in place, with key elements outlined below.

National Challenges

Across the UK and indeed in all developed countries across the world, system leaders are grappling with providing affordable care for an increasingly aging population with increasingly more complex needs. Coupled with ever more medical and technological advances, the range of services available to citizens is also driving up costs. A chronic underinvestment in preventative care and public health has occurred alongside an unprecedented rise in preventable or lifestyle related conditions, such as type 2 diabetes, Chronic Obstructive Pulmonary Disease (COPD) and obesity in both adults in children.

The national drive for better integration is in part a result of these factors and aims to address the fragmentation caused by the organic growth of health and care systems that are reactive to demand.

Additionally there is a national staffing shortage affecting all clinical and professional care staff. This is due to difficulties in recruitment and retention and is exacerbated by a large proportion of the workforce reaching retirement age over the next 5 years. In Q1 2018, there were 87,487 advertised vacancy full-time equivalents in England; the highest percentage of which were for Nursing and Midwifery Registered staff. The previous year had a similar level of vacancies. This is also reflected locally, with WHT and DWMH both reporting significant vacancies in this area and concerns raised over the staffing of the Maternity services at WHT in particular by the CQC in 2017, although actions have been taken since to address these.

Additionally for the UK, although the full impact of Brexit is poorly understood at this stage, there are approximately 60,000 NHS staff and 90,000 social care staff from the European Economic Area (EEA). Possible restrictions on immigration and uncertainty over the rights of EU workers living in the UK is already affecting the attractiveness of the health and care system for migrant workers and the potential impact remains to be seen.

National Strategy

The 'Five Year Forward View' (FYFV) (NHS England) published in 2014, and the follow up report 'Next Steps on the Five Year Forward View ' in 2017 describes in more detail some of the challenges above and outlines the rationale for delivering services in a more integrated way.

The recommendations set out in the FYFV include:

- Developing new models of care – based around partnership, integration and joining up organisations and funding streams. These may require the development of Accountable Care Partnerships/Organisations – now more commonly referred to as Integrated Care Partnerships (ICPs);
- A radical upgrade in prevention and public health;
- Increasing the control patients have over their care when they require access to services.

New national operational plans are in the pipeline but awaiting publication at the time of writing. These are expected to provide support for locally led models of integrated care such as these and no significant challenges to the plans outlined here are anticipated. Investment in Mental Health and Primary Care services are anticipated and will also support the Walsall Together programme.

The recently published NHS Long Term Plan sets out a clear direction of travel for system integration to deliver a new service model for the 21st century by achieving the following key objectives:

1. Boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services

2. The NHS will reduce pressure on emergency hospital services

3. People will get more control over their own health and more personalised care when they need it.

4. Digitally-enabled primary and outpatient care will go mainstream across the NHS

5. Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere

Regional Strategy

Black Country and West Birmingham Sustainability and Transformation Plan (STP)

The Black Country and West Birmingham (STP) was published in November 2016 and outlines the high level plans for health and care services for a population of 1.4 million The STP is a blueprint for the future development of healthcare and wellbeing services across 18 organisations in the Black Country and the West of Birmingham including primary care, community services, social care, mental health and acute and specialised services. STPs offer a new way of working for health and social care services locally, focusing on delivering health and care services defined by local area boundaries, not by organisational boundaries. The aims are to:

- Improve the health and wellbeing of local people;
- Improve the quality of local health and care services;

- Deliver financial stability and efficiencies throughout the local health care system.

The critical recommendations of the Black Country and West Birmingham STP include the implementation of local place-based models of care, extended collaboration between service providers, actions to address the maternal and infant health challenges faced by the STP population, actions in partnership with the West Midlands Combined Authority to address the wider determinants of health and finally to develop the key enablers required to facilitate the transformation.

Walsall is identified in the STP as one of the four established place based care models and has already begun to deliver on some of the planned actions outlined in the STP, including the creation of seven integrated health and care teams assigned to localities and developing a prevention and early intervention offer to keep people well and independent in their communities.

Local Challenges

Many of the population needs in Walsall are no different than to those found across the country, such as an increasingly elderly population with the associated increase in co-morbidities and long term care needs. However there are a number of significant areas in which Walsall is an outlier. These include the inequalities of life expectancy, infant mortality rates and the number of deaths from preventable diseases. The underlying cause of these stark inequalities is undoubtedly linked to the level of deprivation and child poverty in the area, as outlined below.

Deprivation

Walsall is one of the most deprived boroughs in England; ranked 33rd out of 326 local authorities, with 36.21% of children living in poverty (Valadez-Martinez & Hirsch, 2018). This average across the borough hides stark differences between wards across the borough, with the figure for Palfrey to the South of the borough estimated to be as high as 51.7%. These high levels of deprivation are linked to a number of poor health outcomes such as high rates of infant mortality, and at 8 per 1000 births, the infant mortality rate is significantly higher in Walsall than statistical neighbours. The health inequalities that arise between the most and least deprive areas are also stark, with a difference in life expectancy of 11.3 years for males and 7.4 years for females (2014-2016).

Life expectancy

Worryingly, the latest information shows that the both the life expectancy and healthy life expectancy of males in Walsall is decreasing. Male life expectancy is significantly worse than England and has fallen from 78 years (in 2011-13) to 77.2 years (in 2014-16). Male healthy life expectancy in Walsall continues to fall, from 59.8 years (in 2011-13) to 57.7 years (in 2014-16). This is significantly worse than England, with the gap widening. Life expectancy for Walsall females at 82 years (2014-16), is considerably higher than males but significantly worse than the England average of 83.1 years. Female health life expectancy follows a similar worsening trend to males. Females' healthy life expectancy has reduced from 60.3 years (in 2011-13) to 57.2 years (in 2014-16).

This worrying trend widens the gap between Walsall and both regional and national figures, however Walsall is in line with other deprived areas.

	Male		Female	
	Life Expectancy	Healthy Life Expectancy	Life Expectancy	Healthy Life Expectancy
Walsall	77.2	57.7	82	57.2
West Midlands	78.8	62.6	82.7	63.2
England	79.5	62.9	83.1	63.4

Table 1 Life Expectancy and Healthy Life Expectancy comparison (2014-16), Source: Public Health England, Fingertips

Deaths from Preventable Diseases

The incidence of preventable diseases in Walsall is significantly higher than the national average, including; diabetes (8.7% against a national average of 6.4%), coronary heart disease (4.0% against a national average of 3.2%) and chronic kidney disease (5.2% against a national average of 4.1%). Walsall has "significantly worse than England average" scores for the percentage of physically active adults, excess weight in adults and obese children; each of which can be linked to the wider determinants of health. Also correlated is the impact on substance misuse and smoking; Walsall has a significantly higher rate of problematic drug users and the estimated prevalence for smoking 22.7% (c.45,000 adults) and smoking related deaths are significantly higher than national averages.

Diversity

Walsall is a culturally diverse borough, with almost 1 in 4 residents from a minority ethnic group, compared to the England average of 1 in 5. The largest increase has been from people with an Asian background, rising 4.75% from 2001 to 15.2% in 2011. This can impact on community cohesion if an area's ethnic composition has changed quite rapidly over a relatively short space of time, and some areas of the borough have a particularly high concentration of minority ethnic groups of up to 90%. Understanding the specific needs of a community and any barriers to access is key to ensuring equality of access to high quality care that meets the needs everyone; a founding principle of the NHS.

English language proficiency is very good in Walsall and in line with the English and Welsh averages. However 3.3% of households have no occupants that speak English as their main language, 6,200 residents cannot speak English well and 1,200 who cannot speak the language at all. This can make delivering healthcare and wellbeing information challenging and can be a barrier to accessing services. It was also raised as a factor limiting access to services in the Operating Model workshops.

Local Strategy

The Walsall Together Programme outlined in further detail in section 2 is designed to address some of these issues, but there are a number of other local policies and directives to address the wider determinants of ill health, such as the Walsall Partnership Health and Wellbeing Strategy 2017-2020. This outlines the way in which multiple agencies will work together to improve the outcomes for the people of Walsall, including Walsall Council, West Midlands Police, NHS Walsall, Walsall Probation Service, West Midlands Fire Service, Walsall Area Partnerships and representatives from the Walsall Housing Partnership, the Chamber of Commerce, Healthwatch, One Walsall and other key partner agencies.

3 The Strategy

A tiered Operating Model has been co-developed with an increased level of focus on services outside of the acute setting, to move the system towards a population management orientated model with a clear focus on prevention and early intervention. The Resilient Communities element of the Operating Model is a fundamental change in the way a population's health and wellbeing is supported and managed, with the largest volume of care and support provided in the community by Place Based Teams co-located to ensure integrated and joined-up delivery of care.

Overview

The term Operating Model is used to describe at a high level how the health and care providers will work together to deliver health and wellbeing services in Walsall. This includes non-clinical wellbeing and professional services also, such as those provided by the CCG, Local Authority and voluntary sector. The significance of language that is both inclusive and representative of the diverse parties involved was a theme throughout many of the Operating Model workshop sessions and discussions, with colleagues from across the system working side by side on the development of the model and sharing different approaches to the same issues.

To this end, the workstream was led by the Executive Director of Adult Social Care and had membership from all provider and commissioner organisations, including One Walsall and Public Health. The focus of this group was to develop a set of agreed design principles to guide the development of an outline Operating Model. The outputs of this workstream are detailed in the following section.

Development of the Operating Model for Walsall

As outlined in section 1, the Walsall Together programme has been in place since 2016, bringing together providers and commissioners across Walsall to plan, develop and deliver more integrated care. As part of this early work the Walsall Together Partnership Board developed an initial model of integrated care, with the citizen at the heart, as shown on the next page.

Walsall Model of Integrated Health & Social Care

Resilient Communities

Early intervention and prevention to support people and communities to live independently and to have active, prosperous and healthy lives.

General Practice and Integrated Health and Care Teams

People registered with GPs in Walsall will be supported by a team that is made up of GPs, community nursing, social care, mental health and the voluntary sector, providing accessible, high quality co-ordinated care in people's homes and communities.

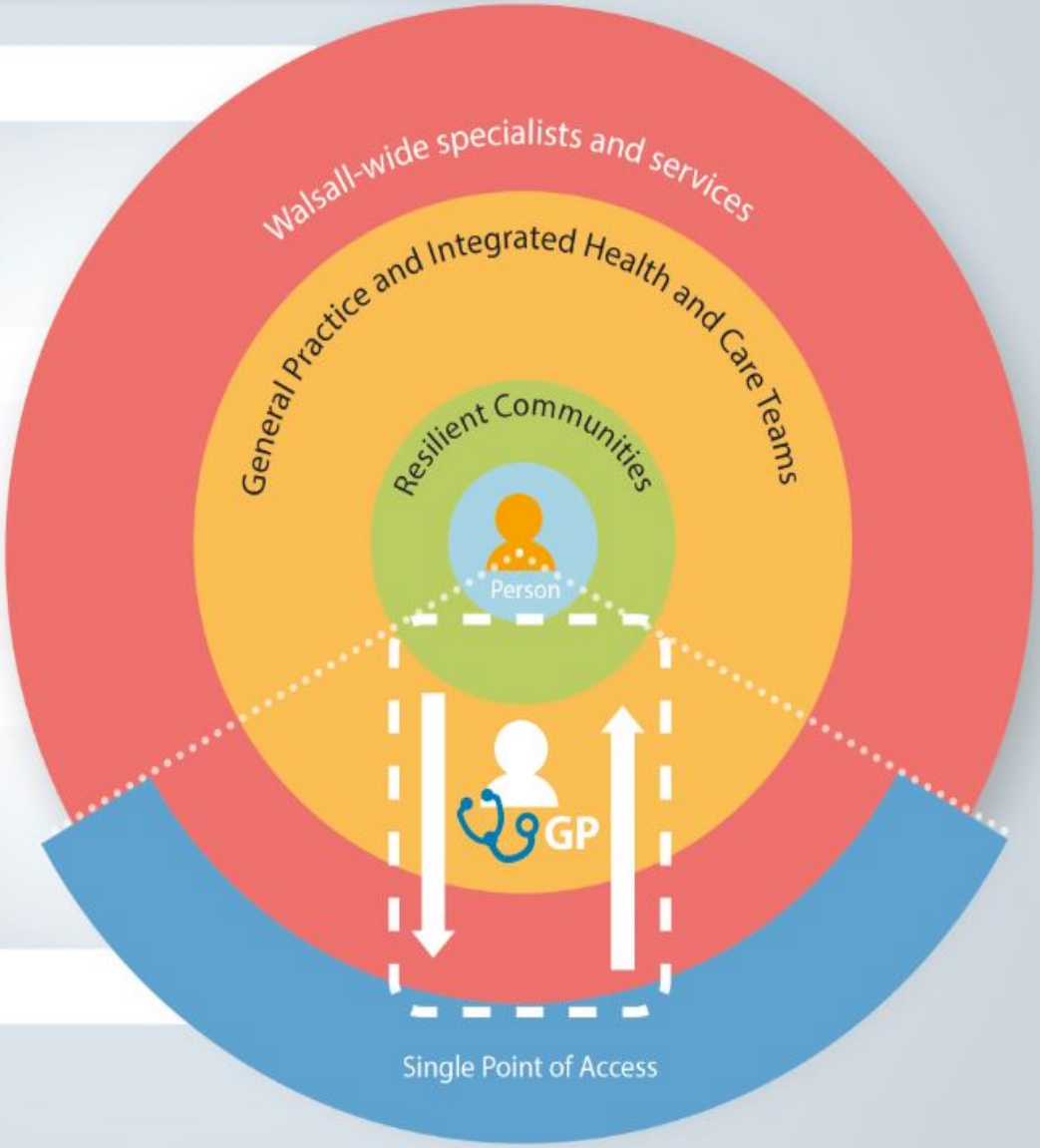
Walsall-wide specialists and service

Accessible, high quality care with local hospital teams working as part of a network of specialist care.

Supporting people with health needs to prevent unnecessary hospital admission and receive care in the most appropriate setting.

Single point of access

A single point of access for care coordination and navigation for all health, care and prevention services. To help ensure rapid and timely access and effective co-ordination for professionals and patients.



Despite this work not being underpinned by contractual obligations, the WTPB have innovated and worked collaboratively as a Partnership to deliver the changes required for the betterment of the Walsall population, including developing a high level timeline for implementation that has been developed and socialised across the health and care system since 2018 (Appendix 3), however this has since been further refined.

This forward-thinking and collaborative attitude has enabled Walsall to progress further than many other neighbouring boroughs and equivalents across the country, including the established Place Based Teams, a coherent and joined up VCSE approach and a well-articulated Resilient Communities offer to address the wider determinants of health. This partnership mentality and drive to deliver on the ground changes continues to permeate discussions and planning currently and moving forward. Further details are provided in sections 6 and 7.

One such on the ground change includes the identified and agreed locality model, based on GP practice location, with Primary Care, Social Care and Community colleagues assigned to these areas to deliver care to a registered population. Furthermore since mid-2017, the WT partners have begun to create multi-disciplinary Place Based Teams (PBT) working in these localities.

The current challenges to locality working include the lack of appropriate working space to facilitate the co-location of these PBT, with clinicians reporting that many current spaces are “make-shift” or too small to allow for meaningful communication collaboration with the full team. Additionally the administrative effort required to facilitate meetings is not available universally to all teams, impacting on the opportunity for and outcome of meetings.

The Operating Model outlined below builds on this locality model and extends the scope of integrated working beyond primary, community and social care and into specialist services and beyond. These plans build on best practice and the experience of other integrated health and care systems, which identify five key areas to inform planning, shown overleaf:

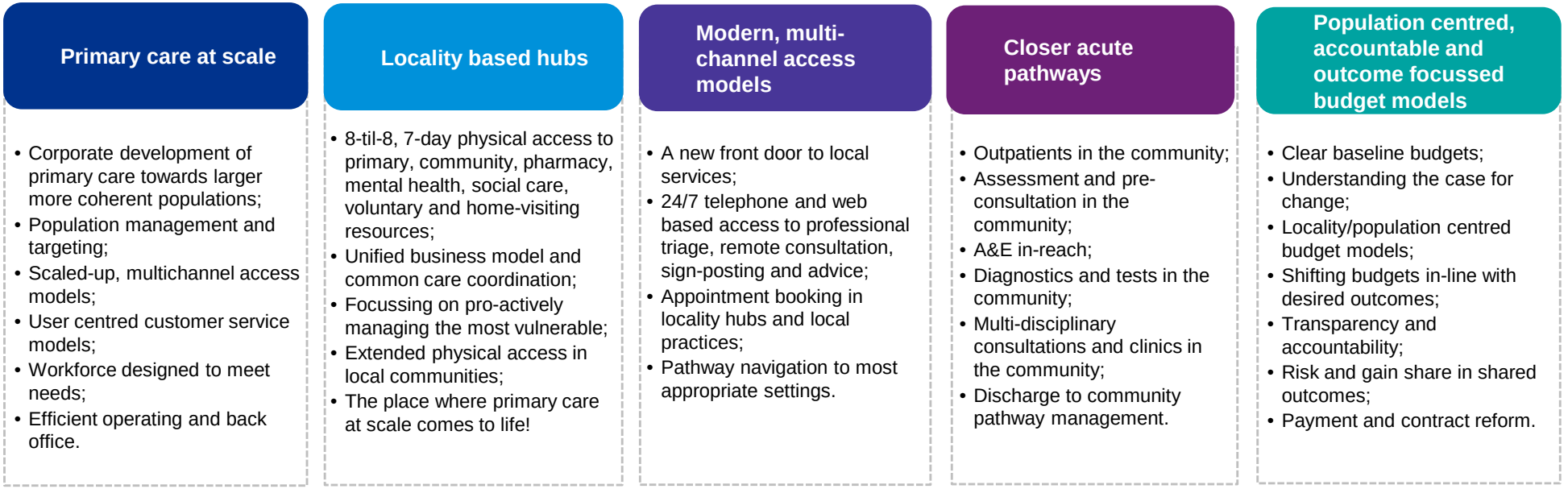


Figure 4 Elements of an Integrated Health and Care System

In order to shape the design of the Operating Model, the Operating Model workstream members identified six design principles aligned to the current local challenges, outcomes framework and vision for the future:

Design Principle	Citizen statement – What does it mean for me?
Collaborative working	My health and wellbeing will be planned holistically, looking at me as a whole person, not a condition.
Care Closer to Home	Wherever possible, I am able to access services or care close to my home.
Prevention and Early Intervention	My health and wellbeing is proactively monitored to ensure issues are identified and managed at the earliest opportunity. I know how to access support to prevent reduced independence.
Reducing Inequalities	If I am at risk of poor outcomes, I will be proactively supported to reduce the likelihood and impact of these factors. I will be supported to be as independent as possible regardless of my personal circumstances.
Resilient Communities	My community is an empowered and active asset in the management of my health and wellbeing and I am supported to take control of my own care.
Admission Avoidance	I am supported to avoid unnecessary admission to hospital or premature admission to long term care and my stays are as brief as possible.

These design principles were then used to guide a process of identifying key features of the desired Operating Model, at both a whole system and locality level, as shown in the figure below. The three green elements in the diagram; payment incentives reform, an integrated workforce plan and population management software and shared records were identified as key enablers of the desire future state.

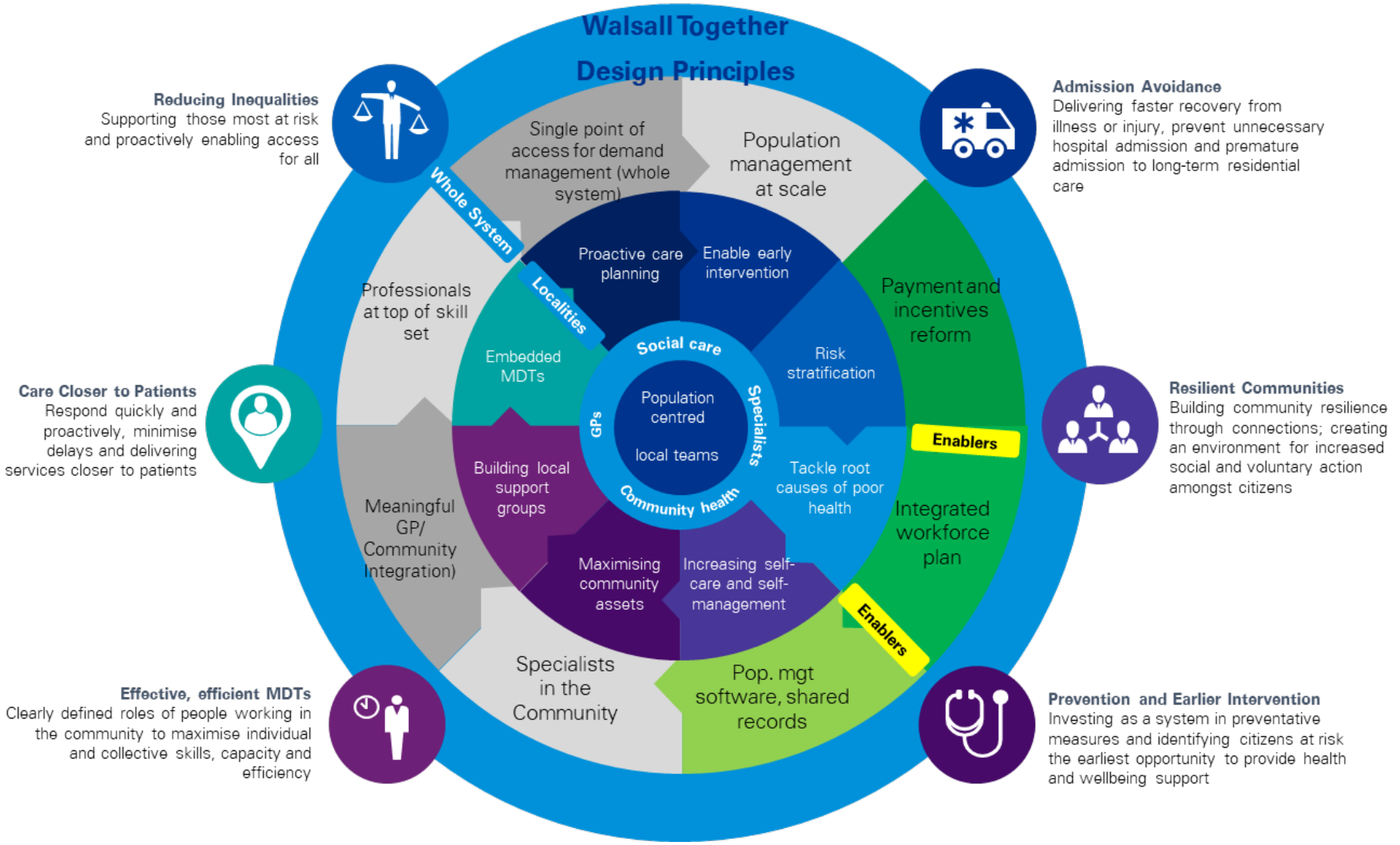


Figure 5 Designing the Walsall Together Operating Model

User Personae were developed in partnership with clinicians and professionals from across Walsall to represent a broad selection of users in Walsall that are currently not receiving the best possible care and/or where there are numerous organisations involved in their health and care. These were used to test the design principles and design a future state Operating Model through the lens of a citizen.

Figure 6 Walsall User Personae

Outline Operating Model

The *Next Steps of the NHS Five Year Forward View* paper published in March 2017 and the recent NHS Long Term Plan outlines the continued focus of NHS England on integration as part of the STPs and more broadly, while also providing an outline of the technology and innovation plans moving forward. While there are a number of formal models emerging such as Multi-speciality Community Providers (MCP) (of which DWMH is part of the Dudley MCP) and the recently identified Accountable Care Systems (ACS), including nearby Nottinghamshire, national policy for integrated care is still in its infancy, with the consultation on the Integrated Care Provider Contract ongoing at the time of print. It is for this reason systems such as Walsall have an opportunity to outline their own intentions for integrated working in a manner that works for their population; breaking down organisational barriers and silo working to deliver the greatest value for the local pound.

Globally health and care systems are reconfiguring services to capitalise on technology and the self-activated, empowered citizen to unlock new possibilities including remote monitoring, self-assessment and virtual consultations, which not only improve user satisfaction and outcome but allow services to be delivered at a lower cost. This aspect is missing in the Walsall Model of Care as shown in figure 3, while other elements do not go far enough to re-envision the delivery model. As such, a new tiered model of care has been developed, Figure 8, with citizens accessing services through a Single Point of Access (SPA). It is from this starting point that all other services can be accessed, with the SPA also acting as a two-way mechanism for the Resilient Communities offering.


Tier 1 – Integrated Primary, Long term condition management, Social and Community Services
Primary Care at scale and integrated health and care teams, working through a hub and spoke model across each locality
Tiers of Care
1
2
3
4
Tier 2 – Specialist Community Services
Outpatients and Diagnostics services delivered from locality based Health & Wellbeing Centres or the home
Walsall Together
Tier 0 – Resilient Communities
An Integrated prevention and early intervention offer to all Walsall citizens
Single Point of Access (SPA)
Care access, navigation and co-ordination including clinical triage
Tier 3 – Intermediate, Unplanned and Crisis Services
Network of specialist care delivered from Health & Wellbeing Centres, preventing unnecessary hospital admissions and facilitating timely discharge from hospital.
Tier 4 – Acute Hospital Services
Access to high quality acute hospital services for patients when they need specialist intervention, provided a) locally and b) at a Black Country, Regional or National level where necessary/

The Tier 0 "Resilient Communities" offering at the centre of the model reflects the substantial shift in thinking in the way this model will operate, with a significant investment in these services required to support it in this role. It is expected that this service will continue to grow from its current incarnation into a clearly defined and well connected infrastructure of VCSE Services, empowering localities to access, shape and deliver a range of health and wellbeing initiatives to improve outcomes for their localities.

Each tier is explained in further detail below:

Tiers	Description
Tier 0	**Resilient Communities** Prevention, identification, early intervention and pro-active self-care, health and wellbeing services.
Tier 1	**Integrated Primary, Long term condition management, Social and Community Services** Integrated health and care, delivering primary, social and community care at scale, with teams working through a hub and spoke model across each locality
Tier 2	**Specialist Community Services** Accessible, high quality care with local hospital teams working in a locality to deliver specialist care, outpatient, and diagnostic services, delivered from "Health and Wellbeing Centres" – repurposed estate used as a hub for MDTs
Tier 3	**Intermediate, Unplanned and Crisis Services** Network of specialist care delivered from a selection of Health and Wellbeing Centres, preventing unnecessary hospital admissions
Tier 4	**Acute and Emergency Services** Access to high quality acute hospital services for patients when they need specialist intervention, provided both in-borough and through a wider network

Single point of Access

Health and Wellbeing Care access, navigation and co-ordination; including triage to clinical and non-clinical services

The Walsall health and care system will develop a Single Point of Access to care and services that is co-ordinated and organised to ensure citizens are able to get to the right part of the system, to the right service and to the right professional in an efficient and timely manner. This service will allow citizens access to services via mobile app, web, phone or face to face at one of the Health and Wellbeing Centres; repurposed current estate offering access to health, care and third sector professionals. In order for this to be an effective service, the digital infrastructure, such as shared patient records and directories of services must be in place. This is described further in Section 7 - Enablers.

Tier 0 – Resilient Communities
Prevention, identification, early intervention and pro-active self-care, health and wellbeing services.

The traditional approach to health and social care has always tended to be reactive, responding when a patient or service user experiences a crisis, in order to return them back to health and provide limited support during the periods between crises. These health and social care approaches have tended to foster a culture of dependency and passivity and an over reliance on interventions, drugs,

clinics and hospitals – even though there is good evidence that the management of long term conditions, for example, usually requires high levels of patient motivation, self-care and behaviour change to be effective.

The Resilient Communities offering to citizens aims to rectify this over dependence and equip communities with the necessary tools and resources to improve the health and wellbeing of their population, by addressing the wider determinants of health such as housing, education and employment and embedding a prevention approach.

Work to date in this area has seen the introduction of "Making Connections Walsall" (MCW), a service targeted at the over 55s to address social isolation and loneliness – supporting over 500 clients since its launch in September 2017. This programme commissioned by Public Health, involves the West Midlands Fire Service acting as a central point of contact and providing "Safe and Well" visits to all vulnerable people accessing the service focusing on three key areas; Home, Community and Care.

Home	Community	Care
• Join up housing related advice and support across sectors and embed in localities; • Provide greater access to Aids/adaptations; • Domestic house & garden support.	• Provide local points of support to build capacity and resilience within communities, through increased social and voluntary action; • Connecting people within communities, developing and sharing skills and capabilities; • Increase support for carers; • Increase coordination and access to information and advice.	• Providing people with Long term conditions with more options to self-care by supporting creation and growth of community-led peer support groups; • Increase access to social prescribing services, wellbeing assessments and plans; • Encourage and support across partnership delivery of evidence based interventions to prevent deterioration and / or escalation.

One Walsall's core activity provides infrastructure support, development and capacity building of the borough's voluntary and community sector. As such, One Walsall will continue to build capability within the VCSE sector to resource the ambitious vision for the wider Resilient Communities approach, in collaboration with MCW's programme.

Resilient Communities will be underpinned by digital tools and technology; enabling access to work, leisure and training for people alongside organisations such as VCSE groups seeking resources or advice. This focus on preventative action is recognised as fundamental to delivering long term improvements in health and wellbeing outcomes for people, and it is anticipated that services delivered at Tier 0 will be evaluated and recognised alongside interventions delivered at other Tiers.

Services delivered through Tier 0 Resilient Communities may include;

- Social Prescribing, delivered consistently and in a co-ordinated manner by One Walsall and health and care professionals, from within the Place Based Teams and Integrated Intermediate Care Service. A current pilot embedding VSC Community Link Officers is underway, with plans to expand this to cover the whole borough if successful.
- Making Connections Walsall Social Connectors;

- Direct access to community assets including VCSE providers and opportunities, housing, education and training information and advice, through an up to date directory of services and point of contact;
- Expert Patient programme;
- Care Navigation and co-ordination;
- Carer support;
- Citizen education for specific clinical pathways e.g. diabetes, respiratory problems;
- Volunteering groups, programmes and opportunities. Currently there is a lack of diverse volunteering opportunities in the borough and great potential to develop volunteer supported projects for areas of varying deprivation, need and demographics. High quality experiences are the key to attracting and retaining volunteers as detailed in the National Council Voluntary Organisations Time Well Spent Survey (2019). Therefore opportunities and investment targeted at VCSE organisations to increase the number of high quality volunteering opportunities is key to unlocking the potential of the Resilient Communities approach.

Citizens will be able to access the services listed here by phone, online or in person, by visiting one of the "Health and Wellbeing Centres" in their locality. For the volume of contacts to be dealt with at this Tier, it is essential that there is 24/7 online access to these services, with a physical presence also provided on an extended hours basis. There needs to be increasing emphasis on assisting citizens to actively engage in education, prevention and wellbeing services using the voluntary sector as a first point of contact and access. However the ongoing and desired increasing contribution of the VCSE outlined here cannot be assumed without acknowledging the capacity limitations of these services.

Tier 1 - Integrated Primary (physical and mental health), Long term condition management, Social and Community Services
Integrated health and care Place Based Teams working through a hub and spoke model

The tier is based on the joined up delivery of wellbeing services, primary care, social care and community services in each locality through Primary Care Networks (PCN). PCNs represent the most local, neighborhood level of care systems and form the foundations of Place Based Care as outlined in the FYFV (NHS England, 2014), Next Steps on the FYFV (NHS England, 2017) and NHS Long Term Plan published in January 2019. They provide the community level mechanism for coordinating Primary Care services for a given population at scale. PCN will interface with the Place Based Teams based at Health and Wellbeing Centres in each of the four localities. These Health and Wellbeing Centres – remodeled and repurposed facilities from the current local estate, as well as other primary care centers and GP surgeries will operate routine, booked, walk-in type facilities with flexibility for unplanned walk-in facilities covering essential and enhanced services. It is proposed that services would be available between 8.00am and 6.30pm Monday to Friday, with extended access from the wider Health and Wellbeing Centres that are part of the Walsall locality network. This will include the integration of place based community, social care and primary mental health professional teams wrapped around locality populations. These professional teams will include but not be limited to:

- Adults Social Care Services;
- Adult Community Health Services;
- Adult Primary Mental Health Services;
- Proactive virtual monitoring.

Tier 2 - Specialist Community Services

Accessible, high quality care with local hospital teams working in a locality to deliver specialist care, outpatient, and diagnostic services, delivered from Health and Wellbeing Centres

The traditional model of specialist care involves a patient attending a Primary Care appointment in order to get a referral for more specialist assessment and care, usually provided by a consultant at the acute hospital. The patient has to travel to the hospital for one or more outpatient appointments with the consultant and for associated diagnostic tests. If a patient requires surgery, some patients may need to stay in hospital for a few days before being discharged home, with one or more subsequent outpatient appointments, again at the hospital with the consultant to confirm progress.

Under the proposed model of care, a Tier 1 or 2 professional (this could be an Advanced Nurse Practitioner, GP or a similarly qualified professional) would refer all but the most complex or low volume cases to a specialist within the community who would undertake a first 'outpatient' consultation at a clinic run in one of four Health and Wellbeing Centres for Specialist services across the Walsall area. Where further investigation by a consultant is required with only the most complex or low-volume cases being seen in an acute hospital setting.

During the first phase of delivery it is proposed the following specialties will be seen in the Health and Wellbeing Centres:

- Respiratory;
- Cardiology;
- Rheumatology;
- Neurology;
- Palliative Care;
- Pain Management;
- Diabetes;
- Urology;
- Gynecology;
- Ear, Nose and Throat;
- Musculoskeletal.

It is envisaged that these will be seen by General Practitioners with a Special Interest (GPwSI), Community Consultants, and out-reach hospital staff by managing care differently and implementing new care pathways.

Tier 3 – Intermediate, Unplanned and Crisis Services

Network of specialist care delivered from Health and Wellbeing Centres, preventing unnecessary hospital admissions.

The aim will be to provide the appropriate level of intermediate care to prevent unnecessary hospital admissions. These services will be time limited, enable better assessment and care planning for

individual patients which is multidisciplinary and focused on active rehabilitation working out of the locality integrated Health and Wellbeing Centres.

Services delivered at this tier are not "in-scope" for Horizon 1, however the future state services may include:

- Integrated Rapid Response Service
- Paramedics in the community

The core aims of these integrated community based services at tiers 0-3 Care:

- To help people achieve their full potential for independence.
- To reduce the need for long term hospital based care.
- To prevent physical and mental deterioration and dependency as a result of hospital admission and long stays in hospital.
- To respond flexibly to the multiple, overlapping and changing needs of vulnerable individuals and the frail elderly.

Unplanned/Urgent Care Services

It is nationally recognised that a significant number of A&E attendances across the country are inappropriate and could be treated or routed through different settings. It is well within the capability of primary care clinicians in a multi-disciplinary setting to be able to deal with a significant proportion of this attendances providing they have access to routine diagnostics and community services.

All major trauma and life-threatening conditions would be treated at the most appropriate acute hospital across the borough and the majority of blue-light ambulance calls would be taken to acute facilities, which would also be open to walk-in patients.

Therefore the new model of unplanned care would see the WHT A&E department being supported by the existing unplanned care facilities led by primary care clinicians, including Out of Hours services in one or more of the Health and Wellbeing Centres.

Tier 4 - Acute and Emergency Services
Access to high quality acute hospital services for patients when they need specialist intervention, provided both in-borough and through a wider network

When patients require acute or emergency care they will be able to access high quality appropriately resourced services delivered from their local hospital. Despite the increased provision and capacity in primary and community services from tier 0-3 patients and professionals still need to know they can get access to high quality acute and emergency services when they require surgery, deteriorate from a current condition or need immediate intervention.

Estate Requirements

It is envisioned these services be provided using the existing estate, however this may require a significant repurposing and reconfiguration in order to deliver the four proposed Health and Wellbeing Centres. Further details of this can be found in the Mobilisation and Implementation section, along with initial investment cost requirements. A representative outline of the estates configuration is provided below.

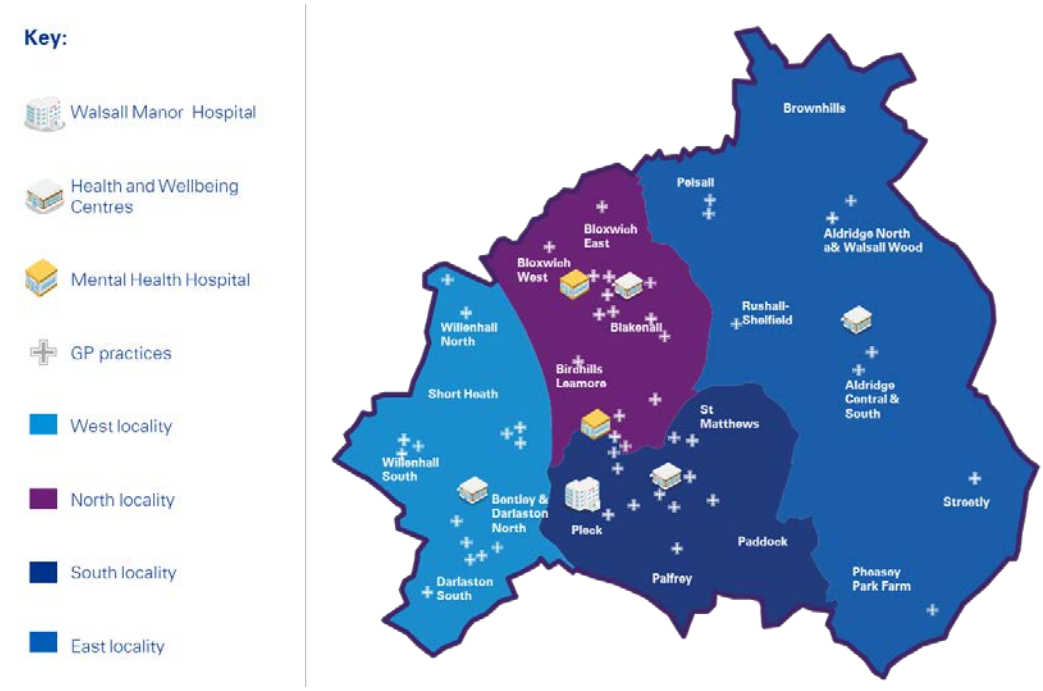


Figure 8 Representative Future Estates Configuration

This locality based model outlines the designation of four Health and Wellbeing Centres based across the four localities, from which citizens can access services (i.e. the SPA and Tier 0, 1, 2 and 3 services subject to the detailed design phase). These Health and Wellbeing Centres will form a hub for the Integrated MDTs working in the community and will be repurposed from existing estate, with the redeployment of resources into these locations. The Manor Hospital is illustrated here, however Tier 4 services also covers those specialist acute services provided outside of Walsall. In the case of the large East, South and West localities these are split into two, with a single multi-disciplinary, Place Based Team (PBT) serving a population of approximately 40,000 registered patients.

- North PBT– covering 58,115 citizens.
- East 1 PBT– covering 32,930 citizens.
- East 2 PBT – covering 42,530 citizens.
- South 1 PBT– covering 41,068 citizens.
- South 2 PBT – covering 49,060 citizens.
- West 1 PBT– covering 39,817 citizens.
- West 2 PBT – covering 39,131 citizens.

This helicopter view of the Walsall system is intended to provide a framework for delivering not only integrated services but shifting care away from the expensive acute environment and delivering a far greater volume of care in the community; alongside increasing citizen activation and community resilience. Each tier increases in the level of acuity and as such, the volume of care delivered at each tier should decrease. The benefits to this model are outlined in further detail below.

What will this mean for patients in the future?

A series of user stories have been generated to illustrate what the new operating model might be like for each of the users, mapped to the relevant tier of care, with a selection of these illustrated below

and further examples in the appendix (3). Note, these have not undergone detailed design with clinicians or professionals and are for illustrative purposes only.

Single Point of Access

Citizens will access all health and wellbeing services, from GP appointments to support for carers' through a single entry point; whether that is via a mobile app, phone number, website or by visiting their local Health and Wellbeing Centre based in their community. The SPA will be supported by an up to date digital directory of services available to be accessed across all the tiers.

Tier 0 - Resilient Communities
Citizens will be able to contribute towards and access locality based services to improve the health and wellbeing of themselves and their community throughout their lives. Preventative services focused on strengthening social networks to prevent isolation and volunteer health 'champions' to tackle issues such as obesity, workplace absence and unemployment will provide the bedrock of the community health and wellbeing services. Place Based Teams of health and care professionals from Primary, Community and Social Care will work alongside VSC colleagues to ensure citizens are provided with the right advice, opportunities and support to enable them to live healthy, fulfilled lives with maximum independence. VCSE Community Link Officers will operate from each of the Health and Wellbeing Services, providing a visible and accessible direct contact for Social Prescribing for citizens and health and care professionals (in addition to the phone, web and mobile access channels provided via the SPA).

Tier 1 - Integrated Primary (physical and mental health), Long Term Condition Management, Social and Community Services
Through the SPA, citizens will be able to arrange the most appropriate appointment for their health and care need from their Place Based Team, whether that is a telephone appointment with their GP regarding a mental health issue, a home visit from a social worker regarding their accessibility requirements or a group learning session held at the local Health and Wellbeing Centre for those newly diagnosed with diabetes. The organisational divisions will be less obvious, with the Place Based Teams co-located in many cases and working collaboratively to ensure citizens receive the right care, at the right time and in the right place. The use of regular, focused Multi-disciplinary team (MDT) meetings will be key to ensuring a holistic approach, allowing professionals to raise concerns or recommendations regarding their cohort of citizens. In line with the NHS Long Term Plan digital technology will be introduced to enhance primary are access and delivery across each locality.

Tier 2 – Specialist Community Services
This tier builds on the development of a network of Specialists providing care across Walsall. In the future state, this will allow citizens to access specialist services without visiting the acute hospital through the use of virtual clinics and digital tools such as remote monitoring devices and sensors. Data will be shared across providers and between citizens and their care providers, allowing real time reactions and informed decision making. This is in line with the NHS Long Term Plan which sets out a key objective that Outpatient services will be fundamentally redesigned in the future.

Tier 3 – Intermediate, Unplanned and Crisis Services

When a citizen requires immediate or urgent care that does not necessitate an acute emergency attendance, they will be able to access services 24 hours a day through the SPA. Through a triage process, citizens will be able to access the most appropriate professional for their needs. This will include mental health nurses and social workers who are able to respond to a crisis and provide the best level of care and support.

Tier 4 – Acute and Emergency Services

At this Tier, the services accessed by citizens will remain largely the same at they are at present, with 24 hour A&E services available at the Manor Hospital for those requiring emergency medical treatment and secondary care and specialist services provided by Walsall Healthcare NHS Trust and other secondary care providers in the region and nationally where necessary. Shared digital records across Walsall will allow clinicians and professionals' real time access to a citizen's engagement with health and care services, allowing for informed and improved decision making and better outcomes. Once a patient is at the hospital, either due to a referral or independently, they can expect to be assessed by a clinical team to ensure acute/emergency treatment is the best course of action, potentially utilising the clinical referral pathways into the SPA, to refer citizens to a service at a lower tier if necessary. If admittance is the most appropriate route, the PBTs will work collaboratively to ensure the citizen is discharged to a setting closer to home as soon as possible, improving outcomes and reducing the number of bed days.

What it could look like for Sophie...

Sophie

Age: 26

Job title: Unemployed

Sophie is an independent but isolated young mother, who's son Joshua has recently started school. She has had difficulty managing her alcohol intake since Joshua was born and has been abusing prescription drugs and cannabis to cope with the violent relationship she has with his father. Sophie has attended A&E on six occasions due to domestic violence but is extremely fearful of losing custody of her son.

Tier of Care:

0 1 2 3 4

1

The social worker at the MDT highlights the risk of domestic violence in the home, while her GP flags that she has struggled with drug and alcohol since Joshua's birth. They agree a Care Plan, to led by her GP and supported by the local family support VCS group.

Following a review from MASH, Sophie meets with a member of the Early Help Team at the Children's Centre, where they discuss how they can support Sophie in caring for Joshua and develop an Early Help Plan. Her Care-coordinator from the PBT also refers Sophie to the Beacon for Drug & Alcohol support.

2

Following the Early Help Plan, Sophie attends a Targeted Parenting programme at her local Children's Centre and receives support from specialist teams to ensure she and Joshua are not at risk from violence. The PBT also guide Sophie to access support for her substance dependencies.

2

With increased confidence and control over her dependencies, Matt works with Sophie and her Social Worker to enrol her on a parenting support programme. Sophie is able to engage better with Joshua and is looking at adult education to improve her employment opportunities.

0

At their monthly review, Sophie confides in Matt that she has not met with the councillor or domestic abuse support as she is fearful her partner will find out. Matt takes this information back to the MDT, who review her Care Plan.

4

Following an attendance at A&E for broken ribs, the consultant flags Sophie as at risk of domestic violence and refers to the PBT and the Multi Agency Safeguarding Hub (MASH) as she has a young child at home.

What it could look like for Karanjit...

Karanjit

Age: 85

Job title: Retired teacher

Karanjit is an intelligent and sociable woman, who enjoys visiting and writing letters to her friends. She is very independent and lives alone in the house she shared with her late husband, despite her family's wishes that she move in with them. She has had a number of falls in the last 5 years, with increasing frequency and also been treated for multiple, recurring UTIs.

Tier of Care:

0 1 2 3 4

Karanjit and her family work with the Care Coordinator to evaluate her home environment. With some small modifications and the installation of monitoring devices, everyone is satisfied Karanjit can continue to live at home safely.

1

By utilising a wide range of digital monitoring devices and software, Karanjit and her family can be assured that she is safe and well at all times. In the event of an emergency or fall, the staff at the Hub can act immediately with the appropriate course of action 24 hours a day, with full shared access to her care record.

3

2

Karanjit is able to attend her local community centre to meet her friends and speak to her Care Coordinator in her mother tongue, who arranges for her to be picked up to reduce her fall risk. She is also able to attend her outpatient appointments at the community centre and her family are pleased she is supported to remain independent.

What it could look like for Muhammad...

Muhammad

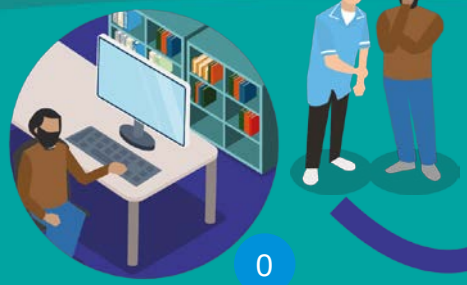
Age: 34

Job title: Unemployed

Muhammad has a passion for fantasy football and would love to spend more time socialising He has moderate learning disabilities and currently lives at home with his parents. Muhammad has little social interaction outside of the family home and is currently overweight and at risk of developing diabetes due to a poor diet.

Tier of Care:

0 1 2 3 4



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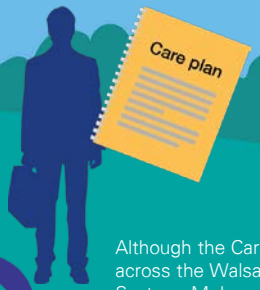
Muhammad is able to access information in his local library about a sports team for adults with learning difficulties and meets with a Care Coordinator who supports him to build a Care Plan, including attending weekly healthy living group.



Although the Care Plan is shared digitally across the Walsall Health and Care System, Muhammad's Care Coordinator ensures this is developed into a format and language that Muhammad is able to access easily and amend.

2

1

Muhammad's Care Coordinator arranges with Muhammed and his family an assessment of his needs at the local community centre. Muhammad is found to be eligible for an individual budget, and a package of care is put in place to support him and his parents.

0

Muhammad and his family lead their own support with the help from the Care Coordinator. Muhammad uses his budget to employ a personal assistant, who accompanies him to the job centre where the DWP run a weekly coaching session.

With renewed confidence and support from the learning disabilities employment scheme, Muhammad begins part time work in a shop – squeezing in fantasy football when he can.

Developing the "Do something" scenario

Using the tiered model of care outlined above along with the future state user journeys and clinical/professional input, the following elements have been identified as featuring in the desired future state.

Tier	Scheme/Service/Initiative
SPA	• Single citizen portal for accessing advice, appointments and support • Online Directory of Services connecting patients to a range of commissioned and independent health and wellbeing services and groups • 24/7 Clinical/Professional triage • Citizen access to health records • Referrals management
0	• Social Prescribing • Support for self-care of long term conditions • Support for carers • Connecting people in communities through shared and common interests, developing skills and capabilities that can be shared • Access to health, wellbeing, benefits and housing information and advice • Aids/adaptations and housing related support to keep people safe at home
1	• Multidisciplinary Place Based Teams of Mental Health, Community, Primary and Social Care professionals • Remote monitoring of citizens with some long term conditions • Telemedicine • Risk stratification and targeted intervention • Shared patient record • Care Planning • Care Home and at home In reach service • Greater Community/Specialist Nursing • Consultants in the community • Condition Specific Rehabilitation
2	• Outpatients in the community • Virtual Outpatient Clinics
3	• Integrated Rapid Response Service • Paramedics in the community
4	• Assess to Admit/Front end streaming • Remote 24/7 monitoring of inpatients • Clear routes to discharge, including Estimated Date of Discharge (EDD)

Evidence base for change scenarios

The table below provides an analysis of evidence based change initiatives that have been developed and implemented in different parts of the U.K. and internationally. These provide an evaluated reference point to the potential impact of these different change initiatives at both a base case and

best case level. This outlines the potential transformation opportunity and impact these initiatives could deliver depending on to what extent they are implemented across a local system:

Tier	Contributing Change Scenarios/initiatives	Impact	Base Case	Best Case	Rationale (sample)
SPA	• Single citizen portal for accessing advice, appointments and support • Online Directory of Services connecting patients to a range of commissioned and independent health and wellbeing services and groups • 24/7 Clinical/Professional triage • Citizen access to health records	Increase in VCSE and Social Care contacts	20%	35%	Increasing citizen awareness of VCSE alongside promotion of these as alternatives to primary/community appointments will result in increased demand. Improved triage will also direct inappropriate primary care appointments to the correct service, as it is estimated 1 in 4 GP appointments could be avoided with more coordinated working, improved technology and access to MDTs. Furthermore, it is estimated a fifth a GPs time is spent dealing with social issues including debt, social isolation, housing, work, relationships and unemployment. (Making Time in General Practice, 2015).
		Reduction in Primary Care Appointments	15%	30%	Clinical triage and advice has been shown to reduce the requirement for face to face primary care appointments by up to 50% (Bunn, Bryne, & Kendall, 2004).
Tier 0	• Social Prescribing • Support for self-care of long term conditions • Support for carers • Connecting people in communities through shared and common interests, developing skills and capabilities that can be shared • Access to health, wellbeing, benefits and housing information and advice • Aids/adaptations and housing related support to keep people safe at home	Reduction in ambulatory sensitive condition admissions	10%	20%	The Compassionate Frome project reported a reduction in emergency hospital admissions of 30% following the introduction of “community connections” (Abel & Clarke, 2018).
		Reduction in A&E attendances	10%	20%	The Nuffield Trust report published in 2017 outlines that self-care in long term conditions has been shown to reduce A&E attendances, in particular for adults with COPD, asthma and heart failure (Imison, et al., 2017).
		Increase in population self-care and self-management	5%	10%	It can be expected that through providing clear and easy access to self-care advice and guidance that the management of self-limiting illnesses will be improved (Rosen, 2014) , with citizens also likely to seek advice and treatment from their local pharmacists.

Tier 1	• Multidisciplinary Place Based Teams of Mental Health, Community, Primary and Social Care professionals • Remote monitoring of citizens with some long term conditions • Telemedicine • Risk stratification and targeted intervention • Shared digital citizen/patient record • Care Planning • Care Home and at home In reach service • Greater Community/Specialist Nursing • Consultants in the community • Condition Specific Rehabilitation • Referrals management	Reduction in ambulatory sensitive condition admissions	10%	20%	This Dutch model empowers teams of nurses to deliver all the care needs of their patient cohort. This has resulted in a 50% reduction in overall hours of care, with a 40% reduction in costs per patient. (Buurtzorg, n.d.)
		Reduction in ambulatory sensitive condition admissions	10%	30%	The Hull tele-monitoring service for heart failure patients reduced admissions in this cohort by 10%, with a return on investment of 48% (Cruickshank & Paxman, 2013). A 2015 Cochrane review revealed a 30% reduction of heart failure related hospitalisations when using remote monitoring (Inglis, Clark, Dierckx, Prieto-Merino, & Cleland, 2015).
		Reduction in A&E attendances	10%	30%	A Unified Care Plan programme in Birmingham found citizens that followed their care plan had a 50% reduction in A&E attendance, and a 25% reduction in non-elective admissions.
		Reduction in outpatient referrals	10%	35%	Electronic referrals, particularly when embedded within a shared electronic record have been shown to reduce inappropriate referrals and improve the quality of diagnosis (Blank, et al., 2014). Communications between GPs and consultants following an e-referral resulted in a 25% reduction of outpatient appointments (Scheibe, et al., 2015). The Torfaen referral evaluation project reduced referral rates in orthopaedics and emergency admissions reduced by up to 50% (Evans, 2009).
		Increase in Community and Social Care Contacts	10%	30%	The use of remote monitoring, remote consultation and telemedicine will enable citizens, their carers and professionals access to clinical advice and guidance without admission or attendance at an acute facility. This will result in more episodes dealt with remotely or by carers or nursing staff directly in the community. An increase in social care contacts will not assume a like for like increase in social care expenditure and will be modelled on marginal cost basis.

		Increase of Community contacts	20%	35%	The expansion of community nursing and shift of appointments from secondary to community services will increase the number of community contacts.
Tier 2	• Outpatients in the community • Virtual Outpatient Clinics • Condition Specific Rehabilitation • Referrals Management	Reduction in outpatient appointments	20%	50%	Renal e-clinics in Tower Hamlets allowed GPs to refer patients to a virtual clinic, resulting in 50% of referrals managed without the need for an outpatient appointment. (NHS England, 2016)
		Reduction in DNAs and length of outpatient appointments	25%	50%	A virtual outpatient scheme called 'Diabetes Appointments via Webcam in Newham (DAWN)' showed an increase in patient satisfaction and a reduction in DNAs by 50% (Vijayaraghavan, et al., 2015).
Tier 3	• Integrated Rapid Response Service • Paramedics in the community	Reduction in ambulatory sensitive condition admissions	40%	50%	NHS England (2013) states that 50% of all emergency call needing an ambulance could be managed at the scene or in the community, preventing unnecessary admissions. The Kings Fund paper (2014) also estimates that up to 30% of emergency admissions could have been avoided if appropriate alternative forms of care are available at the point crisis or if care had been managed better in the period leading up to the admission.
Tier 4	• Assess to Admit/Front end streaming • Remote 24/7 monitoring of inpatients • Clear Routes to discharge/ discharge planning	Reduction in ambulatory sensitive condition admissions	5%	10%	Front end streaming service pilots found a reduction in A&E attendance of 3.5% and non-elective admissions were reduced by an average of 5%.
		Reduced Length of Stay	10%	20%	Monitoring of a patients vital signs when in ICU has shown to reduce length of stay in this unit by 20%.
		Increase in Social Care and Community contacts	25%	30%	The impact of discharging patients from acute beds into the community will increase the demand on Social and Community Care to provide the necessary care for these patients.

Creating Realistic Targets for Walsall's Integrated Care System

While the evidence base for many new models of care both in the UK and globally is still in its infancy (very few studies apply the impact of individual initiatives at the system level overall), with many studies failing to provide high quality evaluations of the impacts (Imison, et al., 2017), a review by the Nuffield Trust in 2017 outlines that by delivering a combination of these initiatives, many of the projected impacts illustrated by The Nuffield Trust for improved patient care are promising, with the following changes to activity projections for 2020/21:

- 15.5 per cent fewer outpatient attendances (range 7–30 per cent).
- 9.6 per cent less elective inpatient activity (range 1.4–16 per cent).
- 17 per cent fewer A&E attendances (range 6–30 per cent).
- 15.6 per cent fewer non-elective inpatient admissions (range 3–30 per cent).

Taking these projections, the evidence base above and by applying a degree of local system knowledge, we are able to estimate the potential impact of change for the existing components of the Walsall system through a set of realistic system targets:

Area of Impact	Average of Base	Average of Best	Walsall Target Assumptions	Walsall Target
Increase in Community Contacts	12%	22%	Grow towards the full target increase in community health contacts	21%
Increase in population self-care and self-management	8%	15%	Deliver this through an integrated SPA and resilient communities offer to a full target of 15% over time. See below.	No impact on existing services
Increase in Social Care contacts	7%	13%	13% increase in social care contacts by year 3 feels realistic	13%
Increase in VCS contacts	10%	20%	Assumed that whilst this takes place it doesn't impact existing services - i.e. it is a consequence rather than a change in itself.	Not modelled no target
Increase of outpatient appointments in the community	10%	20%	Assumed that this is part of the increase in community contacts above and that it isn't additional to that. This recognises the challenges in Walsall around delivering true outpatients appointments in the community.	Not additionally modelled, no additional target

Reduced Length of Stay	10%	20%	Assumed that Walsall over time achieves an average position versus external evidence	15%
Reduction in A&E attendances	10%	25%	Assumed that Walsall grows towards the best case scenario with an up to 25% reduction in A&E attendances, supported by the relative increases in community contacts.	25%
Reduction in ambulatory sensitive condition admissions	15%	26%	Assumed that Walsall grows towards the best case scenario with an up to 26% reduction in ambulatory care sensitive admissions, supported by the relative increases in community contacts.	26%
Reduction in DNAs and length of outpatient appointments	25%	50%	Whilst this makes an efficiency from a usage of workforce time perspective it doesn't change the relative capacity and demand issues in the system and therefore hasn't been put forwards as a modelled scenario.	Not modelled no target
Reduction in outpatient appointments	20%	50%	Assumed that this achieves a level of circa 28% by year 3, recognising that there have been challenges in Walsall around delivering these at scale in the community.	28%
Reduction in outpatient referrals	10%	35%	Included in outpatient appointment changes	Not modelled no target

Reduction in Primary Care Appointments	30%	50%	We would expect to see a reduction in existing primary care contacts of circa 30% in Walsall (as large parts of what GPs currently do will be provided by the SPA, resilient communities and community contacts), albeit GPs will be asked to see more acute patients/manage the care of patients for longer and therefore we envisage no net impact on the capacity required in GP settings (albeit that capacity will need to change what it does).	Not modelled no target

These targets for the existing parts of the system are complemented by the addition of new system components, The SPA and the Tier 0 Resilient Communities offer. We've set a target of these new components growing to 678000 contacts with the people of Walsall per annum, once at full scale.

Note: at this stage we have not included a "big shift" associated with a shift from secondary to primary mental health services. Whilst this is a clear aspiration in Walsall, at this stage there is little evidence for this being possible within the current primary care infrastructure. Additional work would be required in the detail to assess the requirement for the development of primary mental health resources, as a component of enhanced integrated teams. We believe that a more detailed design exercise will inform this.

4 Financial and activity data analysis

The analysis within this business case provides a clear direction for the future model of care in Walsall and the aim of Walsall partners is to move to a position of financial balance alongside an investment into services to improve health outcomes for Walsall citizens. At present, without both efficiency savings and meaningful change to service delivery the baseline position will rise to a very significant gap of £174m by 2023/24. If existing efficiency savings plans are delivered and sustained (year on year), this gap reduces by £113m by 2023/24. Whilst positive this still leaves an additional gap by 2023/24 of £61m.

Without sustainable, system wide transformation in the delivery of care, the system in Walsall will continue to operate in an ever increase deficit yearly position for the foreseeable future. This is the challenge that must be overcome through genuine transformation of services. Achieving the efficiency saving expectations e.g. CIP and QIPP bridges a significant amount of the financial gap as described above and the total impact of delivering the change scenarios as part of the new operating model closes this further to £10.7million by the end of Horizon 3.

Current state – Affordability and capacity

The outputs of the model provide the extent to which the system is likely to be challenged by changes to activity and the impact of inflation on both income and expenditure. This includes forecast changes to the funding allocation received by the CCG as well as budgetary pressures on Local Authority funding.

We have taken a view of the income to the system at the top level – this includes commissioner funding allocation, local authority budget allocation for both Social Care departments and defined programmes delivered by WHT, and defined income to the local authority such as grants and contributions from the population, and income for specialised commissioning. This is compared to system expenditure at the point of delivery, which is a combination of CCG expenditure (where provider level data is unavailable e.g. GP data), and provider expenditure (where the data is available from providers like WHT and DWMHT that tells us the actual cost of treating people from Walsall).

This presents a true system view, without consideration of how the individual providers or commissioners might reconcile their own particular financial situation, and in that sense supports the integrated care system direction.

Proportion of spend by type of service

Analysis of commissioning data gives the following split of system cost, indicating which sectors are currently the biggest cost to the system. As expected, it is the acute sector that costs the most, and therefore in driving savings for the system as a whole, moving activity from a high cost to a low cost area like the Community will be beneficial from both a financial perspective, and the experience of the population.

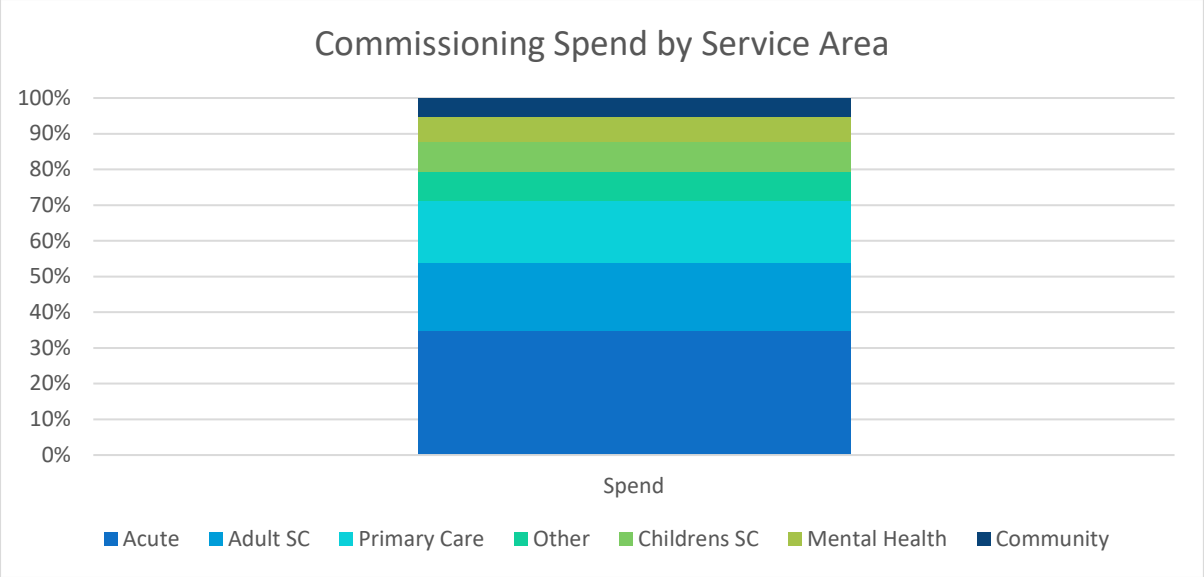


Figure 12 17/18 Base Case relative spend on of health and care services (without overhead allocation)

Income forecast based on the change in profile of the age population and wage and cost inflation

In considering the outputs of the data modelling process, a high level income (projected funding) forecast versus the projected expenditure forecast required to meet growth in activity/population and inflation is shown below.

The forecast system income as defined above for the health and care system is estimated at £675 million by 2023/24 which is an increase of £64 million. This is compared to a total system expenditure at the point of delivery, of £849 million, which is an increase of £216 million over the same period.

That increase is a combination of the inflationary impact of current costs, and the additional cost of treating increased demand (also adjusted for inflation). In the acute setting, this activity growth by the 2023/24 equates to 6,200 more A&E attendances, 16,000 more Inpatient spells, and 113,000 more outpatient appointments/procedures.

The 'do nothing' scenario not only increases running costs significantly but the forecast increased demand would also mean the need for a significantly enhanced and increased hospital facility in Walsall to accommodate the rise in inpatients (24 additional hospital inpatient beds at the Manor by 2021/22), provide more hospital outpatient appointments and undertake more day case procedures.

Horizon	Income	Expenditure	Difference
1 – 2019/20	629,850	679,284	(49,434)
2 – 2020/21	639,604	717,849	(78,246)
3 – 2023/24	675,568	849,999	(174,432)

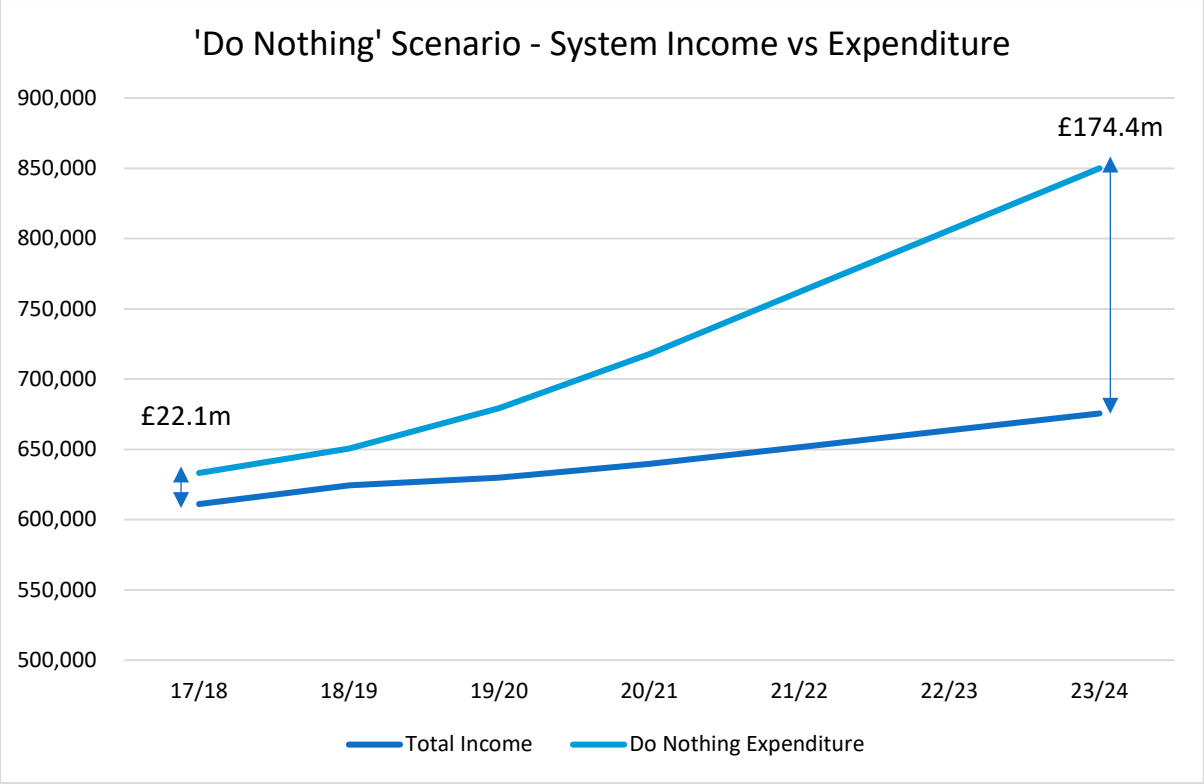


Figure 13 "Do nothing" Forecast

The above graph shows the impact within the 'Do Nothing' Scenario of the combined changes in activity forecast, and monetary inflation based on the assumption set out in Appendix 2.

From a provider perspective, in every case a proportion of costs are fixed but there is an assumption that income is variable in line with activity changes. Therefore any increase in activity results in an improvement in their individual financial position over time. What this does not take into account is the possible increase in fixed costs required to facilitate an increase in activity within certain departments. The greater the increase in activity, the greater the risk that fixed costs would also have to increase, which would worsen the financial position further. Additionally, the above does not include any planned Cost Improvement Programmes or other efficiencies that might reduce expenditure.

The most significant drivers of the worsening financial position are the increased system spend to serve the projected increase in activity, as well as almost £30million of funding pressures within the Local Authority from Adult Social Care and Children's Services alone. In simple terms, the expectation is that the system needs to do more, with less funding.

Current state Summary

In summary, the 'do-nothing' scenario results in a serious financial challenge which could not be addressed without a considerable increase in funding to compensate. As the rest of the developed world is realising, only major transformational change to our health and care systems will address the financial, capacity and staffing gaps which are being driven by increasing demand from the aging population.

Future state – Summary the 'Do-Something change scenario

The objective of the Walsall Together programme has been to deliver a much more integrated care system to improve the health and wellbeing of local people, thereby improving the quality of local health and care services, and delivering financial stability and efficiencies throughout the local health and care system.

As summarised above the 'do-nothing' scenario results in a serious financial challenge across the Walsall system. This approximately level of financial gap has been modelled as £174.4m by 2024. In order for the system to close this gap over time and achieve better quality of care requires a transformation plan to deliver a range of scenarios outlined in section 3 earlier. These are summarised below along with the financial impact of delivering these schemes over a period of time.

Developing the "Do something" scenario

Using the tiered model of care outlined in section 3 along with the future state user journeys and clinical/professional input, the following elements have been identified as featuring in the desired future state:

Tier	Contributing Change Scenarios/initiatives	Impact	Base Case	Best Case
SPA	• Online Directory of Services connecting patients to a range of commissioned and independent health and wellbeing services and groups • Single citizen portal for accessing advice, appointments and support • 24/7 Clinical/Professional triage • Citizen access to health records	Reduction in Primary Care Appointments	15%	30%
		Increase in population self-care and self-management	5%	10%
		Increase in VCSE and Social Care contacts	20%	35%
		Reduction in ambulatory sensitive condition admissions	10%	30%
Tier 0	• Social Prescribing • Support for self-care of long term conditions • Support for carers • Connecting people in communities through shared and common interests, developing skills and capabilities that can be shared • Access to health, wellbeing, benefits and housing	Reduction in A&E attendances	10%	20%
		Reduction in ambulatory sensitive condition admissions	10%	20%
		Reduction in A&E attendances	10%	20%

	information and advice • Aids/adaptations and housing related support to keep people safe at home			
Tier 1	• Multidisciplinary Place Based Teams • Greater Community/Specialist Nursing ("Buurtzorg" model) • Consultants in the community • Condition Specific Rehabilitation • Referrals Management	Reduction in ambulatory sensitive condition admissions	10%	20%
		Reduction in A&E attendances	10%	30%
		Increase of WHT outpatient appointments in the community	10%	20%
		Reduction in outpatient referrals	10%	35%
		Increase in Community and Social Care Contacts	10%	30%
		Increase of Community contacts	20%	35%
Tier 2	• Outpatients in the community • Virtual Outpatient Clinics	Reduction in WHT outpatient appointments	20%	50%
		Reduction in DNAs and length of WHT outpatient appointments	25%	50%
Tier 3	• Integrated Rapid Response Service • Paramedics in the community	Reduction in ambulatory sensitive condition admissions	40%	50%
Tier 4	• Assess to Admit/Front end streaming • Remote 24/7 monitoring of inpatients • Clear Routes to discharge/discharge planning	Reduction in ambulatory sensitive condition admissions	5%	10%
		Reduced Length of Stay	10%	20%
		Increase in Social Care and Community contacts	25%	30%

The above is shown on a scheme by scheme basis. We have taken a consolidated view of the shifts in activity to model through the system in the 'Do Something' scenario, representing the combined impact of the system wide changes set out above. Those shifts are as follows:

	Activity Shifts		
Description	2019/20	2020/21	2021/22
Shift Primary Care to Single Point of Access	15%	29%	43%
Increase Activity in Community Services	11%	16%	21%
Increase Activity in Social Care	7%	10%	13%
Reduction in A&E Activity	-10%	-18%	-25%
Reduction in WHT Inpatient Day Case & Non Elective Admissions	-15%	-21%	-26%

Reduction in WHT Outpatient Activity	-8%	-18%	-28%
Reduction in Length of Stay for Elective and Non Elective Inpatients	-15%	-15%	-15%

In section 3 The Strategy, the evidence base around some of the potential big shifts were outlined these highlighted the increased volume of care that is required to be delivered, or accessed individually, in the community, while the reduction in volume at the acute end of the systems reflects the "left shift" required in the new model; with the vast majority of care delivered in a lower acuity. The hypothesis shows:

- Reduced elective inpatient activity;
- Fewer A&E attendances;
- Fewer outpatient attendances;
- Fewer non-elective inpatient admissions.

As a result we would expect to see an increase in activity in primary and community settings in particular over a 5 year period:

- 15% rising to 43% shift of primary care appointments to the SPA;
- 21.25% increase in Community contacts;
- 13.3% increase in Social Care contacts, resulting in:
  - 13.3% increase in assessments completed;
  - 10% increase in Social Care Community Activity;
  - 3% increase in higher level Social Care interventions (e.g. Residential/Nursing Care)
- 25% reduction in A&E attendances;
- 26% reduction in Ambulatory Sensitive Condition Admissions;
- 28% reduction in outpatient appointments delivered in an acute setting.

"Do something" forecast

The 'Do Something' forecast is a combination of the shifts outlined above that occur as a result of the change in operating model, combined with some expected changes that are already scheduled to occur as a result of local changes and efficiency schemes. Due to the way efficiency savings at the Local Authority are calculated, these are included in the model outputs and not in the explicit savings assumptions outlined below.

Assumption	Description
CIP and QIPP (note, efficiency savings from the LA are also reflected in the model)	Through the data and finance work stream the impact of Cost Improvement Programmes (CIP) at a provider level, and Quality, Innovation, Productivity and Prevention Programmes (QIPP) at the Commissioner level were discussed. For the purposes of the high level business case, the inter-relation between CIP and QIPP schemes was not explored in significant detail although it is recognised that there may be some crossover between the two. Without exploring this in detail, we have applied a 2% CIP for NHS providers, and 1% QIPP to the end point system expenditure within the model outputs as a total 3% reduction in expenditure across the system. Future detailed design would consider these elements in greater detail and potentially account for crossover between the two schemes.

	The CIP and QIPP adjustment is applied cumulatively on the assumption that cost savings will be carried forward to the next year and then additional savings would be found.
Midland Met	The impact of the Midland Metropolitan hospital project which is expected to result in an increase in activity in the Manor in the order of: • 9,000 additional A&E attendances from outside Walsall • 2,694 additional Emergency Admissions resulting from the above There is an existing business case being carried forward for enhancements to the A&E department to facilitate this within the Manor Hospital. This carries with it an assumption of increased fixed costs of £5.4million per year. All of the above has been applied in the 'Do Something' model from 2021/22 onwards, however as this business case is focused on Walsall registered patients, this does not impact on the system position set out above.
Stroke Services Transfer	There are two other known adjustments in the model related to Stroke services which are no longer offered in the Manor Hospital. Firstly, 95% of this activity is transferred out to Wolverhampton from 18/19 onwards. Secondly, amendments to the delivery of Rehabilitation activity are projected to result in a 96% increase from 18/19 onwards.
WHT Non Recurrent Finances	Compared to the 17/18 baseline position there are elements of cost and income that were non recurrent and therefore in the 'Do Something' these are taken out. These are: • £800k reduction in income • £3.6million reduction in expenditure Both are applied from 18/19 onwards
Provider Sustainability Fund	From 19/20 onwards, an assumption that Walsall Healthcare Trust will receive £5million of PSF is applied. The impact on the scenario of this is limited as it effectively reduces the gap for WHT only which is not represented in the summarised figures for the system.
Big Shifts	As per the table above, the activity shifts in line with the change in operating model have been actioned to arrive at the 'Do Something' scenario output.
Activity Shifts – Fixed Costs	As discussed above in relation to activity increases in the 'Do Nothing' scenario, the model is designed to flex income and variable elements of cost only. Therefore, when making big shifts and moving associated costs,

	consideration would need to be given to stranded or stepped up fixed costs to manage that change in activity.
Length of Stay – Financial Impact	Whilst the model output is able to identify the potential reduction in bed usage as a result of big shifts in activity, it does not apply a financial impact. This is because there is no defined income or expenditure for a single bed day. Therefore, when exploring this in the detailed design phase it will be important to explore the reduction in beds and bed days at a detailed specialty level to consider where physical beds could be reduced in the hospital, and the associated reduction in fixed costs.
Primary care appointments transferring to the SPA	The model assumes a shift in primary care activity to be delivered by the SPA in future and that the SPA will be funded from the current and future primary care allocation. This will have the impact of primary care being able to deliver more focussed activity on patients who would normally have be seen in either the community or acute settings. The absolute number of primary care appointments is an approximation per the assumptions listed in Appendix 2.

Change scenarios - Outputs from the change scenarios £ and activity

The total impact of the above is shown in the graph below, whereby the combination of efficiency savings is applied to the 'Do Nothing' expenditure, and then the additional impact of the change scenarios in the 'Do Something' is shown separately.

Achieving the efficiency saving expectations e.g. CIP and QIPP , bridges a significant amount of the financial gap, and the change in operating model closes this further to £10.7million by the end of Horizon 3.

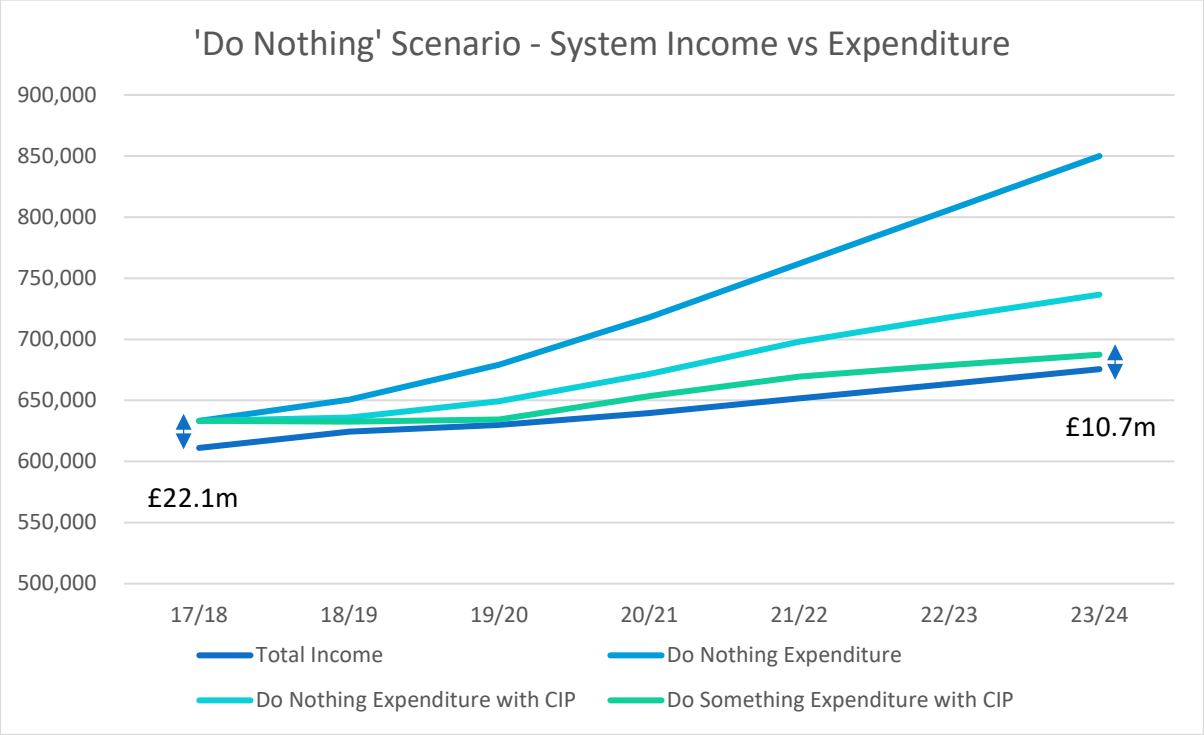


Figure 14 "Do Nothing" Forecast

	17/18	18/19	19/20	20/21	21/22	22/23	23/24
Do Nothing Total Income	611m	624m	629m	639m	651m	663m	675m

Do Nothing Expenditure	633m	650m	679m	717m	761m	805m	849m
Difference	(22m)	(26m)	(50m)	(78m)	(110m)	(142m)	(174m)
Do Nothing Expenditure with CIP & QIPP	633m	635m	649m	671m	698m	718m	736m
Difference	(22m)	(11m)	(20m)	(32m)	(47m)	(55m)	(61m)
Do Something Total Income	611m	624m	630m	640m	652m	664m	676m
Do Something Expenditure	633m	647m	663m	698m	730m	763m	795m
Do Something Expenditure with CIP & QIPP	633m	632m	634m	653m	669m	678m	687m
Difference	(22m)	(8m)	(4m)	(13m)	(17m)	(14m)	(11m)

Table 2 "Do nothing" and "Do something" financial forecast

The above is achieved by moving activity into lower cost areas in line with the details set out in Section 3. This results in the following change in activity profile across key areas:

		Baseline 17-18	Horizon 3 - Do Nothing	Horizon 3 - Do something	Difference
Primary Care	GP Setting	1,595,199	1,595,199	917,239	-677,959
	SPA	0	0	677,959	677,959
Community Contacts		384,292	439,811	573,060	133,249
Social Care Contacts		12,484	13,584	16,263	2,678
Social Care - Short Term Residential/Nursing		744	800	840	39
Social Care - Long Term Residential/Nursing		1,096	1,227	1,287	60
A&E Attendances		91,800	97,993	59,266	-38,728
Inpatient Admissions		80,761	96,729	63,964	-32,764
Outpatient Appointments & Procedures		357,191	470,323	262,896	-207,427

Table 3 "Do something" activity impact

Financial impacts of the Walsall Targets

The system starting point of a £22.1million deficit in 17/18 for Walsall is made up of a number of elements and does not necessarily equate to the combined surplus deficit position of each organisation. At best it represents the true cost of care against the income to the system. Therefore, whilst the individual deficit positions of each organisation add up to approximately £30million, this highlights inherent inefficiency that would be addressed by a move to an integrated care system.

This gives a net change to expenditure as a result of the Big Shifts, as follows:

£000s	Horizon 1	Horizon 2	Horizon 3
Community Setting	2,903.27	4,414.477	9,410.341

Social Care	1,966.165	4,196.714	10,032.14
Accident & Emergency	-707.487	-1,288.02	-6,453.36
Inpatients	-9,436.62	-13,631.5	-44,745.6
Outpatients	-1,504.76	-4,034.3	-12,847.8

Table 4 Net "Do something" expenditure impacts by setting

Financial impacts of the big shifts by organisation

The financial impact of these big shifts and change in income and expenditure by CCG and each of the WT providers is shown in the table below;

Financial Impact in £000s					
			Horizon 1	Horizon 2	Horizon 3
1		Community Setting	2,903.27	4,414.48	9,410.34
1a		WHT - Expenditure*	2,903.27	4,414.48	9,410.34
1b		WHT - Income (CCG Spend)*	3,383.76	5,145.07	10,967.74
2		Social Care	1,966.17	4,196.71	10,032.14
2a		ASC - Expenditure	1,966.17	4,196.71	10,032.14
2b		ASC - Income	197.94	452.46	1,135.22
3		Accident & Emergency	-707.487	-1,288.02	-6,453.36
3a		WHT - Expenditure	-328.83	-598.66	-4,757.05
3b		WHT - Income (CCG Spend)	-918.49	-1,672.16	-4,114.68
3c		Other Provider - Income (CCG Spend)	-378.66	-689.36	-1,696.30
4		Inpatients	-9,436.62	-13,631.50	-44,745.60
4a		WHT - Expenditure	-5,246.74	-7,567.58	-32,426.14
4b		WHT - Income (CCG Spend)	-13,756.17	-19,191.29	-37,248.37
4c		Other Provider - Income (CCG Spend)	-4,189.88	-6,063.95	-12,319.45

5	Outpatients		-1,529.69	-4,061.55	-12,882.71
5a		WHT - Expenditure	-686.56	-1,692.66	-5,198.60
5b		WHT - Income (CCG Spend)	-2,122.29	-5,142.87	-15,677.14
5c		Other Provider - Income (CCG Spend)	-843.14	-2,368.89	-7,684.11

Table 5 Financial Impact of the "Do Something" by setting

Financial risks and mitigations

A full set of the assumptions used in the development of this model is provided in the appendices (2), however it is worth highlighting here that the Finance and Contracting group have acknowledged that the NHS activity growth assumptions are higher than anticipated and therefore add up to a significant increase in activity. The impact of this, should this increased growth not materialise in the future years, means the expenditure will be less than forecast. This will have a knock on effect on the level of impact achieved from the change scenarios.

A second assumption worthy of note is that all CIP and QIPP s for all organisations, apart from the Local Authority where there are not applicable, are assumed to have been fully delivered over a five year period. The consequence of these not being fully realised, the year on year decrease would not be achieved.

Investment requirements

Delivering the transformation required to implement the new Operating Model will require additional investment as a cost of change to the system to deliver the benefits of moving to a move integrated health and care model. These have been included in the model based on an international evidence base for transformation of this scale.

We have carried out a bottom-up costing of the leadership and governance requirements, additional capacity and transformation costs required over each horizons, which is summarised below. These equate to a larger 1.53% of system spend during horizon 1, decreasing to 1.50% in horizon 2 and an average of 0.69% annually across horizon 3. This also includes a budget of 5% of Primary and Community Care spend for dual running and additional Primary and Community Services capacity.

The next stage of detailed design will utilise this as an investment budget which will sit with the CCG and will be triangulated on a tiered programme basis against a bottom up analysis of the tiered Operating Model changes described in section 8, Mobilisation and Implementation, which also includes estimated costs of key enablers such as estates reconfiguration, workforce development and technology transformation.

			Horizon 1	Horizon 2	Horizon 3		
£000s	17/18	18/19	19/20	20/21	21/22	22/23	23/24
Investment	-	-	9,240	9,240	4,364	4,364	4,364
Saving (assuming CIP and QIPP is achieved)	-	-	15,021	18,131	28,701	39,104	49,157

Cumulative Total Investment	-	-	9,240	18,480	22,844	27,208	31,572
Cumulative Total Saving	-	-	15,021	33,151	61,852	100,956	150,113

Table 6 Summary of Investment Requirements

Over a 5 year investment profile we would expect a budget of £31.6m will act as a key catalyst to fund a year on year saving to the system of £150m in total to close the finance gap described above. A detailed breakdown of these figures is provided in Appendix 5.

5 Governance Arrangements

The ICP Board will be established as a sub-committee of Walsall Healthcare NHS Trust's Board as the nominated Host Provider. The ICP Board will be responsible for the delivery of the business plan and chaired by a newly appointed Non-Executive from WHT, whose appointment will be made by the partner organisations. A newly appointed Director of the Walsall Together ICP will be responsible for executing the ICP Board strategy and objectives with support from a Walsall Together ICP Senior Management Team.

This structure supports implementation of the dual responsibility of the ICP Board; for the oversight of services contractually in scope and for the wider system integration and

Overview

An essential enabler for the proposed Operating Model and commercial arrangements is a robust and clearly defined governance structure in which to operate and provide sufficient assurances to Boards and Cabinet, both in the initial year from April 2019 (Horizon 1) and beyond (Horizons 2 & 3).

At the commencement of the business case development, the Programme Steering Group established a Governance and Organisation working group tasked with the responsibility of developing the approach to governance. The details outlined below are therefore the agreed outputs of this workstream.

The Host Provider Model

Host Provider arrangements were identified as the most appropriate model to move forward the Walsall Together programme as part of the Phase 1 Case for Change. The intention is that the Host organisation will provide a vehicle for governance of the ICP by establishing an ICP Board and management structure within the framework of its existing corporate structure. The ICP partners would work to initially align the objectives and agree the processes before delegating authorities to their representatives on the ICP Board through an Alliance Agreement and a Section 75 agreement. A Section 75 is a legal requirement to allow for partnership working between local authorities and NHS bodies in relation to certain functions. It allows for the pooling of local authority and NHS budgets in order to deliver these services or functions more effectively.

In this way the Alliance Agreement would be the mechanism for defining the membership and terms of reference for the ICP Board, with the additional Section 75 supporting the legal requirements for Walsall MBC. The Alliance Agreement would also be the mechanism for defining the final agreed membership and terms of reference for the ICP Senior Management Team and for providing resources to enable the management team to carry out its functions.

This is a specific variation on the more familiar Lead Provider model and distinctly so, due to the delegation of decision making authority to a Board with representation from partner organisations rather than the Board of the host/lead provider. Decisions to delegate authority to the Board will be made as and when this this required and agreed by the Boards of the partner organisations.

It is proposed the ICP Board will therefore be established as a sub-committee of the Host Provider's Board. While the structures outlined below are intended to support governance arrangements from April 2019 onwards, the WT partner organisations anticipate that these are subject to change with the emerging objectives and direction of the ICP as it moves into Horizon 2 and 3. Where possible, the

arrangements beyond 2019/20 are outlined on the basis that these are agreed in principle only at this stage. Any further changes would be subject to agreement by all partner organisation's boards and governing bodies.

Options Appraisal

The Walsall Together Partnership Board agreed that the role of the Host Provider could have been potentially filled by one of three organisations in the area; Walsall Metropolitan Borough Council; Walsall Healthcare Trust, or Dudley and Walsall Mental Health Foundation Trust. This is documented in the *Case for Change* agreed by WTPB in January 2018:

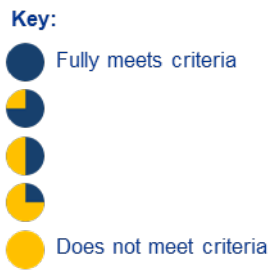
'*In the Walsall health and social care economy, the role of Host Provider could be fulfilled either by the Council or one of the two NHS Trusts. These are the organisations with the inbuilt capacity to absorb some of the functions necessary to act as a Host Provider (such as strategy functions and contracting teams) as well as the fact that they are most able to bear risk due to their scale.'*

During this second phase of planning, the Governance group identified seven key factors to be considered in selecting the host organisation.

Key factors	Rationale
Credibility	The host organisation should have a credible track record in corporate governance, quality of service and financial management
Vires	The host organisation should have the legal powers and relevant regulatory accreditation(s) or approvals to perform the host functions
Corporate structure	The host organisation should have a corporate structure within which an integrated care Board and management structure may operate
Conflicts	The host organisation should not be conflicted out or perceived to be conflicted out of performing the host functions
Scope of services	The host organisation should provide a significant scope of the services to be integrated through the Walsall Together programme
Strategic fit	The strategic priorities of the host organisation should be aligned to the strategic aims and direction of the Walsall Together programme
Management capacity	The host organisation should be able to invest sufficient management capacity to developing the host functions

Table 7 Considerations for a Host Provider

Each organisation was evaluated by the group against each of these factors, with a summary of this process provided in appendix 5. A summary of this appraisal is provided below.



Key factors	Walsall Council		Dudley and Walsall Mental Health Partnership Trust		Walsall Healthcare Trust	
Credibility	Credible candidate.		Credible candidate, good CQC rating.		Credible candidate due its role as the main provider of hospital and community health services and its location in Walsall – however rated as overall "Inadequate" by the CQC.	
Vires	Not licenced as provider of NHS healthcare services.		Licenced provider of NHS healthcare services.		Licenced provider of NHS healthcare services.	
Corporate structure	Corporate structure with powers to provide health related services.		Corporate structure within which an integrated care Board and management structure could be developed.		Corporate structure within which an integrated care Board and management structure could be developed.	
Conflicts	Could be perceived conflict between host provider functions and local authority commissioning functions.		None identified.		None identified.	
Scope of services	Responsible for commissioning/provision of significant scope of services within Walsall Together.		Responsible for providing community mental health services within the scope of the Walsall Together programme, as well as inpatient mental health services for Walsall outside of this programme, and services across a wider geographical footprint.		Responsible for providing a significant scope of the services to be integrated over the next phase of the Walsall Together programme, including community health services and acute hospital services at the Manor Hospital.	

Strategic fit	The strategic priorities of the Council are aligned to the aims of the Walsall Together programme although its focus is on developing its role as a strategic commissioner. Has not set out an ambition to extend its role in providing NHS services.		Strategic aims are aligned to the aims of the Walsall Together programme although will have other key priorities due to position in the Dudley ICS and across the wider STP footprint.		Strategic priorities are aligned to the aims of the Walsall Together programme although other key priorities include acute hospital integration and potential chain arrangements across the Black Country.	
Management capacity	To take on the role of the host organisation would require diversion of management resources.		Wider footprint may put pressure on senior management capacity to fulfil role of Host Provider.		Most able to prioritise senior management resources to fulfil the role of the host and to engage with partners in developing its functions.	

Table 8 Host Provider Appraisal Summary

Operation of the ICP Board

As a result of the options appraisal outlined above, the Governance working group, led by the Director of Commissioning for Walsall CCG and the WTPB recommends that WHT fulfil the role of host organisation. While the areas in which WHT does not fully meet the criteria is recognised by the Steering Group and the WTPB, partner organisation are supportive of the provider that currently delivers the largest volume of services e.g. Secondary and Community Services fulfilling the role of Host Provider.

WHT is closely embedded within the Walsall community and also provides the bulk of hospital and community services to be integrated during Horizon 1 of the Walsall Together programme. The strategic priorities of WHT and its medium term quality and financial improvement objectives are also closely aligned to the strategic aims of Walsall Together programme.

The alternative options are also credible, but are not recommended at this time. For the Council to fulfil the role of the host provider would risk creating public misconceptions that developing the Host Provider model in Walsall could lead to services and staff being transferred out of NHS bodies. This could appear at odds with the recommendations of the Parliamentary Health Select Committee that integrated care partnerships should be established as NHS Bodies and would be a distraction from the Council developing its role as a strategic commissioner, whilst DWMH provides a smaller scope of services in Walsall compared to WHT.

Risks

The main risks to be managed in selecting WHT as the host organisation are to balance the investment of senior management attention in developing the host functions against the need to maintain focus on delivering its own statutory quality and financial improvement plans. This will also be a risk to manage in building public confidence in the Walsall Together programme given the need to address issues identified by the CQC rating of WHT as 'Requires Improvement', in addition to the failure to achieve key financial metrics.

WHT will need to be able to assure NHSI that these risks are being managed adequately and that it has the support of its commissioners and provider partners in developing its role as the host organisation. This will be addressed as a primary objective for the ICP Board upon its formal appointment in April 2019, with further details outlined in Mobilisation and Implementation.

A proactive communications strategy will also be required to set out the aims and benefits of the Walsall Together programme and to explain the role of the Host Provider as a vehicle for delivering integrated care. In addition to setting out key messages, communications will also need to address potential misconceptions about potential major service reconfigurations, privatisation, takeovers or staff transfers.

Establishment of the ICP Board

The formal establishment of the ICP Board for April 2019 is a primary recommendation of this paper, to provide the governance for the ongoing and continual development and delivery of the Walsall Together Programme. It is expected that the below details be formalised through an Alliance Agreement that will establish Terms of Reference including the delegated authorities for the ICP Board from April 2019.

As Walsall Healthcare Trust has been identified as the recommended Host Provider for the Walsall system, for clarity, the Board of the ICP will exist as a sub-committee of Walsall Healthcare NHS Trust's Board, with the ICP Director having full voting rights on WHT's Board. An additional Non-Executive Director appointment will be made to the WHT Board, the appointment to be made by all partner organisations. This individual will chair the ICP Board.

While the establishment of an ICP Board will provide the forum for decision making and strategic direction, in order to formalise the arrangement, the WT partners intend to enter into an Alliance Agreement. Further detail is provided in the Alliance Agreement section below.

Roles and Responsibilities

The primary responsibility of the ICP Board will be the integration and transformation of services deemed to be "in scope" and not for the delivery of those services.

The functions of the ICP Board would be to:

- Provide strategic leadership and oversight of service delivery for in-scope services and for ICP programme work streams;
- Oversee the development of, and transition to, new models of care in priority areas/in scope services;
- Make decisions in the context of the shared vision for the Walsall Together Partnership, and as detailed in the Alliance Agreement;
- Consider investment and any disinvestment decisions across the partnership;
- Collectively hold ICP partners to account for upholding the commitments made in the Business case, and the Alliance contract.

Partner organisations, through membership of the ICP Board will not be expected to delegate responsibility for service provision but to be a partner to the integration and transformation of services. The legal responsibility for the delivery of services will remain with each of the current providers, alongside the responsibility for the quality of those services and the assessment of these by regulatory bodies such as the CQC.

As a sub-committee of WHT, the ICP Board will report to WHT's Board, alongside each of the parties to the Alliance Agreement. It is also anticipated that as the ICP Board will effectively replace the Walsall Together Provider Board, this will be formally closed as a forum for the Walsall Together Providers to plan integrated care.

Delegated Authority

During Horizon 1 there will be no delegated authority to the ICP Board from the partner organisations. At such a time that this is required, this will first be referred to the respective Partner's governing bodies for approval. It is anticipated that during Horizon 1, the full scope of services and any necessary delegation of authority will be reviewed and refined by the partners, with iterations anticipated throughout the Horizon 1 period and beyond. The full Terms of Reference (ToR) for the ICP Board will be established through the Alliance Agreement and while in draft currently for finalising in the period prior to April 2019, a summary is provided below, with the current draft ToR provided in Appendix 7:

Extracts from the ICP Board Terms of Reference (Appendix 7)

Constitution

1.1 The Integrated Care Partnership Board is established by the Participants, who remain sovereign organisations. It is established as a Board Committee of the host provider to provide a governance framework for the delivery of the Walsall Together Plan.

1.2 The Alliance is not a separate legal entity, and as such is unable to take decisions separately from the Participants or bind its Participants; nor can one or more Participants 'overrule' any other Participant on any matter (although all Participants will be obliged to comply with the terms of the Agreement).

1.3 Each Partner shall delegate to its representative to the ICP Board, such authority as is agreed to be necessary in order for the ICP Board to function effectively in discharging the duties within these Terms of Reference. Authority delegated by the Participants shall be defined in writing and agreed by the Participants, and shall be recognised to the extent necessary in the Participants' own schemes of delegation or similar.

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

Purpose

2.1 The ICP Board has been established to provide strategic direction to the partnership and has responsibility for the delivery of the Walsall Together Plan.

2.2 Thus the ICP Board will have responsibility for the oversight of services contractually in scope and for the wider system integration and transformation

Membership

It is proposed that the ICP Board should have a mix of executive, professional and non-executive membership which reflects the nature and scope of the partnership, the purpose and duties of the Board and is not too large to risk its ability to operate effectively. An outline of the proposed membership is provided below:

- The ICP Board to be chaired by a newly appointed non-executive of the host provider.
- Representation from partner organisations:
  - Chief Executive, Walsall Healthcare Trust.
  - Chief Executive, Dudley and Walsall Mental Health Partnership Trust
  - Director of Adult Social Care, Walsall MBC
  - Director of Public Health, Walsall MBC.
  - Director of Children's Services, Walsall MBC
  - Chief Officer, Walsall CCG
  - Chief Executive, One Walsall.

- GP representation.[1]
- Director of Walsall Together.

- Professional Representation:
  - Consultant, professional lead for in-scope hospital services.
  - Consultant, professional lead for mental health.
  - Professional lead for nursing and AHPs.
  - Professional lead for Adult Social Care
  - Professional lead for Children's Services.

- In attendance functions (by invitation):
  - Finance Director.
  - HR Director.
  - Strategy Director.
  - Governance Director.

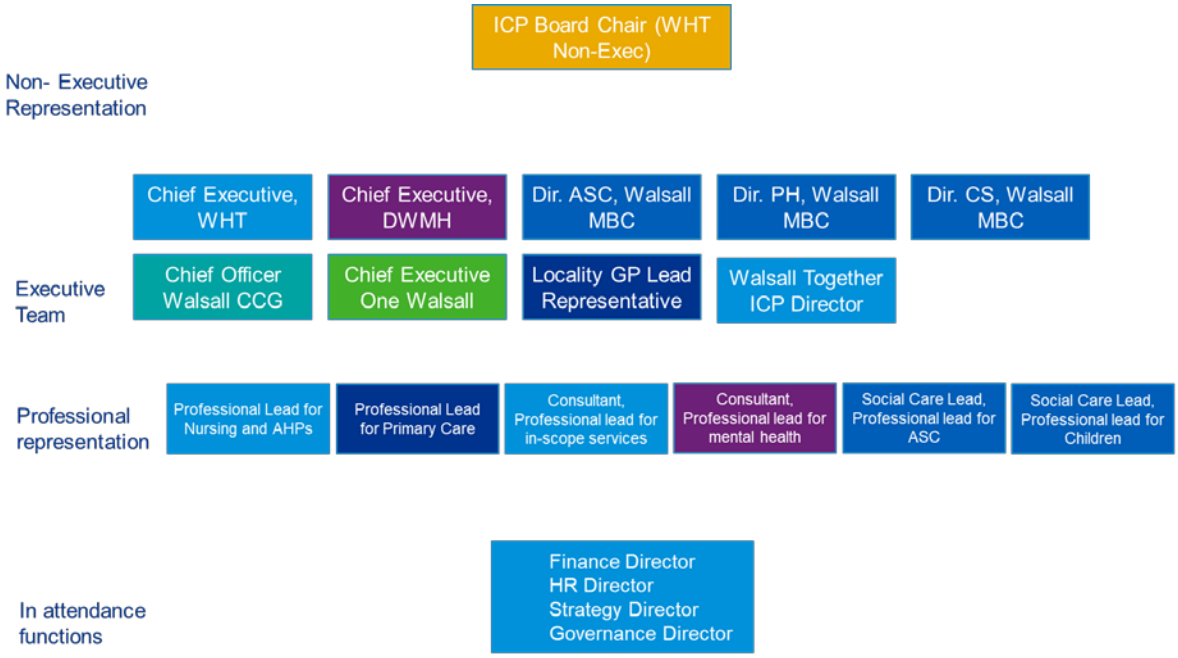


Figure 15 Walsall Together ICP Board

Wider Governance and Relationships

The governing arrangements illustrated in this business case are focused exclusively on the Walsall Together partners, however the Walsall Together ICP Board will interface with existing health and care governing bodies in Walsall, such as the Joint Commissioning Committee (JCC) and the Health and Wellbeing Board (HWBB). Ultimately, the ICP Board is accountable to the WHT Trust Board and WHT is now an active member of the HWBB.

[1] While there are a number of options for GP representation, at this stage it is proposed this position be rotated/shared between the currently appointed four GP Locality Representatives. Each GP Locality Representative will constitute a member, with a single representative vote.

This place-based programme must also ensure it continues to align with and support regional plans, including the Black Country STP/ICS. These relationships ensure the ICP operates in line with the regional health and care objectives and support the NHS Long Term Plan and STP plans.

Formal Powers

The formal powers of the ICP Board will be established through the Alliance Agreement, to be in place for April 2019.

ICP Senior Management and Delivering the Transformation

The strategic direction and plans from ICP Board will be effected through the newly created ICP Senior Management Team, under the leadership of the Walsall Together ICP Director. This structure ensures alignment between strategic and management of integration of services and provides a direct line of communication.

The ICP Senior Management team will be responsible for delivering the ICP Board's purpose and priorities and support the Board as a formal operating group. It will be required to interface with each of the WT partner organisation's Senior Management Teams to ensure the delivery of ICP "in-scope" services are meeting the ICP Board's objectives.

The diagram below outlines the proposed structure of the ICP Senior Management Team to be established during 2019/20:

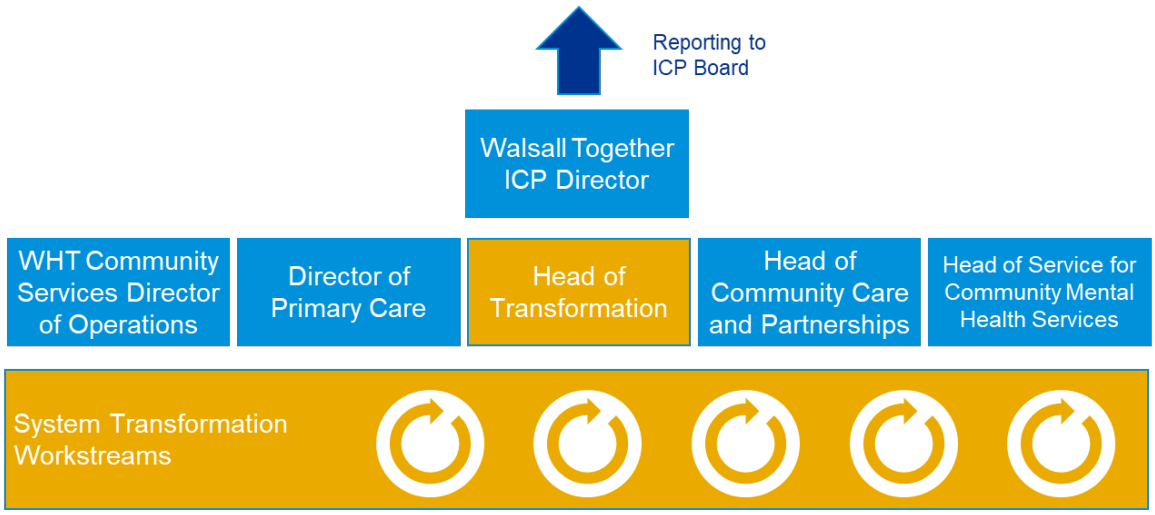


Figure 16 Walsall Together ICP Senior Management Team 2019/20

The Walsall Together Director will have 5 senior leadership colleagues from across the system, including some new roles, each with the following responsibilities:

- Walsall Together ICP Director – Oversee transformation and integration for the initial proposed 3 year timescale with 5 senior colleagues in Year 1;
- Community Services Director of Operations – This existing role from WHT will be responsible for the operational management of the in-scope community and acute services;
- Director of Primary Care – This existing role will be responsible for supporting the development of Integrated Primary Care;
- Head of Community Care and Partnerships – A current Adult Social Care post from the Council will assume responsibility for the management of in-scope care services;

- Head of Service Community Mental Health Services – Will be drawn from the Senior Management Team at DWMH, this role will be responsible for the management of in-scope mental health services;
- Head of Transformation – responsible for transforming the health and care delivery model overall and managing the transformation programme office.

This group is ultimately charged with two tasks; delivery of "in scope" services and transformation of the wider system as per the desired operating model. To achieve this, there are two capability and capacity gaps to be filled:

- The establishment of a robust Transformation Programme Office (TPO) that drives the programme forwards and manages stakeholder relationships through to delivery
- The establishment of a clear and repeatable process for co-designing the detailed service change required and actually implementing it through front line staff.

The TPO will include workstream leads who will be held to account for workstream delivery through the Head of Transformation and TPO. The SMT will also invite representatives of Public Health and Children's Services to develop their future involvement in the Alliance. This reflects the way in which the role and structure of the SMT will mature over time, with the initial expected requirements for each horizon outlined below:

Horizon 1 – A mix of existing roles representing the current line management of the "in-scope" services. Full representation of all current organisations is required. During this initial year the SMT will be supported by additional management, including a "Lead Professional Group" and two new management roles; a "Lead Commissioner for Resilient Communities" and the "Single Point of Access Lead."

Horizon 2 – It is anticipated that some senior and operational roles will become joint appointments as the ICP gains traction;

Horizon 3 – A truly integrated line management structure will be designed and implemented in accordance with the WT Alliance objectives; some roles will blend accountability across professions, organisations and statutory duties (including regulations) others will not as appropriate.

The TPO office should adopt a rapid cycle implementation approach that takes strategic objectives and engages frontline staff in real world change to deliver it on the ground. Interdisciplinary action teams should be participating in high intensity workshops where they design and implement new care pathways for patients. Solutions are developed using existing resources and infrastructure. In a relatively short period of time, new ways of working – can be launched, embraced by staff, and real impact in terms of process and outcome change delivered.

Alliance Agreement

The WT Partners have identified an Alliance Agreement as the preferred vehicle for formalising the governance arrangements from April 2019, with an initial duration of two years, with an option to extend. The Alliance Agreement is still in development and will be subject to all partner organisation Board and governing body sign off prior to planned implementation in April 2019, as shown in the implementation timeline (figure 22).

This time frame provides enough space for the planning and initial implementation and evaluation that will take place during this period, without requiring further contractual amendments before April 2021. This also correlates with the model forecasts, allowing for a degree of validation of progress against a basepoint.

The Alliance Agreement will not be an NHS contract as outlined in Section 9 of the National Health Service Act 2006, but supplements and operates in conjunction with existing Service Contracts. All members remain separate sovereign Partners, and will work together over the period of this agreement positively and in good faith, in accordance with the ICP Principles, to achieve the ICP Objectives.

The Objectives as agreed by partner organisations are to deliver sustainable, effective and efficient Services with significant improvements over the term of the agreement. Members of the ICP have agreed the following:

To work collaboratively to:

- Improve the health and wellbeing outcomes for the Walsall population;
- Improve care delivery and quality standards in the provision of care;
- Meet the statutory financial duties of all partner Partners.

The Alliance agreement enables a formal mechanism in which the ICP Partners will work together to perform the obligations set out in the Alliance Agreement and, in particular, achieve the Alliance Objectives.

In order to achieve the objectives we will work to the following principles:

- work towards a shared vision of integrated service provision, acknowledging the phasing required in the journey to an Integrated Care System;
- commit to delivery of system outcomes in terms of clinical and professional matters, Service User experience and financial matters;
- commit to common processes, protocols and other system inputs for those in-scope services, as defined within this case;
- take responsibility to make unanimous decisions on a Best for Service basis;
- always demonstrate the Service User' best interests are at the heart of Our activities;
- adopt an uncompromising commitment to trust, honesty, collaboration, innovation and mutual support;
- establish an integrated collaborative team environment to encourage open, honest and efficient sharing of information, subject to competition law compliance;
- adopt collective ownership of risk and reward, including identifying, managing and mitigating all risks in performing our respective obligations in this Agreement; and
- co-produce with others, especially service users, families and carers, in designing and delivering the Service,

To achieve the ICP Objectives, the Partners of the ICP will operate from the principle of professionally led, collaborative working between the Partners, in order to ensure the services meet the health and care needs of the local population.

The ICP Board will be accountable to the boards and governing bodies of all participants, to enable recommendations to be made between the ICP Partners. This approach does not require formal decision making delegations from statutory boards and is founded on a number of Governance Principles, namely that we will,

- Strive to reach joint consensus prior to any further decisions which may be required at an organisation level;
- Maintain strong clinical/professional leadership through a clinically/professionally led process to ensure that decision makers can be confident that changes are being made in the best interests of patients;
- Provide oversight to the operation of the alliance agreement;
- Use business as usual / standard governance procedures as widely as possible to take decisions;
- Commit to wider integration with Local Government and other strategic partnerships which add value for the taxpayer;
- Remain transparent and open to scrutiny from patients and the public; and
- Provide assurance in a coherent manners to Our regulators.

Through the Alliance Agreement the partners will define the membership and Terms of Reference for the ICP Board, which will be the team responsible for leading the Alliance. The ICP Board will hold to account the Senior Management Team.

6 Commercial arrangements

The contractual structure of the ICP will be virtually integrated from 2019/20 under an Alliance Agreement that will provide for integrated contract management of in-scope services under oversight of the ICP Board. Contractual accountability lines will continue to be bilateral between commissioners and providers as in 2018/19. Contract variations will be implemented to define where the integrated contract management processes would apply. Any future commissioning decisions to consolidate in-scope services within a single contract, would be subject to procurement rules. In the interim, providers may agree, subject to commissioner approval, to subcontract services to the Host as the ICP governance matures and as they can be assured in delegating contractual responsibilities.

Overview

Key terms of the commercial model

As recognised above, the commercial model from April 2019-March 2021 is intended as a transitionary period to allow for the development of the necessary governance, payment and contracting environment in which an integrated care Operating Model can be designed and implemented. It is also intended to support the necessary investment decisions to be made by Walsall system partners to support the other enablers of the Operating Model, such as technology, workforce and estates reconfiguration.

Contractual structure

During Horizon 1, contractual accountability lines will continue to be bilateral between commissioners and providers as in 2018/19. The addition of an Alliance Agreement will provide a mechanism for integrated contract management of in-scope services under oversight of the ICP Board (i.e. integrated contract management will be a hosted function). Contract management reviews and variations will distinguish between in-scope and out-of-scope services under separate clauses and schedules to define for which services the 'hosted' contract management processes would apply. There will be no separate bilateral contract management processes for in-scope services to avoid duplication.

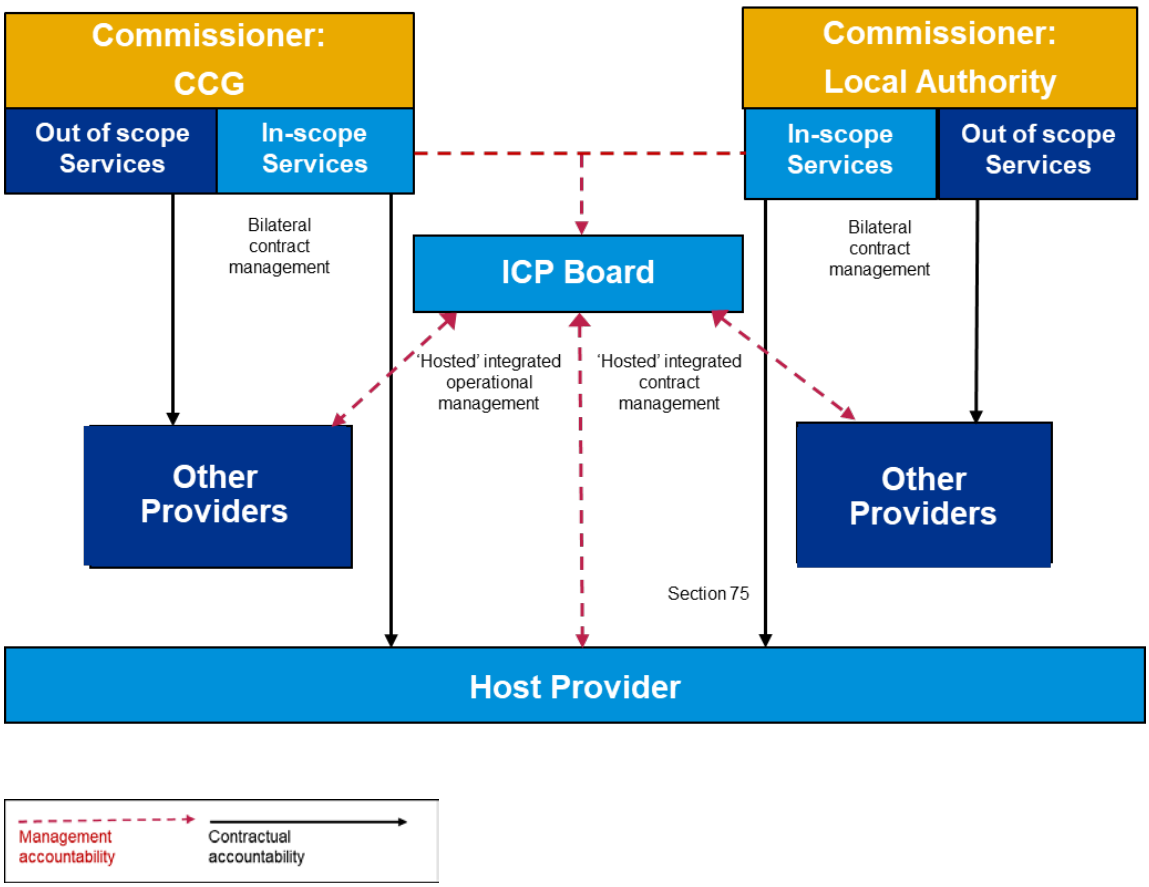


Figure 18 Contractual arrangements for April 2019/20

Objectives

The effect of this arrangement will be to create a virtually integrated contractual structure. This virtual integration, as described by NHS England, uses an Alliance agreement as a "wrapper" around existing contracts, allowing existing commissioning contracts to remain in place but providing an environment in which the management of services can be integrated. This will enable an integrated approach to contract management under oversight of the ICP Board (i.e. integrated contract management will be a hosted function).

The primary objective of this approach is intended to strengthen collective accountability for integration of in-scope services to deliver the ICP aims and objectives for improving outcomes and value. A secondary objective is to avoid duplication in parallel contract management processes, which should improve the efficiency of these processes and may potentially reduce transaction costs. The ICP Board's ability to influence decisions, such as wider commissioning within Walsall and regionally, is expected to evolve over time and with ongoing guidance and support from regulators, such as NHS England.

This virtual integration arrangement can be established within the existing bilateral contractual structure as a transitional measure without delay. Any potential future commissioning decisions to consolidate services under a single contract for integrated service delivery would be subject to procurement rules and NHS regulatory oversight. In the interim providers may decide, subject to commissioner approval, to subcontract services to the Host as and when the ICP governance matures and they can be sufficiently assured in delegating contractual responsibilities that they will remain accountable for.

Risk sharing

For 2019/20 the default assumption is that any risk sharing is expected to be bilateral between commissioners and providers. However, the Alliance Agreement will provide a framework within which a multilateral risk sharing mechanism could be developed for Horizon 2 and beyond.

7 Enablers

The Operating Model outlined above will require a drastic transformation of the way services are currently accessed and delivered, impacting on citizens, professionals and organisations. It will be the responsibility of the ICP Board to ensure the necessary enablers are provided at the relevant touch points to facilitate this; including workforce, estates and technology. Current assumptions on the requirements of these three aspects are outlined below. In their role as Host Provider, in addition to the Community Services provider, WHT has an integral role in shaping and delivering these enablers, alongside partners, to achieve the desired future state.

Digital and Technology

As the Host Provider for the ICP, WHT will be responsible for ensuring the resources, investment needs and digital tools and infrastructure are in place to enable the ICP to be effective. To this end, in parallel to the development of this business case, WHT have developed a complimentary IT strategy that serve the needs of the acute Trust alongside the wider ICP objectives within the currently disjointed system of multiple partners. The WTPB recognise the need to review the below in light of the ICP plans, and agreeing a suitable system IT strategy will be a primary focus of the ICP Board once established in April 2019.

The draft strategy below supports the technology and digital enablers outlined as part of the tiered Operating Model outlined above, including the Single Point of Access, Population Management capabilities and development of a shared digital record.

This approach takes into account the current fragmentation across providers, with multiple record systems in place that are poorly integrated and with limited mobile capabilities e.g. relying upon Wi-Fi to download files, upload edits and a lack of real time updates. Consequently the technology architecture is not a “one size fits all” approach and allows for integration without forcing assimilation of software and processes.

A layered structure, with level 1 being citizen facing and level 4 encompassing all of the current Patient Administration Systems (PAS) has been proposed, with the middle levels providing the integration and interoperability capabilities. This system IT architecture is outlined below, with further detail provided in Appendix 7:

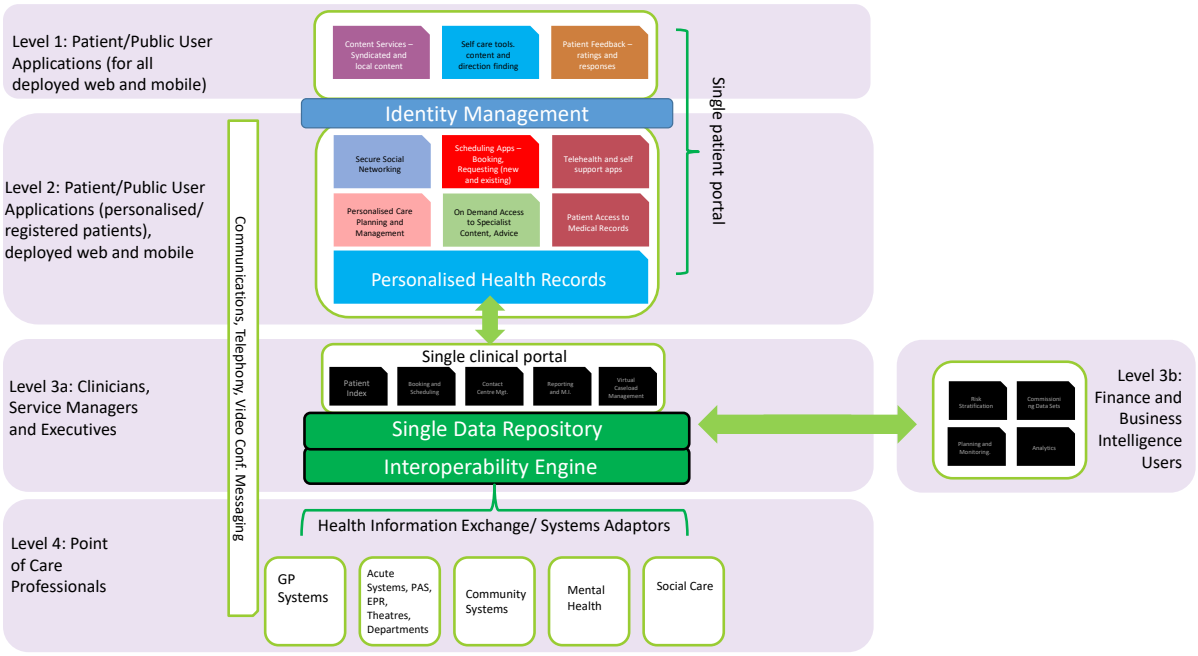


Figure 19 Walsall Together IT Architecture

The Level 1 here fulfils many of the requirements of the SPA by providing a patient/public portal through which citizens can access content, non-personalised self-care tools, advice and service finding (including those provided by One Walsall and/or those part of the Resilient Communities offer) and access to personalised services provided at the other Tiers e.g. appointment booking. This level will also provide the ability to leave feedback – giving transparency in terms of service feedback and response and creating a 'customer service' culture from the outset.

Level 2 provides citizens with a personalised service response and therefore requires the sharing of data within a secure environment. It requires a secure identity management layer, which services can be added to gradually over time, providing a "one-stop-shop" to access any health and wellbeing service, including the Resilient Communities offer. This will require a common identity standard and consent framework for citizens wishing to access health and care services on-line. This will also facilitate the integration of further on-line services such as telehealth, appointment booking and sharing of data amongst providers (with consent) and third parties, such as fitness trackers and monitoring devices via Application Program Interfaces (API).

Level 3 is split between functions for Service Management (3a) for use by Clinicians, Service Managers and Executives and a Finance and Business Intelligence Function (3b) for corporate users. 3a provides the Population Management and Care Coordination required for Tier 1 of the Operating Model, by allowing data exchange and interoperability. In order to facilitate interoperability, a single data repository will be required to scrape data from the separate clinical record systems, in addition to a common user interface for clinicians and professionals.

The Finance and Business Intelligence function at 3b is built upon the functionality provided at 3a, however for the purpose of enabling risk stratification, population identification and predictive analytics. This provides the data for forward planning, informed commissioning, budgeting and monitoring. This is vital to empower the prevention and early intervention agenda of the new Operating Model, supporting the proactive approach to reducing inequalities; a key design principle of the model.

The final Level 4 accommodates the individual PAS of the current providers, without requiring any change in software. This approach facilitates the integration and capabilities required at a system level, without requiring investment or changes at an individual provider level. It is assumed that the changes outlined above would be jointly funded by the ICP investments that is required along with some cost covered by WHT.

In order to deliver this digital and technology transformation it will require the WT partners to investment around £6m over a five year period as part of the implementation of the operating model. This is outlined in the investment plan shown in appendix 5 as part of the transformation section of the overall investment required.

Estates

Delivering high quality facilities - a facilities model for health and social care

Taking all of the tiers of services outlined in section 3 into account, the resulting configuration of facilities across the Walsall area under the proposed model of care is shown below:

As for the IT strategy, this high level outline of the estates plan will require review, refinement and agreement by the ICP Board during horizon 1 to ensure it meets the objectives of the ICP and is fit for purpose.

SPA Hub

A Single Point of Access hub will sit within one of the four locality Health and Wellbeing Centres serving the whole of the Walsall area delivering care access, navigation and co-ordination services including clinical triage to ensure patients can navigate across the system efficiently.

Tier 0 – Resilient Communities

In addition to a strong online presence, this offering will be available to access physically at each of the of the four locality Health and Wellbeing Centres, providing citizens the opportunity to speak face to face with VSC Community Link Officers, access the Directory of Health and Wellbeing Services or receive health and care advice and support from Care Coordinators, clinicians and professionals.

Tier 1 – Integrated Primary, Long term condition management, Social and Community Services

These units will operate from a number of facilities across the borough and will ensure that integrated primary, social and community care services are delivered from purpose-built premises that offer easy access and provide the facilities required for primary care clinicians and care professionals to make the best use of their skills. This will include active care remote care management of citizens with long-term conditions and those at risk of hospital admission.

By delivering primary care at scale GP practices can share a single larger building, while retaining their individual identities. This will make it possible to provide a wider range of facilities and services than before, as practices can jointly generate enough activity to justify specialist staff, treatment rooms, and additional equipment that would otherwise be beyond the ability of any one practice alone. These centres would also offer the facilities for group teaching to be carried out, enabling patients to take a more proactive role in self-care.

Tier 2 - Specialist Community Facilities

These facilities will provide managed care models for pre-booked or rapid access specialist primary care services for further intervention, treatment or therapy services. The facilities will also provide a single point of access for demand management services for in scope services. It is anticipated that these facilities would also provide services to people with more complex long-term conditions.

Tier 3 – Intermediate, Unplanned and Crisis Services

This will be co-located within one of the four locality based Health and Wellbeing Centres providing access to intermediate, unplanned and crisis management services for patients to prevent avoidable and unnecessary hospital visits to A&E or admission to an acute physical or mental health bed. The service and facilities will increase the level of integration of work across integrated primary, social and community care and walk-in type services. The additional capacity provided by walk-in facilities should support both A&E and primary care in the delivery of access for patients.

Tier 4 – Acute Hospital Services

Access to high quality acute hospital services, including A&E, from Walsall Manor Hospital. Specialist acute services will continue to be provided through the wider regional and national acute network.

In order to deliver estates reconfiguration required to deliver the new operating model and specifically the four health and wellbeing centres in each locality the WT partners will need to investment around £2m over a two year period. This is outlined in the investment plan shown in appendix 5 as part of the transformation section of the overall investment required.

Workforce

Development of a high quality workforce - a workforce model for each tier of care

Taking all of the tiers of services outlined in section 3 into account, the development of locality based integrated Place Based Teams to deliver patient focussed services across the Walsall area under the proposed model of care is shown below:

SPA Hub

A single point of access team will be developed serving the whole of the Walsall area delivering care access, navigation and co-ordination services including clinical triage to ensure patients can navigate across the system efficiently.

Tier 0 – Resilient Communities

A dedicated team of integrated care workers, including a Community Link Officer, will provide access to proactive population health and care management services for patients as part of the Resilient Communities offer. This will include social prescribing, active care, remote care management of patients with long-term conditions and those at risk of hospital admission.

Tier 1 – Integrated Primary, Long term condition management, Social and Community Services

Place Based Teams will be expanded to deliver joined up primary, social and community services for citizens, including the following:

- General practice;
- Community nursing and therapy services;
- Primary care mental health;
- Social care and enablement services.

Tier 2 – Specialist Community Services

Teams of specialists will work alongside primary, social and community care professionals from the Health and Wellbeing centres delivering a range of specialist, outpatient and diagnostic services providing more local access for citizens.

Tier 3 – Intermediate, Unplanned and Crisis Services

A network of specialist care professionals and workers will work in an integrated way to deliver a range of intermediate, unplanned and crisis services from a locality Health and Wellbeing Centre to prevent unnecessary hospital admissions.

A detailed workforce development model will be developed alongside the transitional transformation and implementation plan as the Walsall Together model of integrated care evolves over time.

Tier 4 – Acute and Emergency Services

Workforce planning for Tier 4 is anticipated to take place during the next phase of detailed design.

In order to implement new ways of working within the new tiered operating model will require some element of dual running of teams and training and development of existing staff. Therefore a workforce development and training and development budget of £1m over a five year period has been included in the investment plan shown in appendix 5. In addition an investment for dual running (which has been calculated on the basis of 5% of total primary and community services spend) has also been included which equates to a budget of £12m over a five year period.

8 Mobilisation and Implementation

The WT partners are tasked with agreeing, designing and implementing significant transformation of their individual operating models in order to deliver their shared vision for the future over the next five years; detailed here across three Horizons. A detailed design phase during Horizon 1 will inform the scope, objectives and requirements for the subsequent Horizons. To drive forward this programme, a significant investment outlined in the previous sections will be required to enable the scale of transformation.

Overview

This section outlines the overall transformation plan to be established from April 2019 (Horizon 1) and the anticipated timeline for implementation across 2 subsequent Horizons.

Transformation plans and timeline

In order to deliver the significant programme of transformation outlined in this business case, the Walsall Together partners require the following key elements:

- The resource, capacity and process for co-designing and implementing the detailed service changes required;
- The establishment of a robust and experienced Transformation Programme Office (TPO) that drives the programme forwards and manages stakeholder relationships through to delivery;
- A commitment from each partner organisation to the delivery of all the key milestones over the next five years.

The first 6 months of Horizon 1, beginning April 2019, will be focused on the detailed design of the service pathways and contracting to support this, alongside establishing the governance and management structures outlined above. It is expected the first phase of service implementation will take place from late October 2019.

Horizon 2 will see the first application of any new contracts to support the ICP objectives and delivery of additional integrated services as part of the Alliance Agreement. Ongoing evaluation of progress and success against agreed KPIs will inform the services and scope of the ICP in Horizon 3. The WT partners will also need to engage with the regulatory bodies, including but not limited to NHS England, to ensure parties are meeting their statutory requirements and that the plans outlined in this business case are fit for purpose. For Walsall CCG, additional assurances may need to be provided to NHS England with regards the "four tests" following the detailed design phase of services. A high level analysis of the programme's progress against these four tests is outlined below, however it is noted that these are clinically focused and more appropriate criteria for an integrated care programme will need to be developed in due course:

- **Strong public and patient engagement** – At this stage, as outlined in section 3, there has been limited clinical involvement outside of the Operating Model working group, and no public or patient engagement has been completed at this stage. A Stakeholder engagement and communications group has developed a plan for subsequent engagement post April 2019.
- **Consistency with current and prospective need for patient choice** – This element will be addressed during the detailed design phase post April 2019.
- **Clear, clinical evidence base –** Once a clear scope of services has been defined, the WT partners will seek guidance from local, national and international examples of clinical best practice to inform the detailed design of pathways.

- Support for proposals from clinical commissioners – The proposals within this business case have the support of Walsall CCG, who have played an active and central role throughout. The four Locality GP Representatives have also been involved, however the wider clinical network will be engaged fully at the point of detailed design. In addition, the local authority have been involved throughout as a clear partner from both a commissioning and delivery perspective.

If during the detailed design phase there was an intention to reduce the number of beds, Walsall CCG would also need to ensure this is justified according to the Proposed Bed Closures test. However at present there is no plan to do this.

The diagram below outlines the implementation steps envisioned across each of the 3 Horizons.

Do Something Initiative Implementation

While the detailed design phase required during Horizon 1 will identify and refine the service pathways to be delivered, an approximate timeline for implementation of these has been provided below.

Tier	Initiative	Horizon 1 – 2019/20	Horizon 2 – 2020/21	Horizon 3 – 2021/22 – 2023/24
0	Single citizen portal for accessing advice, appointments and support, including Resilient Communities offerings	For VCSE, Community and Adult Social Care	For Primary Care, including Primary Mental Health	Whole system, including Secondary Services and Allied Health Professionals
	Multi-channel Contact Centre (SPA)	For VCSE, Community and Adult Social Care	For Primary Care, including Primary Mental Health	Whole system, including Secondary Services and Allied Health Professionals
	Online Directory of Services connecting patients to a range of commissioned and independent health and wellbeing services and groups (Resilient Communities)	For VCSE, Community and Adult Social Care	For Primary Care, including Primary Mental Health	Whole system, including Secondary Services and Allied Health Professionals
	24/7 Clinical/Professional triage			
	Citizen access to health records			
	Remote monitoring of citizens with some long term conditions			
	Telemedicine			
	Risk stratification and targeted intervention			
	Shared patient record			
	Social Prescribing (Resilient Communities0			
	Care Planning			

	Care Home and at home In reach service			
1	Multidisciplinary Place Based Teams			
	Referrals management			
	Greater Community/Specialist Nursing			
	Consultants in the community			
	Condition Specific Rehabilitation			
2	Outpatients in the community			
	Virtual Outpatient Clinics			
3	Integrated Rapid Response Service			
	Paramedics in the community			
4	Assess to Admit/Front end streaming			
	Remote 24/7 monitoring of inpatients			
	Clear routes to discharge, including Estimated Date of Discharge (EDD)			

Table 9 Draft Initiative Implementation Timeline

Overall Programme Timeline

The Gantt chart below outlines the key elements of the transformation programme between December 2018 and April 2021. These milestones are subject to change as the programme transitions from the detailed design phase and into implementation during Horizon 1, and will be dependent on the resource commitments and agreements made during this period.

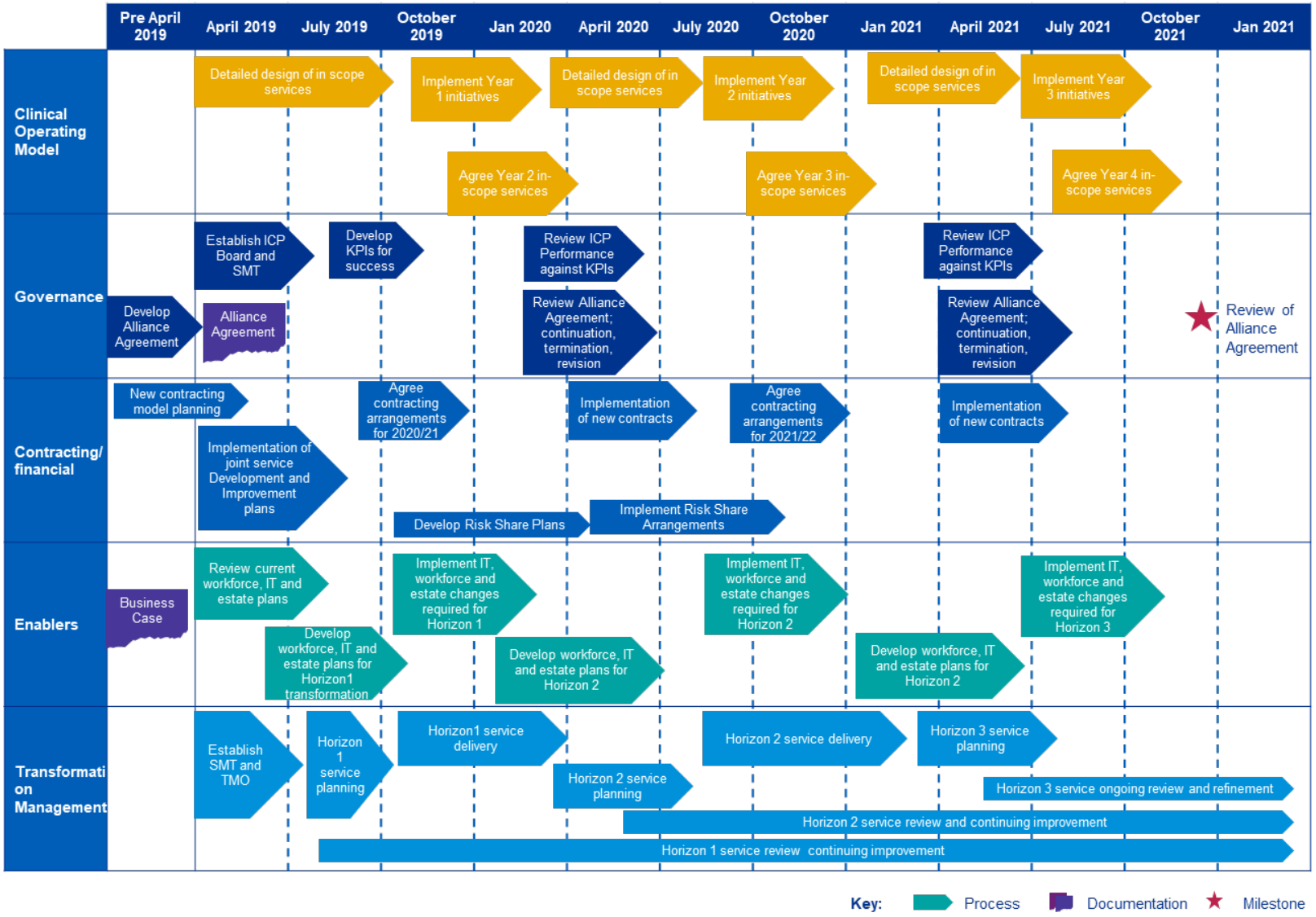


Figure 21 Timeline for Implementation

9 Glossary

Alliance Agreement	A contractual agreement that sits alongside existing NHS and LA contracts, providing a single line of communication between the commissioner and the Alliance Leadership Team (ICP Board) for the services.
Host Provider	The provider organisation hosting the ICP Board, as a sub-committee of the Executive Board.
ICP Board	A sub-committee of the Host's Board, with representation from all providers bound by the Alliance Agreement.
Section 75	A legal agreement made under section 75 of the National Health Services Act 2006 between the Local Authority and NHS organisations. A Section 75 allows for the pooling of resources and the delegation of certain functions to the other partner(s).

10 Appendices

Appendix 1: Group membership

Operating Model Workstream		
Paula Furnival - Lead	Exec Director of ASC	Walsall Council
Mark Axcell	CEO	Dudley and Walsall Mental Health Partnership NHS Trust
Marsha Foster	Director of Operations	Dudley and Walsall Mental Health Partnership NHS Trust
Daren Fradgley	Director of Strategy and Transformation	Walsall Healthcare NHS Trust
Richard Beeken	CEO	Walsall Healthcare NHS Trust
Matthew Lewis	Medical Director	Walsall Healthcare NHS Trust
Kerrie Allward	Head of Integrated Commissioning, Adult Social Care	Walsall Council
Simon Brake	Chief Officer	Walsall CCG
Paul Tulley	Director of Commissioning,	Walsall CCG
Martin Thom	Head of Community Care, Adult Social Care	Walsall Council
Dr Barbara Watt	Director of Public Health	Public Health
Sarah Shingler	Chief Nurse	Walsall CCG
Simon Harlin	GP	Walsall CCG
Anand Rischie	Walsall CCG Chair and GP	Walsall CCG
Shadia Abdalla	GP Commissioning	Walsall CCG
Carsten Lesshaft	GP	Walsall CCG
Narindar Sahota	GP Lead for engagement - WEST	Walsall CCG
Hammad Lodhi	GP Lead for engagement - SOUTH	Walsall CCG
Bhupinder Sarai	GP Lead for engagement - EAST	Walsall CCG
Israr Ahmed	GP Lead for engagement - NORTH	Walsall CCG
Andy Griggs	Programme Manager	Walsall Healthcare NHS Trust
Alex Boys	CEO	One Walsall
Mark Weaver	Joint Medical Director	Dudley and Walsall Mental Health Partnership NHS Trust

Rosie Musson	Acting Director of Nursing	Dudley and Walsall Mental Health Partnership NHS Trust
Iftikhar Ahmad	Joint Medical Director	Dudley and Walsall Mental Health Partnership NHS Trust
Donna Chaloner	Director of Community Adult Nursing	Walsall Healthcare NHS Trust
Kelly Geffen	Care Group Manager/Professional led-Adult Community Nursing	Walsall Healthcare NHS Trust
Becky Temple-Purcell	Associate Director of Nursing	Dudley and Walsall Mental Health Partnership NHS Trust
Jacky O'Sullivan	Clinical Service Director	Dudley and Walsall Mental Health Partnership NHS Trust
Sarah Taylor	Development Officer	One Walsall
Uzoma Ibechukwu	Deputy Director of Pharmacy	Walsall Healthcare NHS Trust
Robin Vickers	Director	KPMG
Sarb Basi	Senior Manager	KPMG
Hannah Lewis	Assistant Manager	KPMG

Data and Analytics Workstream		
Russel Caldicott - Lead	Director of Finance	Walsall Healthcare Trust
Kevin Slater	Performance and Systems Manager	Walsall Council, Adult Social Care
Jill Brittle	Performance & Systems Development Officer	Walsall Council, Adult Social Care
Helena Kucharczyk	Head of Performance Improvement and Quality	Walsall Council, Children's Social Care
Michelle Gordon	Deputy Director of Finance	Walsall CCG
Kevin McGovern	Head of Finance - Information	Walsall CCG
Dylan Morris	Head of Contracting and Income	Walsall Healthcare Trust
Tony Kettle	Assistant Director of Finance	Walsall Healthcare Trust
Tracy Simmonds	Costing & Income Accountant	Dudley and Walsall Mental Health Trust
Paul Chamberlain	Head of Financial Planning	Dudley and Walsall Mental Health Trust

Finance and Contracting Workstream		
Matthew Hartland - Lead	Director of finance	Walsall CCG
Rob Pickup	Director of Finance	Dudley and Walsall Mental Health Partnership NHS Trust
James Parker	Commissioning Liaison and Contracting Manager	Dudley and Walsall Mental Health Partnership NHS Trust
Daren Fradgley	Director of Strategy	Walsall Healthcare Trust
Russell Caldicott	Director of Finance	Walsall Healthcare Trust
Tony Gallagher	Director of Finance	Walsall CCG
Paul Tulley	Director of Commissioning	Walsall CCG
Ross Hutchinson	Finance Business Partner, Adult Social Care	Walsall Council
Tracey Simcox	Lead Commissioner Adult Social Care	Walsall Council
Suzanne Letts	Interim Lead Accountant, Adult Social Care	Walsall Council
Mark Banks	Deputy Director of Finance	Dudley and Walsall Mental Health Partnership NHS Trust
Seb Habibi - KPMG Lead	Director	KPMG
Sarb Basi	Senior Manager	KPMG
Hannah Lewis	Manager	KPMG
Andy Griggs	WHT - Programme Manager	Walsall Healthcare Trust
Kerrie Allward	Head of Integrated Commissioning, Adult Social Care	Walsall Council
Michelle Gordon	Deputy Director of Finance	Walsall CCG
Kevin McGovern	Head of Finance & Information	Walsall CCG
Kevin Slater	Performance and Systems Manager	Walsall Council
Tony Kettle	Assistant Director of Finance WHT	Walsall Healthcare Trust
Jane Sillitoe	WHT - Programme Support	Walsall Healthcare Trust
Roseanne Crossey	WHT - Head of Business Development and Planning	Walsall Healthcare Trust
Dylan Morris	WHT - Head of Contracting	Walsall Healthcare Trust
Paul Steventon	WHT - Head of Financial Management	Walsall Healthcare Trust
Helena Jucharczyk	Head of Performance Improvement & Quality	Walsall Council

Paul Clarke	Manager	Walsall Council
Jill Brittle	Performance & Systems Development Officer	Walsall Council
Paul Chamberlain	Head of Financial Planning, DWMHT	Dudley and Walsall Mental Health Partnership NHS Trust
Imran Hussain - KPMG Lead	Senior Manager	KPMG
Gareth Richards	Manager	KPMG

Governance and Organisation workstream		
Paul Tulley - Lead	Director of Commissioning	Walsall CCG
Daren Fradgley	Director of Strategy	Walsall Healthcare Trust
Jenna Davies	Director of Governance	Walsall Healthcare Trust
Marsha Foster	Director of Operations	Dudley and Walsall Mental Health Partnership NHS Trust
Paul Lewis Grundy	Company Secretary	Dudley and Walsall Mental Health Partnership NHS Trust
Kerrie Allward	Head of Integrated Commissioning	Walsall Council
Mark Axcell	CEO	Dudley and Walsall Mental Health Partnership NHS Trust
Sebastian Habibi - KPMG Lead	Director	KPMG
Sarb Basi	Senior Manager	KPMG
Hannah Lewis	Assistant Manager	KPMG
Robin Vickers	Director	KPMG
Andy Griggs	Programme Manager	Walsall Healthcare Trust
Jane Sillitoe	Programme Support	Walsall Healthcare Trust
Paul Clarke	Manager	Walsall Council

Appendix 2: Data Analysis, process and assumptions

In order to support the Walsall Together Programme, a data and analytics work stream was set up in order to pull together the data requirements to support the programme. Data was obtained from each of the organisations in the partnership to enable the creation of an activity linked financial model. The purpose of the model was to establish a 'Do Nothing' scenario that showed how the system is likely to develop through to the end of the 2021/2022 financial year, with an additional trend analysis to carry that through to the end of Horizon 3. This was followed by the development of 'Do Something' scenarios that show how significant changes to the operating model across Walsall could impact on the activity and finances for the overall health and care system and each partner organisation.

Initial Data Request Meeting

An initial meeting with key data leads from the partner organisations was convened at the beginning of the project to facilitate a discussion around the modelling exercise and identify the source data each organisation holds that would be relevant to this project. The timelines, data requirements, and individual organisation challenges were discussed and addressed, to inform the model inputs for the 'Do Nothing' baseline year.

Data Request Submission

With data sharing agreements in place, data was requested from each organisation in line with the initial specification of the financial and activity model. This consisted of the following key elements data specification;

Data Item	Explanation
Provider/Organisation Name	The main provider of the treatment / care.
Specialty / Service Line Code	To identify the Specialty / Service Line under which treatment or care is being delivered.
Specialty / Service Line Name	
POD Code	To identify the Point of Delivery (if applicable) - e.g. inpatient care, community, outpatient
POD Name	
GP Code	To identify the locality of the patient without requiring patient identifiable data. GP has been translated into Locality (North, East 1, South 2 etc.)
Age Band	To identify population group without requiring patient identifiable data. Age bands are set out in the table below
Activity Count	For baseline setting and to model activity over time as population changes
Length of Stay (in days)	For baseline setting and to look at bed requirements over time and in 'Do Something' scenarios

Age band profiles:

Age Bands		
0-4	30-34	65-69

5-9	35-39	70-74
10-14	40-44	75-79
15-17	45-49	80-84
18-19	50-54	85-89
20-24	55-59	90+
25-29	60-64	

Income and expenditure data requests;

Data Item	Example
I&E Category (Income, Expenditure)	Income
Provider	Provider X
Specialty / Service Line	e.g. Cardiology
POD	Non Elective
Year Total	£xxx,xxx
Total Income	£xxx,xxx
Total Expenditure	£xxx,xxx
Of which	
Expenditure - Fixed	£xxx,xxx
Expenditure - Semi Variable	£xxx,xxx
Expenditure - Variable	£xxx,xxx

Receipt of Baseline Data

Each organisation prepared data in accordance with the data requests discussed with them individually and submitted this to the data analytics team. The following table outlines the status of data received from each organisation;

Organisation	Activity Data	Finance Data
Walsall CCG	• Data falling outside the scope of the other Walsall providers, particularly where Walsall patients receive treatment or care outside the Walsall area	Detailed financial information linked to the activity taking place at providers outside the Walsall area Full CCG financial information including yearly funding allocation and current expenditure
Walsall Healthcare Trust	• SLAM data providing full details of acute activity in A&E, Inpatients and Outpatients • Additional activity datasets for other service lines outside the above	• Detailed financial information linked to the activity being delivered by WHT • Additional income received on block or for which activity detail is not available

	• Activity data by service line within the Community services, by CCG	• Detailed expenditure by Point of Delivery and Service Line
Dudley and Walsall Mental Health Trust	• Line item data for all activity delivered on behalf of Walsall CCG	• Detailed financial information linked to the activity being delivered on behalf of Walsall CCG, including Income and Expenditure
Walsall Council – Adult Social Care	• Line item data for all activity	• Detailed financial information for the Adult Social Care department of the council including income and expenditure
Walsall Council – Children's Social Care	• Summary data for activity relating to Early Help and Social Care referrals, Child Protection, Looked After Children and Children with Special Educational Needs	• Detailed financial information for the Children's Social Care department of the council including income and expenditure

Data Processing

On receipt of the above data for the baseline year 2018/19, we processed that data to consolidate the various service lines and other parameters into a manageable list for the model. If we were to use the data in its raw format we would expect to see several hundred different service lines and points of delivery, as well as data from the Local Authority of a very different nature to NHS data. The processing stage of the project was to bring this data into a single coherent model that would align the data for all organisations, whilst still being able to recognise the inputs individually from partner organisations and split by commissioners and providers.

In addition to this mapping and consolidation exercise it was also necessary to, in some cases, complete additional data processing to align the finance data with the activity data, and to 'fill gaps' where the data provided did not go down to the same level of detail and granularity as the model would expect.

Finally, in order to establish the future state of the system, we used projections for activity changes across Walsall. For Local Authority activity this meant using population changes to prepare age weighted projections of activity change. For health organisations we have used the NHS projections for activity growth as per the below:

GP Referrals	0.8%
Other Referrals	4.6%
TOTAL REFERRALS	2.2%
Consultant led 1st OP attendances	6.4%
Consultant led follow-up OP attendances	4.1%
TOTAL OUTPATIENT ATTENDANCES	4.9%
Elective admissions: Day Cases	4.2%
Elective admissions: Ordinary	0.3%
TOTAL ELECTIVE ADMISSIONS	3.6%
Non-Elective: Zero day LoS Spells	5.6%
Non-Elective: 1+ LoS Spells	0.9%
TOTAL NON-ELECTIVE ADMISSIONS	2.3%
All A&E Attendances	1.1%
A&E Attendances - Type 1	1.1%

Initial Data Validation

Once the above processing had been undertaken, packs were prepared for each individual organisation in order to view a summary of the data, mapping and consolidation that had taken place to align their information with the model structure. This included an outline of the data for the baseline year as well as the forecasting projections being used to predict activity changes until 2021/2022.

Group Data Validation

Following on from the initial validation, the outputs of the 'Do Nothing' scenario modelling have been brought to a series of workshops that join the Operating Model and Finance and Contracting elements of the project supported by the Data Analytics work stream. This group, consisting of data and finance leads from each organisation, has considered the outputs and raised points for clarification and validation.

Baseline 'Do Nothing' Assumptions

The following assumptions were made in order to build and populate the baseline model;

Baseline Year – 2017/18

The base year for the 'Do Nothing' scenario was the 2017/2018 financial year.

Activity Forecast – ONS Population Projections

The detailed activity forecast for the Local Authority was populated using ONS Population Projections for Walsall as set out in the following table. These projections were applied to the baseline activity resulting in either growth or reduction in activity based on the increase or decrease in population size.

AGE GROUP	2017	2018	2019	2020	2021
0-4	19.2	19.1	19.0	19.0	18.9
5-9	19.5	19.7	19.9	20.1	20.1
10-14	17.8	18.4	18.8	19.3	19.6
15-17	10.1	10.0	10.0	10.0	10.3
18-19	6.7	6.6	6.6	6.7	6.8
20-24	16.7	16.6	16.4	16.2	16.1
25-29	19.3	19.2	19.2	19.0	18.7
30-34	18.9	19.2	19.5	19.6	19.9
35-39	17.2	18.0	18.3	18.6	18.8
40-44	16.1	15.7	15.9	16.4	16.8
45-49	19.3	19.0	18.4	17.7	16.9
50-54	18.8	18.9	18.9	19.1	19.1
55-59	16.9	17.3	17.9	18.3	18.5
60-64	14.2	14.4	14.6	15.0	15.5
65-69	13.6	13.3	13.2	13.1	13.2
70-74	12.5	12.7	12.7	12.8	12.8
75-79	9.9	10.0	10.2	10.3	10.5
80-84	7.3	7.6	7.8	7.8	7.8
85-89	4.3	4.4	4.4	4.5	4.6
90+	2.2	2.3	2.3	2.4	2.5
All ages	280.5	282.3	284.0	285.7	287.4

Activity Forecast – NHS Growth Projections

The detailed activity forecast for NHS organisation was populated using NHS Growth Projections as set out in the following table. These projections were applied to the baseline activity resulting in growth of activity in line with national assumptions.

GP Referrals	0.8%
Other Referrals	4.6%
TOTAL REFERRALS	2.2%
Consultant led 1st OP attendances	6.4%
Consultant led follow-up OP attendances	4.1%
TOTAL OUTPATIENT ATTENDANCES	4.9%
Elective admissions: Day Cases	4.2%
Elective admissions: Ordinary	0.3%
TOTAL ELECTIVE ADMISSIONS	3.6%
Non-Elective: Zero day LoS Spells	5.6%
Non-Elective: 1+ LoS Spells	0.9%
TOTAL NON-ELECTIVE ADMISSIONS	2.3%
All A&E Attendances	1.1%
A&E Attendances - Type 1	1.1%

Activity – Bed Usage

The model assumes that beds are used for 92% of the time, on the basis that there will be some turnaround in bed usage for cleaning, restocking equipment etc.

Finances – Income

From a provider perspective, where activity data was provided and linked to income, any changes to activity will result in a direct change to income. The model does not fix elements of block contracts if the activity and finance data for those contracts has been provided. This means that the forecast changes to activity based on the population forecasting do impact on the provider income and subsequently the projected commissioner cost.

The CCG provided funding allocation information up to 2020/2021, and for the purposes of the model it was assumed that 2021/2022 would see the same percentage increase in allocation as 2020/2021. That has then been carried forward in the trend analysis.

The Local Authority has some income linked to activity in the same way as the other NHS provider income, but this is significantly less than expenditure. The remaining funding that provides the balance is allocated from a central budget from the Council's overall income.

Finances – Income Forecast

In addition to the changes to income resulting from activity shifts, the income is forecast to change in line with inflation.

For NHS organisations, NHSE inflation projections are used. The latest NHS figures go to the end of the 2020/21 financial year and therefore 2021/22 has been populated with the combined forecast inflation rate from RPI and CPI projections. This gives the following projection:

	2018/19	2019/20	2020/21	2021/22
Yearly	2.00%	2.00%	2.90%	2.95%
Cumulative	2.00%	4.04%	7.06%	10.22%

For non NHS organisations, specifically the Social Care departments of the Local Authority, the NHS projections were not considered appropriate and therefore the Consumer Price Index inflation rate was used, as follows;

	2018/19	2019/20	2020/21	2021/22
Yearly	2.30%	1.90%	2.00%	2.10%
Cumulative	2.30%	4.24%	6.33%	8.56%

Finances – Expenditure

All organisations provided expenditure data split into Fixed, Semi Fixed and Variable. Similar to income, where activity data was provided and linked to expenditure, any changes to activity will result in a direct change to Variable Expenditure, as well as a proportion of the Semi Fixed expenditure. The proportional changes are different for each organisation per the following table:

Organisation	Semi Fixed Sensitivity
Walsall Healthcare Trust - Acute	70% Fixed, 30% Variable
Walsall Healthcare Trust - Community	14.6% Fixed, 85.4% Variable
Dudley and Walsall Mental Health Trust	80% Fixed, 20% Variable
Walsall Council – ASC and CSC	50% Fixed, 50% Variable

Regarding the Fixed costs, and the fixed element of Semi Fixed Costs, the model will not increase these at any given thresholds, these are deemed to be entirely fixed. Therefore, when considering the baseline position in terms of increase activity over time, as well as the impact of change scenarios, it is important to interpret the outcomes in that context. A significant increase in activity may require an investment in fixed costs, and consequently a decrease in activity might require a reduction in fixed costs left stranded by those shifts.

Finances – Expenditure Forecast

The same inflation rates were applied to Expenditure as they were for Income for each organisation.

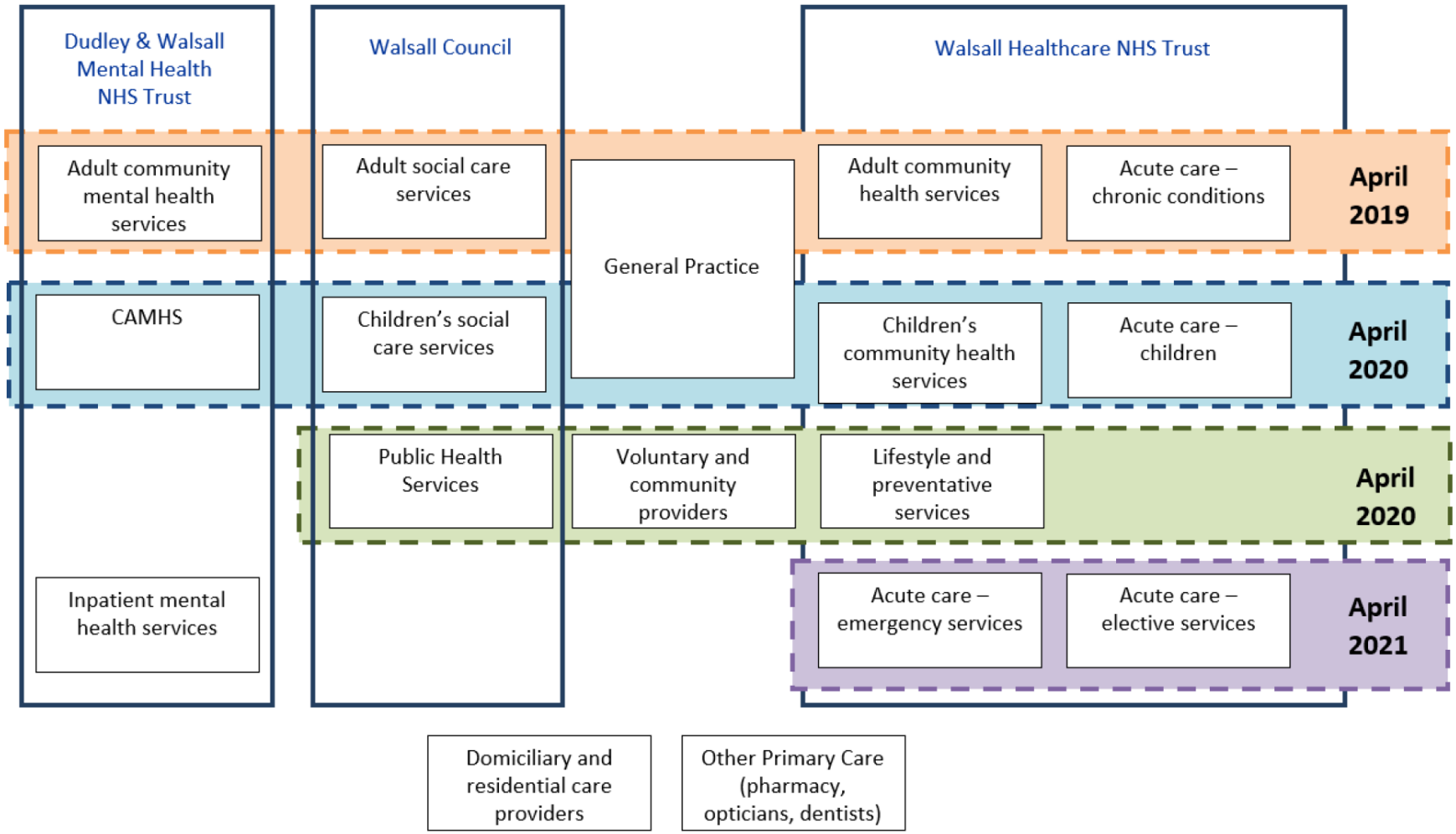
Organisation Assumptions

The following assumptions were also agreed and made for each individual organisation:

Organisation	Assumption
Walsall Healthcare Trust - Acute	Day Case bed usage is assumed to be 1 day when calculating bed requirements
Walsall Healthcare Trust - Community	The service is assumed to 'break even' in that the same data has been used for expenditure and income
Dudley and Walsall Mental Health Trust	The data within the model is for activity undertaken on behalf of Walsall CCG only, therefore the model is not representative of the activity or financial position of the Trust overall.

	Any data which is showing for a GP that does not come under Walsall CCG has been put under the category of 'Other – Walsall' (0.1% of activity)
Walsall Council – ASC and CSC	Only Adult Social Care department activity has been included. Additional activity within the council such as public health initiatives were not within the scope of the modelling project. Only Children's Social Care department activity has been included. Additional activity within the council such as public health initiatives were not within the scope of the modelling project.
Walsall CCG	GP activity data could not be provided. Data obtained from NHS Digital has been used however this only covered November 2017 to October 2018. The total appointments for Walsall has been calculated from this, plus an extra 10% as only 90% of GP's data was included in the dataset. Similarly, there are costs for the CCG to commission specific services for which there is no activity data. As a result, we have adjusted the financial inflation to account for the forecast increase in demand. Individual organisation inputs have been reconciled against headline data for the CCG, with 'balancing lines' entered into the model to account for variation between the contract value in the CCG data versus additional items of income for providers.

Appendix 3: Initial High Level Timeline for Integration Implementation



Appendix 4: Future State Citizen Stories

What it could look like for Joshua...

Joshua

Age: 7

Job title: Student

Joshua is a quiet boy who lives with his mother, Sophie. He sees his father infrequently due to the violent arguments that can sometimes break out between his parents. At home, he looks after himself most of the time, as his mother is frequently incapacitated. His school is unaware of the situation at home and Joshua's recent decline in performance has been largely overlooked by his teachers.

Tier of Care:

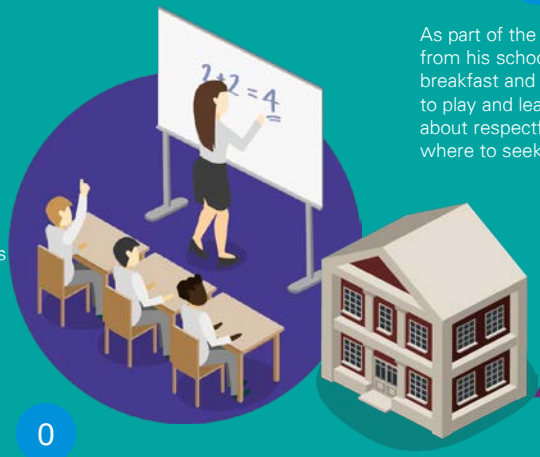
0 1 **2** 3 4

2

Following a referral to MASH, Joshua's mum visits the local Children's Centre, where a domestic abuse worker discusses their disruptive home life and ways the family can be supported, developing an Early Help Plan.

0

As part of the Early Help Plan and with support from his school, Joshua begins attending breakfast and after school clubs, where he is able to play and learn from other children. He is taught about respectful adult relationships and knows where to seek support if needed.



0

The Targeted Parenting programme attended by Joshua's mum is having a huge impact on Joshua and their relationship. Joshua feels safer at home and having clear routines and boundaries means he is more alert at school; and his grades are improving. The Early Help Team are in regular contact with the family and have noticed the growth in his confidence.

What it could look like for Cassie...

Cassie

Age: 32

Job title: Manager

Cassie is an outgoing and confident young woman who works as a Manager. She has Lupus, but is otherwise healthy and she manages her condition well. She is 3 months pregnant with her first child and her Lupus means that it is considered high risk. She is anxious the pregnancy and becoming a mother. She has a busy full time job which can make attending medical appointments difficult.

Tier of Care:

0 1 2 3 4

Cassie is allocated a case loading midwife who will manage her pregnancy, including her birth and after care. Cassie will continue updating her record digitally for the pregnancy, as she does for her Lupus, allowing clinicians to monitor throughout.

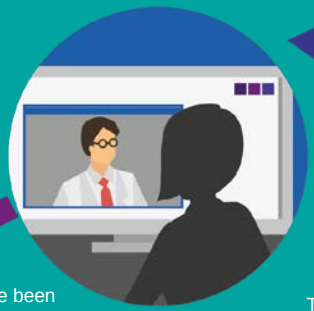
2

0

Cassie is able to search for local pre-natal exercise classes through the and joins a pregnancy yoga class and meets other new mums to be.

1

The use of digital records means that Cassie can have her bloods taken at her local GP surgery with the results being made available within 24 hours to her hospital based consultant. Her consultant is able to offer Cassie a virtual clinic, assessing her blood results alongside her daily monitor of disease activity.



Cassie and her midwife have been able to put in place a postnatal lupus care plan, including visits from her midwife in the evening when her husband is at home and able to offer support. She feels very supported and is enjoying motherhood.

1

What it could look like for John...

John

Age: 41

Job title: Builder

John is a family-orientated hardworking man from the travelling community. His lifestyle means accessing consistent care has been difficult in the past, however he is very self-sufficient and has kept himself well throughout his life, more or less. He does enjoy and drink and is a heavy smoker. He is highly influential in his community and wants to support grass roots initiatives close to his heart.

Tier of Care:

0 1 2 3 4

John is able to view a directory of local services on his smartphone and can complete a questionnaire to direct him to the most appropriate service, without requiring registration.

0

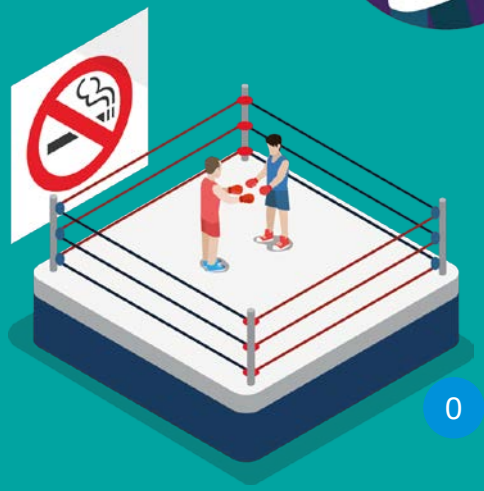
By having full access to his digital care record on his phone, John is able to share this with the health and care professionals he engages with, regardless of their location.

John finds the drop in sessions at the Health and Wellbeing centre are the most convenient for him and he develops a good relationship with the Care coordinators, who put him in touch with a local boxing club.

2

With support from the local community, John sets up a local boxing club at the Community Centre. The centre also offers Stop Smoking drop in sessions and John begins a smoking cessation programme.

0



What it could look like for Maria...

Maria McBride

Age: 14

Job title: Student

Maria is a quiet, anxious teenager with undiagnosed depression. Her family are concerned that she is being bullied at school, however Maria is unwilling to disclose information and asked her parents not to tell school. She has been experiencing suicidal thoughts and has begun self-harming. She has a very small group of friends but does not feel able to share her feelings and is convinced she will fail her upcoming exams.

Tier of Care:

0 1 2 3 4

0

Maria attends an assembly at her school organised by CAMHS and a local mental health charity, in which people talk openly about their challenges with mental health. She downloads the recommended app and recognises that she needs support.

Maria speaks to an advisor, who arranges a face to face counselling session at her school, as well as directing her to self-monitoring tools and mindfulness techniques. She discusses her progress with the councillor, who is able to message Maria via the app in between their sessions.

1

Maria is encouraged to broaden her social network by joining an after-school art class, where she can nurture her talent for art alongside building her confidence. Following the early intervention, Maria's depression is prevented from escalating and she is better equipped to manage her mental health challenges in the future.

0

What it could look like for Clara...

Clara

Age: 84

Job title: Retired bookkeeper

Clara is a softly spoken woman with 12 grandchildren and 3 great-grandchildren; of whom she is very proud. Following the death of her husband 3 years ago and a diagnosis of dementia the following year, Clara's condition has steadily deteriorated. Her family have been able to support her to date, however she is at risk of admission to institutional care if not properly supported.

Tier of Care:

0 1 2 3 4

Clara's family want her to be supported to live at home for as long as possible and so work with her GP and the local community teams to develop a comprehensive care package. 1

Clara's care package includes regular appointments with a Consultant Geriatrician at the local Community Centre. The Health and Wellbeing Centre is also open 24/7, allowing social care and health workers access to advice and support at any time. 2

Using proactive care planning, Clara is able to live at home for longer with access to local, integrated teams of specialists and professionals. 0

What it could look like for David...

David

Age: 68

Job title: Retired carpenter

David is a considered and contemplative man who enjoys spending time at home with his wife. They have no children or other family nearby, but have always enjoyed gardening and visiting museums. He was diagnosed with bowel cancer 3 years ago and has been placed on palliative care. Since this diagnosis, he has struggled to communicate his wishes directly and is feeling isolated for the first time in addition to worrying about his wife when he passes.

Tier of Care:

0 1 2 3 4

David and his wife are able to visit his Care coordinator at the local Health and Wellbeing Centre to discuss and review his care at any time, which they prefer over the telephone number that is available 24/7.

2

David's records are shared amongst all the providers involved in his care and the ambulance service, should their be an emergency, ensuring his EoL plan is followed and he remains at home where possible.

1

0

The Care coordinator refers David to Macmillan services, allowing him a safe space to speak openly about his cancer. They also find a local boules club that David and his wife are able to join and have made new friends together. David feels relieved that his wife has a wider network than before.

The palliative nurse works closely with David and his wife to minimise the number of appointments and wherever possible sees him at home, providing as much time as possible for David and his wife to be together.

1

What it could look like for Marvin...

Marvin

Age: 52

Job title: Warehouse Night Manager

Marvin is a night shift worker in a warehouse, who values the time outside of work he can spend with his family. He doesn't prioritise his health and has poorly managed Type 2 diabetes and has been recently been diagnosed with COPD. He is distrusting of health professionals and avoids visiting his GP, as they always seem to find something to lecture him about – like his diet.

Tier of Care:

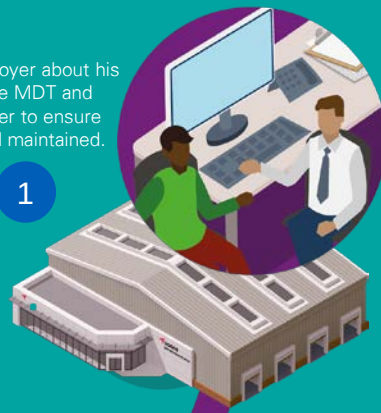
0 1 2 3 4

Marvin is able to access the Health and Wellbeing centre out of hours to suit his shifts. He is encourage to self-monitor his diabetes to reduce the need for appointments. The Care Coordinator also suggested he speaks to his employer.

2

Marvin speaks to his employer about his Care Plan developed by the MDT and how they can work together to ensure his health is prioritised and maintained.

1



Marvin is now able to better control his diabetes through self monitoring and diet. This has enabled him to stay well and out of the hospital. He is able to access a local gym out of hours and has much more time to spend with his family.

0

Appendix 5: Investment Requirements Breakdown

Walsall Together - Investment Profile								
	Revenue	Capital	total		Horizon 1	Horizon 2	Horizon 3	Total
Leadership and Governance	£ 497,730	£ -	£ 497,730		£ 497,730	£ 497,730	£ 1,493,189	£ 2,488,648
Capacity	£ 3,998,162		£ 3,998,162		£ 3,998,162	£ 3,998,162	£ 7,032,394	£15,028,718
Transformation	£ 7,411,000	£ 3,000,000	£ 10,411,000		£ 4,744,333	£ 4,744,333	£ 4,566,333	£14,055,000
Total	£ 11,906,892	£ 3,000,000	£ 14,906,892		£ 9,240,225	£ 9,240,225	£ 13,091,916	£31,572,366
Percentgae of total system spend								
	Year	investment @ 1%	investment costs	%	ROI	total saving	ratio	
Horizon 1	19/20	£ 6,056,000	£ 9,240,225	1.53%	system saving	£150,000,000	4.75	
Horizon 2	20/21	£ 6,151,000	£ 9,240,225	1.50%				
Horizon 3	21/22	£ 6,268,000	£ 4,363,972	0.70%				
	22/23	£ 6,352,000	£ 4,363,972	0.69%				
	23/24	£ 6,447,000	£ 4,363,972	0.68%				
total		£ 31,274,000	£ 31,572,366					

Capacity																				
								Annual								Horizon 1		Horizon 2		Horizon 3
Capacity Building and Development			Resource	Number of sessions pw				Budget												
				Medic	Nurse / AHP	SC rep		Rate (per session)	Sessions (pw)		Cost	On costs (27%)	Total (£)			Total (£)		Total (£)		Total (£)
Clinical backfill	Detailed design Clinical patient cohorts	LTC	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Frailty	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Primary Mental Health	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		OP & Diagnostics	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Urgent Care	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Intermediate and Care management	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
				Operations manager	Service Devleopment lead	SC operations rep		Rate (per session)	Sessions (pw)		Cost	On costs (27%)	Total (£)			Total (£)		Total (£)		Total (£)
	Detailed design Operational Service development	Tier Development - Tier 0	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Tier Development - Tier 1	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Tier Development - Tier 2	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
		Tier Development - Tier 3	3.00	1.00	1.00	1.00		£ 300	3.00	138.00	£ 41,400	£ 11,178	£ 52,578			£ 52,578		£ 52,578		£ 52,578
Total			30.00	10.00	10.00	10.00		£ 3,000	30.00	1,380.00	£ 414,000	£ 111,780	£ 525,780			£ 525,780		£ 525,780		£ 525,780
				Finance	Gvoernance/ HR	Operstions		Rate (per session)	Sessions (pw)		Cost	On costs (27%)	Total (£)			Total (£)		Total (£)		Total (£)
Professional backfill	Detailed design Clinical patient cohorts	LTC	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Frailty	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Primary Mental Health	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		OP & Diagnostics	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Urgent Care	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Intermediate and Care management	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
				Operations manager	Service Devleopment lead	SC operations rep		Rate (per session)	Sessions (pw)		Cost	On costs (27%)	Total (£)			Total (£)		Total (£)		Total (£)
	Detailed design Operational Service development	Tier Development - Tier 0	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Tier Development - Tier 1	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Tier Development - Tier 2	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
		Tier Development - Tier 3	3.00	1.00	1.00	1.00		£ 250	3.00	138.00	£ 34,500	£ 9,315	£ 43,815			£ 43,815		£ 43,815		£ 43,815
Total			30.00	10.00	10.00	10.00		£ 2,500	30.00	1,380.00	£ 345,000	£ 93,150	£ 438,150			£ 438,150		£ 438,150		£ 438,150

Additonal Capacity in Community Services																				
Dual running costs and transformation	Costed at 5% Primary Care and Community Services												£ 3,034,232			£3,034,232		£3,034,232		£ 6,068,464.10
Total Capacity Costs			Resource	Number of sessions pw				Rate (per session)	Sessions (pw)		Cost	On costs (27%)	Total (£)			Total (£)		Total (£)		Total (£)
Total	Clinical backfill	Detailed design Clinical patient cohorts	18.00	6.00	6.00	6.00		£ 1,800	18.00	828.00	£ 248,400	£ 67,068	£ 315,468			£ 315,468		£ 315,468		£ 315,468
		Detailed design Operational Service development	12.00	4.00	4.00	4.00		£ 1,200	12.00	552.00	£ 165,600	£ 44,712	£ 210,312			£ 210,312		£ 210,312		£ 210,312
	Professional backfill	Detailed design Clinical patient cohorts	18.00	6.00	6.00	6.00		£ 1,500	18.00	828.00	£ 207,000	£ 55,890	£ 262,890			£ 262,890		£ 262,890		£ 262,890
		Detailed design Operational Service development	12.00	4.00	4.00	4.00		£ 1,000	12.00	552.00	£ 138,000	£ 37,260	£ 175,260			£ 175,260		£ 175,260		£ 175,260
	Dual running costs and transformation	Costed at 5% Primary Care and Community Services											£ 3,034,232			£3,034,232		£3,034,232		£ 6,068,464
Total			60.00	20.00	20.00	20.00		5,500.00	60.00	2,760.00	759,000.00	204,930.00	3,998,162			£3,998,162		£3,998,162		£ 7,032,394

PMO	Position	Resource			Budget				Horizon 1	Horizon 2	Horizon 3
		Number (WTE)			Rate (pa)	Cost	On costs (27%)	Total (£)	Total (£)	Total (£)	Total (£)
	Senior Programme Manager	1.00			£ 80,000	£ 80,000	£ 21,600	£ 101,600	£ 101,600	£ 101,600	£ 304,800
	Programme Manager	1.00			£ 40,000	£ 40,000	£ 10,800	£ 50,800	£ 50,800	£ 50,800	£ 152,400
	Programme Support officers	2.00			£ 30,000	£ 60,000	£ 8,100	£ 68,100	£ 68,100	£ 68,100	£ 204,300
Total		4.00	-	-		£ 180,000	£ 40,500	£ 220,500	£ 220,500	£ 220,500	£ 661,500

Change Management Team	Position	Resource			Budget						
		Number (WTE)			Rate (pa)	Cost	On costs (27%)	Total (£)	Total (£)	Total (£)	Total (£)
	Technology Transformation manager	1.00			£ 50,000	£ 50,000	£ 13,500	£ 63,500	£ 63,500	£ 63,500	£ 190,500
	Estates Transformation manager	1.00			£ 50,000	£ 50,000	£ 13,500	£ 63,500	£ 63,500	£ 63,500	£ 190,500
	WF Transformation manager	1.00			£ 50,000	£ 50,000	£ 13,500	£ 63,500	£ 63,500	£ 63,500	£ 190,500
Total		3.00	-	-		£ 150,000	£ 40,500	£ 190,500	£ 190,500	£ 190,500	£ 571,500

External transformation support	Position	Resource			Budget						
		Number (WTE)			Rate (pa)	Cost	On costs (27%)	Total (£)	Total (£)	Total (£)	Total (£)
	Tier Change Management	6.00				£ -	£ -	£ 1,000,000	£ 1,000,000	£1,000,000	£1,000,000
	Technology Transformation support	1.00						£ 6,000,000	£ 2,000,000	£2,000,000	£2,000,000
Total		7.00	-	-		-	-	£ 7,000,000	£ 3,000,000	£3,000,000	£3,000,000

Capital Investment	Position	Budget									
				Number	Unit Cost			Total (£)	Total (£)	Total (£)	Total (£)
	Estates reconfiguration	H&W HuB development		4.00	£ 500,000	£ 2,000,000		£ 2,000,000	£ 1,000,000	£1,000,000	
	Training and Development	Tier and clincial devleopment						£ 1,000,000	£ 333,333	£ 333,333	£ 333,333
Total		-	-	-		£ 2,000,000	£ -	£ 3,000,000	£ 1,333,333	£1,333,333	£ 333,333

Leadership and Governance - Summary		Resource			Budget						
		Number	Days (pa) each	total days (pa)	Rate (pa)	Cost	On costs (27%)	Total (£)	Total (£)	Total (£)	Total (£)
PMO		4.00	-	-	-	£ 180,000	£ 40,500	£ 220,500	£ 220,500	£ 220,500	£ 661,500
Change Management Team		3.00	-	-	-	£ 150,000	£ 40,500	£ 190,500	£ 190,500	£ 190,500	£ 571,500
External transformation support		-	-	-	-	£ -	£ -	£ 7,000,000	£ 3,000,000	£3,000,000	£3,000,000
Capital Investment								£ 3,000,000	£ 1,333,333	£1,333,333	£ 333,333
Total		7.00	-	-	-	£ 330,000	£ 81,000	£ 10,411,000	£ 4,744,333	£4,744,333	£4,566,333

Appendix 6: Rationale for identifying Walsall Healthcare NHS Trust as recommended Host Provider

1. The WTPB agreed that the role of the Host Provider could potentially be fulfilled by one of three organisations:
   - Walsall Council ('the Council');
   - Walsall Healthcare Trust (WHT); or,
   - Dudley and Walsall Mental Health Foundation Trust (DWMHPT)

2. This is documented in the *Case for Change* agreed by WTPB in January 2018:

'*In the Walsall health and social care economy, the role of Host Provider could be fulfilled either by the Council or one of the two NHS Trusts. These are the organisations with the inbuilt capacity to absorb some of the functions necessary to act as a Host Provider (such as strategy functions and contracting teams) as well as the fact that they are most able to bear risk due to their scale.'*

Procurement and competition considerations

3. Three potential procurement and competition issues have been considered as follows:

- Procurement - The selection of the host organisation is not a procurement process. The Walsall joint commissioners (Walsall CCG and Walsall Council) will not be awarding or transferring any new contract to the host organisation upon selection. However, procurement regulations will apply to any potential future contract awarded or transferred to the host organisation by commissioners. Therefore the commissioners will need to consider case by case where an open competitive tendering process may be required.

- Merger – The selection of the host organisation does not constitute either a merger under the Enterprise Act or an NHS merger by statutory reorganisation. Firstly, because no enterprises or parts of enterprises will cease to be distinct upon selection of the host organisation this will not trigger requirements for review by the Competition and Markets Authority. Secondly, the selection of the host organisation and establishment of an Integrated Care Board and management structure will not be a Statutory Transaction requiring Secretary of State approval or statutory instrument.

- Anti-competitive conduct – NHSI maintains guidance on its approach to regulating procurement, choice and competition in the NHS[2]. The selection of the host organisation will not impact on competition in and of itself. However, anti-competitive conduct regulations would prohibit any agreement(s) to develop the Host Provider model for integrated care in Walsall having the object or effect of restricting competition against the interests of patients. Similar prohibitions would apply to the conduct of the participants in the Host Provider arrangements. For example NHSI has established licence conditions relating to anti-competitive that reflect UK competition legislation by preventing a licensee from:

  - Entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of healthcare users.

  - Engaging in any other conduct which has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of healthcare users.

  NHSI applies similar regulations to prohibit restrictions on patient choice.

  NHSI also has a duty to promote integration and its guidance includes hypothetical scenarios that illustrate how cooperation between commissioners and providers to deliver integrated care should not necessarily restrict competition against the interests of patients. It should also be noted that NHSI Annual Reports for 2016/17 and 2017/18 do not include a single reference to investigations of anti-competitive conduct cases

[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/354079/cc__licence_conditions_guidance.pdf

during a period where integrated care models have been developed in many local areas. The risk of a successful challenge to development of the Host Provider model of integrated care under anti-competitive conduct regulations could therefore be considered to be low.

These issues would need to be kept under review and any future conduct by participants in the Host Provider model that had the object or effect of restricting patient choice or competition could be subject to investigation. The potential risk of challenge could increase in the context of any future procurement or contract award, transfer or extension relating to services within the scope of Walsall Together. Examples of potential anti-competitive conduct could include excluding others from participating in the Host Provider arrangement or restricting access to information where this had the effect of preventing the introduction of new providers in Walsall.

Potential requirements for reporting and detailed review by NHS Improvement

4. WHT and DWMHPT will need to engage with NHSI regarding their participation in the Host Provider model under the risk assessment framework and to notify any governance changes as required under the terms of their Licence. NHSI may determine the proposed arrangement to be a new care model that amounts to a 'material' or 'significant' transaction where it affects 25%-40% of capital or income for either Trust (see Annex for details of NHI thresholds for reporting and detailed investigation). This is likely to be triggered only at the point that contracts and/or resources are transferred so may not be applicable for April 2019. However, NHSI guidance states that such issues must be considered case by case and advises early engagement with the regional team.

Detailed considerations

Walsall Council

5. The Council is a credible candidate to fulfil the role of the host organisation. It has a corporate structure within which an integrated care Board and management structure could be developed. It has statutory duties to promote health and wellbeing and to meet the needs of people in Walsall for personal care, as well as powers to provide health related services. However, the Council is not currently licenced by NHS Improvement as a provider of NHS healthcare services.

6. There may be perceived conflicts between the host provider functions and the Council's functions as a commissioner and in oversight and scrutiny of the health service in Walsall. However, these issues could be managed in a similar way to the Council currently manages boundaries between its functions as both a commissioner and a provider and in political oversight and scrutiny of social care.

7. The Council is responsible for commissioning and/or provision of a significant scope of services to be integrated within the Walsall Together programme, including social care and public health.

8. The strategic priorities of the Council are aligned to the aims of the Walsall Together programme although its focus is on developing its role as a strategic commissioner. The Council has not set out an ambition to extend its role in providing NHS services and to take on the role of the host organisation would require diversion of management resources.

9. Taking on the role of the host provider could also potentially lead to misconceptions within the community. For examples there are risks that the Council taking on the role of the host provider could lead to public perceptions that it disagrees with the view of the Parliamentary Health and Social Care Select Committee that integrated care organisations should be NHS Bodies[3]. This could also risk creating misconceptions amongst local NHS staff that

[3] House of Commons Health and Social Care Committee: *Integrated care: organisations, partnerships and systems*; Seventh Report of Session 2017–19

the development of a Host Provider model for delivering integrated care in Walsall could lead to their employment transferring to the local authority.

Dudley and Walsall Mental Health Partnership Trust

10. DWMH is also a credible candidate to fulfil the role of the host organisation and has been rated as 'Good' by the Care Quality Commission. It has a corporate structure within which an integrated care Board and management structure could be developed. It has statutory powers to provide health and care services and is licenced by NHS Improvement.

11. There should be no conflicts for DWMH in fulfilling the role of the host.

12. DWMH is responsible for providing community mental health services within the scope of the Walsall Together programme, as well as inpatient mental health services for Walsall outside of this programme. DWMHPT also provides community mental health services in Dudley and provides inpatient care across a wider geographical footprint.

13. The strategic aims of DWMH are aligned to the aims of the Walsall Together programme although it also has other key priorities to address in developing its future role position in the Dudley ICS and across the wider STP footprint.

Walsall Healthcare Trust

14. WHT is considered to be the most credible candidate at this time to fulfil the role of the host organisation, despite a current CQC rating of "Requires Improvement" and challenges meeting their financial metrics. Thus is due to the corporate structure within which an integrated care Board and management structure could be developed alongside the statutory powers to provide health and care services and is licenced by NHS Improvement. Additionally the Community Services which make up the majority of services to be delivered initially by the ICP are rated "Outstanding."

15. There should be no conflicts for WHT in fulfilling the role of the host.

16. WHT provides a significant scope of the services to be integrated over the next phase of the Walsall Together programme, including community health services and acute hospital services at the Manor Hospital. The Manor Hospital is located in Walsall. The majority of patients it serves are from the Walsall community and significant numbers of its staff are Walsall residents.

17. The strategic priorities of WHT and its medium term quality and financial improvement objectives are aligned to the aims of the Walsall Together programme.

Alternative Options

18. The alternative options of the *One Walsall* group of voluntary and community providers and the *Walsall Alliance* GP federation have not been considered as potential candidates for the Host Provider role because it is clear that neither would meet some of the basic criteria at this stage. For example, at this point in time neither of these organisations has a corporate structure within which an ICP Board could be established or the capacity to invest sufficient management capacity to develop the host functions.

Conclusion

19. The working group is recommending that WHT be selected as the host organisation as it is closely embedded within the Walsall community and provides the bulk of hospital and community services to be integrated in the next phase of the Walsall Together programme. The strategic priorities of WHT and its medium term quality and

financial improvement objectives are closely aligned to the strategic aims of Walsall Together. WHT is therefore able to prioritise investment of senior management resources to fulfilling the role of the host.

20. The alternative options are also credible, but are not recommended at this time. For the Council to fulfil the role of the host provider would risk creating public misconceptions that developing the Host Provider model in Walsall could lead to services and staff being transferred out of NHS Bodies. This could appear at odds with the recommendations of the Parliamentary Health Select Committee that integrated care organisations should be established as NHS Bodies and would be a distraction from the Council developing its role as a strategic commissioner. DWMHPT provides a smaller scope of services in Walsall compared to WHT.

Appendix 7: Terms of Reference for the ICP Board (Draft)

Walsall Together
Joining up your health and social care

INTERGRATED CARE PARTNERSHIP BOARD

TERMS OF REFERENCE: Version 0.1

RATIFIED BY THE TRUST BOARD ON:

NEXT REVIEW DUE:

1. CONSTITUTION

1.1 The Integrated Care Partnership Board is established by the Participants, who remain sovereign organisations. It is established as a Board Committee of the host provider to provide a governance framework for the delivery of the Walsall Together Business Plan.

1.2 The Alliance is not a separate legal entity, and as such is unable to take decisions separately from the Participants or bind its Participants; nor can one or more Participants 'overrule' any other Participant on any matter (although all Participants will be obliged to comply with the terms of the Agreement).

1.3 Each Partner shall delegate to its representative to the ICP Board, such authority as is agreed to be necessary in order for the ICP Board to function effectively in discharging the duties within these Terms of Reference. Authority delegated by the Participants shall be defined in writing and agreed by the Participants, and shall be recognised to the extent necessary in the Participants' own schemes of delegation or similar.

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

2. PURPOSE

2.1 The ICP Board has been established to provide strategic direction to the partnership and has responsibility for the delivery of the Walsall Together Plan.

2.2 Thus the ICP Board will have responsibility for the oversight of services contractually in scope and for the wider system integration and transformation.

3. MEMBERSHIP

3.1 As a the Sub Committee is one focused on partnership working across the borough of Walsall, the ICP Board will include members of Partner organisations.

The Membership of the Committee shall consist of;

- A newly appointed Non-Executive Director of WHT, appointed by all system partners, as Chair
- Two Non-Executive Directors
- Chief Executive Officer (Walsall Healthcare NHS Trust)
- Director of Walsall Together

3.2 Partner representative's

- Chief Executive, Dudley and Walsall Mental Health Partnership Trust
- Director of Adult Social Care, Walsall MBC
- Director of Public Health, Walsall MBC.
- Director of Children's Services, Walsall MBC
- Chief Officer, Walsall CCG
- Chief Executive, One Walsall.
- GP representation.

3.3 Professional Representation

- Consultant, professional lead for in-scope hospital services.
- Professional lead for Primary Care.
- Consultant, professional lead for mental health.
- Professional lead for nursing and AHPs.
- Professional lead for Adult Social Care.
- Professional lead for Children's Services.

4. ATTENDEES

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

5. ATTENDANCE

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

6. QUORUM

6.1 A quorum shall be 2 Non-Executive Directors and one Executive Director from the host organisation

6.2 In addition to the above quorum also requires two thirds of its partner and professional representation are present

6.3 Where a member cannot attend a meeting, the member can nominate a named deputy to attend. Deputies must be able to contribute and make decisions on behalf of the Participant that they are representing. Deputising arrangements must be agreed with the Chair prior to the relevant meeting.

7. FREQUENCY OF MEETINGS

7.1 The Committee will meet 10 times a year additional meetings may be arranged as required.

8. CHANGES TO TERMS OF REFERENCE

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

9. ADMINISTRATIVE ARRANGEMENTS

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

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

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

10. ANNUAL CYCLE OF BUSINESS

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

11. REPORTING TO THE PARTNER ORGANISATIONS

11.1 The Chair of the ICP board will on behalf of the Board provide a highlight report monthly to each of the partner organisations outlining key actions taken with regard to the issues, key risks identified and key levels of assurance given. A report will also be provided to the Walsall Health & Wellbeing Board.

12. STATUS OF THE MEETING

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

13. MONITORING

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

14. DUTIES

14.1 The primary responsibility of the ICP Board will be the integration of services deemed to be “in scope” and not for the delivery of those services.

14.2 The functions of the ICP Board would be to:

- To provide strategic leadership and oversight of service delivery for in-scope services and for ICP programme work streams;
- To ensure alignment of all organisations to the Walsall Together vision and objectives;
- To promote and encourage commitment to the Alliance Principles and Alliance Objectives amongst all Participants;
- To oversee the development of, and transition to, new models of care in priority areas/in scope services;
- To consider investment and any disinvestment decisions across the partnership;
- To collectively hold ICP partners to account for upholding the commitments made in the Business case, and the Alliance contract.
- To provide assurance that needs of the community and patients are best serviced by the proposed partnering arrangements
- To respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Alliance or any Participants to the extent that they affect the Participants' involvement in the Alliance;
- To ensure that the risks associated with the delivery of the programme are identified and managed where necessary with the Participants' own risk management arrangements;
- To generally ensure the continued effectiveness of the Alliance, including by managing relationships between the Participants and between the Alliance and its stakeholders;
- To review the governance arrangements for the Alliance at least annually.

Appendix 8: WHT IT Strategy as an enabler to the transformation

Within the architecture outlined in section we have assumed that everything above level 4 has to be scalable (i.e. deployed once, on an integrated care system level, and with the opportunity for significant growth in terms of patient numbers and transactions across an integrated network of provider organisations).

What this means is that each organisation within the Walsall Together system can have a separate operational plan (run by a local IT team) for day-to-day clinical/professional/operational IT at level 4 – that interoperates with a wider group strategy in all other tiers.

This is important given that the existing makeup of the provider system has differential systems and strategies at a level 4. It also allows for operational choices to be made at Level 4 (e.g. replacing Lorenzo in the hospital or moving from Oasis to Rio in the mental health trust) without affecting the overall strategy (provided that the choices made at Level 4 are supportive of the wider strategy).

So what does this approach mean for our key user groups in the future?

1. Level 1 Patients/Public All – would have access to specific health and care related services, delivered on-line and through mobile channels (i.e. as a central web/app service). This should include:
    a. Content services – syndicated advice from services such as NHS Choices, plus group specific content designed to encourage patients/citizens to follow the optimal pathway for their care;
    b. Non personalised self-care tools, advice and service finding (e.g. where do I go for my cough);
    c. The ability for customer/citizen feedback and ratings to be embedded from the outset – giving transparency in terms of service feedback and response and creating a 'customer service' culture from the outset;
    d. Act as a gateway and referral pathway to Level 2, where patients/personalised have a personalised experience within a single joined up approach.
2. Level 2 Personalised Patients/Public – the establishment a single, registered patient facing digital service as a single platform/framework for citizens. This service must:
    a. Provide a common identity standard and consent framework for patients/citizens wishing to access health and care services on-line;
    b. Be personalised...i.e. it is about me and my health...or indeed about my carers supporting my health;
    c. Be deployed agnostic of digital devices (e.g. via smartphone apps, web browser etc.)
    d. Act as a framework through which different services and applications can be deployed over time (telehealth, appointment booking, on demand access to content, joining groups etc.);
    e. Be based on the principle of 'connected', personalised, health and care records (PHRS) where people are able to store and share their own data (with consent) within their own PHRs (note most are moving to mobile here);
    f. Enable device and app connectivity to PHRs via APIs (application program interface). Essentially this means that I can connect my Fitbit, digital scales, Bluetooth telehealth devices in to my own personal single data repository;
    g. Receive content, messages and services from Tier 3.
3. Level 3a Clinicians, Service Managers and Executives – the establishment of a unified approach and toolset to support unified service management, and care coordination across the group (population management), this should include:
    a. A very mature approach to data exchange and interoperability. Within your model this will need to handle four types of data (patient owned/held, clinically owned/held, operational capacity and

demand, communications). Level 3a therefore requires an ability to hold, and interface each of these types of data in various formats (e.g. flat file, messages, images etc..) and handle them at different frequencies (e.g. some real time, some daily, some weekly etc..). This requires an interoperability engine that is dedicated to resolving these specific challenges.

   b. A single data repository, that is separate to each of the individual clinical/professional systems at Tier 4 and enables you to build up a longitudinal view of patients across all providers and (with consent) from the patient (and carers themselves).
   c. A common user interface for service managers and clinicians (the "clinical portal) that is separate to individual clinical systems at Level 4. This enables clinicians, care coordinators and managers to manage care across settings with a single version of the truth ("population management"). Within your context this would include functionality such as patient index and spine services, remote booking and scheduling, contact centre and communications management, a view on the single clinical data repository itself, clear access to reports and management information, and the ability to deliver virtual caseload management from a single application. In itself this component of the architecture de-risks a number of the operational challenges at Level 4 and enables greater clinical efficiency and workflow management.

4. Level 3b Finance and Business Intelligence Users – the creation of a direct link to Level 3a for finance and business intelligence users as secondary users of whole pathway data to include functionality such as:
   a. Risk stratification, population identification and predicative analytics;
   b. Whole pathway commissioning/payment data including expenditure, activity tracking, and touch points across all providers etc.
   c. Planning, monitoring and budgeting;
   d. Prescribing, medicines adherence, drugs monitoring etc.
5. Level 4 Point of Care Professionals – where it is assumed that all individual providers will continue to utilise their own/current operational IT systems*. To achieve this the following will be required:
   a. Utilisation of clinical systems adapters to exchange data (where possible) with each clinical system. These are invisible to users at Level 4, but critical in delivering the overall model;
   b. An exposure of the Level 3a user interface at Level 4 (e.g. providing a view on the whole pathway within individual providers).
6. ALL – across all Level a common approach to communication which implies the need for a single, cloud based telephony solution, combined with VOIP communications, secure messaging and recording etc.
7. ALL - Deploying all of the above within a scalable architecture that can be easily deployed to new sites/services as the group grows and indeed offered on a commercial basis to other providers if required.

*This architecture will broadly enable the individual operational IT plans of the group to remain as-is at Level 4. From an operational perspective it makes logical and financial sense to consolidate operational/IT systems wherever possible at this level – but that is a secondary issue to the strategy overall. I.e. the strategy has to be right for the group overall without the need to change all the clinical systems in individual providers.

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MEETING OF THE PUBLIC TRUST BOARD – 4th JULY 2019			
Walsall Together: Programme Update			**AGENDA ITEM: 14**
Report Author and Job Title:	Graeme O' Malley Walsall Together Programme Manager	**Responsible Director:**	Daren Fradgley Interim Walsall Together Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	This paper is submitted to the members of the Trust Board to describe the programme plan contained tracking delivery of the Walsall Together business case and its overall programme aims. The Walsall Together business case (January 2019) aims to accelerate this change, bringing together colleagues from across Public Health, Primary Care, Community Services, Social Care, Mental Health & Secondary Care to deliver the shared Walsall Together vision of transformation, "*Addressing the changing needs of our population with integrated care solutions that maximise the potential of the individual person, the teams supporting them & the wider health and care system*." Partners believe this will bring the Walsall Together programme to a significant milestone in the transformation journey, with a clear plan for detailed design, implementation and continual refinement provided over the next three years supported by commissioners and partner providers. Ambitions and plans are aligned to the recently published NHS Long Term Plan and staff, partners and citizens will bring this vision into existence for the current and future generations of Walsall residents. In recognising the integral role public and patient engagement has in this transformation, Healthwatch Walsall has been commissioned to develop a 'Walsall Together User Group'. This group will contribute to the identified priorities for service redesign associated to the transformation and in the co-design and implementation of any detailed service change. This paper describes the processes underpinning delivery of the plan and the associated governance. The paper also highlights the link to the outcome framework and the partnerships intention to get data built against each workstream at an early stage. The programme plan has been built by the partners through the Walsall Together Senior Management Team and approved by the ICP Committee. Regular progress updates will be provided through that route with evolving benefit mapping as it evolves.		
Recommendation	Members of the Trust Board are asked to: Note the content of the report for information and discussion.		

Risk in the BAF or Trust Risk Register	This paper provides assurance to the board to mitigate the risks in relation to the following BAF risks: BAF004 Failure to progress the delivery of the Walsall Integrated model for health and social care.	
Resource implications	At this point, there are no new resource requirements requested within this report. A resource requirement will be built within each workstream PID which will outline required resources on a case by case basis and presented through the governance structures.	
Legal, Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper, but an impact assessment will be required for the programme as a whole and each workstream. This will be presented to the ICP Committee	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

WALSALL TOGETHER: PROGRAMME UPDATE JULY 2019

1. INTRODUCTION

The business case 'Walsall Together, Joining up your health and social care' sets out the aim to bring together colleagues from across Public Health, Primary Care, Community Services, Social Care, Mental Health and Secondary Care to deliver the shared Walsall Together vision of "…*addressing the changing needs of our population with integrated care solutions that maximise the potential of the individual person, the teams that support them and the wider health and care system."* Future plans will also include Children's Services and Public Health.

The business plan brings the Walsall Together programme to a significant milestone in the transformation journey, with a clear plan for detailed design, implementation and continual refinement provided over the next three years supported by commissioners and partner providers. The ambitions and plans are aligned to the recently published NHS Long Term Plan and bring the vision into existence for the current and future generations of Walsall residents.

In order to deliver this significant programme of transformation as outlined in the business case, the Walsall Together partners required the establishment of a robust and experienced Walsall Together Office (WTO) team that drives the programme forwards and manages stakeholder relationships through to delivery. This paper confirms this team is now established and in place and is actively driving forward the delivery objectives of the business plan.

2. PUBLIC & PATIENT ENGAGEMENT

Strong public and patient engagement is a key component of this transformation including the co-design and implementation of the detailed service change required. As such, Healthwatch Walsall has been commissioned to develop a 'Walsall Together User Group' which will contribute to the identified priorities. This User Group will work with the agreed workstreams (detailed further) in a co-productive manner to influence final service design and delivery. In addition to the User Group, Healthwatch Walsall will recruit:

- An independent Chair for the User Group;
- A Senior Engagement Lead to undertake the interface with the Walsall Together Senior Management Team (SMT), ensuring alignment with any other public engagement around Walsall Together.
- The Senior Engagement Lead will meet key stakeholders and will ensure that engagement with the public, community groups, citizens and service users and wider stakeholders is undertaken in a consistent way.

This is representative of the Walsall Together partner organisations commitment to ensuring public and patient engagement throughout the transformation cycle and that citizens are at the heart of how services are designed and delivered.

3. **GOVERNANCE, RISKS AND ISSUES**

Walsall Together governance structures, with partner organisation membership, have been established with clear decision making protocols in place (Appendix 4, Figure 3). The Senior Management Team (SMT) holds overall programme and operational responsibility for ensuring delivery, including the management of risks and issues. It meets weekly to ensure sufficient focus on the operational agenda including implementation of the programme plan – all workstreams (as highlighted in the Programme Plan) will meet in the next month. The SMT reports progress, items for escalation to the Integrated Care Partnership (ICP) Board who hold decision-making responsibility.

4. OPERATING MODEL

The vision for Walsall Together will see health and care providers working collaboratively to deliver integrated health and wellbeing services in Walsall, with citizens at the heart of how services are designed and delivered. To achieve this, a tiered operating model has been co-developed which will develop services in a population management orientated model focussing on prevention and early intervention. This model allows us to extend the scope of integrated working beyond primary, community and social care and into specialist services.

Within this model are five tiers of care which align to current local challenges, outcomes framework and Walsall's vision for the future. Each tier will offer citizens access to a range of services through a Single Point of Access (SPA). The SPA will provide health and wellbeing care access, navigation and coordination, including triage, to clinical and non-clinical services.

The current operating model will require transformation in the way services are currently accessed and delivered. Therefore, necessary enablers are needed at the relevant touch points to facilitate this including workforce, estates and technology – these enablers are required across all tiers and are integral to achieving the desired future state. As such, alongside the five tiers are two additional tiers 'Digital & Technology' and 'Enablers'. Each of the tiers is described in Appendix 1.

Programme plan

The Programme Plan (Appendix 2, Figure 1) provides a visual representation of the Operating Model. The dark blue boxes on the plan represent the tiers of care and the infrastructure to support mobilisation and overall delivery of the programme. Beneath these, the lighter blue boxes are the individual projects that will achieve operational implementation within Year 1 (2019/20). The plan considers that projects may be being delivered already across Walsall that support Health and Care integration – as these become known, these will be incorporated into the overall programme plan.

A workshop for each of the projects will be undertaken within the next 4 weeks in order to understand current state and reflect progression to future state. To ensure appropriate governance, a Project Initiation Document (PID) will be developed for each project and brought to the ICP Board for discussion and agreement. If additional resources or significant changes are required, then cases will pass through establish partner governance structures as outlined in the business case. The projects each have a recognised Senior Responsible Officer (SRO) and a SMT member responsible for leading the projects to delivery against the tiers. The WTO will be responsible for

ensuring engagement of partner members, public and patients in the delivery of the projects and milestones as set within.

Clinical pathway redesign (Amber boxes) demonstrates the clinical connectivity and cross over between care pathways and each project – these also represent the patient pathway from start to end. Supporting the governance of this, the ICP Board has approved the establishment of a Clinical Operating Model Group (COM). This will ensure clinical decision making is core to programme delivery and in ensuring clinical inputs are provided into each of the projects and any consequential pathway redesign(s). Project leads will work together to ensure coherent coordination around the COM and care pathways so as to achieve project objectives. Specifically, the COM is a significant developmental area for the transformation and will give strategic direction and oversight to the design and implementation of the following agreed priority pathways:

- Diabetes
- Respiratory
- Cardiology
- End of Life
- Mental Health Outpatients
- 0-19 Healthy Child Programme
-

These pathways have been selected based on the needs and challenges of the population and triangulated against the data that the partners hold

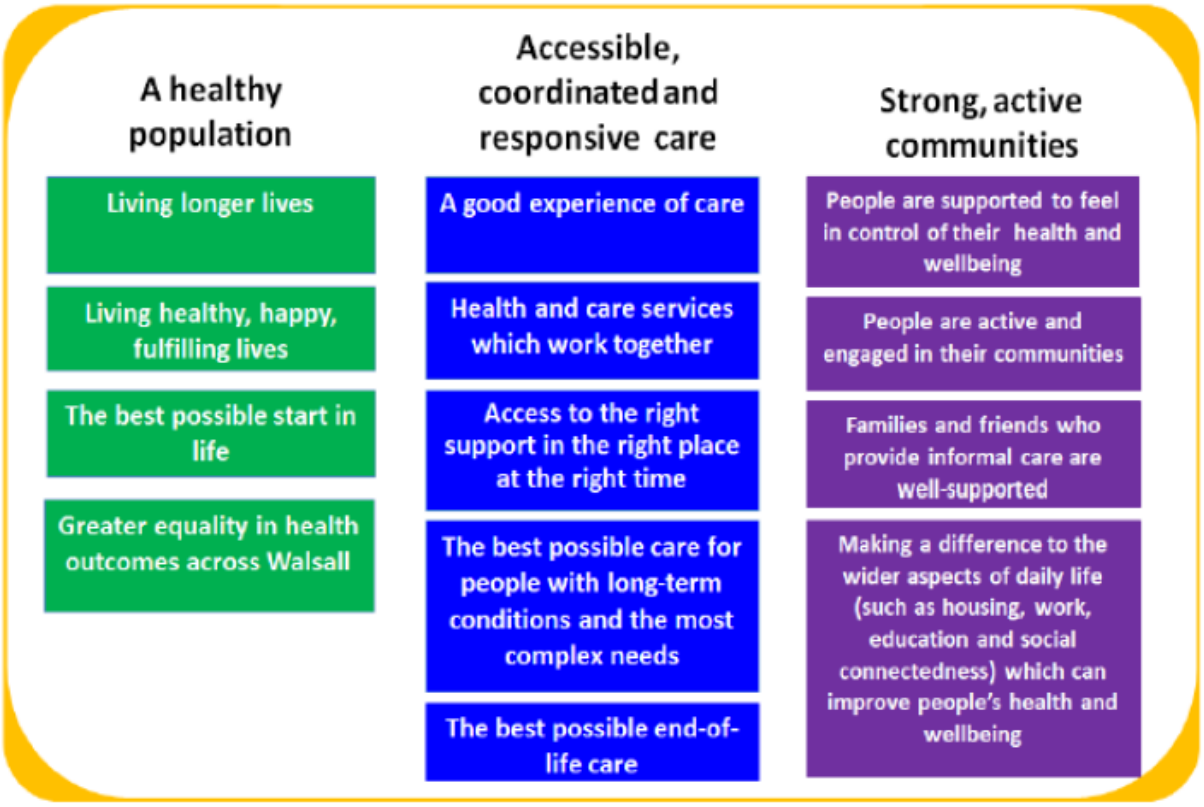
The COM Group has already commenced and ToR and scope for each pathway are being discussed. Again, each pathway will have a PID mapped to the benefits.

5. BENEFITS REALISATION

The Walsall Together programme will deliver three key aims:

- Improving health and wellbeing outcomes for the Walsall population;
- Improving care and quality standards in the provision of care;
- Meeting the statutory financial duties of all partner organisations.

The Walsall Together Outcomes Framework, developed by Walsall CCG and Walsall MBC, will support the move to more integrated delivery and once implemented across Walsall, will provide the framework and metrics against which all providers of health and care services will be measured. Expected benefits/gains realised from the programme will demonstrate alignment to this Outcomes Framework as shown below. In the interim period, operational metrics measuring the activity of the services in scope are being collated.



6. RECOMMENDATION

The Board is recommended to NOTE the content of the report for information and discussion.

Walsall Healthcare NHS
NHS Trust

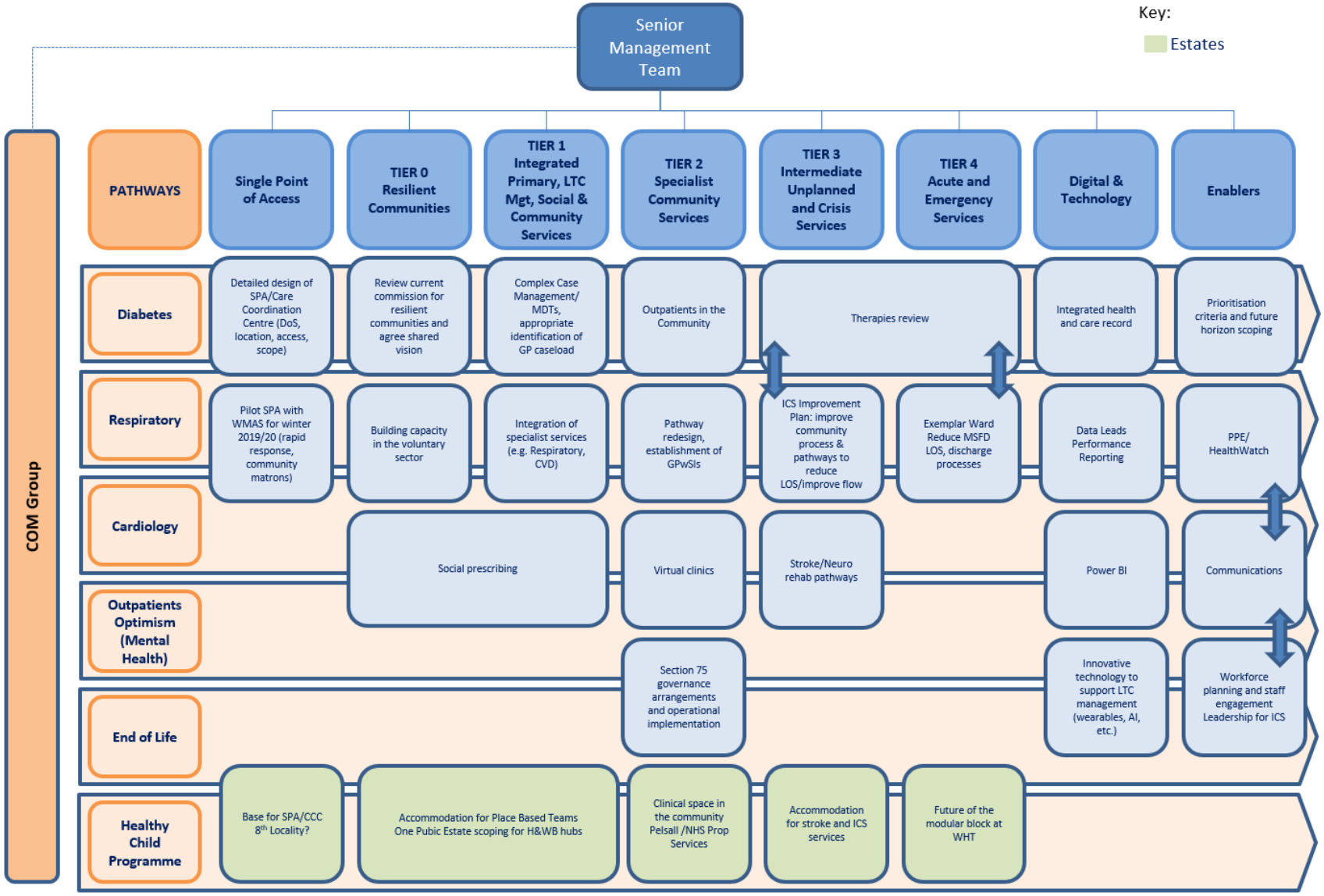
Appendix 1 – Tiers of Care

Appendix 2
Figure 1 – Programme Plan

Walsall Healthcare NHS

NHS Trust

Horizon 1 Tiers of Care

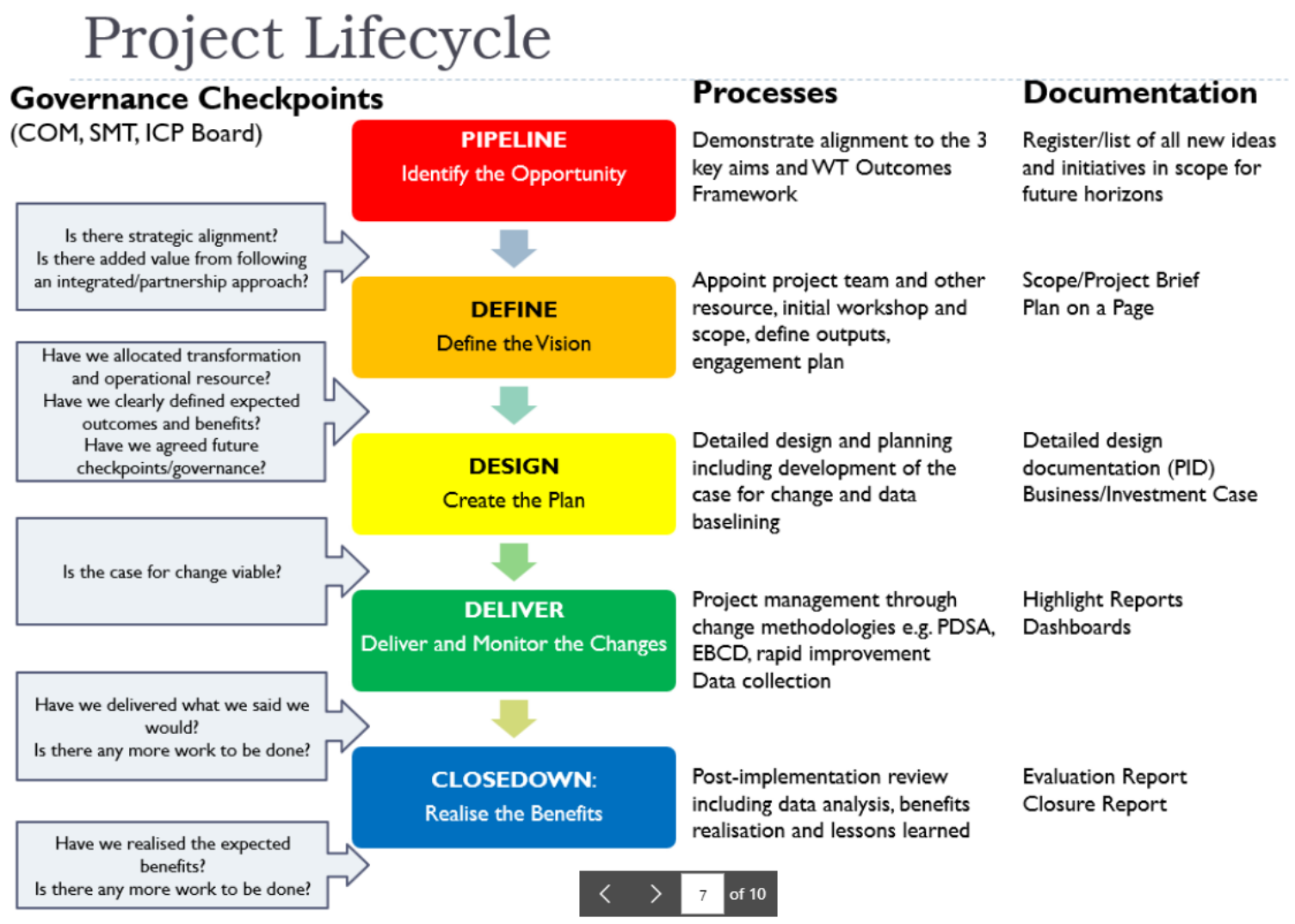


Appendix 3
Figure 2 – Workstream (Tiers of Care) Leadership

Confirmed Workstream Leadership

Single Point of Access	TIER 0 Resilient Communities	TIER 1 Integrated Primary, LTC Mgt, Social & Community Services	TIER 2 Specialist Community Services	TIER 3 Intermediate Unplanned and Crisis Services	TIER 4 Acute and Emergency Services	Digital & Technology	COM
SRO Marsha Foster	SRO Alex Boyes	SRO Daren Fradgley	SRO Mathew Lewis	SRO Meradin Peachy	SRO Ned Hobbs	SRO Daren Fradgley	SRO Paula Furnival
SMT Andy Rust	SMT Sarah Taylor & Uma Viswanathan	SMT Matthew Dodd	SMT Matthew Dodd	SMT Carl Griffiths & Kerrie Allward	SMT Matthew Dodd	SMT Kelly Geffen	SMT Tracy Simcox, Uma Viswanathan & Andy Rust
Programme Manager Graeme O'Malley	Programme Manager Graeme O'Malley	Programme Manager Jane Sillitoe	Programme Manager Jane Sillitoe	Programme Manager Michelle McManus	Programme Manager Michelle McManus	Programme Manager Frank Botfield	Programme Manager Michelle McManus

Appendix 4
Figure 3 – Project Lifecycle: Governance Checkpoints



Walsall Healthcare NHS
NHS Trust

Performance Report

June 2019

(May 2019 Results)

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

Walsall Healthcare NHS
NHS Trust

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Resources
Respect
Compassion
Professionalism
Teamwork

Walsall Healthcare NHS
NHS Trust

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: Anne Baines

Key Areas of Success

- No MSA breaches in May. However, there is a risk of MSA breaches occurring on the wards in the West Wing due to the ward layout and availability of bathroom facilities
- 1:1 care in labour was 100%
- Level 2 Safeguarding Children Training compliance target was achieved in May after being below the target for the previous 5 months

Key Areas of Concern

- The total of number of C.diff cases reported in May 2019 was 3 against a target of no more than 26 in 2019-2020
- Performance for the MCA stage 2 tracking reduced in May and remains well below the Trust target
- VTE compliance improved in May but remains below the Trust target
- Dementia screening improved in May to 63% but has not achieved the 90% target since January 2019

Key Focus for Next Committee

The committee will receive details of the agreed complaints metrics next month

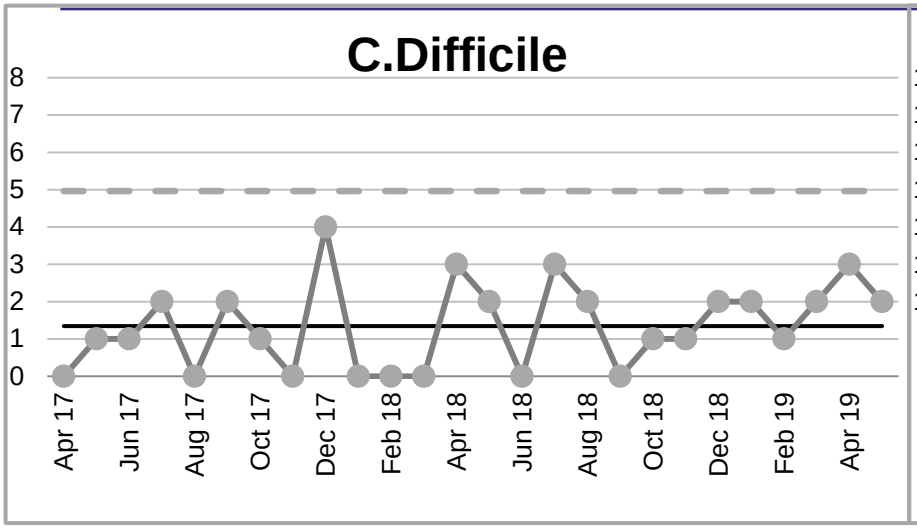
The committee wish to focus on VTE

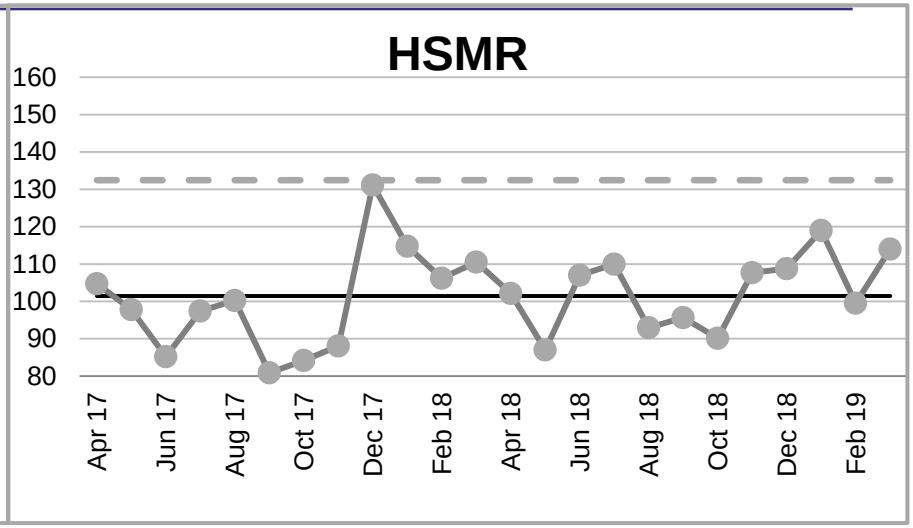
The committee will focus on dementia screening

Walsall Healthcare NHS
NHS Trust

Quality, Patient Experience and Safety Committee

SPC Key: Mean; Process limits - 3σ; High or low point; Special cause - improvement; Special cause - concern; Target; 0





Narrative (supplied by Director of Nursing)

In May 2019 there were 3 CDiff cases attributed to the Trust. The number of CDiff cases YTD is 6 against a Trust Target of 26 cases for 2019-2020. Although this was not above the threshold for May there are some concerns

The C.diff cases were on ward 9 (unavoidable), ward 15 (unavoidable) and ward 1 (unavoidable)

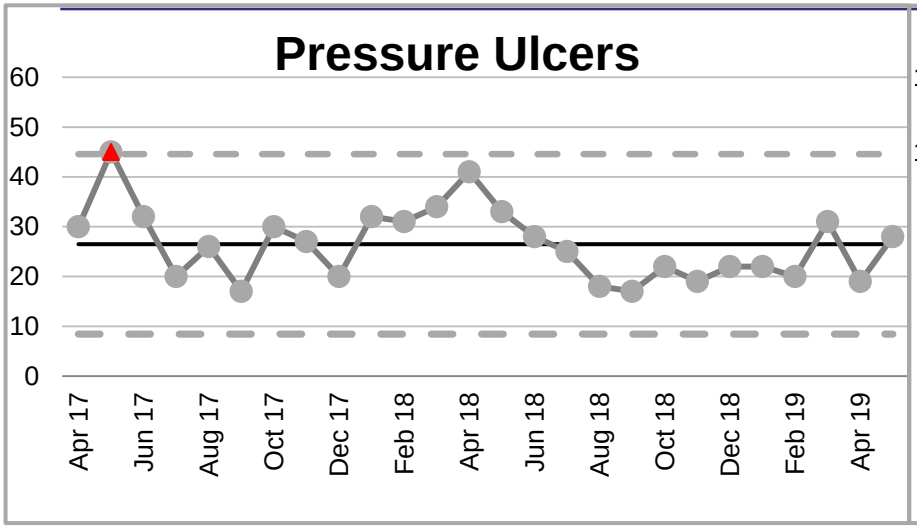
Narrative (Supplied by Medical Director

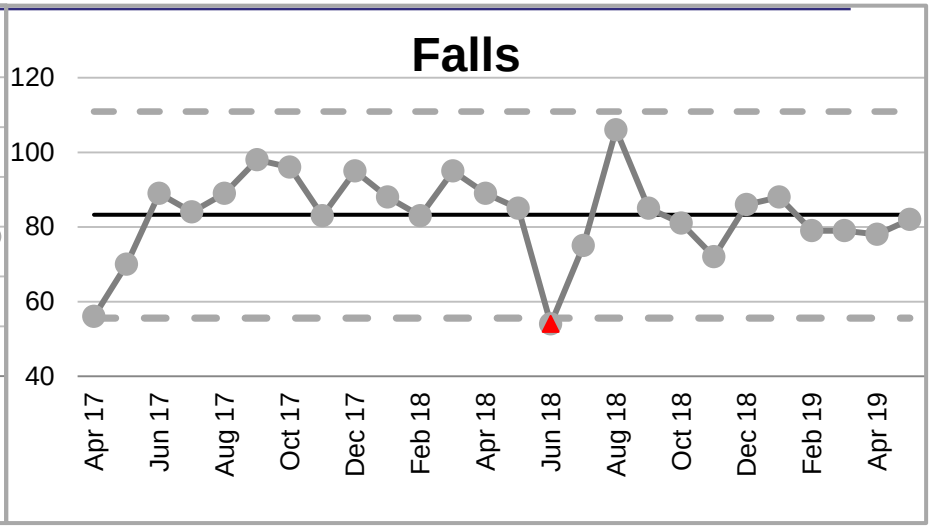
Headline metrics, including HSMR, remain close to national standards but further analysis and inquiry is required to identify full opportunities for learning.
We have recently held a number of discussions with other trusts, NHSI and the coroner to review process for Learning from Deaths. New standards have been agreed with Care Group Mortality Leads to include turnaround time for reports and templates for presentation at Mortality Surveillance Group. The Medical Examiner role will start in September 2019

Walsall Healthcare NHS
NHS Trust

Quality, Patient Experience and Safety Committee

SPC Key: Mean; Process limits - 3σ; High or low point; Special cause - improvement; Special cause - concern; Target; 0





Narrative (supplied by Director of Nursing)

There was a total of 28 acquired pressure ulcers reported for the hospital and community in May 2019, an increase from the previous month.

This increase was due to a higher incidence of category 2 pressure ulcers being reported.

Narrative (supplied by Director of Nursing)

The number of falls increased in May 2019 to 82 compared to the 79 falls reported in previous months

In May 2019 the ratio of falls per 1000 bed days increased to 5.17 from 5.08 in April 2019, this means despite having less beds open more patients fell as a ratio of bed days.

There was one fall resulting in severe harm in May

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE 2019-2020

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no..	HSMR (HED) nationally published in arrears	108.76	118.99	99.52	114.00				100.00		N
no..	SHMI (HED) nationally published in arrears	103.82							100.00		BP
no	MRSA - No. of Cases	0	0	0	0	0	0	0	0	2	N
no	Clostridium Difficile - No. of cases	2	2	1	2	3	3	6	26	19	N
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays	1.05	0.84	0.66	0.91	0.64	0.70				
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population	0.28	0.34	0.34	0.55	0.31	0.59				
no..	Falls - Rate per 1000 Beddays	5.68	5.01	5.19	4.82	5.02	5.17		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	1	1	0	0	4	1	5	0	13	BP
%..	VTE Risk Assessment	94.67%	95.00%	93.61%	91.94%	91.01%	92.02%	91.52%	95.00%	94.90%	N
no	National Never Events	15	0	0	0	0	0	0	0	17	N
no..	Midwife to Birth Ratio	1:27.7	1:31.4	1:25.2	1:28.1	1:24.2	1:26.9		1:28	1:28.1	N
%..	C-Section Rates	36.27%	30.77%	33.70%	26.33%	29.20%	27.55%	28.35%	30.00%	28.46%	BP
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	11.14%	10.53%	10.27%	11.56%	11.12%			10.00%	10.73%	L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	81.04%	80.48%	82.68%	83.65%	85.23%	85.72%	85.48%	100.00%	84.47%	N/L
%..	Compliance with MCA 2 Stage Tracking	55.56%	33.33%	46.15%	66.67%	68.97%	59.26%	62.65%	100.00%	62.44%	BP
%..	Friends and Family Test - Inpatient (% Recommended)	96.00%	96.00%	97.00%	95.00%	96.00%	96.00%		96.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	96.27%	94.39%	93.63%	93.62%	93.72%	92.69%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	90.37%	88.82%	88.73%	88.65%	89.12%	85.74%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	94.31%	93.19%	94.33%	96.27%	97.04%	96.21%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	91.44%	90.95%	91.60%	92.23%	92.67%	92.85%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	90.50%	90.42%	90.58%	89.50%	89.16%	84.75%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	96.45%	94.85%	95.20%	95.48%	95.37%	95.08%		95.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	83.78%	82.04%	82.08%	83.42%	83.38%	85.12%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	90.91%	89.08%	89.05%	90.81%	88.98%	90.37%		85.00%		L

Walsall Healthcare NHS
NHS Trust

Integration

Caring for Walsall together

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NHS Trust

Integration – Highlight Page

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

Key Areas of Success

SPA for pilot scheme for WMAS to refer urgent support to Adult Community Nursing Services has launched on Monday, 10th June. Phones triaged by B6 RRT nurse and Community Matron with a 2 hour response time. Operational time- 08.30-18.00 5 days per week. SPA pilot scheme for WMAS to refer for urgent 2 hour response to Adult Community Nursing Services has been launched on Monday, 10th June. Phones triaged by B6 RRT nurse and Community Matron. Operational time- 08.30-18.00 5 days per week. The SPA will further enhance avoidance of hospital admissions and effectively manage long term conditions in the community .

The unit continues with mixed occupancy of general medical and stroke patients. Average Occupancy rate for stroke patients is 52.8% (12) and 47.2% (11) medical patients. New stroke transfers from RWT is 6. Transfer of care process is running well. Therapy staff is supporting medical and neurological patients when capacity allows.

Key Actions Taken

Quality initiative scheme is planned from July 2019 until March 2020 . This being an integrated Health and Social care project to support the 23 Residential homes in Walsall, aiming to reduce avoidable harms and emergency admissions into hospital. This initiative will be an extension of the Winter pilot which had a focus on just 7 residential homes where there was evidence of high emergency admissions into hospital .

Key Focus

- Review the ICS model with the aim of reducing LOS in community ICS pathways, 3 key areas of focus identified that reflect the original model to be forged ahead – Role of Reablement Offices, Hospital Team to be based in Community and role of DISCOs
- Review of SPA data from day 1 - arrange a project catch up meeting to review the progress of the SPA, having substantial data to analyse / study.
- Community matron service review is underway, capacity and demand review has been completed, Adult Community Clinical Lead Dr Harlin is meeting with all community matrons to review caseloads and provide professional supervision. Review is expected to be completed by end of July with plans to merge Rapid Response into place base to have capability and capacity to respond to acutely exacerbating patients within 2 hours.
- To clarify work around the MDT coordinator post to support and build on GP led locality MDT's

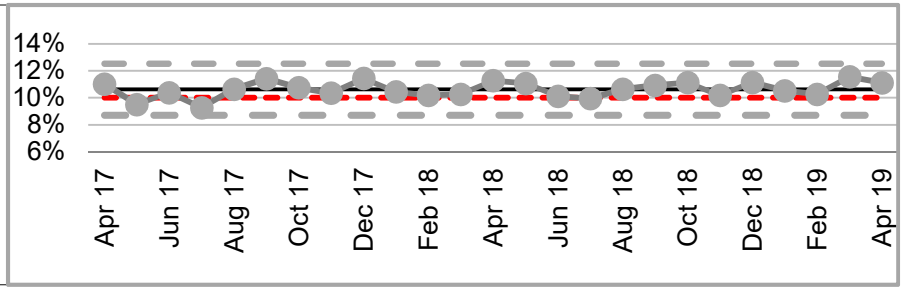
Walsall Healthcare NHS
NHS Trust

Integration

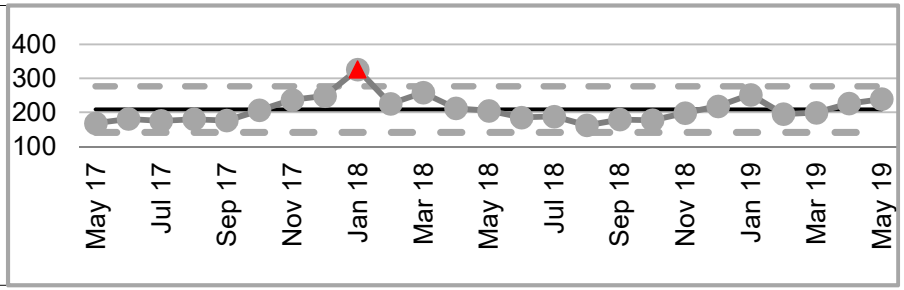
SPC Key

Mean | Process limits - 3σ | High or low point | Special cause - improvement
Special cause - concern | Target | 0

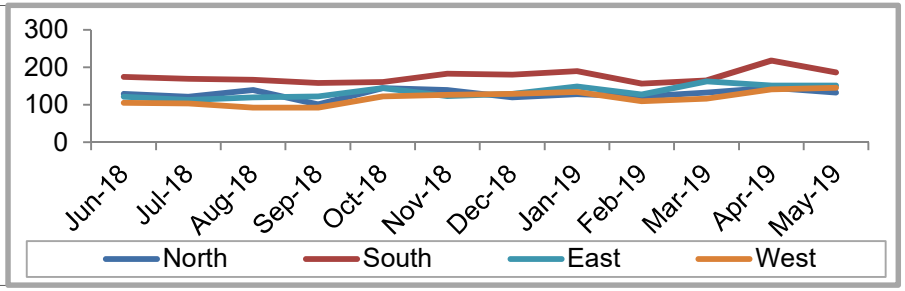
Emergency Readmissions



Rapid Response – Avoidable Att / Adm



Readmissions by Locality



Narrative (supplied by Director of Strategy & Improvement)

Service delivery improvement plans (SDIP) investment has been shared with CCG with positive outcomes, awaiting final approval.

These plans seek to effect a balance between the need to respond to specific service developments combined with a requirement to expand the staffing base of the community service to deal with increased demand.

Monthly community contract review meetings progressing from May 2019.
There has been a steady decline in admission for known high users with LTC on community caseloads.

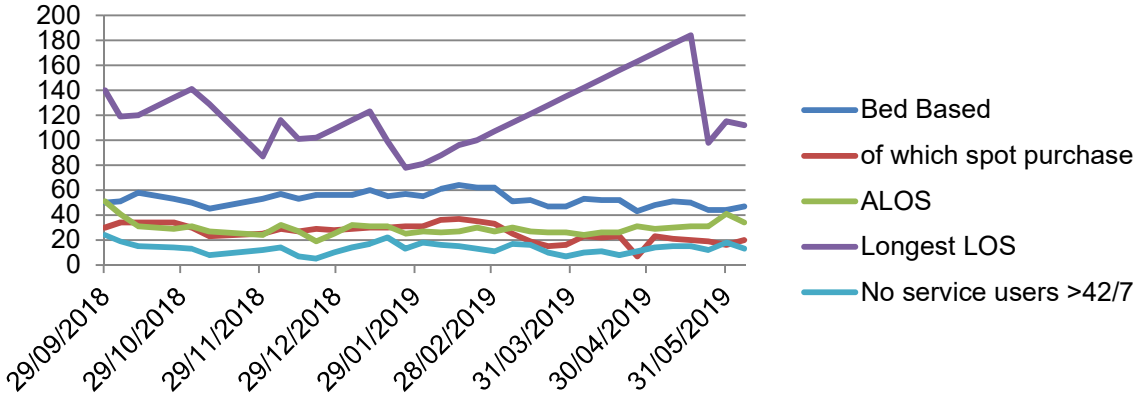
Referrals to Rapid Response during May 276, Recruitment for 1 additional post underway. 3 ACPs now in post.
Plans to increase ANP posts to 4 having 1wte ANP in each place base i.e. North, South, East and West.

Plans include:

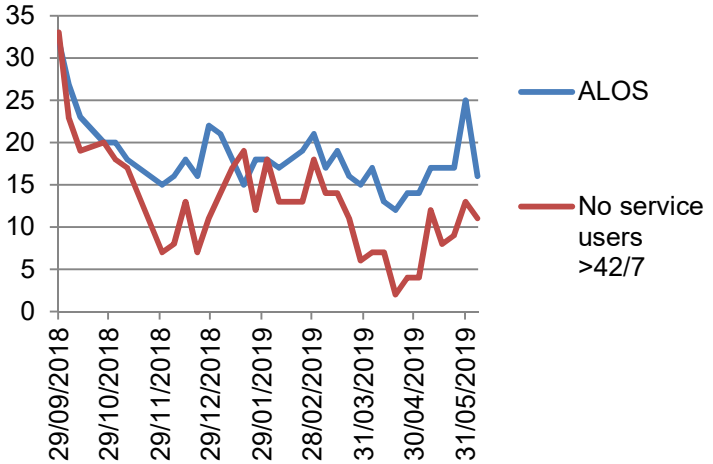
- Plans for redesign of urgent care services by enhancing integration between Rapid Response and Placed Based Care
- Approve funding and role of MDT co-ordinator

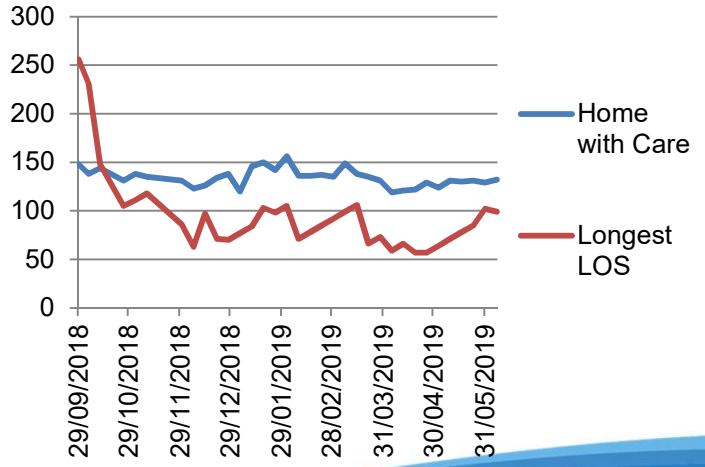
Walsall Healthcare NHS
NHS Trust

Community Pathways: Bed Based & Home with Care



- A joint review of the case mix for the block beds is to be undertaken with commissioning to ensure this is aligned to demand
- The ALOS of patients in beds is increasing despite the longest wait patient being discharged – key delays on bed-based pathways relate to patients requiring therapy assessment & intervention





- Short term team changes have adversely impacted on throughput for home with care – this is being reviewed by the team leader

Walsall Healthcare NHS
NHS Trust

INTEGRATION
2019-2020

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	11.14%	10.53%	10.27%	11.56%	11.12%		11.12%	10.00%	10.73%	L
no	Rapid Response Team - Total Referrals	248	292	228	221	273	276				L
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission	218	252	195	199	226	239				L
%	Rapid Response Team - % of patients referred requiring a 2 hour response who are subsequently seen within 2 hours	58.25%	53.02%	46.62%	91.04%	71.08%	66.28%				L
%	Histopathology - % of Diagnostic Biopsies reported within 7 days of sample received	60.00%	56.00%	62.00%	64.00%	44.00%	45.00%		90.00%		L
%	Histopathology - % of Histopathology test reported within 10 days of sample received	43.00%	51.00%	42.00%	50.00%	19.00%	25.00%		90.00%		L
%	Histopathology - % of Gynae tests reported within 10 days of sample received	68.00%	88.00%	90.00%	85.00%	35.00%	53.00%		90.00%		L
no	Histopathology - Backlog			466	930	709	141				L
	CARE AT HOME										
%..	ED Reattenders within 7 days	8.01%	7.71%	7.31%	7.13%	7.18%	7.79%	7.50%	7.00%	7.43%	BP
	RESOURCES										
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only	37	38	42	41	24	31				L
no	Average Number of Medically Fit Patients - Trust	42	39	36	38	41	29				L
	PARTNERS										
Rate	Occupied Beddays per Locality - Rate per 1000 GP Population (GP Caseload)	34.80	42.20	34.99	37.49	37.88	36.26				L
no	Nursing Contacts per Locality - Total	17854	18487	16944	18784	18619	19182	37801		205571	L
Rate	Emergency Readmissions per Locality - Rate per 1000 GP Population (GP Caseload)	1.84	1.99	1.70	1.90	2.16	2.03				L
no	No. of patients on stroke pathway in partnership with Wolverhampton (one month in arrears)	4	13	10	10	3					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. Proactive engagement with Manual Handling colleagues has resulted in reduced MSK injuries.
2. Appraisal compliance has improved during May-19, achieved via a number of methodologies, such as working with Team Leads, chasing individuals and partnership working with ESR.
3. New starters to the trust complete several mandatory training elements before attending Trust Induction, meaning they are compliant before starting in their departments. Inter Authority Transfers (IAT) are completed where possible, to enable new starters to carry over any compliant training from other Trusts.

Key Areas of Concern

1. Retention – Retention is lowest within the MLTC & WCCSS divisions, with the retention of support to clinical colleagues a concern within the former, and retaining Allied Health Professionals an issue within the latter.
2. Sickness Absence – Despite recent improvements; the committee was keen to earmark this a moment to learning from pockets of excellence within the Trust, and ensure that the engagement of service with support function is proliferated amongst areas where absence levels are rising.
3. Mandatory Training - The only core mandatory competence to show a decline is Clinical Update, with a number of extra training sessions now made available to address the capacity vs. demand issues identified.
4. Appraisals - There has been a notable deterioration in compliance amongst Admin & Clerical colleagues, falling to 75% trust wide during May-19.

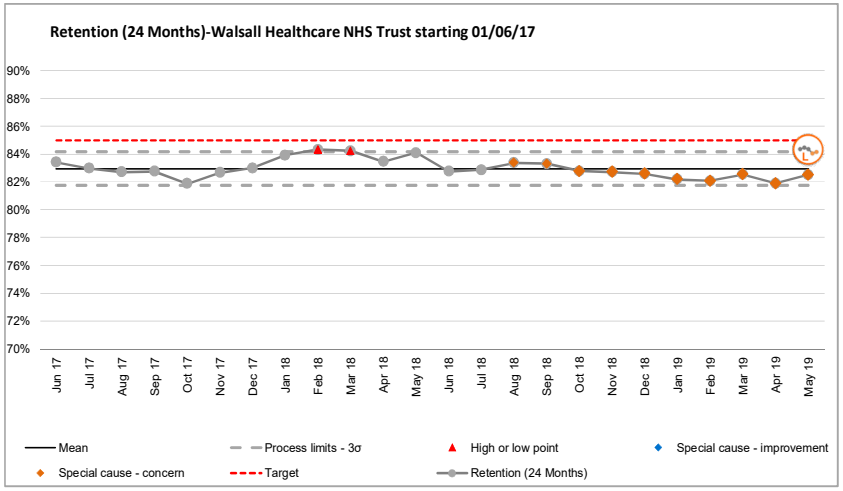
Key Actions Taken

1. A detailed review of retention and turnover trends has begun to identify specific areas of concern within the organisation, and this evidence will be used to develop targeted interventions at both the staff group and divisional level.
2. The Trust is in the final stages of agreeing to a revised Attendance policy. The policy adopts an approach of supporting staff health & wellbeing at an earlier stage.
3. The Trust is investing in a Fast Track physio service available from June 2019.
4. The Trust is progressing an Employee Assistance Program (EAP).
5. The Learning & Development team continue to implement processes which encourage training compliance throughout the employee life cycle.
6. 95 Clinical Update sessions are available over the next 12 months, providing services with more flexibility when releasing colleagues for training.
7. The appraisal paperwork has been redesigned and reflects the new Trust Values & Behavioral Framework. A launch for the new paperwork will take place late October following ratification.

Key Focus for Next Committee

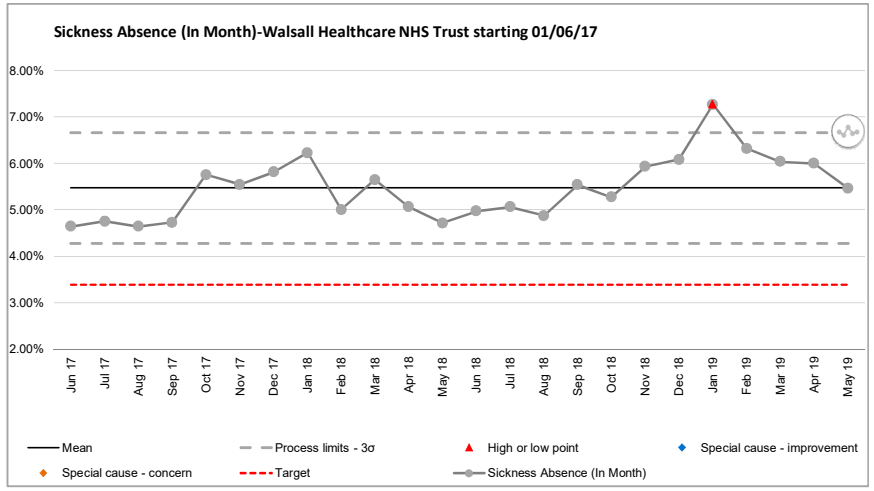
1. A review of workforce metrics by staff group.
2. Exit Interview Process – Improvement Progress Update. (Deferred)
3. Draft WRES & WDES submissions. (Deferred)

People and Organisation Development Committee



Retention is lowest within the MLTC & WCCSS divisions, with the retention of support to clinical colleagues a concern within the former, and retaining Allied Health Professionals an issue within the latter. Recent fluctuations in the retention outturn are connected to the fortunes of these divisions, with Trust wide improvement during May-19 a reflection of upturns within these two areas.

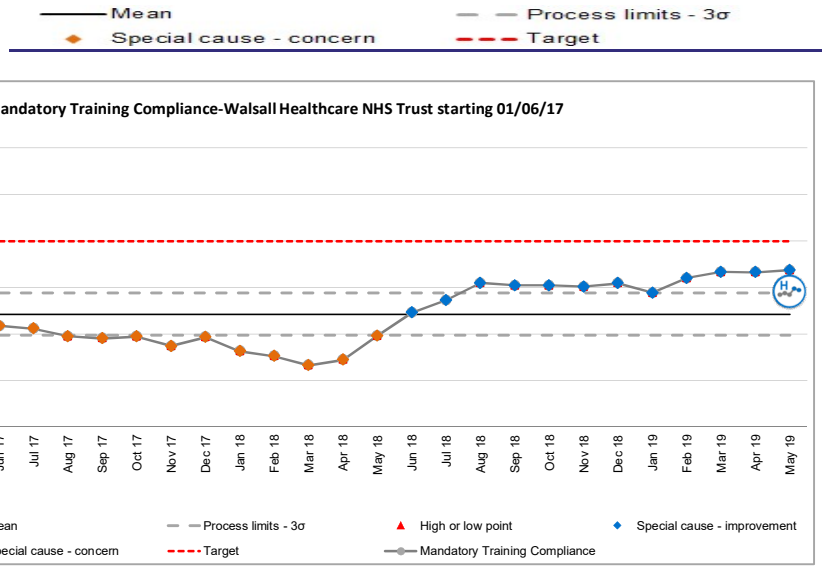
Nursing and Midwifery retention is greatest within the Community and DoS divisions, a trend replicated amongst Medical and Dental colleagues, whereby retention is lowest within the WCCSS division and highest with DoS.

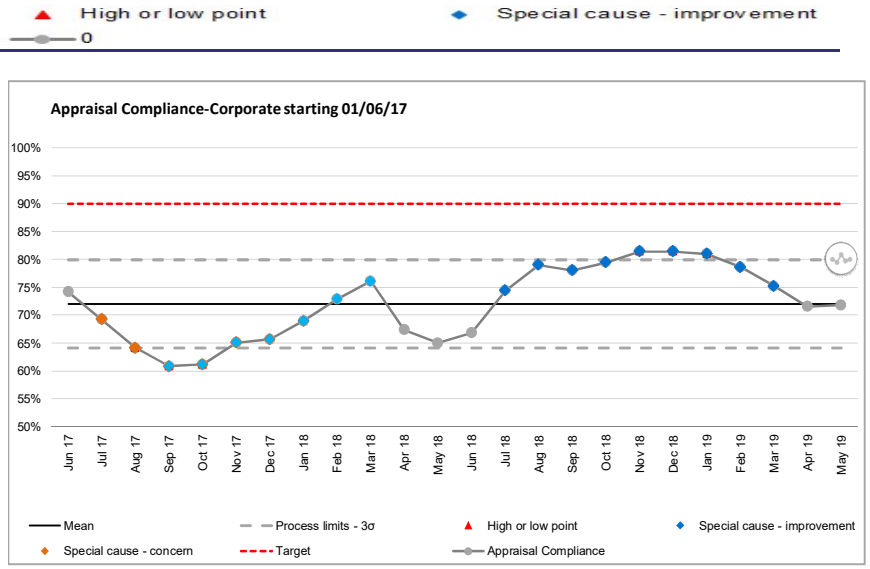


Sickness absence (In Month) has continued to fall, for the fourth month in succession, reflecting a 2% reduction since a high-point during Jan-19.

There has been a sustained decline in the number of colleagues absent due to musculoskeletal and back-related problems; an improvement which correlates to increased engagement with the Manual Handling team, which in turn has led to increased colleague referrals to Occupational Health and reduced Therapies referrals.
The MLTC division remains a concern, with rising sickness levels within this area not mirroring the trust-wide trend. There has been an increase in long-term absence within this division, particularly where episodes due to MSK-related illnesses are concerned. Engagement with the Manual Handling team is advised.

People and Organisation Development Committee





Mandatory Training improvement trends have been sustained, with the 87% outturn maintaining a 24-month compliance high point.

The following competencies have improved by between 14% and 19% since the Mar-18 compliance low point;

- Corporate Update
- Fire Safety
- Information Governance
- Safeguarding Children Level 3

The only core mandatory competence to show a decline during this period is Clinical Update, with 95 training sessions made available over the next 12 months to address this slide.

Since autumn 17/18 low points; Appraisal compliance has improved by 6%, with the May-19 outturn representing a return to a positive trajectory, following a few months of decline.

Compliance within the Community, E&F & WCCSS division did not mirror the Trust decline, with 88%+ consistently achieved with these areas. Amongst other divisions, compliance has fallen by up to 10% since Dec-18.

There has been a notable deterioration in compliance amongst Admin & Clerical colleagues, falling to 75% trust wide during May-19. Within the clinical workforce, appraisal compliance is highest amongst Allied Health Professionals & Nursing colleagues.

Walsall Healthcare NHS
NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 2019-2020

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	% of RN staffing Vacancies	7.95%	8.14%	8.11%	8.44%	9.65%	10.74%				BP
%..	Mandatory Training Compliance	85.45%	84.42%	86.01%	86.67%	86.62%	86.84%		90.00%	86.67%	L
%..	PREVENT Training - Level 1 & 2 Compliance	96.27%	94.39%	93.63%	93.62%	93.72%	92.69%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	90.37%	88.82%	88.73%	88.65%	89.12%	85.74%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	94.31%	93.19%	94.33%	96.27%	97.04%	96.21%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	91.44%	90.95%	91.60%	92.23%	92.67%	92.85%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	90.50%	90.42%	90.58%	89.50%	89.16%	84.75%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	96.45%	94.85%	95.20%	95.48%	95.37%	95.08%		95.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	83.78%	82.04%	82.08%	83.42%	83.38%	85.12%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	90.91%	89.08%	89.05%	90.81%	88.98%	90.37%		85.00%		L
	VALUE COLLEAGUES										
%..	Sickness Absence	6.09%	7.27%	6.32%	6.04%	6.00%	5.47%		3.39%	6.04%	L
%..	PDRs	88.06%	86.96%	86.71%	83.66%	80.67%	81.60%		90.00%	83.66%	L
	RESOURCES										
%..	Bank & Locum expenditure as % of Paybill	8.50%	9.81%	9.29%	9.12%	6.84%	7.26%		6.30%	9.14%	L
%..	Agency expenditure as % of Paybill	5.28%	5.81%	5.23%	4.46%	4.17%	4.83%		2.75%	4.90%	L
no	Staff in post (Budgeted Establishment FTE)	3981	3978	3981	3981	3994	4028				L
%..	Turnover (Normalised)	11.29%	11.54%	11.55%	11.58%	11.65%	11.92%		10.00%		

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.

- Trust has attained plan at a £2.1m deficit at month 2, though has an operational deficit of £1m YTD that requires recovery later in the financial year
- Cost Improvement Programme delivery remains on plan (though is not attaining the stretch targets)

Key Areas of Concern

- The Emergency Department (ED) has been unable to attain the constitutional standard for the past 12 months and has seen attendances increasing in the Trust and surrounding providers in recent months.
- The Trust has historically delivered strong performance on Cancer standards, though an increase in referrals seen by Walsall and neighbouring Trusts for Breast is placing continued attainment of the two week cancer wait at risk
- The Trust has attained a £1m operational deficit to plan, though following a reserve adjustment of £1m has delivered the planned deficit of £2.1m for month 2. The Trust will need to mitigate the £1m adverse operational deficit through continued focus being placed upon improvements within medically stable, closure of additional capacity, focus on reductions in sickness and overall reducing temporary workforce, alongside grip and control measures and a focus placed within supporting the Medical and Long Terms Conditions (MLTC) Division to control cost overruns.
- The financial plan indicated a run rate risk of £0.5m per month (approximately £6m per annum) and mitigation of this risk is key to attainment of the financial plan

Key Actions Taken

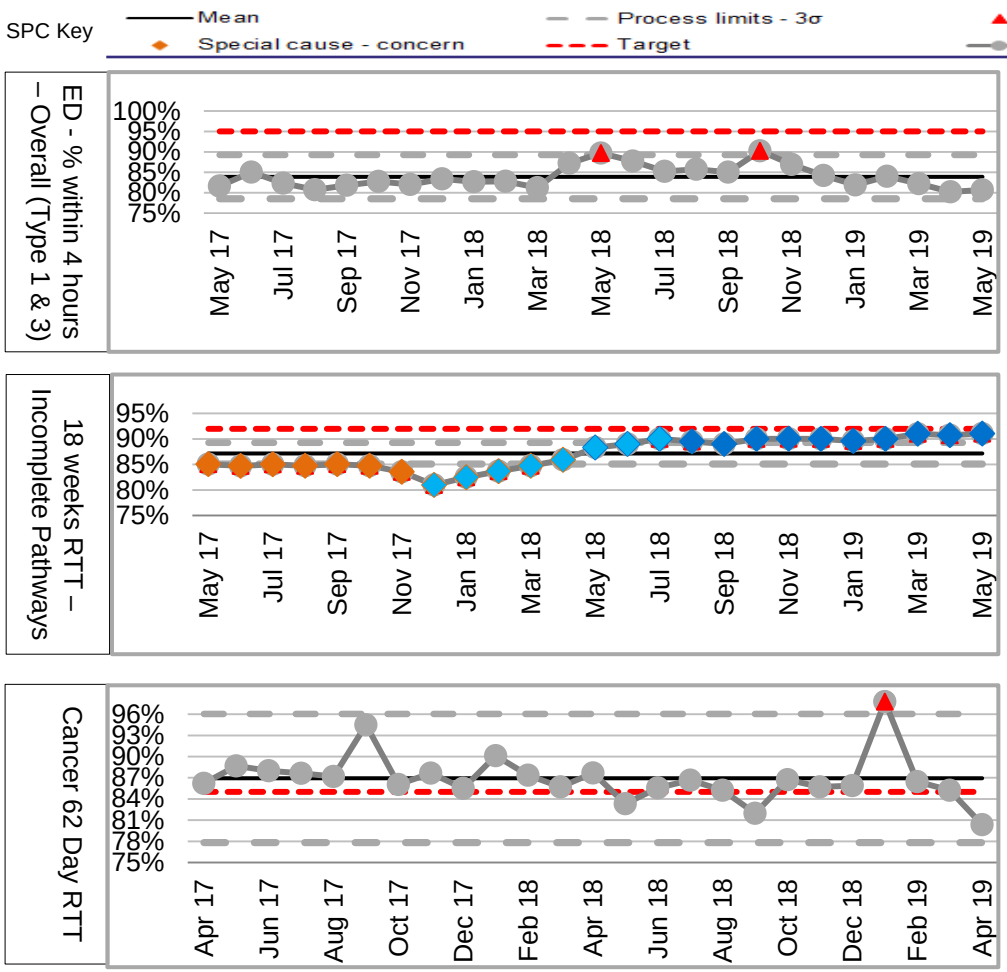
- SAFER deployed within the Trust to support enhanced ED performance, FES re-organised to reduce elderly admissions
- Implementation of the Executive led measures to improve run rate (endorsed at Extra-ordinary Trust Board) with further reviews on-going to assure full mitigation of the £0.5m monthly run rate risk (improved patient flow, reduction in medically stable/stranded patient, improved sickness absence management examples)
- Escalation of financial performance at Divisional Performance Reviews, to ensure attainment of productivity (theatres/outpatients) and Obstetric activity and financial recovery plans of the MLTC Division
- The Trust Board forming the Financial Cabinet to endorse Executive recommendations for run rate improvements to mitigate this financial risk to the 2019/20 financial plan, performance to be monitored through PFIC and a forecast produced for quarter 1 to indicate risk to delivery of the financial plan

Key Focus for Next Committee

- Continued focus on performance against constitutional standards, Cancer and ED 4 hour performance a focus
- Review of the forecast deficit and normalised position, key to attainment of the financial plan for 2019/20 being as follows;
- The newly formed Financial Cabinet (Chair and Chairs of sub-committees of the Board, Director of Finance, Deputy Chief Executive and Chief Executive) to continue to review all measures available to control costs and mitigate run rate risks during 2019/20
- The outputs from the bi-weekly performance reviews to assess KPI's on attainment of performance
- PFIC to monitor implementation of the run rate improvements
- Board Development session arranged to review Medically Fit for Discharge

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee



Narrative (supplied by interim Chief Operating Officer)

Emergency/Urgent Care

Whilst there was a slight improvement to performance in May compared to April, the organisation continued to fail to meet the constitutional standard for 4 hour waits in ED both nationally and against trajectory. The ability to reduce the number of 4 hour breaches for the organisation has continued to be challenged as the average number of patients attending ED continues to remain higher than over the winter period. Whilst attendances were high in ED, there was an improvement seen against April 19 with Time to Triage and Time To Be Seen. Across the Hospital and Community, challenges have remained during May with closures of beds due to Norovirus.

Elective Access

The Trust has achieved 91.04% incomplete performance in May 19.
Long waiters continue to reduce in month 1 and 2, with no 52 week breaches

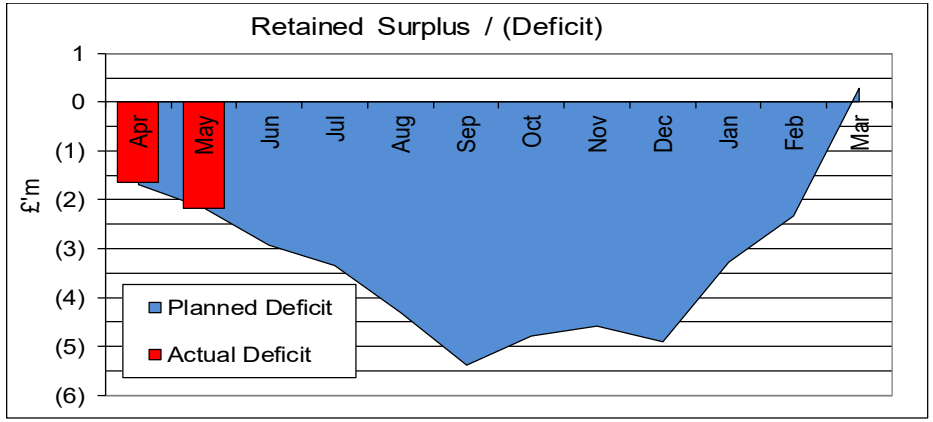
Cancer

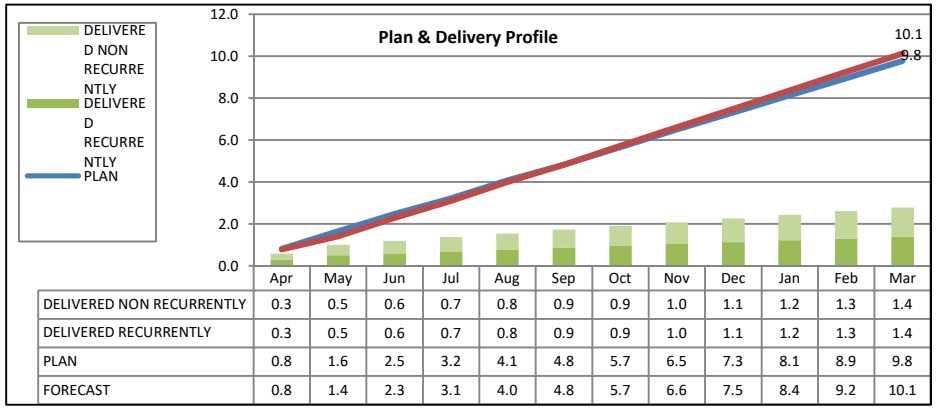
All national cancer measures achieved in April 2019 with the exception of:

- 2 week GP referral to 1st outpatient appointment,
- 2 week GP referral to 1st outpatient appointment - breast symptoms
- Cancer - 62 day referral to treatment all cancers.
- Cancer - 62 day referral to treatment from consultant upgrade.

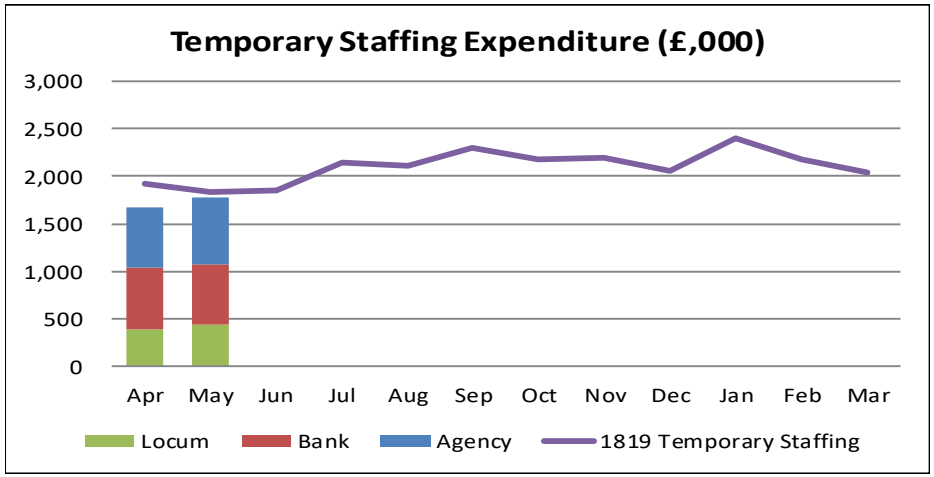
The Trust failed to achieve the 2WW GP and Breast Symptomatic constitutional measures. A remedial action plan has been developed at the request of Walsall CCG with a trajectory to recover the 2WW GP by May 2019 and Breast Symptomatic by July 2019. Diagnostic waiting times, reporting times and histopathology remain a challenge.

Financial Performance to May 2019 (Month 2)





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.3	0.5	0.6	0.7	0.8	0.9	0.9	1.0	1.1	1.2	1.3	1.4
DELIVERED RECURRENTLY	0.3	0.5	0.6	0.7	0.8	0.9	0.9	1.0	1.1	1.2	1.3	1.4
PLAN	0.8	1.6	2.5	3.2	4.1	4.8	5.7	6.5	7.3	8.1	8.9	9.8
FORECAST	0.8	1.4	2.3	3.1	4.0	4.8	5.7	6.6	7.5	8.4	9.2	10.1



Financial Performance

- Trust has an operational deficit of £1m, though has attained plan following a movement in reserves.
- Overspending on pay is reflective of the cost overruns within MLTC (sickness and servicing of additional capacity)
- MLTC has been escalated for financial performance off plan as part of the Trust's Accountability Framework following the Divisional Review
- The Executive have endorsed improved run rate measures (endorsed at Extra-ordinary Trust Board) to mitigate run rate risks and further reviews are ongoing to assure full mitigation of the £0.5m monthly run rate risk
- Income is below plan, largely as a consequence of reduced births in April/May (approximately 290 in month)
- The profile for Provider Sustainability Funds (PSF) and Financial Recovery Fund (FRF) are heavily weighted into the second half of the financial year (£6m April to September 2019 and £11m October to March 2020). This is the main driver of the profile denoted within the report

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding is £1.1m.
- Failure to deliver mitigating actions will result in increased spending, as such will place additional pressure on management of cash flow.

Capital

- The year to date capital expenditure is £1.2m, with the main spends relating to Estates Lifecycle (£0.2m) and Maternity (£1m).
- The national availability of capital is placing pressures on maintaining the estate

Financial Performance - Period ended 31st May 2019

Description	Annual Budget	Budget to Date	Actual to Date		Variance
	£'000	£'000	£'000		£'000
Income					
CCGs	210,799	35,184	34,947		(237)
NHS England	18,390	3,157	3,228		70
Local Authorities	8,593	1,433	1,436		3
DoH and Social Care	18,380	1,930	1,930		0
NHS Trusts/FTs	1,008	166	174		8
Non NHS Clinical Revenue (RTA Etc)	960	177	176		(0)
Education and Training Income	6,869	1,159	1,140		(19)
Other Operating Income (Incl Non Rec)	7,548	1,329	1,490		161
Total Income	**272,546**	**44,536**	**44,522**		**(14)**
Expenditure					
Employee Benefits Expense	(179,110)	(29,577)	(29,900)		(323)
Drug Expense	(7,347)	(3,102)	(3,151)		(49)
Clinical Supplies	(15,172)	(2,840)	(2,973)		(134)
Non Clinical Supplies	(17,099)	(3,015)	(3,028)		(13)
PFI Operating Expenses	(5,444)	(907)	(921)		(14)
Other Operating Expense	(31,479)	(4,451)	(3,940)		512
Sub - Total Operating Expenses	**(255,650)**	**(43,892)**	**(43,914)**		**(21)**
Earnings before Interest & Depreciation	**16,896**	**643**	**608**		**(35)**
Interest expense on Working Capital	51	9	14		6
Interest Expense on Loans and leases	(10,387)	(1,731)	(1,783)		(52)
Depreciation and Amortisation	(6,560)	(1,093)	(1,008)		85
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(16,896)**	**(2,815)**	**(2,777)**		**39**
Total Expenses	**(272,546)**	**(46,708)**	**(46,690)**		**17**
RETAINED SURPLUS/(DEFICIT)	**0**	**(2,172)**	**(2,169)**		**3**

Use of Resources Ratings (M2)

Finance and use of resources rating	03AUDITPY	03PLANYTD	03ACTYTD	03PLANCY	03FOTCY
i	Audited PY 31/03/2019 Year ending Number	Plan 31/05/2019 YTD Number	Actual 31/05/2019 YTD Number	Plan 31/03/2020 Year ending Number	Forecast 31/03/2020 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	2	2
I&E margin: distance from financial plan	4		1		1
Agency rating	3	1	2	1	1

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending May 2019	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	(400)
Depreciation and Amortisation	1,008
Donated Assets Received credited to revenue but non-cash	0
(Increase)/Decrease in Trade and Other Receivables	(1,541)
Increase/(Decrease) in Trade and Other Payables	(1,370)
Increase/(Decrease) in Stock	23
Interest Paid	(1,783)
Net Cash Inflow/(Outflow) from Operating Activities	**(4,063)**
Cash Flows from Investing Activities	
Interest received	**14**
(Payments) for Property, Plant and Equipment	**(1,741)**
Net Cash Inflow/(Outflow)from Investing Activities	**(1,727)**
Net Cash Inflow/(Outflow) before Financing	**(5,790)**
Cash Flows from Financing Activities	2,687
Net Increase/(Decrease) in Cash	**(3,103)**
Cash at the Beginning of the Year 2018/19	4,186
Cash at the End of the May	**1,083**

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending May 2019	Balance as at 31/03/19	Balance as at 31/05/19	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Total Non-Current Assets	**141,208**	**141,461**	**253**
Current Assets			
Receivables & pre-payments less than one Year	16,532	17,987	1,455
Cash (Citi and Other)	4,186	1,083	(3,103)
Inventories	2,362	2,340	(22)
Total Current Assets	**23,080**	**21,410**	**(1,670)**
Current Liabilities			
NHS & Trade Payables less than one year	(29,461)	(27,646)	1,815
Other Liabilities	(1,445)	(1,477)	(32)
Borrowings less than one year	(15,590)	(15,043)	547
Provisions less than one year	(117)	(117)	-
Total Current Liabilities	**(46,613)**	**(44,283)**	**2,330**
Net Current Assets less Liabilities	**(23,533)**	**(22,873)**	**660**
Non-current liabilities			
Borrowings greater than one year	(202,939)	(206,021)	(3,082)
Total Assets less Total Liabilities	**(85,264)**	**(87,433)**	**(2,169)**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	64,190	64,190	-
Revaluation	15,925	15,925	-
Income and Expenditure	(165,379)	(165,379)	-
In Year Income & Expenditure	-	(2,169)	(2,169)
Total TAXPAYERS' EQUITY	**(85,264)**	**(87,433)**	**(2,169)**

Walsall Healthcare NHS
NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2019-2020

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)	84.20%	81.88%	84.02%	82.21%	80.22%	80.68%	80.44%	95.00%	85.90%	N
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	69.72%	62.00%	64.71%	65.43%	62.49%	66.92%	64.67%	100.00%	72.20%	BP
no	Ambulance Handover - No. of Handovers completed over 60mins	11	38	44	22	35	16	51	0	155	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	96.04%	89.96%	92.67%	87.38%	82.46%	94.54%	89.17%	93.00%	93.59%	N
%..	Cancer - 62 day referral to treatment of all cancers	97.78%	86.46%	85.23%	80.37%	80.90%	77.17%	79.01%	85.00%	85.35%	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	90.01%	89.60%	90.01%	91.02%	90.72%	91.04%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	0	0	0	0	0	0	0	0	1	N
0	% of Service Users waiting 6 weeks or more from Referral for a Diagnostic Test	0.15%	0.31%	0.31%	0.12%	3.15%	6.50%	4.85%	1.00%	0.32%	N
no	No. of Open Contract Performance Notices	8	8	8	9	10	11	11	0	9	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	8.01%	7.71%	7.31%	7.13%	7.18%	7.79%	7.50%	7.00%	7.43%	BP
	RESOURCES										
%..	Outpatient DNA Rate (Hospital and Community)	11.35%	10.61%	9.87%	9.94%	10.63%	10.35%	10.49%	8.00%	10.44%	L
%..	Theatre Utilisation - Touch Time Utilisation (%)	85.24%	78.74%	80.05%	92.73%	89.54%	86.70%		75.00%		L
%..	Delayed transfers of care (one month in arrears)	3.04%	2.51%	2.85%	2.86%	3.51%			2.50%	3.46%	L
no	Average Number of Medically Fit Patients (Mon&Thurs)		95	93	99	86	72				
no	Average LoS for Medically Fit Patients (from point they become Medically Fit) (Mon&Thurs)		11	10	11	12	10				
£	Surplus or Deficit (year to date) (000's)	-£22,610	-£23,953	-£27,159	-£27,669	£45	£3	£3		-£27,669	L
£	Variance from plan (year to date) (000's)	-£8,987	-£11,199	-£14,393	-£17,038	£45	£3	£3		-£17,038	L
£	CIP Plan (YTD) (000s)	£9,000	£10,500	£12,000	£15,500	£900	£1,600	£1,600		£15,500	L
£	CIP Delivery (YTD) (000s)	£7,200	£8,300	£9,500	£11,100	£800	£1,400	£1,400		£11,100	L
£	Temporary Workforce Plan (YTD) (000s)	£14,400	£16,100	£17,700	£19,400	£1,300	£2,700	£2,700		£19,400	L
£	Temporary Workforce Delivery (YTD) (000s)	£18,500	£20,900	£23,100	£25,200	£1,700	£3,500	£3,500		£25,200	L
£	Capital Spend Plan (YTD) (000s)	£7,600	£8,600	£7,300	£12,200	£500	£800	£800		£12,200	L
£	Capital Spend Delivery (YTD) (000s)	£9,400	£10,800	£11,700	£13,100	£700	£1,200	£1,200		£13,100	L

Walsall Healthcare NHS
NHS Trust

Glossary

Glossary

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

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

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

HALO – Hospital Ambulance Liaison Officer

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

Glossary

M cont
MST – Medicines Safety Thermometer
MUST – Malnutrition Universal Screening Tool
N
NAIF – National Audit of Inpatient Falls
NCEPOD – National Confidential Enquiry into Patient Outcome and Death
NHS – National Health Service
NHSE – NHS England
NHSI – NHS Improvement
NHSIP – NHS Improvement Plan
NOF – Neck of Femur
NPSAS – National Patient Safety Alerting System
NTDA/TDA – National Trust Development Authority
O
OD – Organisational Development
OH – Occupational Health
ORMIS – Operating Room Management Information System
P
PE – Patient Experience
PEG – Patient Experience Group
PFIC – Performance, Finance & Investment Committee
PICO – Problem, Intervention, Comparative Treatment, Outcome
PTL – Patient Tracking List
PU – Pressure Ulcers
R
RAP – Remedial Action Plan
RATT – Rapid Assessment Treatment Team
RCA – Root Cause Analysis
RCN – Royal College of Nursing
RCP – Royal College of Physicians
RMC – Risk Management Committee
RTT – Referral to Treatment
RWT – The Royal Wolverhampton NHS Trust
S
SAFER – Senior review - All patients will have an expected discharge date - Flow of patients - Early discharge – Review
SAU – Surgical Assessment Unit
SDS – Swift Discharge Suite
SHMI – Summary Hospital Mortality Indicator
SINAP – Stroke Improvement National Audit Programme
SNAG – Senior Nurse Advisory Group
SRG – Strategic Resilience Group

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

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

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

MEETING OF THE PUBLIC TRUST BOARD - 4th July 2019			
The review of the winter plan for 18/19			**AGENDA ITEM: 16**
Report Author and Job Title:	Ned Hobbs, Chief Operating Officer Ian Billington, Head of EPRR Dan Hodgkiss, MLTC Governance Adam Townsend, A&E Delivery Board	**Responsible Director:**	Ned Hobbs Chief Operating Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	The Trust has reviewed the management of safe, timely emergency care over Winter 2018/19. During iterations of the review it has been presented to People & Organisational Development Committee, Quality, Patient Experience & Safety Committee and the A&E Operational Group during May 2019. The review encompasses an assessment of the performance, quality and financial impact of how Winter 2018/19 was managed. The review has been assessed and finalised by the Trust's new Chief Operating Officer in preparation for Trust Board. **Quality** Evidence from the following metrics suggests that during Winter 2018/19 the Trust improved safety, and reduced harm • Mortality rates • Incidents • Serious Incidents • Clinical Observations • Falls • Pressure Ulcers **Finance** An Annual budget of £1m was assigned to the Winter plan 18/19, the Trust net expenditure totalled £2.1m on winter. The additional expenditure over plan (£1.1m) centred upon the early opening of bed capacity (the summer ward) that was partially off-set by generating elective income (£0.8m) and additional expenditure over the winter period beyond plan (£0.3m).		

	Performance During 2018/19 the trust had 3026 more ED attendances from patients than 2017/18, representing a 3.97% increase over the full financial years. Quarter 4 (January-March 2019) saw a 5.88% increase in ED attendances compared to Quarter 4 of 2017/18. The Trust admitted 23,608 patients as emergency admissions in 2018/19 (23,713 admissions made in 2017/18) which reflects a reduction of -1.4% in the conversion rate from ED attendances to emergency admissions. There was a significant increase in the number of patients who were managed into ambulatory or short stay (0-2 days) pathways during 2018/19 ED key performance indicators were consistently improved in 2018/19 when compared to 2017/18. **Conclusion** The Trust delivered improved emergency access standard performance, and there is evidence of improved quality of care during Winter 2018/19. However delivery of improvement incurred more costs than budgeted for.	
Recommendation	Members of the Trust Board are asked to receive assurance that Winter 2018/19 has been reviewed and that this review has assessed the quality, performance and financial impact of how Winter 2018/19 was managed. Members of the Trust Board are asked to note findings, which will be used to inform the Winter Plan for 2019/20.	
Does this report mitigate risk included in the BAF or Trust Risk Registers?	This paper provides assurance against a number of BAF risks. Specific risks are highlighted throughout the report	
Resource implications	Resource implications will be considered as part of planning for Winter 2019/20.	
Legal and Equality and Diversity implications	None.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Walsall Healthcare NHS
NHS Trust

The review of the winter plan for 18/19

Thematic, Qualitative and Quantitative review of actual vs planned actions and activity Oct 18 – March 19

Compiled by Ian Billington, Dan Hodgkiss and Adam Townsend May 19

Reviewed and finalised by Ned Hobbs, Chief Operating Officer June 2019

Executive Summary (part 1)

- The Trust has reviewed the management of safe, timely care over Winter 2018/19.
- During iterations of the review it has been presented to People & Organisational Development Committee, Quality, Patient Experience & Safety Committee and the A&E Operational Group during May 2019.
- The review encompasses an assessment of the performance, quality and financial impact of how Winter 2018/19 was managed.
- The review has been assessed and finalised by the Trust's new Chief Operating Officer in preparation for Trust Board.

Quality

- Evidence from the following metrics suggests improved safety, and reduced harm during Winter 2018/19
  - Mortality rates
  - Incidents
  - Serious Incidents
  - Clinical Observations
  - Falls
  - Pressure Ulcers

Finance

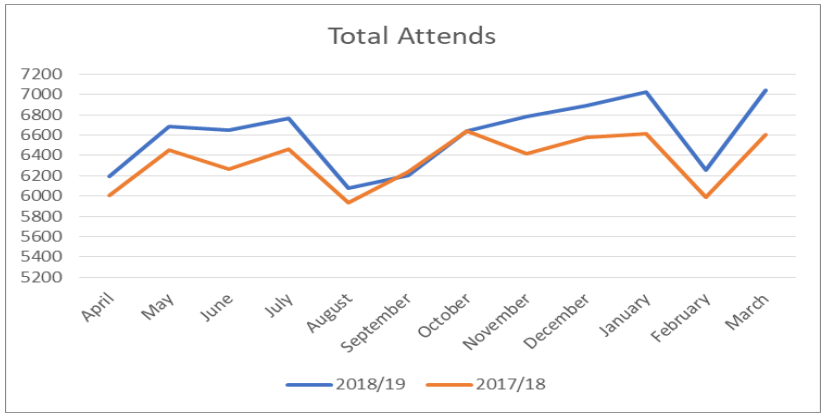
- An Annual budget of £1m was assigned in 18/19 to support the winter plan, the Trust net expenditure totalled £2.1m on winter.
- The additional expenditure over plan (£1.1m) centred upon the early opening of bed capacity (the summer ward) that was partially off-set by generating elective income (£0.8m) and additional expenditure over the winter period beyond plan (£0.3m).

Executive Summary (part 2)

Performance

- During 2018/19 the trust had 3026 more ED attendances from patients than 2017/18, representing a 3.97% increase over the full financial years.
- Quarter 4 (January-March 2019) saw a 5.88% increase in ED attendances compared to Quarter 4 of 2017/18.
- The Trust admitted 23,608 patients as emergency admissions in 2018/19 (23,713 admissions made in 2017/18) which reflects a reduction of -1.4% in the conversion rate from ED attendances to emergency admissions.
- There was a significant increase in the number of patients who were managed into ambulatory or short stay (0-2 days) pathways during 2018/19
- ED key performance indicators were consistently improved in 2018/19 when compared to 2017/18.
- The overall LoS and number of patients staying over 7 and over 21 days (stranded and super-stranded patients) remained challenging and should be a focus for improvement in the coming year

ED attendances 2017/18 and 2018/19



4hr Emergency Access Standard (Type 1) performance 2017/18 & 2018/19

Contents

Approach for thematic review

- The thematic review has taken a 'balanced scorecard' approach to understanding and learning from the approach to the winter period last year. We have drawn insight, analysis, observations and conclusions under 3 key headings:

- Patient Safety
- Performance
- Finance

N.B. We are mindful that the report has failed to include a significant amount of staff feedback. Should the Trust feel its omission fundamentally devalues the report and cannot accept and adopt the recommendations and if resource and time were available, a detailed appreciative inquiry could be undertaken to validate and/or expand the learning from these 4 themes

Walsall Healthcare NHS
NHS Trust

Patient Safety Review

Caring for Walsall together

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

Patient Safety

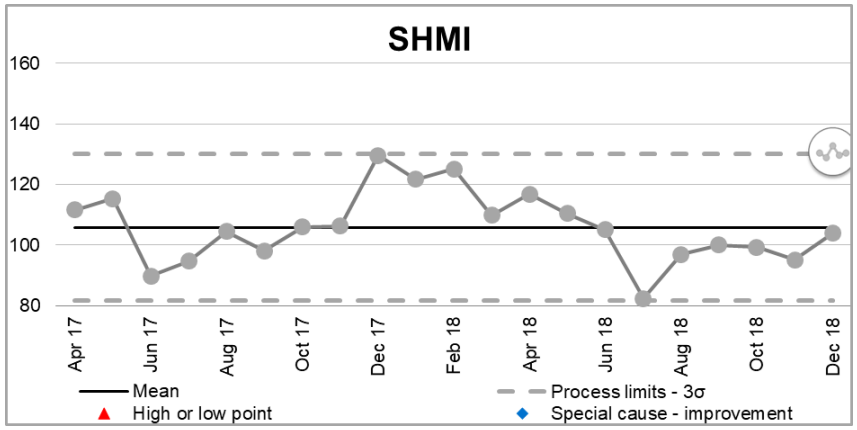
- To establish how safely patients were managed during the winter 18/19 period we have chosen to test the following hypothesis:

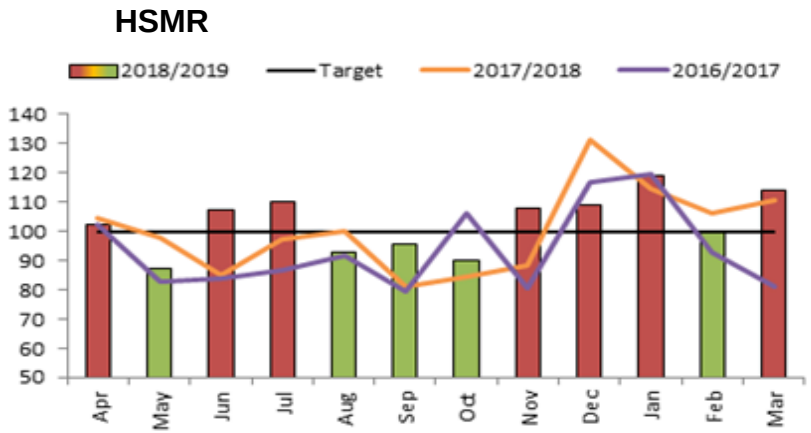
Increased bed occupancy, due to reduction in escalation beds open during the winter period, led to increased operational pressure which resulted in **increased harm or risk of harm** to patients

We have chosen to test the negative hypothesis to avoid positive bias and have sought to use data which is consistently reported in the Trust for consistency across comparison periods

Safety – Mortality

- Winter 2018/19 saw a demonstrably lower SHMI for the Trust compared to Winter 2017/18
- Although there were in-month variances, Winter 2018/19 saw a relatively consistent overall HSMR to Winter 2017/18





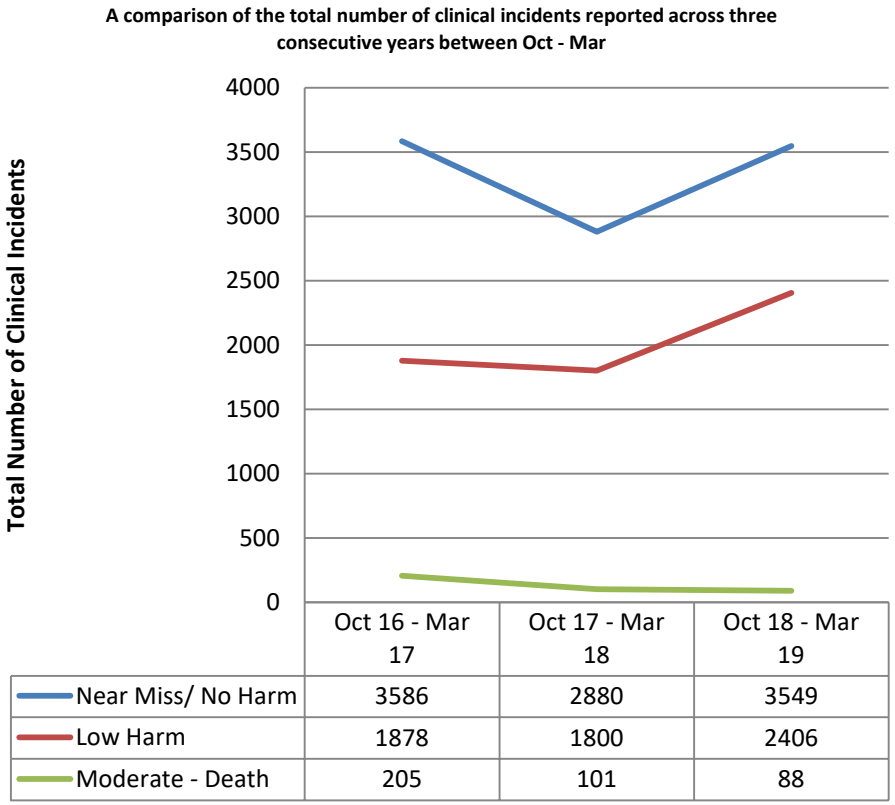
Safety – Incident Reporting

- Between Oct 18 – Mar 19 there were a greater number of clinical incidents reported totalling 6043 which is a 26% increase when comparing to Oct 17 – Mar 18; and a 7% increase for Oct 16 – Mar 17. In the same period however Moderate to Death incidents fell YoY

- When testing the hypothesis the graph demonstrates an increase in both Near Miss/ No Harm incidents and Low Harm incidents for Oct 18 – Mar 19 when compared with Oct 17 – Mar 18. When looking at Moderate, Severe and Death incidents, there has been a year on year decrease

Type of Harm	Oct 16 - Mar 17	Oct 17 - Mar 18	Oct 18 - Mar 19
Near Miss/ No Harm	63.26%	60.24%	58.70%
Low Harm	33.13%	37.65%	40.00%
Moderate – Death	3.62%	2.11%	1.46%

- Even though there was increased bed occupancy leading to increased operational pressure and an increase of patients coming through A&E, the data disproves the hypothesis as the harm caused to patients decreased over the same period vs prior yr.



	Oct 16 - Mar 17	Oct 17 - Mar 18	Oct 18 - Mar 19
Near Miss/ No Harm	3586	2880	3549
Low Harm	1878	1800	2406
Moderate - Death	205	101	88

Safety continued - incidents by type and seriousness

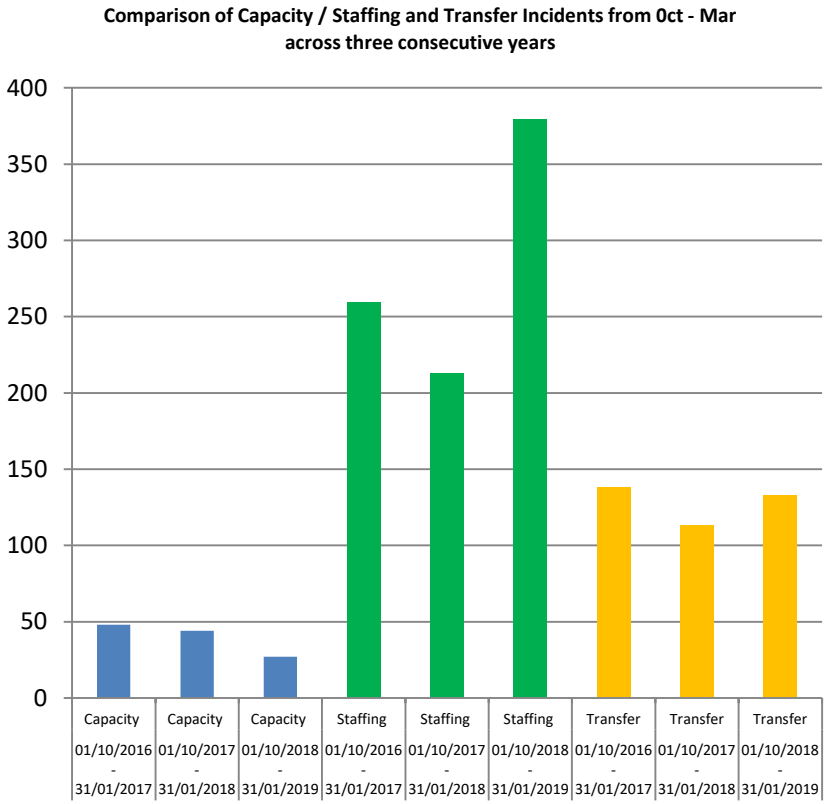
- When focusing on serious incidents in relation to suboptimal care of a deteriorating patient there has been a year on year decrease in the number of serious incidents reported.

- Serious Incidents – Suboptimal Care of Deteriorating Patient
- **Oct 16 - Mar 17 - 7**
- **Oct 17 - Mar 18 - 3**
- **Oct 18 - Mar 19 – 2**

- There were two serious incidents reported between Oct 18 – Mar 19, one was on Ward 10 (Winter Capacity Ward) and the other on Ward 29. Both of these wards demonstrated pressure in relation to timeliness of observations. Both serious incidents had similarities in relation to lack of recognition and escalation for poor urine output. RCAs on both incidents were completed in line with Trust policy. **In both cases there was no evident correlation between staffing levels and root cause.**

- Following a review of themed incidents relating to capacity there has been a year on year decrease. With a 39% decrease for Oct 18 – 19 when compared to Oct 17 – Mar 18. None of the capacity incidents had resulted in moderate or above harm. The number of transfer incidents has remained consistent across the three comparative years. There was a notable increase in staffing incidents between Oct 18 – Mar 19 when compared to the same period in previous years. The majority of the staffing incidents related to nursing staffing levels on the wards.

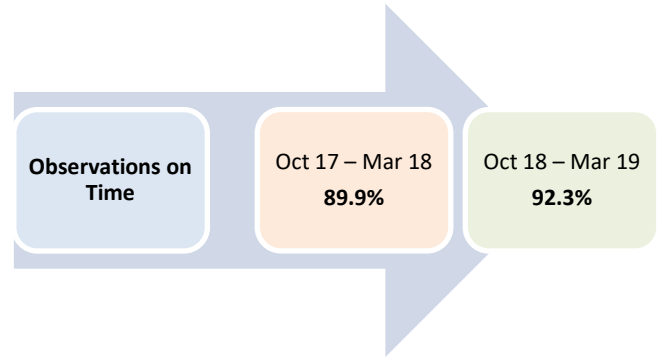
N.B. Routine investigation of staffing incidents showed that there was no harm to patients as a result of these incidents . (source KB)

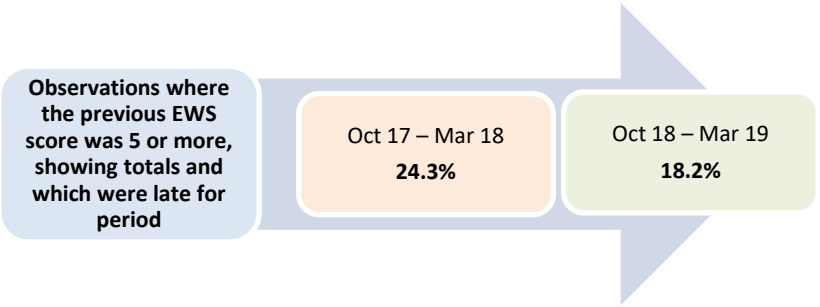


Safety continued - Timeliness of patient observations

A comparison can only be made between Oct 17 – Mar 18 and Oct 18 – Mar 19 as the audit was not in place prior to capture the data, the secondary reason is due to Vitalpac not being embedded across all ward areas in previous years.

- 2.4% increase in the total number of timely observations for Oct 18 – Mar 19 when compared to Oct 17 – Mar 18
- There has been a reduction in the number of late observations where the previous NEWS (National Early Warning Score) was 5 or above from 24.2% between Oct 17 – Mar 18 to 18.2% between Oct 18 – Mar 19.
- These two indicators demonstrate there has been a decrease in the level of risk for failing to recognise if a patient is at risk of or is deteriorating.

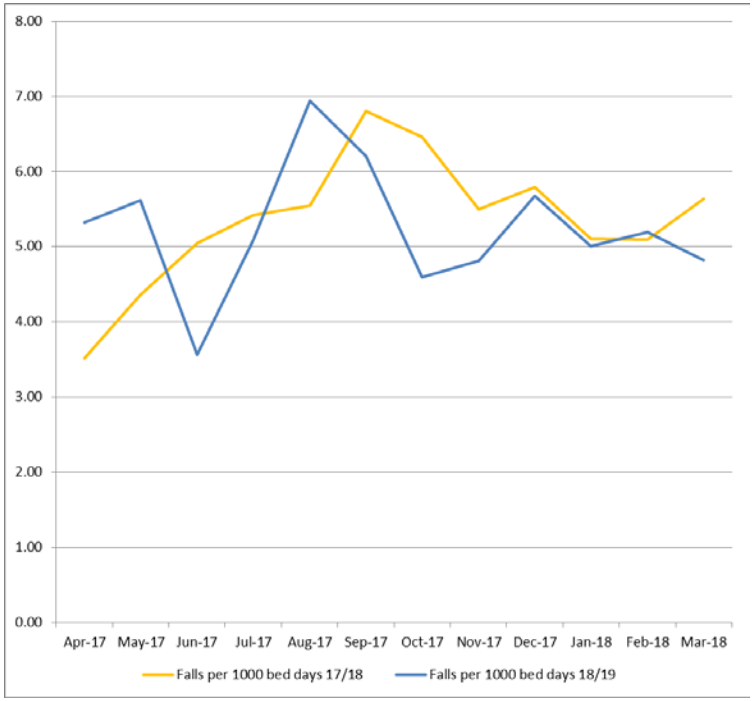




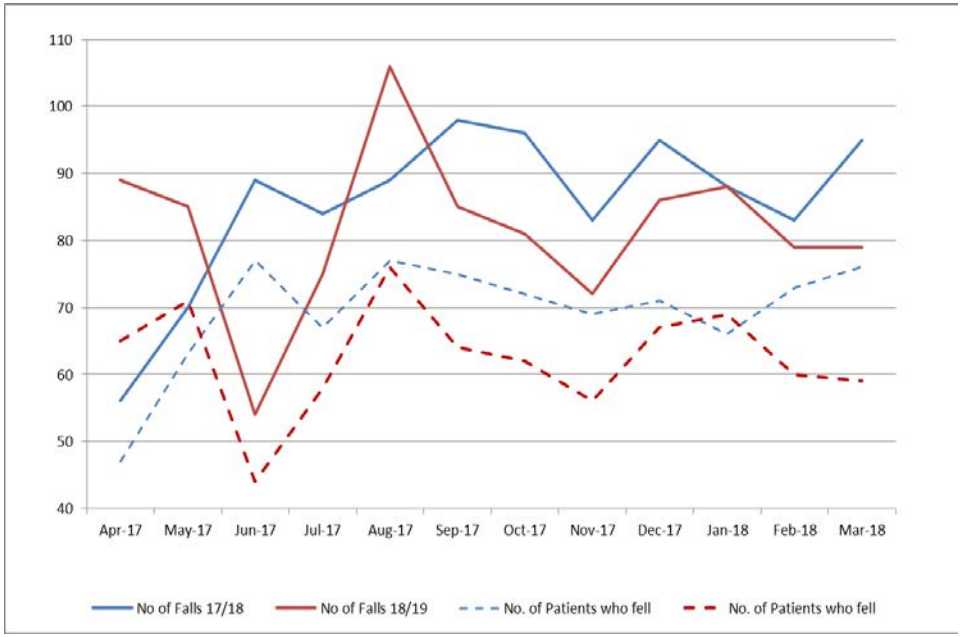
Safety – Falls

- Falls per 1000 bed days did not alter significantly between 17/18 and 18/19.
- Total falls were lower in 2018/19 than 2017/18

Falls per 1000 bed days

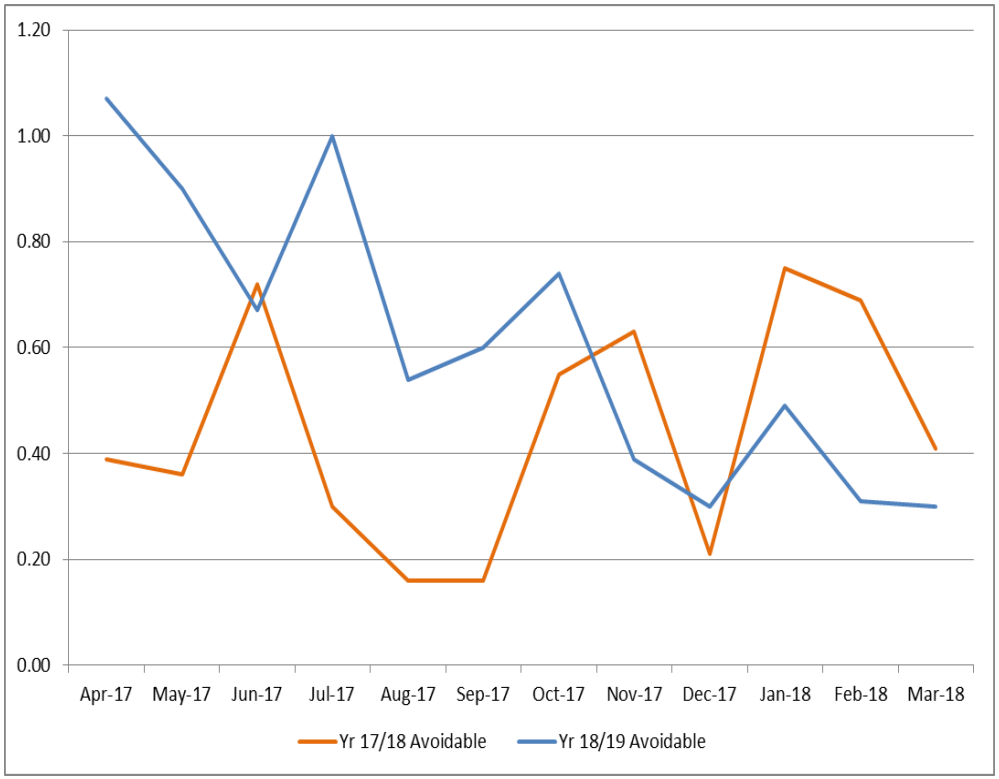


Total Falls



Safety – Pressure Ulcers

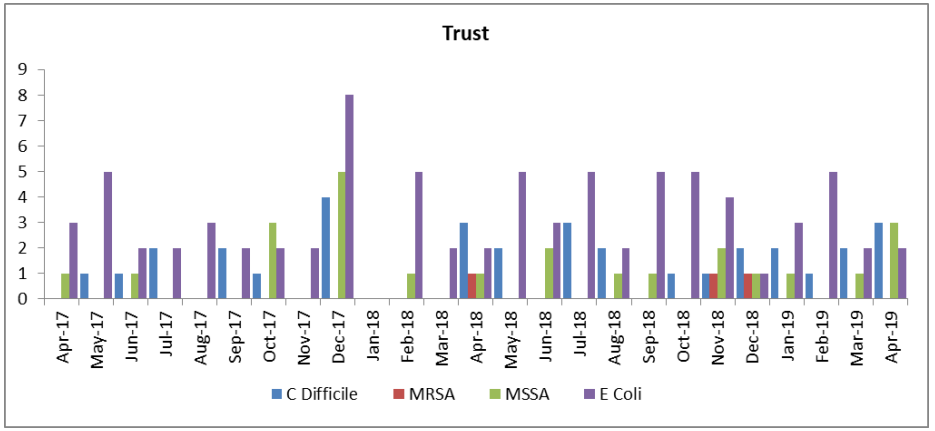
- Pressure Ulcers were higher in 2018/19 Q1-Q3 than 2017/18.
- Pressure Ulcers reduced significantly in Q4 of 2018/19, and indeed when compared to Q4 2017/18.

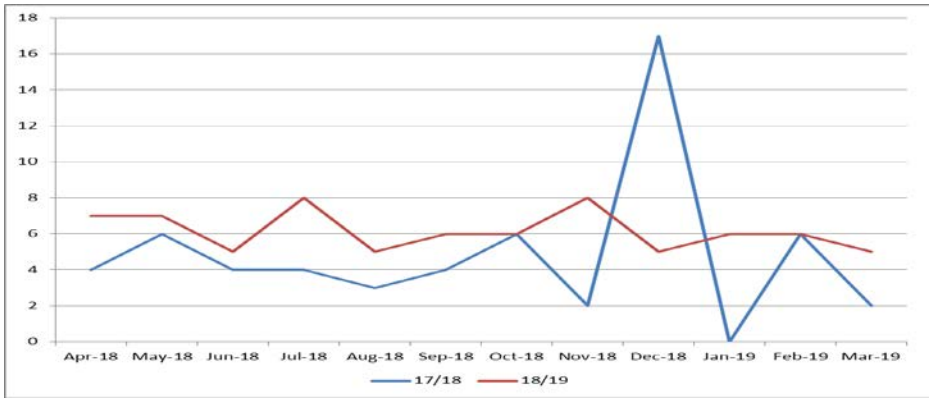


Safety – Infection Control

Cases of infection have been higher in 2018/19 than 2017/18.

Containment of outbreaks were managed during 2018/19.





Safety – use of capacity areas

- The winter plan set out a program of escalation to and de-escalation from capacity areas over the winter period to cope with surges in emergency demand. Core to this was the re-purposing of Ward 10 from Frailty and Discharge Lounge to a sub acute ward area.
- This area opened on 06/10/2019 until 12/2/19 and subsequently re-opened during March.
- This temporary capacity area was needed significant vigilance with regards to patient safety, and incidents were actively monitored.
- From 06/01/2019 – 12/02/2019 there were 15 clinical incidents reported by Ward 10 relating to environmental issues, clinical care/ assessment/ treatment issues and staffing issues as cause groups identified on the incident reporting system (Safeguard);
- All of the 15 clinical incidents make reference to the inability to care for patients due to the ward not being appropriately resourced at the point it was opened. There were a further 11 clinical incidents relating to patient falls, wounds sustained in our care, pressure ulcers and medication errors during the same period.
- One incidents was reported as a Serious Incident surrounding the suboptimal care of a deteriorating patient. During the same period there were also three complaints relating to the treatment of patients not being supervised appropriately.
- RCAs were undertaken on pressure ulcers (category 3 and above) and falls with harm - there were no correlations with staffing levels for these cases.
- Lessons learnt from these incidents include safe and coordinated opening of additional capacity and equipment for these areas, and full adherence to use of the extra capacity checklist at the point of opening.
- In balance to this it should also be noted that both Endoscopy and Cardiac Intervention Suite were not routinely used for extra capacity patients which allowed elective planned theatre lists to continue and avoided inpatients being managed in an inappropriate unit.

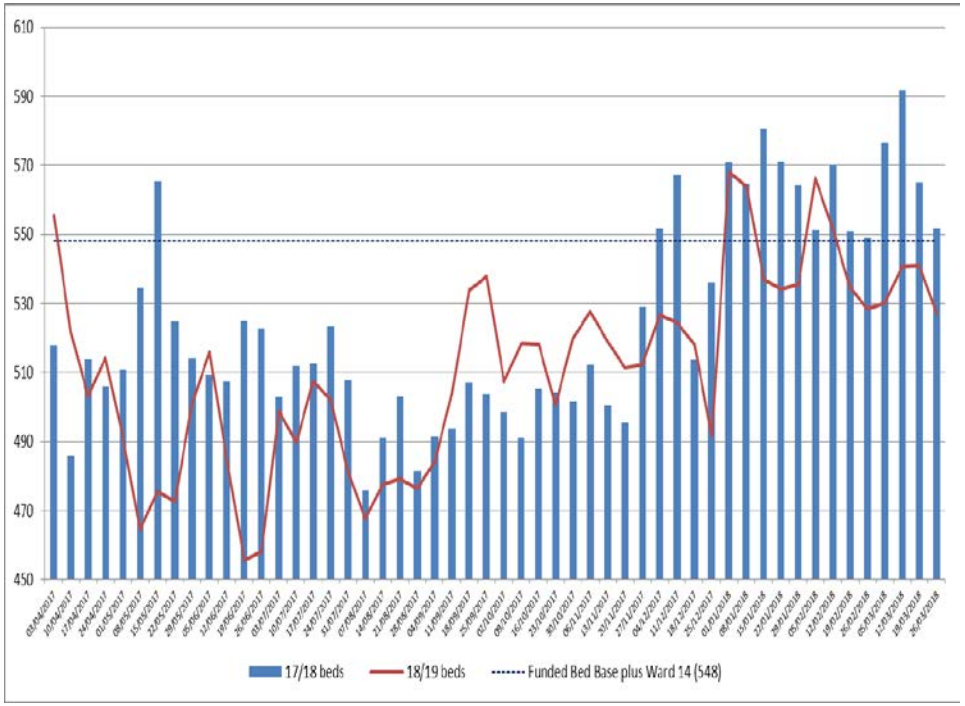
Walsall Healthcare NHS
NHS Trust

Performance Review

Caring for Walsall together

Weekly bed demand 2018/19 vs 2017/18

Occupied Bed days were lower in 2018/19 than in 2017/18, despite the fact that ED attendances were 3026 higher – reflecting the reduced conversion rate from ED attendances to emergency admissions.



Walsall Healthcare NHS
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Key Performance Indicators

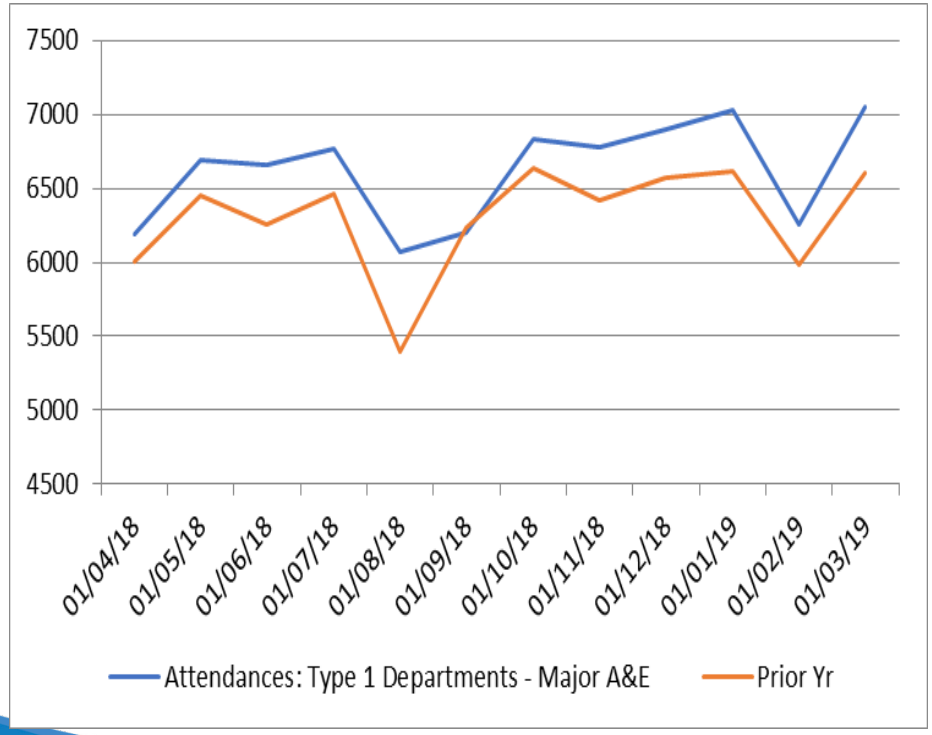
	2018/19	2017/18	2016/17
KPI	Winter (Nov 1st - Mar 31st)	Winter (Nov 1st - Mar 31st)	Winter (Nov 1st - Mar 31st)
4 hour standard (all types activity (Type 1, Types 3 (Mat Triage, FAU, UCC, WiC))	83.86%	82.45%	79.44%
Ambulance turnaround times	67.52%	65.73%	58.78%
Triage times in ED (Average - minutes- All attendances)	24	33	27
Triage times in ED (Average - minutes- All 'walk-in' attendances)	29	40	56
Time to treatment times in ED	88.63	98.73	144.57
Time to theatre for Trauma patients (Average hours from Admission)	56.26	39.99	36.29
Length of stay in hospital	7.03	7.46	7.58
Overarching waiting time's standards for patients with suspected cancer	94.27%	96.86%	96.43%
Overarching waiting time's standards for patients with suspected cancer	85.70%	88.18%	86.89%
18 week referral to treatment waits	91.02% (annual)	84.74% (annual)	85.22% (annual)

Walsall Healthcare NHS
NHS Trust

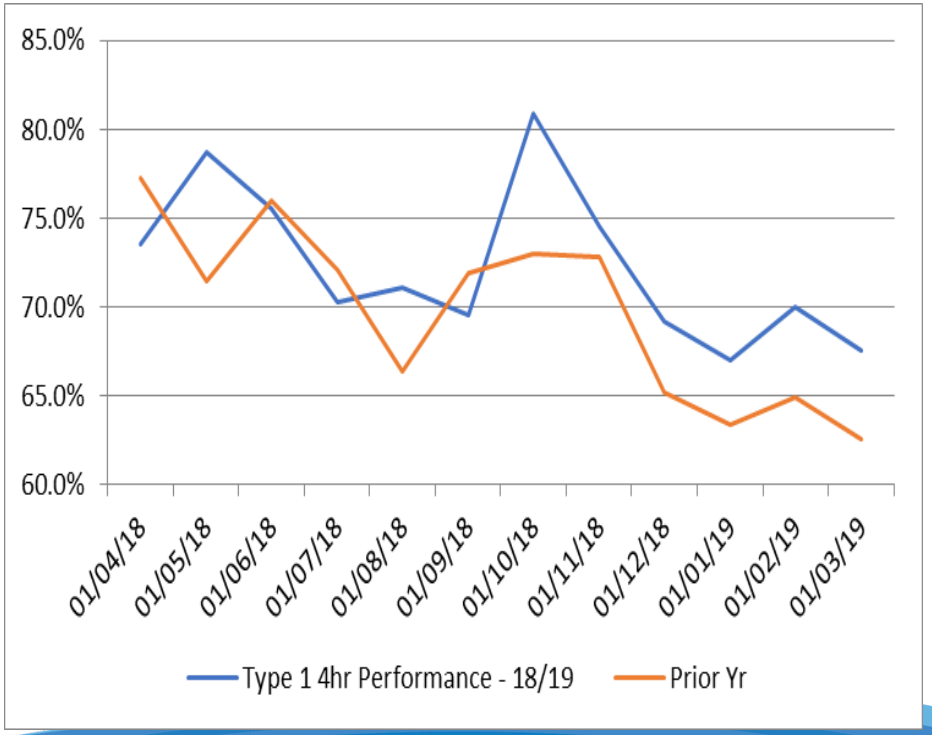
A&E Attendances & 4hr Performance (All Types) 18/19 vs 17/18

Despite a significant increase in Type 1 attendances ,4-hour Emergency Access Standard performance was consistently higher than the previous year

ED attendances 2017/18 and 2018/19

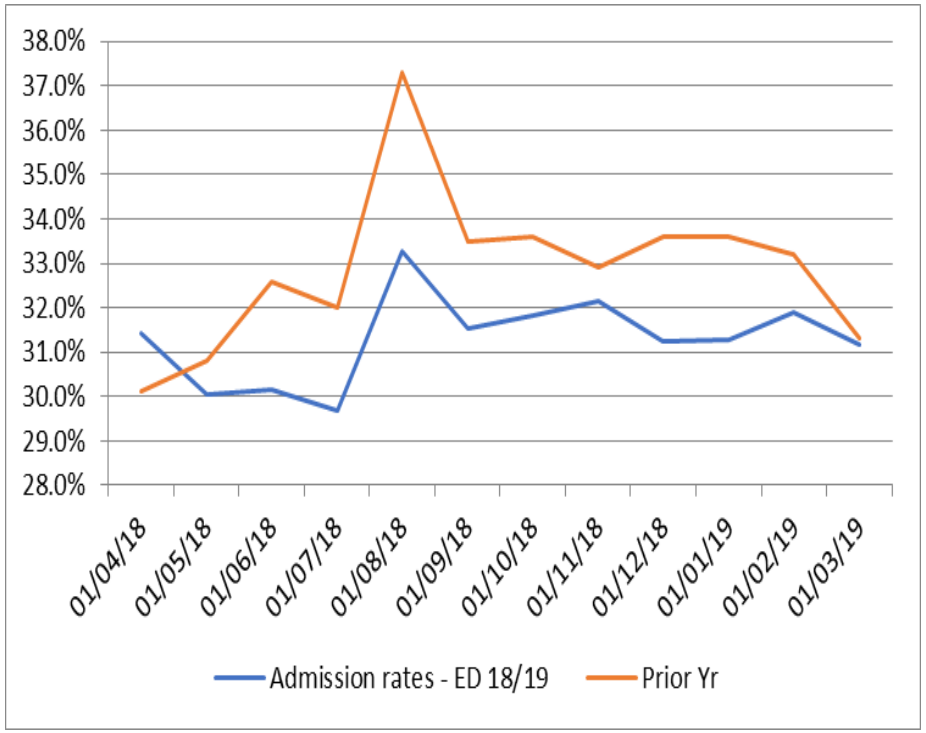


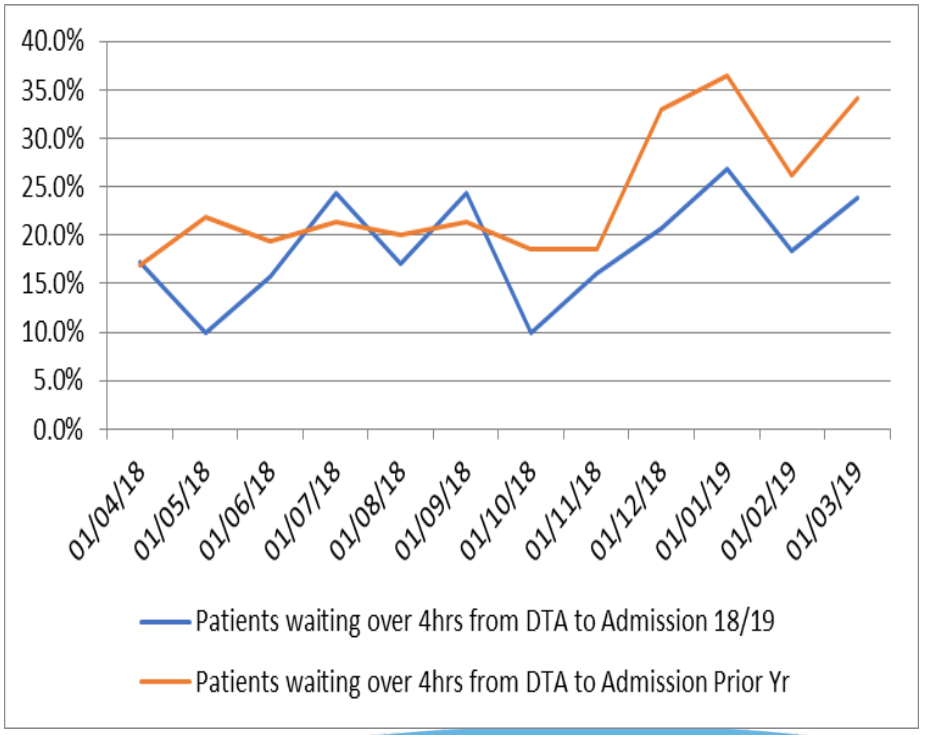
4hr Emergency Access Standard (Type 1) performance 2017/18 & 2018/19



Other ED performance metrics

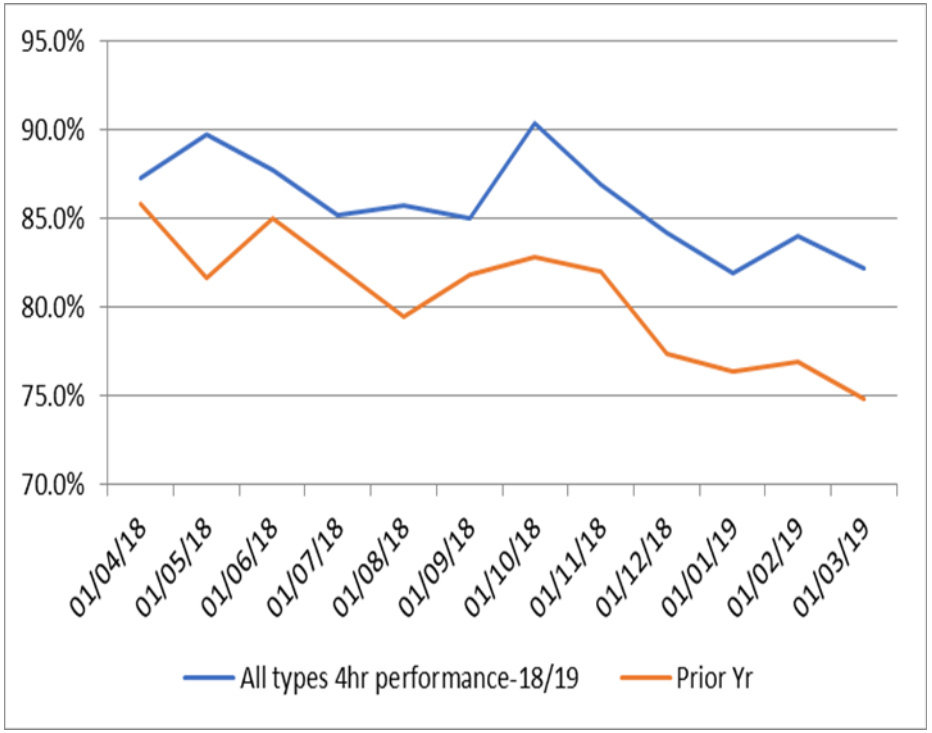
Despite the additional pressure of attendances the Trust managed to sustain lower admission rates and also reduced waiting times following a decision to admit





All Type 4hr Performance

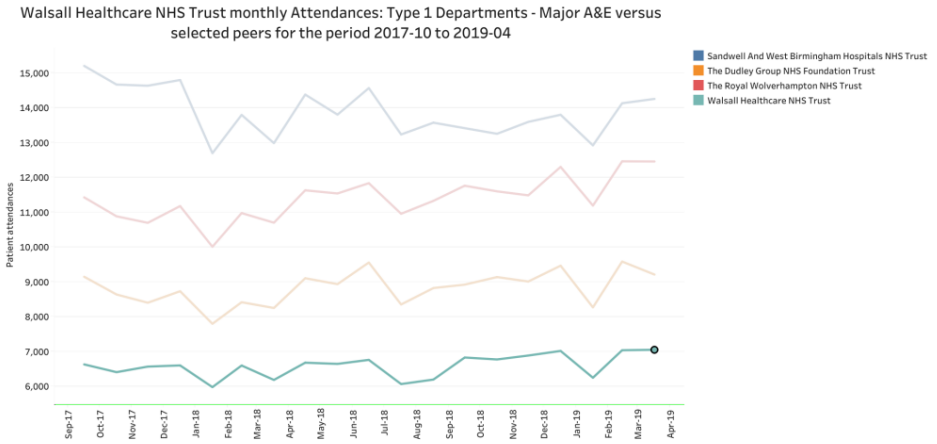
A significant (as high as 16%) reduction in type 3 – UCC patients over the winter period has meant All type performance has not improved in line with Type 1 but has, nevertheless, improved year on year.

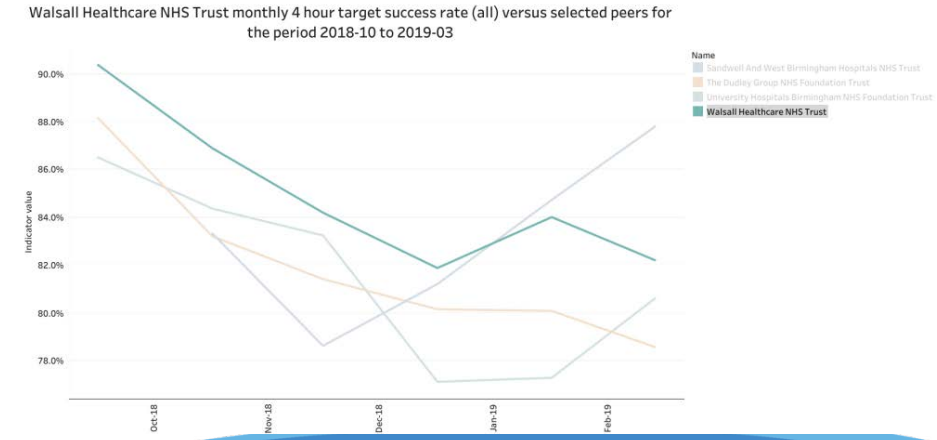


Our performance compared to regional peers

Within the black country and beyond ED attendances where substantially higher than predicted and than prior years.

This impacted performance across the whole region however, Walsall performed better than its regional peers other than Sandwell who have recovered their performance significantly

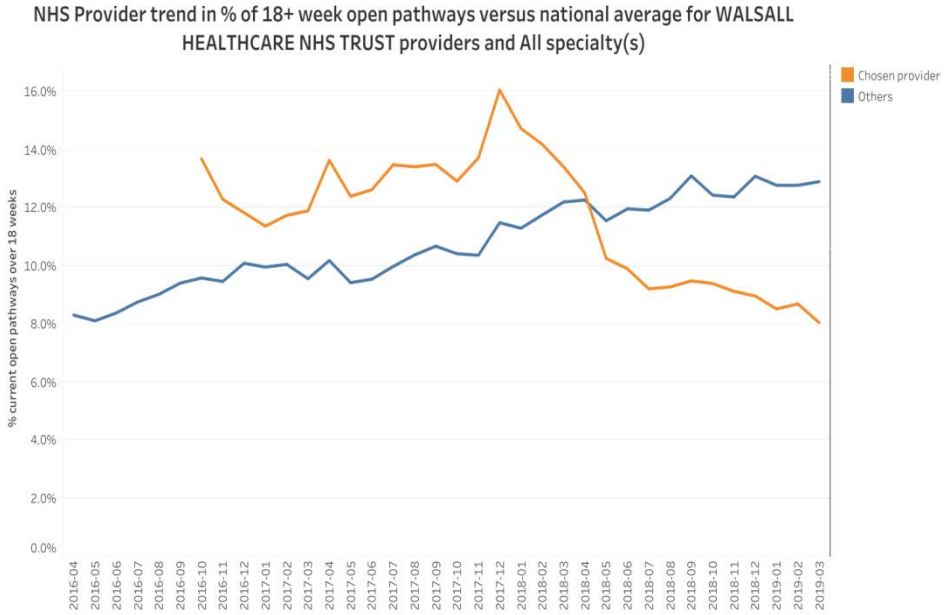




RTT Performance

Despite the winter plan calling for a stop to elective inpatient activity in Jan to allow the expected increase in non elective & medical patients to use surgical bed capacity the RTT 18 week performance has not been detrimentally effected.

Having fallen below the national average it continues to trend downwards despite the national trend being a deteriorating one



Walsall Healthcare NHS
NHS Trust

Risk Management (performance)

Risk	Mitigation Actions	Judgement
Lack of capacity to cope with increased demand	Improved patient flow management from October 2018 through obligatory use of SAFER principles to reduce LOS and create capacity to meet demand.	Compliance was variable but there was an improvement based on previous year's performance.
Lack of capacity to cope with increased demand	Review of capacity management processes and escalation triggers to identify if and where capacity needed in advance.	Review was completed and informed Escalation Action Cards implemented as a result
Patients remaining in hospital who no longer require acute care	ICS MSFD & > 6/52 community stay: Weekly Complex Discharge Meetings to set discharge dates with stakeholders, escalating where appropriate to remove blockage	Daily review of caseload by local managers with weekly meeting led by Services Director to review all ICS & OOA MSFD as well as all community service user >21/7 and agree actions for each service user
Emergency Department attendances exceed plan	Use of Walsall Healthcare NHS Trust Escalation Policy	This was utilized a number of times during Q4 (Jan/Feb and March 2019). Silver Command gave direction and took actions to support the Trust achieve recovery and capacity to meet demand safely during short periods of high pressure. The Trust did not report any 12 hour breaches this winter.
Emergency Department attendances exceed plan	Use of Walsall Healthcare NHS Trust Escalation Policy	CCG invited to Silver Command escalation meetings to assist in alerting primary care of peaks in emergency demand. This did not result in any visible reductions in demand.

Winter Actions (performance)

Area	Compliance	Commentary
Enhanced Community Nursing Rapid Response Team by November 2018	Yes	Enhanced staffing for RRT by November 2018 RRT recruited 2 ACPs (uplift from 2 previous B7 Roles), 1 joined the team November, 1 mid- December
Enhanced community matron in-reach from October 2018	Yes	Community matron supported in-reach team in a jeep over weekends throughout October, early November and Christmas & New Year week. Community matrons in-reaching to own caseload 7 days a week completed. Extra capacity allowed community matrons to in-reach to acute wards during times of high demand and also enhance Rapid Response to allow capacity to remain open within the service. Monthly data collated to show number of avoided admissions, reduced admissions and reduced length of stay, over the winter period.
Offering UCC slots after midnight to ED streamers and triage (November 2018)	Yes	Slots made available but the slots were largely unused

Opening Capacity (performance)

Area	When	Compliance	Variance
Ward 23	15/11/18–01/03/19	Yes	Yes, utilisation still ongoing
Ward 29 upgrade of bays	12/11/18	Yes	Work completed
Completion of W29 works	08/12/18	Yes	Work completed
Impact on FES & Discharge Lounge	08/12/18	Yes	Relocation of service, there was continuity throughout the reporting period
Create A&E Assessment Facility in HDU	20/12/18	Yes	Assessment area completed
Winter Ward	08/12/18-11/02/18	Yes	The Ward remained open past the identified Winter period.
Additional Surge Capacity (SRU)	Flex	Yes	Yes, utilisation of this area continued after the reporting period. The aim is to withdraw from this area.
CIU & Endoscopy	Flex	Yes	Yes (but only on a handful of occasions) utilisation significantly reduced based on previous year's performance
ASU x 12 beds	Flex	Yes	Yes
Relocation of Stroke Rehabilitation Ward	01/01/19	No	To be decided

Walsall Healthcare NHS
NHS Trust

Finance Review

Caring for Walsall together

Finance Position (as at M12)

Division	Actual Winter Spend 2018/19					
	M8 £000's	M9 £000's	M10 £000's	M11 £000's	M12 £000's	Total £000's
MLTC	239	206	443	378	181	1,447
Surgery	4	7	9	8	3	31
WC&CSS (per plan)	46	72	79	49	10	256
Estates (per plan)	40	30	50	0	8	128
Total	**329**	**315**	**581**	**435**	**202**	**1,862**
Expenditure already incurred (months 1-7)						523
Total Expenditure incured 2018/19						**2,385**
Less Additional income generated from early opening of winter capacity (the Summer Ward)						(301)
Net impact of Winter						**2,084**

- An Annual budget of £1m was assigned in 18/19 to support the winter plan, the Trust net expenditure totalled £2.1m on additional interventions to manage emergency demand.
- The additional expenditure over plan (£1.1m) centred upon the early opening of bed capacity (the summer ward) that was partially off-set by generating elective income (£0.8m) and additional expenditure over the winter period beyond plan (£0.3m).

MEETING OF THE PUBLIC TRUST BOARD – 4th July 2019			
Quality, Patient Experience & Safety Committee Highlight Report			**AGENDA ITEM: 17**
Report Author and Job Title:	Kara Blackwell Deputy Director of Nursing	**Responsible Director:**	Anne Baines, Non-Executive Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The paper provides a highlight report from the Quality, Patient Experience & Safety Committee held on the 27th June 2019 chaired by Mrs Anne Baines, Non-Executive Director. The committee resolved to highlight the following items: • Hospital acquired infections • A non-executive lead identified for end of life care • Accelerated development of the performance report using SPC charts • Interim National Inpatient Survey results showing an improved response rate and an overall positive report The committee recommended approval of: • The Quality account for 2018/19		
Recommendation	Members of the Trust Board are asked to note the report and support any further action required.		
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	Compliance with Trust Standing Orders		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Walsall Healthcare NHS
NHS Trust

Quality Patient Experience & Safety Committee: June 2019

Highlight Report to the Trust Board

Report for Trust Board meeting on:	4th July 2019
Report From:	27th June 2019

Highlight Report:

Hospital Acquired Infections
At the date of the committee meeting there has been a total of 6 hospital acquired C. Diff infections and 0 MRSA bacteraemia to May 2019.

Interim National Inpatient Survey Results 2018
The committee received the interim results of the National Inpatient Survey of patients seen in July 2018. The results are embargoed for wider circulation until the national benchmarking data is published by CQC.
The trust had an improved response rate. Overall the report is positive and the results will be fed into the improvement programme.

National Audit of Care at the End of Life (NACEL)
The committee were informed that a non-executive lead for end of life has been identified as Pam Bradbury

Quality Account 2018/2019
The committee recommend approving the quality account for 2018/19

Performance report
The committee would like to see an accelerated development of the performance report using SPC charts to enable a more robust discussion

Action Required by the Trust Board:

The Trust Board is asked to note the report and support any further action required.

Anne Baines, Non-Executive Director and Dr Karen Dunderdale, Director of Nursing/Deputy Chief Executive

June 2019

MEETING OF THE PUBLIC TRUST BOARD – 4th July 2019			
Performance, Finance & Investment Committee (PFIC) update report			**AGENDA ITEM: 18**
Report Author and Job Title:	Mr R Caldicott – Director of Finance & Performance	**Responsible Director:**	Mr J Dunn – Chair of PFIC (Non-Executive)
Action Req	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		

Executive Summary	The report indicates the key messages from PFIC meeting in June 2019 for escalation to the Trust Board, namely;
	• Trust attained a £2.1m deficit for month 2 (in line with plan). However, delivered £1.0m operational overspends (£0.5m run rate risk materialising) key drivers being;
	  • High use of temporary workforce (capacity pressures and sickness)
	  • The births remaining below plan
	  • Theatres productivity reducing throughout the month of May 2019
	• The current run rate (if unmitigated) would result in an operational deficit in excess of £6m and with loss of Provider Sustainability Funding the deficit could exceed £9m
	• The Trust Executive have initiated the following actions to mitigate the risk to delivery of the financial plan;
	  • Escalation of the Division of MLTC using the Accountability Framework
	  • WC&CSS to targeting increased deliveries/reduction in costs
	  • Surgical Division Executive oversight and support to increase productivity
	  • Implementation of agreed mitigation schemes endorsed through Trust Board
	
	Oversight through the bi-weekly performance meetings, the financial cabinet, Performance and Finance Executive and PFIC and a forecast outturn to determine the impact of the above is to be presented to the next meeting of PFIC, which needs to identify mitigations of £6m to deliver 2019/20 plan.
	
	Members received a report on performance against constitutional standards;
	• Cancer targeted performance has been impacted upon by the significant increases in referrals for breast Surgery, and the potential impacts from supporting neighbouring Trust's was debated. The result will be further pressures for attainment of the cancer 2 week target
	• ED performance was below target owing to the increased demands placed upon the service from increased attendances.
	• RTT performance was above target at 91% and compares well when viewed against peers (though below constitutional standard of 92%)
	
	Committee received an update on the Urgent Care Centre, a review of the effectiveness of the Meridian commission for Medical workforce in Medicine and Elderly Care and approved the case for replacement of Mammography equipment.		

Recommendation	Members of the Board are asked to note the increased ED activity, the risk to the cancer two week wait and the run rate risk to delivery of the financial plan		
BAF or Trust Risk Register	This report aligns to the BAF risk associated with delivery of the financial plan, with the risk rated as red at present		
Resource implications	The implications are lost financial support resulting in additional borrowings (interest charges) and the effect on 'use of resources' rating. Alongside performance risks.		
Legal, Equality & Diversity	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 (PFIC)

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.

2. KEY ISSUES

2.1 The meeting was declared quorate and Chaired by Mr Dunn, Non-executive Director, Vice Chair of the Trust and Committee Chair.

2.2 Financial performance

The report indicates the key messages from the PFIC meeting in June 2019 for escalation to the Trust Board, namely;

- Trust attained a £2.1m deficit for month 2 (in line with plan). However, delivered £1.0m operational overspends (£0.5m run rate risk materialising) key drivers being;

  - High use of temporary workforce within the Medicine and Long Term Conditions (MLTC) Division, driven through capacity pressures and sickness
  - The births managed within the Women, Children's and Clinical Support Services (WC&CSS) Division remaining below plan
  - Theatres productivity being led by the Surgical Division reducing throughout the month of May 2019

- The current run rate (if unmitigated) would result in the Trust realising an operational deficit in excess of £6m, loss of Provider Sustainability Funding (PSF) through not attaining control total would results in a further loss of £3m and the deficit increasing to approximately £9m (plan being to break-even for the year).

The Trust Executive has initiated the following actions to mitigate the risk to delivery of the financial plan;

- Escalation of the Division of MLTC using the Accountability Framework and their production of a Financial Recovery Programme

- WC&CSS to target increased Obstetric activity (births) or identify cost reduction mitigations, with the plan endorsed through the next PFIC meeting
- Surgical Division oversight and support to increase productivity
- Implementation of agreed run rate mitigation schemes (endorsed through Trust Board) in full
- Oversight through the bi-weekly performance meetings, the financial cabinet meetings, the Performance and Finance Executive and then Performance, Finance and Investment Committee

Forecast outturn to be produced, so as to model the impact of the mitigations and further challenge regarding Divisional performance following the Performance reviews (using the Accountability Framework). Presentation to the next meeting of PFIC a forecast which will need to identify mitigation of £6m to ensure delivery of the 2019/20 financial plan.

2.3 Trust performance against constitutional standards

The Chief Operating officer took members through the report, key items of note being;

- Cancer targeted performance has been impacted upon by the significant increases in referrals for breast Surgery, and the potential impacts from supporting neighbouring Trust's was debated. The result will be further pressures for attainment of the cancer 2 week target
- ED performance was below target owing to the increased demands placed upon the service from increased attendances.
- RTT performance was above target at 91% and compares well when viewed against peers (though below constitutional standard of 92%)

Members noted the content of the report and potential impact on future reported performance through attainment of the two week cancer targets.

2.4 Business cases

Committee received an update on the Urgent Care Centre, a review of the effectiveness of the Meridian commission for Medical workforce in Medicine and Elderly Care and approved the case for replacement of Mammography equipment.

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 – 4th JULY 2019			
Integrated Care Partnership (ICP) Committee Highlight Report			**AGENDA ITEM: 20**
Report Author and Job Title:	Graeme O' Malley Walsall Together Programme Manager	**Responsible Director:**	Daren Fradgley Interim Walsall Together Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	This report provides the key messages from the Integrated Care Partnership (ICP) Board June 2019: • There has been no GP representation at either of the ICP Board meetings. Chair agreed a letter to be sent to PCN leads requesting future attendance; • Board agreed that patient stories (with patient consent) are brought to future meetings – A end of life story was discussed; • The ICP Board endorsed the Terms of Reference and recommended approval by Partner Boards; • Dr E. Whitehouse and Dr Radka Klezlova presented the End of Life strategy. The Board agreed to work together to take the strategy forward and that it sat in the Clinical Operating Model (COM) as a workstream with Walsall Together; • Board agreed the Clinical Operating Model (COM) noting the mental health workstream requires further work – to change from crisis to outpatients; • Board noted the outline programme plan and where there are service changes, these will require public consultation;		

	• Items escalated were: o Population health management – refer to SMT o EoL strategy - to include in COM o Terms of Reference – to take to partner Boards for agreement • Highlight report to be developed for partners to share with their respective Boards Members agreed there was good debate and challenge among partners at the meeting and progress was being made. They felt it

	was a positive meeting and highlighted some complexities which needed to a pragmatic approach to manage. There was a brief discussion that partnership governance needed to be included in the structures of the Health & Wellbeing Board.	
Recommendation	Members of the Trust Board are asked to NOTE the business of the Highlight Report.	
Risk in the BAF or Trust Risk Register	This paper provides assurance to the board to mitigate the risks in relation to the following BAF risks: BAF003 If the Trust does not agree a suitable alliance approach with the Local Health Economy partners it will not be able to deliver a sustainable integrated care model;	
Resource implications	There are no new 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 ☐	

INTEGRATED CARE PARTNERSHIP COMMITTEE HIGHLIGHT REPORT JULY 2019

1. INTRODUCTION

The Integrated Care Partnership (ICP) Board met in June 2019 following its shadow meeting in May 2019. The ICP Board will continue to meet monthly and is expected to be formally established once the Terms of Reference are approved by all partners and appointment of a Chair is confirmed.

This report provides an overview of the key items discussed at the meeting held in June 2019.

2. BACKGROUND

The ICP Board has been established to oversee the integration and transformation of in scope services. The Board is responsible for decision making and strategic direction in the context of the Walsall Together Business Plan.

3. DETAIL

3.1. Attendance, Apologies and Quorum

The Board was Chaired by Mrs Anne Baines, Non-Executive Director, Walsall Healthcare NHS Trust. The meeting was not quorate but the Chair agreed the meeting would go ahead and items for agreement would be discussed and endorsed, as appropriate. Apologies were received from:

- Richard Beeken, Walsall Healthcare NHS Trust
- Simon Brake, Walsall CCG
- Mark Axcell, Dudley and Walsall Mental Health Trust

3.2. Minutes of last meeting and matters arising

Members agreed minutes. Matters arising were reviewed and additional issues were highlighted:

- Primary Care Network (PCN) representative - there was no GP representative present at this meeting or the previous one. There has been some reluctance to attend due to wanting to establish the networks in the first instance. Members were concerned regarding GP engagement and that the PCNs have a role to engage with partners and in ensuring their attendance. It was agreed that a letter be sent to PCNs reminding them of their place around the table. Mr Tulley confirmed that he had spoken to Dr

Anand Rischie regarding attendance and advised all PCNs are due to meet with the CCG regarding the issue.

3.3. Patient Story

The Chair introduced the report on the patient story and discussed that it is key for the group to receive a patient story. Comments were received and noted e.g. ensuring patient consent, terminology required explanation to non-clinical readers, ensuring the story included broader aspects of impacts and responses, inclusion of all partners and capturing their inputs from start to end of care, good practice points and learning opportunities. The Board agreed that patient stories are to be brought to future meetings.

3.4. Terms of Reference

It was confirmed that comments against the draft Terms of Reference (ToR) received at the last meeting were now incorporated. In particular, members noted the changes at section 3.2 (narrative changed, membership from host and membership from partner organisations) and 4.1 (noting CCG as attendees). The Board endorsed the ToR and recommended approval by partner Boards.

Business Case (under ToR discussion)

There was discussion relating to the business case and taking this to partner public boards (it was noted that all boards had seen this but mostly in private session). Walsall Council confirmed they had taken the business case into the public domain. Members were reminded a co-produced cover sheet for the business case asked Boards to approve the model of operating for services as described, support the developments of business cases (as they emerge), support the establishment of the Walsall Together ICP Board, approve that senior management roles will be working in conjunction with that Board and approve the Trust as the “Host” and support the formation of an s75 NHS Act contract during 2019/20. He reaffirmed that it was agreed by NHS partners that the business case along with the ToR will go through their board(s) with the high level programme plan in the next round of Board meetings.

3.5. Alliance Agreement

There were no updates for the Alliance Agreement as the Task and Finish Group were to meet after the date of the ICP Board. An update will be provided at the July ICP Board meeting.

3.6. Recruitment of Non-Executive Director Chair

Mrs Anne Baines, Non-Executive Director Walsall Healthcare NHS Trust remains interim Chair whilst recruitment is being undertaken via NHS Improvement (NHSI). An update will be provided at the July ICP Board meeting.

3.7. Annual Cycle of Business

The previously circulated annual cycle of business set out a series of reports and the frequency in which the ICP would receive updates. A forward planner had been added which brought documents into the ICP and the second section on programme reports would include any PIDs and associated business cases - the overall intention being that agenda's would be formed through this structure. It was confirmed this had been agreed with partner Company Secretaries as the route for agenda items. A section on operational oversight, including quality and performance issues, would be added. The Board agreed the Annual cycle of business.

3.8. End of Life Strategy

The End of Life strategy was presented to the Board. The Chair acknowledged this was a great strategy and a good, co-produced, piece of work. It was confirmed as for both adults and children. Members agreed to work together to take the strategy forward and that it will sit in the Clinical Operating Model (COM) as a workstream with Walsall Together.

3.9. Senior Management Team

The Senior Management Team (SMT) have been meeting weekly and the team has an established office-base. The ToR for the Senior Management Team (SMT) was discussed and agreed.

3.10. Creation of Clinical Operating Model

The Clinical Operating Model (COM) report (previously circulated) sets out the priorities across the system and the rationale for working on them. Members noted that roles and responsibilities requires completion and these will be different depending on the priorities. Health visiting and school nursing is one of the priorities for this year and the Council is exploring a s75 agreement which is part of the alliance. It was noted that the mental health crisis workstream (in the COM) is to be changed from crisis to outpatients. The Board agreed the COM.

3.11. Outline Programme Plan

The Board noted the outline programme plan which describes the current model and proposed projects according to a matrix model of programme governance. The COM is delivered through the tiers of care and design/implementation of agreed pathways. Work is required on the design of each project and a Senior Responsible Officer is required for each of these, assigned by the ICP Board. Where there are service changes, members agreed these will require patient involvement and public consultation. The Board noted the outline programme plan.

3.12. Population Health Management

Population Health Management (PHM) provides an intelligence led approach to identifying key issues in the population and putting in place the interventions to address. A paper was previously circulated which discussed an approach to developing the infrastructure for PHM. SMT were supportive and the Board agreed The direction of travel with next steps to be outlined by the SMT.

3.13. Integrated Performance Report

The Integrated Performance Report (IPR) has been developed based on health and social care indicators and a full dashboard is being developed by the team based on the outcomes framework. The Board noted the IPR.

3.14. Items for Escalation

Items escalated were:

- Population health management – refer to SMT
- EoL strategy - to include in COM
- Terms of Reference – to take to partner Boards for agreement

3.15. Reflections on Meeting

Members agreed there was good debate and challenge among partners at the meeting and progress was being made. They felt it was a positive meeting and highlighted some complexities which needed to a pragmatic approach to manage. There was a brief discussion that partnership governance needed to be included in the structures of the Health & Wellbeing Board.

4. RECOMMENDATION

The Board is recommended to NOTE the content of the report for information and to formally approve the decisions made.