Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 5 SEPTEMBER 2019 AT 14:00
IN THE LECTURE SUITE, MLCC, MANOR HOSPITAL, WALSALL

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A G E N D A

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
1.	Patients, Carer and Staff Story	Learning	Director of Nursing	Verbal	1400
CHAIR'S BUSINESS					
2.	Apologies for Absence	Information	Chair	Verbal	1410
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1	
4.	Minutes of the Board Meeting Held on 4th July 2019	Approval	Chair	ENC 2	
5.	Matters Arising and Action Sheet	Review	Chair	ENC 3	1415
6.	Chair's Report	Information	Chair	ENC 4	1420
7.	Chief Executive's Report	Information	Chief Executive	ENC 5	1425
SAFE HIGH QUALITY CARE					
8.	Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Director of Nursing	ENC 6	1430
9.	CQC Report	Discussion	Director of Governance	ENC 7	1440
BREAK – TEA/COFFEE PROVIDED					
RESOURCES					
12.	Performance Report	Discussion	Director of Finance & Performance	ENC 8	1450
13.	Review of the 18/19 Winter Plan	Discussion	Chief Operating Officer	ENC 9	1500
CARE AT HOME					
15.	Walsall Together Update	Information	Interim Walsall Together Director	ENC 10	1510

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
16.	Alliance Agreement	Approval	Interim Walsall Together Director	ENC 11	1515
GOVERNANCE AND COMPLIANCE					
17.	Medical Revalidation Annual Organisational Audit	Approval	Medical Director	ENC 12	1520
18	Annual Infection Prevention & Control report	Approval	Director of Nursing	ENC 13	1525
19.	Quality, Patient Experience and Safety Committee Highlight Report	Information	Committee Chair	ENC 14	
20.	POD Highlight Report	Information	Committee Chair	Verbal	
21.	Integrated Care Partnership Committee Highlight Report	Information	Committee Chair	ENC 15	
22.	Audit Committee Highlight report	Information	Committee Chair	ENC 16	
23.	**QUESTIONS FROM THE PUBLIC**				
24.	**DATE OF NEXT MEETING** Public meeting on **Thursday 3rd October 2019** at 14:00 at the Manor Learning and Conference Centre, Manor Hospital				
25.	**Exclusion to the Public** – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).				

MEETING OF THE PUBLIC TRUST BOARD – Thursday 5 September 2019			
Declarations of Interest			**AGENDA ITEM: 4**
Report Author and Job Title:	Jo Wells Senior Executive Assistant	**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 September 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.
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
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

Report Author: Jenna Davies, Director of Governance
Date of report: September 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 4TH JULY 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 J Dunn	Non-Executive Director
Mr S Heer	Non-Executive Director
Mr P Gayle	Non-Executive Director
Mrs A Baines	Non-Executive Director
Mrs P Bradbury	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
Mr N Hobbs	Chief Operating Officer

In Attendance:

Mr D Fradgley	Director of Strategy & Improvement
Ms J Davies	Director of Governance
Ms C Griffiths	Director of People & Culture
Mrs J White	Trust Secretary
Miss J Wells	Senior Executive PA (Minutes)

Members of the Public
Members of Staff 2
Members of the Press / Media
Observers 7

042/19 Patient Story

The Patient Experience team attended and introduced the Ward 7 team who presented a staff story along with a patient who is now a staff member.

Sarah Gubbins was a patient on Ward 16 and got inspired to undertake a Prince's Trust placement at the Trust. Whilst an inpatient, Sarah was supported and mentored by the Ward Manager Patricia Tapp and Ward Clerk Maureen Harwood. Sarah's experience led her to apply to train as a CSW (Clinical Support Worker). Patricia and Maureen motivated and helped her through this process and Sarah will be joining the Trust Bank soon.

Ms Oum thanked Sarah for sharing her powerful story and poem which she read out. It was clear that there was good leadership within the team who made a great contribution to the service.

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Dr Dunderdale thanked Sarah and the team for attending, which demonstrated their kindness and compassion. Dr Dunderdale added that she would be really proud of Sarah joining the nursing workforce team.

043/19 Board Walk Feedback

Mrs White informed that following the introduction of the new Board day format which incorporates Board walks, over 40 areas of the Trust have been visited.

Mrs White identified some of the key themes including staff having a great understanding of the Trust values, being proud of the work they were doing and demonstrated good innovation.
Staff were always keen to share ideas for service changes and there was a feeling the culture was changing.

A number of issues were also highlighted around equipment problems, lack of understanding of the wider service changes and lack of consideration given to back office functions regarding changes.

Ms Oum thanked Mrs White for the update and coordinated approach to Board visits.

044/19 Apologies for Absence

Apologies were received from:

- Dr E England, Associate Non-Executive Director
- Mr A Yates, Associate Non-Executive Director
- Ms S Rowe, Associate Non-Executive Director

Ms Oum gave thanks to Mrs Jackie White, Interim Trust Secretary who had supported the Trust as Trust Secretary and assisted the organisation with CQC preparation.

Ms Oum also gave thanks to Dr Elizabeth England who was stepping down from her role as Associate Non-Executive Director following appointment to a new role.

Ms Oum welcomed Mr Ned Hobbs, newly appointed Chief Operating Officer.

045/19 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)

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is present.

046/19 Minutes of the Board Meeting Held in Public on 6th June 2019

Mr Beeken informed that 027/19 should read 111 provisions 'to the Emergency Department' was high.

Dr Dunderdale informed that the ED Establishment Review was included on the agenda.

The minutes of the meeting held on 6th June 2019 were approved as a correct record with the above amendment.

047/19 Matters Arising and Action Sheet

205/18 – Ms Oum suggested that the Winter Plan was reviewed and debated at the Performance, Finance and Investment Committee prior to a review at Trust Board in September and therefore deferred from today's meeting.

008/18 – Dr Dunderdale updated that the Nursing and Midwifery Safer Staffing Report benchmarking data would be reviewed at the next Quality, Patient Experience and Safety Committee.

234/18 – Dr Lewis advised that mental health CPR compliance would be reviewed at Trust Board in September.

032/19 – Mr Hobbs informed that the Performance, Finance and Investment committee would review any VTE options at the meeting in July.

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

048/19 Chair's Report
Ms Oum presented the report which was taken as read.

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

049/19 Chief Executive's Report
Mr Beeken presented the report and highlighted the following key points:

High ED attendance had continued into June. On 24th June, the organisation treated a record number of admissions within a 24 hour period. The implication was the need to increase staffing resilience and bed capacity. The People and Organisational Development Committee would conduct a review in due course. The A&E Delivery Board had reviewed the root cause, concluding that the biggest contributor was a linear grown in dispositions from **PODC**

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the 111 service to ED. This was a region wide issue.

The Improvement Programme was discussed at the Board Development session held earlier in the day. A development day was held on 18th June with representatives from patient groups and Engageants. The main focus was priorities, with the aim of achieving the ambition of receiving an outstanding service rating by 2022.

The Health and Wellbeing Board had overseen a Walsall Plan which had been refocused on 3 priorities:

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

It was agreed that the Trust would take on the responsibilities for being the lead partner in delivering smoke free sites. Ms Griffiths would lead in house with Mrs Jane Longden, Head of Estates and Facilities to include reviewing cycling to work, employee health and wellbeing and making the Trust site smoke free by the end of the financial year.

In reference to partnership working, the Trust would be establishing a joint group with the Royal Wolverhampton to ensure that both Boards oversee collaboration of clinical services.

All STP partners had received correspondence from the NHSI Finance Director advising that the capital loan requests exceed the money available. Trusts had been approached collectively using the STP forums to reduce the capital ask by 20% across the whole STP. Walsall requirements related only to; completing capital works that had already started and replacing medical equipment or dealing with the urgent backlog of maintenance.

Mr Heer queried the impact upon capital plans such as the new ED and facilities. Mr Beeken replied that the main risks were highlighted. Mr Caldicott added that the agreed timeline for review would be available for the next meeting. The Trust would resubmit the outline business case and reaffirm capital spend. The OBS had already been endorsed and a refresh of the case had been requested.

Mr Dunn asked what monetary reduction was being sought across the STP. Mr Caldicott confirmed that it was in the region of £60m.

Mr Beeken continued that the Trust would take the view of business as usual. Board oversight would be tracked through the performance report.

Resolution
The Board:

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- **Received and noted the content of the report.**
- **Noted further STP updates would be included within the Performance Report.**

050/19 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:

- Vacancy and sickness position continued to drive a temporary workforce need, though the gap was reducing.
- Utilisation of the use of planned open capacity.
- Reduction of agency usage within ED, Ward 29 and ASU. **QPES**
- 6% shift fill rate would be discussed at the Quality, Patient Experience and Safety Committee. NHSI had been approached to obtain further information.
- Fill rate overall for days had slightly reduced from 93% to 91%. There was a slight decrease during nights but Dr Dunderdale remained satisfied that there were no quality concern correlation.

Mr Dunn asked for confirmation that as there were fewer births than planned, staffing capacity would be reduced safely to match demand and Dr Dunderdale confirmed that this would be addressed through reducing bank shifts. Dr Dunderdale also advised that she was working with the Head of Midwifery to put in place Birthrate Plus which would assist in monitoring the expected levels of births within the Trust. Mr Beeken noted that there was confidence within the service that birth rates would rise later in the year. Ratios were reviewed on a daily basis.

Mr Heer queried the grip and control arrangements in place within the nursing workforce and asked whether it they were fully implemented or menu driven. Dr Dunderdale responded that it was not a menu, though she could not give assurance of full implementation of grip and control at this time. Dr Dunderdale advised that her team are providing support to some of the operational staffing decisions being made on a daily basis.

Ms Oum noted the update and was satisfied with the work underway.

Mrs Bradbury asked when the steps being taken would be in place. Dr Dunderdale replied that culture and behaviours needed to be addressed through engagement with the staff. A plan would be presented at the next Quality, Patient Experience and Safety Committee which would include timescales and milestones. **QPES**

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

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051/19 Emergency Department Review

Dr Dunderdale presented the report for approval which set out the process and outcome of a review of the nurse establishment within ED. A proactive approach had been taken including engagement from all staff within the department creating rosters.

Dr Dundertale advised that the new establishment allowed staff to undertake advanced mandatory training, and an extra 5 days had been built in to accommodate this. Shift times had been aligned to demand and activity within the ED. The next stage was a management of change to move to the new roster by December.

Mr Hobbs endorsed the review, adding that staffing had been better matched to capacity and demand.

Mrs Baines requested that a review is built in after a period of time to review how things went.
Dr Dunderdale informed that in addition there would be an annual review of nurse staffing establishments and this would be presented to the Board in October/November. **Trust Board**

Ms Oum asked for clarification of the process of undertaking the annual nurse establishment and Dr Dunderdale replied that Ann Casey from NHSI had revisited the Trust to review if the recommendations identified by NHSI had been implemented and the report was imminent. Dr Dunderdale advised that once received the report will be shared with the Quality, Patient Experience and Safety Committee and People & Organisational Development Committee. **QPES** **PODC**

Mr Gayle asked if equality and diversity implications had been considered and Dr Dunderdale responded that she had received assurance and suggested that the equality impact assessment was presented at the People and Organisational Development Committee. **PODC**

Mr Dunn referenced the volume of activity in ED and asked whether this had been factored in.
Dr Dunderdale confirmed that both the adult and paediatric activity was reviewed and factored into the establishment.
Mr Hobbs advised that emergency demand differed and there was a seasonal variation in various conditions, particularly respiratory issues.

Mr Caldicott informed that there was investment in staffing in ED a number of years ago and the changes to the establishment was cost neutral.

The Emergency Department establishment Review was approved.

Resolution
The Board:

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- **Received and noted the content of the review.**
- **Approved the Emergency Department Review.**

052/19 CQC Update

Mr Beeken gave a verbal update, informing that the Trust had received the draft CQC report. Factual accuracy checks had been completed and submitted to the CQC within the timeframe.
The main challenges made related to the ratings grid and elements of the Well Led inspection conflictions. Indications were that the final report would be published within the next 2 weeks.
NHSI would notify whether the Trust remained in or had moved out of special measures.

Resolution
The Board received and noted the verbal update.

053/19 Learning from Deaths

Dr Lewis introduced the report, highlighting the following key points:

- HSMR was reported at 114 which was slightly higher than the national average comparison.
- Areas of focus related to respiratory, renal failure and fractured neck of femur.
- Reviews were ongoing into the deaths of patients with a learning disability.
- Fractured neck of femur featured high on HSMR. A new consultant had been recruited to the department.
- In terms of future actions, the Medical Examiner role had been appointed to which consisted of 3 members of staff. The lead was creating a process to start from September with a plan to go live by April 2020.

Dr Lewis added that he was producing a report which outlined the changes since implementing the learning from deaths policy, using best practice from other Trusts which would be presented to the Quality Patient Experience and Safety Committee.

Ms Oum thanked Dr Lewis for the report which was more concise and more clearly focused on learning. Ms Oum advised members that Mrs Bradbury would temporarily be the Non-Executive Director lead for Learning from Deaths and link with Dr Lewis on the agenda.

Mr Heer referred to one of the cases which resulted in death and whether being a medical outlier contributed to the death.
Dr Lewis advised that the location of care did not contribute to the death and mechanisms were in place to ensure continuity of care when patients were not on base wards

Resolution

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The Board received and noted the content of the report.

054/19 Walsall Together Business Case and Terms of Reference

Mr Fradgley presented the papers which had been considered at Private Trust Board, which were now being reviewed by all governing bodies and Boards for approval.

Members noted that the Board had already had a significant debate regarding the details and noted that there was still some additional financial analysis required. All had agreed that it was indicative at this time and changes would be looked at on a case by case basis.

Mr Fradgley added that elements of user engagements in the models and principles were consistent with national policies.

Mr Heer recognised the complexities of the partnership and noted the absence of an alliance agreement. Mr Fradgley stated that there the alliance agreement was drafted Next steps included 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.
Mr Beeken reiterated the huge potential would be limited if the Trust did not invest.

Mr Heer asked whether the dynamics could change and how social service funding was going to be increased and ring fenced.
Mr Fradgley replied that a full diagnostic had not yet been undertaken. Mr Fradgley added that he had not yet experienced any negativity from national press.

Mr Hobbs supported the level of ambition and commitment.

Referring to the draft terms of reference for the ICP Board, Mrs Baines discussed that there would be a balance of assurance and facilitating delivery required. It was an exciting task but at this stage, pragmatism was required.

Ms Oum stated that the ambitious initiative was about improving patient experience, outcomes, sustainability and achieving a much more efficient way of working. Ms Oum observed that the equality and diversity section and not been addressed however and asked for consideration to be given.

The Terms of Reference were approved.

Resolution
The Board:

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

055/19 Walsall Together Programme update

Mr Fradgley provided the following update:

- The STP was now running and seeing evidence of early change.
- 260 pilot calls had been taken and 95% were dealt with within the resource of the community teams.
- Horizon 2 work was underway.
- There had been a national policy change regarding Safeguarding Families which embeds into a community model for children. It was being used as the next tier of the plan.
- It was anticipated that charts for each of the work streams would be rolled out over the next few months. The Integrated Care Partnership Board would be the Guardians.

Ms Griffiths informed that a new way of working was required and she was reviewing how the workforce were equipped.

Mr Heer asked what the mechanism was for ensuring pace and delivery if there was a delay from a partner. Mr Fradgley replied that there was a high level of focus across all organisations. As the host, the Trust needed to set the pace. Regular updates and regular challenges were In place.

Mr Fradgley reported that the one immediate risk was GP engagement. Members noted that the GPs were largely engaged with the locality work and business case however further work needed to happen to get the level of engagement back up.

Ms Oum encouraged close working with the local GPs though some elements may not progress at pace, others would. Ms Oum reiterated the need to demonstrate the commitment to deliver despite limited resources.

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

056/19 Performance Report

Quality, Patient Experience and Safety Committee

Dr Dunderdale updated that there had been no single sex accommodation breaches, though it was recognised that the west wing did have issues with the availability of bathrooms.
Children's Safeguarding level 2 training was below target and would be discussed at the Divisional Performance Review meeting. Sepsis and patient deterioration were under review.
VTE had slightly improved during May.

Dr Lewis stated that the VTE target is 95% but that he had

agreed a trajectory with the CCG to achieve 92% in June and 93.5% in July, and was on track to achieve 95% in August.

Ms Oum expressed concern with DNAR compliance. Dr Lewis acknowledged that this was problematic. An audit was completed on a monthly basis. The DNAR forms were not user friendly and the Trust had been looking at replacing them with a RESPECT form. The issue would be discussed at the next Deteriorating Patients and Sepsis Committee.

Mrs Baines referred members to the appendix of the CEO report and advised that the process of assurance had not yet been shared with the Board and she did not feel assured that the appropriate Committees were reviewing the items for action.
Ms Oum requested that the CEO Report appendix was updated to detail which committee would review the national publications.

Integration Committee

Mr Fradgley reported that the Trust had secured £250k though social care and the CCG to fund an extension of a nursing home project which starts in July. Mr Fradgley also raised some concerns regarding length of stay in community beds however the length of time patients were waiting was reducing.

Mr Fradgley noted that the Rapid Response service continued to report high numbers of referrals, which has led to some concerns about the services ability to maintain the 2 hour response standard. The governance team were completing an audit of the 2 hour misses and the quality impacts.

Mr Fradgley drew the Boards attention to the Histology performance noting that the recovery of the Histology performance backlog was almost complete. Currently, only 42 remained and Mr Fradgley thanked the Black Country Pathology Service Team in their efforts to reduce the backlog.

Mr Heer queried how Histology improvement could be influenced and whether the framework could be exercised. Mr Beeken replied that the Trust were responsible for part of the service and should influence from within.

People and Organisational Development Committee

Ms Griffiths reported systemic issues within training such as the capturing of mandatory training, the number of modules include within mandatory training and how it is received by staff. Ms Griffiths noted that she would work with executive colleagues and members of her team to review the Trusts approach to training which would be overseen by the People and Organisational Development Committee.

Ms Griffiths highlighted that the HR policy workstream was

improving and Ms Griffiths was working closely with staff and union to continue to develop HR policies that were fit for purpose

Ms Oum questioned whether the behavioural framework was embedding. Ms Griffiths replied that the work completed to date was policy light and included a flowchart procedure. Guidance was being built into training and development.

Performance, Finance and Investment Committee

Mr Hobbs updated the Board on the continued risk relating to achievement of the emergency access standard, due to the demand on the service. Mr Hobbs noted that elective access had been commended with improved performance which was ahead of trajectory.

Cancer performance continues to be a challenge, particularly during April. This was a particular issue relating to breast screening, the Trust had committed to support improvements across the black country and ensuring that women received timely breast assessments. There were also challenges reported within Radiology and a meeting was planned for discussion next week.

Ms Oum agreed that the Trust should be assisting colleagues with seeing breast referral patients in a timely manner.

Mr Caldicott informed that the Trust had attained a plan at a £2.1m deficit at month 2. However Mr Caldicott noted that there was an ongoing £1m operational deficit and a £500k run rate risk. Measures were in place and would be reviewed at the Financial Cabinet.

Mr Caldicott noted that key workstreams which continuing to gain grip specifically temporary workforce, however the risk around capacity and sickness were driving the overspend within temporary workforce

Mr Caldicott highlighted the risk within obstetrics, due to birth booking number which were substantially down on the numbers expected. The Performance, Finance and Investment Committee would continue to scrutinise the recovery plan as well as oversight through the regular performance reviews.

Ms Oum noted that whilst the Trust at month 2 had delivered to the financial plan the risks identified at the start of the year remained and she urged continued focus on those areas.

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

057/19 The review of the Winter Plan for 18/19
The review of the Winter Plan for 18/19 was deferred until

September following a full review at each of the Board Committees within September

Resolution:
The Board agreed that the Winter Plan would be presented to each Board Committee in September.

058/19 Quality, Patient Experience and Safety Committee Highlight Report

Mrs Baines highlighted that she had requested that the performance report for QPES be redeveloped using SPC charts.

Ms Oum stated that the presentation of data was vital. A number of Board members were attending workshops NHSI had set up focused on presenting data.

Mrs Baines added that Inpatient Survey results were still awaited though an interim report had been received which indicated a general improvement. The results would help to drive a greater change for next time.

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

059/19 Performance, Finance & Investment Committee Highlight Report

Mr Dunn cautioned that the run rate remained unmitigated and the Trust would be heading for a deficit if the initiatives did not come into effect.

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

060/19 People and Organisational Development Committee Highlight Report

Mr Gayle noted a month on month reduction in sickness and also highlighted that The Committee could not approve the EDF2 and asked for it to be discussed at the next Committee

Ms Oum emphasised the importance of quoracy of the Committee.

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

061/19 Integrated Care Partnership Committee

The report was noted

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Resolution

The Board received and noted the content of the report.

070/19 Questions from the Public

Mr Lemord, Staff Side Representative asked for clarity regarding the workforce changes and apprentice provision within the Emergency Department Review. Dr Dunderdale replied that the Trust were keen to support CSWs, support talent and ensuring that there was an apprenticeship provision. The establishment review would look to see if there was scope to do both with an intention of replacing CSWs who had qualified as an RN with an apprentice and backfilling.

Ms Crowther, Birmingham Community Healthcare asked if the Board were assured that the equality and diversity actions were not going to just be a tick box exercise. Ms Oum replied that equality diversity was a very explicit part of the Trust Strategy. Regular reviews took place at the People and Organisational Development Committee and the Equality Diversity and Inclusion Group, Chaired by Mr Gayle. Equality, diversity and inclusion was very much a work in progress therefore the Board were not completely assured currently but had pledged that this was a Board priority and so would continue to challenge and support. Ms Griffiths added that there was a strategy and framework in place.

071/18 Date of Next Meeting

The next meeting of the Trust Board held in public would be on Thursday 5th September 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.

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Action log
Updated from Trust Board Meeting: July 2019

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	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	06/06/2019	Update – the review of the winter plan for 18/19 has been considered by POD and QPES and has now been reviewed by PFIC meeting on 24 July 2019. It is on the agenda for presentation to full Trust Board in September.	Complete
234/18		Improvement Update	Dr Lewis to review the underlying evidence in relation to mental health CPR compliance. Feedback to be reviewed at the Quality, Patient Experience and Safety Committee.	Medical Director/QPES	04/09/2019	On the agenda for QPES in May. This has been deferred to July	Open
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	Complete
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. Review completed by the Divisional Director of Nursing for Surgery. EIDO Healthcare (industry standard) information is used for patients. However, pathway for post-operative complex wound management can be improved and these patients will be managed through the new Surgical Ambulatory Care Unit.	Complete
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	Open

Action log
Updated from Trust Board Meeting: July 2019

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	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	Planned in new EPR deployment. Options to be reviewed at PFIC in July.	Open
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 PFIC. Meeting deferred so now scheduled September PFIC	Open
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	This item was deferred untill September	Open
049/19		Chief Executives Report	PODC to review the implications of staff resilience as a result of high ED demand.	Director of Culture & People	05/09/2019	This item was deferred untill September	Open
050/19		Nursing & Safer Staffing Report	QPES to receive a plan and milestone overview including communication and staff engagement in relation to the new e-rostering system.	Director of Nursing	05/09/2019	Allocate Porgress was dicussed at the QPES committee in August	Complete
051/19		ED Review	Annual review of staffing establishment to be reviewed at Trust Board in October	Director of Nursing	07/11/2019	On track	Open
051/19		ED Review	QPES and PODC to review the findings of the Ann Casey report.	Director of Nursing/Director of People & Culture	04/10/2019	Awaiting report from NHSI	Open
051/19		ED Review	PODC to review the equality impact assessment of the ED review.	Director of Nursing/Director of People & Culture	05/09/2019	The Equality impact assessment of the ED review was disucssed at PODC in August 2019	Complete
056/19		Performance Report	Dr Lewis to discuss replacing DNAR forms with RESPECT forms. The issue would be discussed at the next Deteriorating Patients and Sepsis Committee. Results and assurance to be presented at QPES.	Medical Director	04/10/2019	On the agenda for QPES in September	Open
056/19		Performance Report	CEO Report appendix to detail which committee would review national publications.	Trust Secretary	05/09/2019	on the agenda	Open

Action log

Updated from Trust Board Meeting: July 2019

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status

Complete
Open
Delayed (1 meeting)
Overdue (14+ days)

MEETING OF THE PUBLIC TRUST BOARD – Thursday 5th September 2019			
Chair's Report			**AGENDA ITEM: 6**
Report Author and Job Title:	Danielle Oum, Chair	**Responsible Director:**	Danielle Oum, Chair
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The report contains information that the Chair wants to bring to the Board's attention and includes a summary of the meetings attended and activity undertaken by the chair since the last Board meeting. In keeping with the Trust's refocusing on core fundamentals, this report has been restructured to fit with the organisational priority objectives for the coming year. With regard to the priorities 3 and 4, I 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 ☒		

Chair's Update

PRIORITY OBJECTIVES FOR 2018/19

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

   I was delighted that the Trust had moved out of special measures and the CQC rating for caring was outstanding. This is a credit to all staff within the Trust who had strived to make improvements within their areas and encouraged to continue their hard work.

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

   I participated in a Financial Cabinet meeting to support the Trust's financial improvement work.

   I chaired an Extraordinary Trust Board and attended an Extraordinary Performance, Finance and Investment Committee to review the Emergency Department selection process and documentation.

   Along with Richard Beeken, I joined a call with the Chief Executive, NHS Providers to discuss regulatory processes and feedback from being a Trust in special measures.

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

   I met with Mr Simon Johnson, who has returned to the Trust to follow up on the engagement work which commenced two years ago.

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

   I met with the Black Country Chairs and Chief Executives to discuss current updates and issues.

   I was happy to form part of the interview panel for a Non-Executive Director role at The Shrewsbury and Telford Hospital.

Meetings attended / services visited

One to one meetings with Executive Directors and Non-Executive Directors
Trust AGM
NHS Leadership Academy
NHSI
Mentoring session with a member of staff from the nursing team.
NHS Talent Management

RECOMMENDATIONS
The Board are asked to note the report

Danielle Oum, September 2019

MEETING OF THE PUBLIC TRUST BOARD – Thursday 5th September 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 or must, engage in, set against the organisation's strategic objectives. This month, I focus on the post special measures environment for our Trust, in particular the three pronged approach we must adopt to delivering our strategic objectives and our overall ambition of having outstanding rated services by 2022. I also go on to summarise the changes being made by NHSE and NHSI with respect to their regulatory oversight framework, setting out the implications for us. Finally, I briefly describe the shift to Integrated Care Systems as the main vehicle for the delivery of the NHS Long Term Plan and how we must adapt our thinking to that changing environment. The report also sets out to the Board, the significant level of guidance, instruction and best practice adoption we received during July and August 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 • Discuss and agree to the principles of my proposed approach to delivery of our strategic objectives and longer term ambition		
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 directly associated with this report		

Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Chief Executive's report

1. PURPOSE OF REPORT

The purpose of the report is to provide the Board with my appraisal of the high level, critical activities which the organisation has ben or must engage in, 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 Delivering our strategic objectives and organisational ambition

We have enjoyed the moment of coming out of special measures, after three years of work which concentrated on the fundamentals of care, staffing safety, patient safety culture staff engagement and leadership improvements. As a thank you to our staff, we have been allocating a redeemable meal voucher to all colleagues and the executive team have been hand delivering many of these to our wards, departments and community venues. They have been almost universally well received. The message we now must give to colleagues following this achievement is that we have achieved only the first step on the journey to maximising our potential and delivering our ambition of having outstanding rated services by 2022. Momentum and continuous improvement must be maintained.

To achieve the ambition we have, we must now increasingly turn our attention as a Board and then as a wider organisation, to strategic matters. In particular, we must be aligned as a Board about how our progress towards that ambition should be realised. I propose that we take a three pronged approach to the delivery of our strategic objectives and quality ambition:

A. "Sweep our side of the street clean".

By this, I mean that we should deliver a culture of continuous improvement through our Improvement Programme that will ensure that we maximise our potential within our current construct. For example, that we:

- Demonstrate strong learning from excellence and incidents within the patient safety sphere
- Achieve productivity metrics that benchmark with upper quartile performance nationally (ie. Length of stay, outpatient DNA rates, theatre utilisation)
- Deliver nationally defined clinical best practice where resources and staffing allow
- Achieve workforce productivity, engagement and wellbeing metrics that benchmark with the best in class

B. Deliver the Walsall Together business case

It is clear to me that, even by delivering the kind of consistency I describe above, we will be unable to ensure a clinically sustainable service without seeking to manage the seemingly elastic demand which we face, both electively but in particular in our emergency portals. To reduce demand effectively, we must adopt the principles of the Five Year Forward View and the NHS Long Term Plan. This means we need to lead the work with partner organisations and the voluntary sector through the Walsall Together programme to deliver the business case all local statutory organisations have agreed in principle. This will include:

- Developing resilient communities, focusing on good housing, employment and social cohesion as key ways of generating stronger health and wellbeing
- Investment in public health initiatives and responding to public health information on changing health need
- Integrating health, mental health, primary care and social care teams to better manage chronic disease
- Shifting resources from maintenance of the current paradigm of provision, to the community

To achieve this, we will need to remember how bold we said we would have to be, in changing the current approaches to resource allocation. This will need a radical reassessment of our risk appetite in this space, but will be consistent with national policy.

C. Horizontal integration of acute hospital services and exploration of an acute hospital chain model

Even if the maximum opportunities shown us in the Walsall Together business case are achieved, there will remain significant issues at Walsall Manor Hospital which we will not be able to resolve on our own without a significant acceleration of cooperation and integration of services across the Black Country. Residual problems which we would seek to tackle include:

- Poor 7 day emergency service resilience for reasons of both staffing availability and financial constraint
- Inadequate capacity in more specialist services and a corresponding lack of resilience
- Inability to eradicate premium rate, temporary staffing in all circumstances
- Leadership capacity and capability issues set against an increasingly challenging regulatory and quality agenda
- Continued financial sustainability concerns due to diseconomy of scale
- Poor maximisation of workforce integration and back office consolidation between all the Black Country acute trusts
- Unsustainable/unviable service provision continues to a greater or lesser extent in all Trusts in the Black Country

We have established an executive steering group to accelerate acute service collaboration between ourselves and The Royal Wolverhampton NHS Trust. We will soon receive the view of The Dudley Group FT regarding their participation in this. I will be playing my part in bringing further considerations regarding deeper integration between the Black Country Trusts, driven by that executive group, in the new year. The Board can expect to receive updates on service collaboration progress, via my reports and separate updates, from October onwards.

3.2 The new NHSE/I oversight framework

A document has now been published by NHSI/E which replaces the previous oversight framework for CCGs and Trusts, managed separately previously, by both regulatory organisations. It sets out how the two regulators will deepen their own working relationship to ensure that systems are managed collectively, rather than through their separate, constituent parts.

Regional teams will be wholly responsible for determining the support, improvement and, where necessary, regulatory intervention required to ensure national deliverables are sustained. Increasingly, aspirant Integrated Care Systems (Currently STPs) will be involved in providing assurance to NHSI/E for the whole system, as well as recommending interventions required. This will necessarily mean that we will see the performance management of the NHS Long Term Plan (LTP) deliverables via STPs (our own STP in the Black Country and West Birmingham is already setting itself up to do this) and collective accountability between different 'sovereign' organisations will be encouraged and even mandated. In our STP, because of the distinct nature and identity of the 5 "places" (Dudley, Wolverhampton, Walsall, Sandwell, West Birmingham) and the strength of the local authority presence, NHSI/E oversight will begin at place based level, not just at STP level. An encouraging start has already been made, with the first system review meeting with NHSI/E having been held for Walsall. It was pleasing to see both CCG and Trusts being held to account for the whole range of deliverables expected of us, rather than the focus being purely on provider organisations and the CCG being perceived more as a regulator itself.

As the sophistication and collective responsibility of the BCWB STP develops, the Board can expect our accountability to be delivered via this route, rather than just solely to NHSI. Individual accountable officers across the STP have been asked to take on senior responsible officer roles for the different programmes of work to deliver the LTP. For example, I have been SRO for the elective care transformation work stream and will shortly swap that responsibility for leading the urgent care work stream across our STP. This new approach will be an important test of each constituent Board's preparedness to live by the principles of the STP Memorandum of Understanding and work in the collective best interests of service users and the public, not just their own individual organisations. The points made about statutory accountability of Boards are pertinent, but should not be seen as an obstacle to consensus decision making and collective accountability.

4. RECOMMENDATIONS

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

Richard Beeken
Chief Executive
27/8/19

NEW NATIONAL GUIDANCE, REPORTS AND CONSULTATIONS

The following guidance and policy actions, which have been received from the wider regulatory and policy system since July 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
1.1	**New Freedom to Speak Up (FTSU) training guidelines** The new national guidelines that are designed to improve the quality, clarity and consistency of speaking up training across the health sector in England to support those commissioning and delivering training. The guidelines are set out in three parts covering three broad groups of workers: core training for all workers; line and middle managers training; and senior leaders training. They include details of the methodology that organisations could employ when designing training.	**Action** **POD Committee September**	**Director of People and Culture**
1.2	**Integrated Care Provider Contract** NHS England and NHS Improvement have published the Integrated Care Provider Contract, as well as associated explanatory resources. The contract is one of the options available to systems and commissioners to integrate care using a single contract for provision of general practice, NHS and local authority services.	**Information**	**Director of Finance and Performance**
	The mental health implementation plan 2019/20-2023/24 The NHS long term plan (LTP) builds on the commitments for mental health services set out in the five year forward view for mental health (FYFVMH), The implementation plan provides a framework to support the delivery of these commitments locally, and sets out a combination of fixed, flexible and targeted approaches, with core national targets supported by flexibility for local systems to agree how best to deliver services.	**Information**	**Director of Nursing**
1.4	**Single oversight framework** NHS England and NHS Improvement are aligning	**Information**	**Chief Executive**

	their operating models to support system working. This framework summarises how this new approach to oversight will work from 2019/20 and the work that will be done during 2019/20 for a new integrated approach from 2020/21.		

MEETING OF THE PUBLIC TRUST BOARD **5th September 2019**			
Monthly Nurse Staffing Report – July 2019 Data			**AGENDA ITEM: 8**
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	July continued to see the use of some additional capacity beds which resulted in the continued use of additional temporary staffing. Ward 14 continues to be an unfunded ward will all ward staffing reflected as additional capacity. Bank use and Agency use followed a normal trend in month but usage was less than in the same period last year. Overall the total temporary staffing usage is showing a smaller amount of variability to what we have seen in previous years. A number of process actions have been strengthened to ensure grip and control remains around request of temporary staffing. The RN fill rate average for July 2019 overall was 91.4%. 11 areas had a < 90% RN overall fill rate on days and 2 areas on nights. 2 areas had an <80% CSW overall fill rate on days and all areas had over 80% fill of CSW at night. There was one off framework agency nurse shift within ICU during July. This paper has been considered at the Quality, Patient Experience and Safety Committee.		
Recommendation	The Committee is requested to note the contents of the report and make recommendations as needed.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Objective No 5: Establish a substantive workforce that reduces our expenditure on agency staff. Corporate Risk No 11: Failure to assure safe nurse staffing levels.		
Resource implications	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

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 4 key areas- which include the workstreams in the nursing workforce transformation programme – Shift Fill Rates; Temporary Staffing; eRostering; Staffing 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.

1.SHIFT FILL RATES

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.

The RN fill rate average for July overall was 91.4% which splits in to the following day and night average:

- 88.26% for day shifts
- 95.75% for night shifts

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).

Of the 22 areas reported on during July 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.

- 11 areas recorded less than 90% shift fill rate on days for RN

  - Wards 1 / 2 / 3 / 4 / 7 / 15 / 16 / 20a / 29 / AMU / ICU
- 2 areas recorded less than 90% shift fill rate on nights for RN
  - AMU / ICU
- 2 areas recorded less than 80% shift fill rate on days for CSW
  - Wards1 / 24&25
- No areas recorded less than 80% shift fill rate on nights for CSW

Table 1

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	7	11								
Night	RN	1	0	1	2								

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	5	2								
Night	CSW	1	1	1	0								

Ward 2 continued to have a lower RN day fill rate at 78.9%. This is an improvement on last month and shows a continued improved fill rate position over the last three months.

Ward 7 also experienced a low RN fill rate on days at 85.9%, an improvement of 5% on last month but still lower than a desired fill rate.

Ward 20b/20c saw an improvement of 4% on last month to 94.6% for RN fill rate on days.

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.

The Director of Nursing continues to give assurance that staffing remains safe.

1.1 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 2 (red is an increase between this and last month)

Areas with less than 90% fill rate		Ward 1	Ward 2	Ward 3	Ward 4	Ward 7	Ward 15	Ward 16	Ward 20A	Ward 29	AMU	ICU	Total
Number of falls	Jul-19	14	4	9	7	4	7	0	4	5	4	0	58
	Jun-19	5	7	11	11	2	4	0	6	6	9	0	61
	May-19	8	1	11	6	5	6	2	1	5	7	0	52
Number of PU (grade 2)	Jul-19	0	0	2	0	0	0	0	0	0	0	0	2
	Jun-19	1	1	0	1	0	1	0	0	0	0	0	4
	May-19	1	1	0	0	0	1	2	0	1	0	0	6
Number of PU (grade 3/4/unstageable)	Jul-19	0	2	0	1	0	0	0	0	0	1	1	5
	Jun-19	0	0	0	0	0	0	0	0	0	0	0	0
	May-19	0	0	0	0	0	0	0	0	0	1	0	1

Table 2 shows for the wards with a <90% RN day fill rate, the number of pressure ulcers acquired in month and patient falls recorded over the last three months (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.

Eight of the 11 wards with a RN day fill rate of <90% in July had the same number or less falls than the previous month, although there was an increase on 3 areas- Wards 1,7 and 15. Correlation between staffing levels and patient harm must be considered in this instance as part of the RCA.

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.

2.TEMPORARY STAFFING

2.1 Total Temporary Staffing Use

The total Agency nurse usage for July 2019 was less than in June (138 shifts) and usage was considerably lower (527 shifts) than for the same period last year (Chart 1).

Bank usage remained consistent during July and did not follow the trend of last year where we saw a rise in usage (Chart 2).

So, overall the total temporary staffing usage in July 2019 was less than for the same period last year and is continuing to show a smaller amount of variability to what we have seen in previous years. (Chart 3).

Reviewing the data from last year showed an increase during August 2018. Weekly summer Annual leave data has been shared with Divisional Directors of Nursing and is monitored at the Workforce Transformation Meetings to ensure any areas of elevation are addressed.

Chart 1

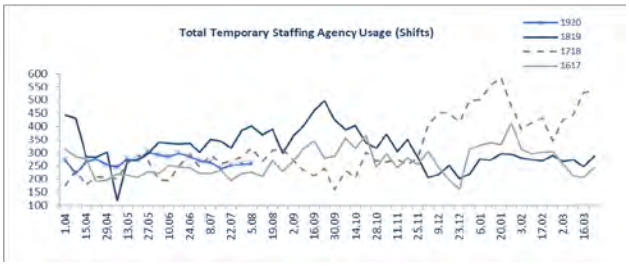
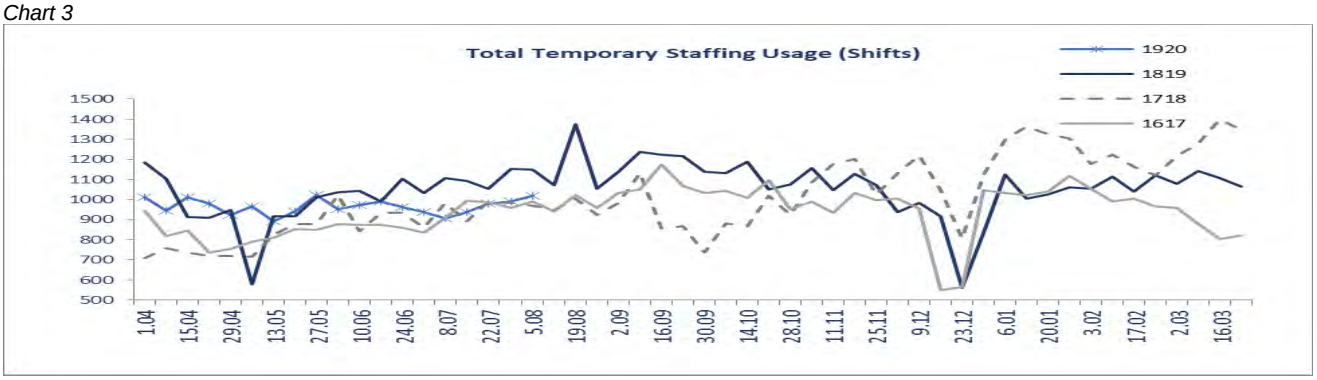


Chart 2

Chart 3



	Total Temporary Staffing Usage (shifts by week)																	
	01-Apr	08-Apr	15-Apr	22-Apr	29-Apr	06-May	13-May	20-May	27-May	03-Jun	10-Jun	17-Jun	24-Jun	01-Jul	08-Jul	15-Jul	22-Jul	29-Jul
2019/20	1011	946	1012	979	924	967	891	940	1022	951	971	990	963	937	905	939	981	990
2018/19	1183	1104	913	908	947	578	918	916	1013	1036	1043	992	1104	1034	1108	1092	1055	1154

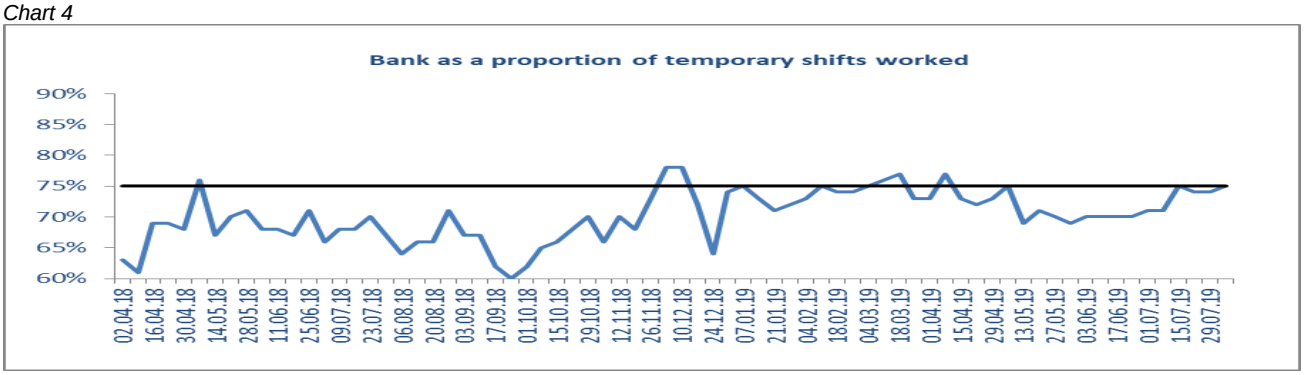
The figures above show a continued trend from 3rd June of less temporary staffing shifts in 2019/20 compared to 2018/19.

2.2 Bank Use

The internally set target of 75% temporary staff shift fill using bank (Chart 4) has ranged between 69% – 71% during July. This contributes to the use of agency nurses in month to

bridge the gaps of temporary staffing shifts. The Temporary Staffing Team continue to recruit to bank staff each month.

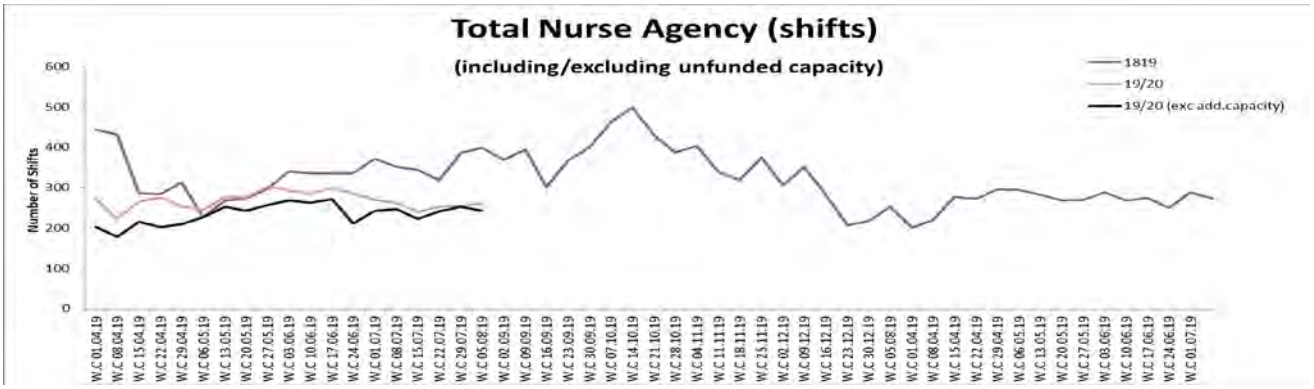
Chart 4



2.3 Agency Use

The graph below shows the impact of unfunded capacity upon the agency use within the Trust. There is clear evidence that unfunded capacity contributes to the use of Agency nurses within the Trust (Chart 5). Previous years data did not extract the extra capacity for comparison of data.

Chart 5



The top four reasons for Agency staff use within this financial year, which include unfunded capacity are shown below in Charts 6-9:

Chart 6

Chart 7

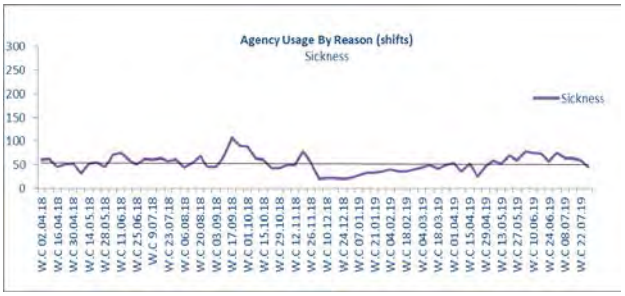


Chart 8

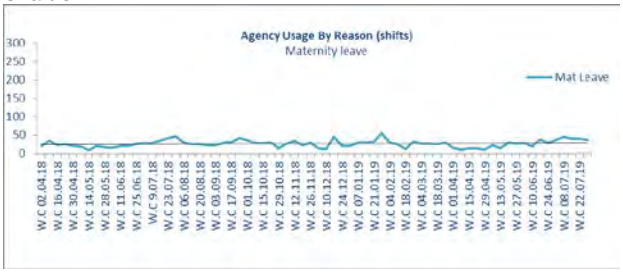
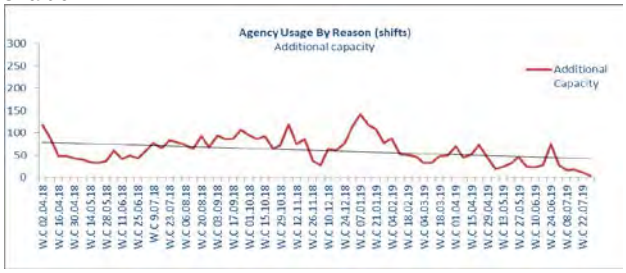


Chart 9



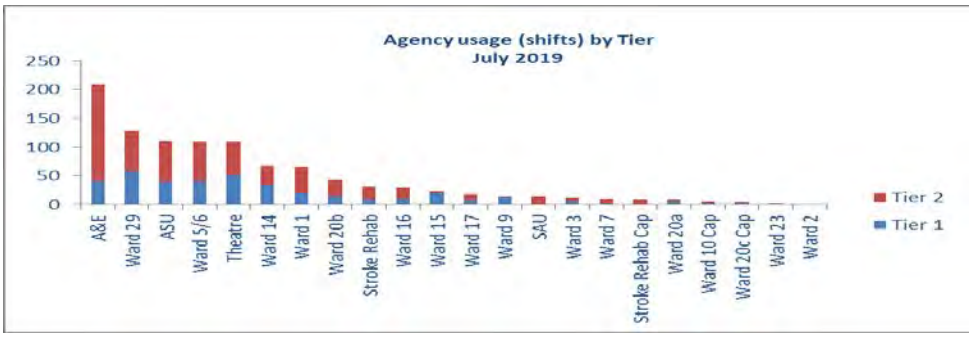
'Vacancy' as a reason for Agency use is currently subject to a number of actions. MLTC Division have completed assurance testing against the reported vacancy numbers in ESR and Finance Ledger. The impact from this was an increase in the total budgeted nursing staff and consequently a higher vacancy position. Surgery Division are completing the same piece of work. 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 for temporary staffing to their current vacancy position at daily staffing meetings. Since these extra actions have been put in place there has been less weekly variation in the vacancy use.

Both sickness and maternity cover with temporary staffing has showed less variation and these two reasons for cover are both included in the Matron cross checking expected before staffing is escalated.

2.4 Tier 2 Agency Use

The ward areas with the highest volume of Agency use during July 2019 are captured below (Chart 10) by tier.

Chart 10



ED remains a consistent highest user of Agency nurses and has a RN vacancy gap of 21.01 wte (27%), the second highest users are Ward 29 and ASU with a vacancy gap of 6.95 wte and 8.24wte (32% and 22% respectively).

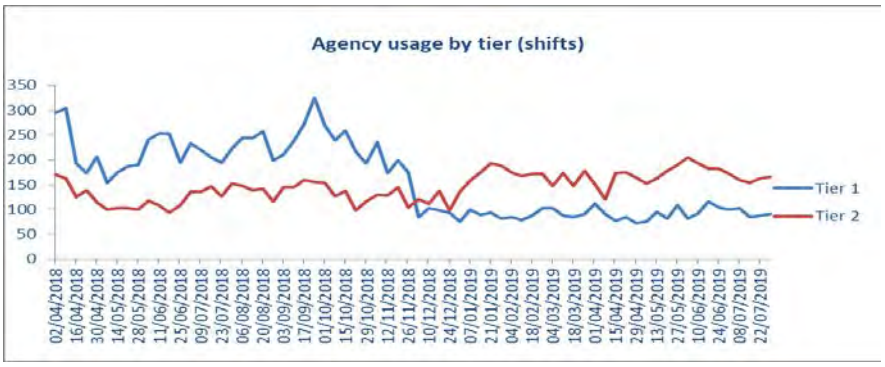
ED shifts are filled at Tier 2 and above due to the specialist skill set required for that area and the current vacancy position that includes the paediatric nurse posts, which are required in the 24 hour establishment cover.

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

Chart 11 shows the increase in Tier 2 agency nurse use. Escalation to Tier 2 occurs within 72 hours of shift and is partly due to short notice shift fill cover and non fill by Bank or Tier 1. Since November 2018, all wards are asked to staff night shifts substantively as a priority leaving majority day shifts for Bank or Agency. Tier 1 workers prefer to book for night shifts due to enhanced levels of pay received however the majority of our agency shifts are within the day.

Wards are asked to grade shifts Red or Amber to reflect urgency and level of escalation for Bank Office to fill. Red shifts are filled with tier 2 agencies which accounts for those wards without additional beds but those that have been deemed as 'red' for shift cover priority after risk assessment and acuity consideration during the twice daily approval meetings.

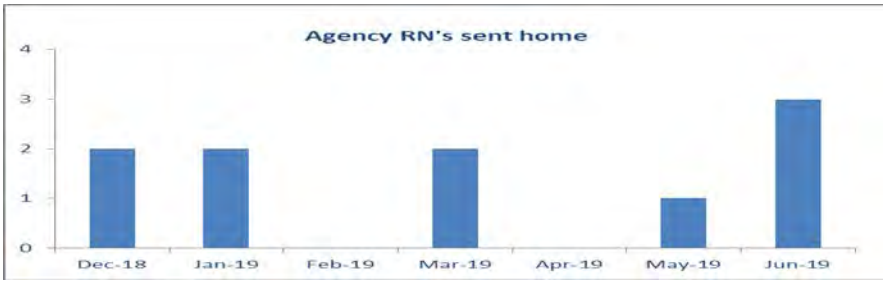
Chart 11



Agency Controls are in place as part of the Workforce Transformation Meetings and the Temporary Staffing office conduct Agency staff 'check-in' each evening. Wards are undertaking the morning 'check- in' following the same process. The control was put in place in December 2018 and includes a cross check of the attending worker against the booking as well as a review of uniform and Identification. The objective of this was to safeguard against Agency workers turning up on shift that were not required or who had not been booked. During check in, if the worker is found not to have been booked then they are sent home and the Agency informed.

This is considered a saving for the Trust as previously the Agency worker could have been kept on duty with an invoice following afterwards. Chart 12 below shows the number of Agency RNs sent home per month which finance are able to cost as a saving achieved through the Workforce Transformation Meeting.

Chart 12



2.5 Cap Compliance and Off Framework Use

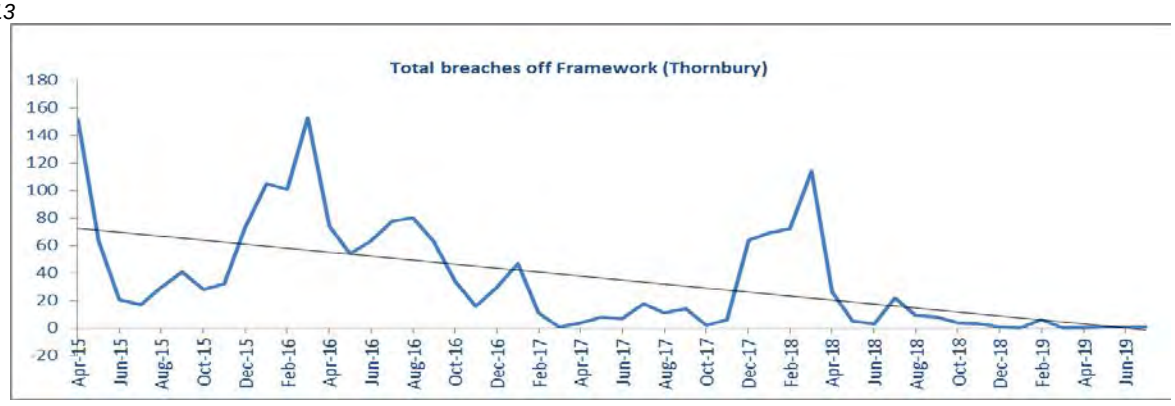
The Trust are required to report the use of Agency staff that breach the price caps and Non Framework use. Table 3 below shows the use for the month of July.

Table 3

Staff Group	01.07.19			08.07.19			15.07.19			22.07.19		
	Total Agency Shifts	Of which breach Price cap	Of which breach Price cap & Non Framework	Total Agency Shifts	Of which breach Price cap	Of which breach Price cap & Non Framework	Total Agency Shifts	Of which breach Price cap	Of which breach Price cap & Non Framework	Total Agency Shifts	Of which breach Price cap	Of which breach Price cap & Non Framework
Nursing, Midwifery & Health Visiting	213	119	0	208	111	0	192	111	0	188	108	1
Day	102	78		109	82		81	70		81	68	
Night/Saturday	89	29		81	23		85	29		80	27	1
Sunday/Bank Holiday	22	12		18	6		26	12		27	13	

There was 1 off framework shift used during July 19. Chart 13 below shows the trend of off framework use over the last 4 years and demonstrates the reduction in use. The Trust have a greater level of control with use of off framework. The shift during July 19 was used for cover in Intensive Care Unit and an RCA is underway.

Chart 13



3. E-ROSTERING

The quality of rosters at ward level is still variable across the Divisions and contributes to the staffing shortfalls and roster inefficiencies. Detailed reports including the information in Table 4 are 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 at divisional/Ward level.

The introduction of Allocate as an alternative rostering system for Nursing was approved and training for implementation of the system has commenced. A project team has been established with a Project board being chaired by the Director of Nursing. It is expected that the system will be in use for some areas from December 2019. A new Roster Policy and Temporary Staffing policy will be circulated for review ahead of November.

The Director of Nursing will be able to provide more assurance with regard to compliance with roster efficiencies once the Allocate system is implemented.

Table 4 reflects the roster KPI performance for the roster period 17th June till 14th July 2019 (signed off 22nd April 2019)

Table 4

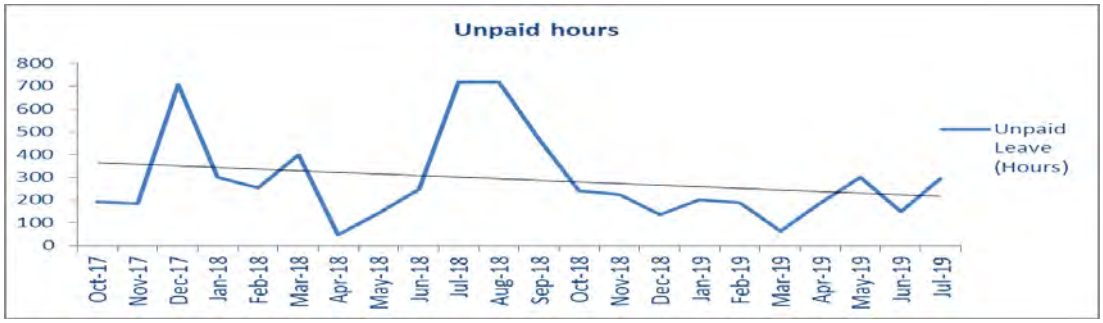
KPIs - Roster Period 17.6.19-14.7.19 SIGNED OFF 22.4.19	Target	Tolerance	MLTC Summary of compliance with target	Surgery Summary of compliance with target	WCCSS Summary of compliance with target
Compliance with sign off on correct date	100%		66%	83%	67%
Shifts to BANK at Sign-Off compliance	100%		100%	80%	n/a
Planned number of shifts without NIC cover	0	0	38.5	9	38
Actual number of shifts without NIC cover	0	0	28.5	37	52.5
Planned sickness headroom (not ESR data)	Not exceeding 3.30%		100%	80%	100%
Actual sickness headroom (not ESR data)	Not exceeding 3.30%		16%	0%	0%
Planned study leave headroom	not exceeding 3%		100%	100%	100%
Actual study leave headroom	not exceeding 3%		100%	100%	80%
Planned annual leave headroom	14%	+/-3%	58%	67%	100%
Actual annual leave headroom	14%	+/-3%	83%	80%	100%

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. Chart 14 shows an increase in unpaid leave hours for July. Positive progress is being made but continued sustained efforts to reinforce the key messages is still required.

Chart 14



4. STAFFING ESTABLISHMENTS

The current overall establishment gaps from ESR as of July 2019 (excluding theatres) are shown below in Table 5 and includes numbers of pipeline recruits over July-Sep 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 5

							RN Recruitment Pipeline –(Next 3 months)			
Division	**Establishment Gap (%) RN Vacancy**	**Establishment Gap (WTE) RN Vacancy**	**Long Term & Sickness Gap (WTE)**	**Maternity & Adoption Leave (WTE)**	**Total Gap (WTE)**	**Trend compared to last month (Total Gap)**	**Pipeline – Aug**	**Pipeline –Sep**	**Pipeline – Oct**	**Total**
SURGERY	8.37%	20.39	11.7	4.46	36.55	↓	1	18	1	20
MLTC	15.53%	43.69	14.92	11.2	69.81	↓	6	21	2	29
WCCSS	3.07%	3.11	1	1.93	6.04	↓	0	2	0	2
COMMUNITY	3.67%	6.57	3.4	11	21.61	↑	1	0	0	1
	10.73%	70.65	31.02	28.59	134.01	↓	8	41	3	52

ED establishment review has completed and applied 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 that has been approved. Management of Change will be undertaken for the new established roster to come into effect from 4th November 2019 roster.

Table 6 below reflects the ongoing recruitment of RN and CSW to the nurse bank. In addition,since November 2018, the Trust is offering a bank contract at Trust Induction for all new starters.

Table 6- Number of RN and CSW recruits

	Target	Baseline Number (as of June 19)	**July Target increase**	**July Actual recruited**	**Aug Target increase**	**Aug Actual recruited**	**Sep Target increase**	**Sep Actual recruited**	**Oct Target increase**	**Oct Actual recruited**	**Nov Target increase**	**Nov Actual recruited**
RN	To increase by 40% by 31.3.20	60	3	17	3		3		3		3	
CSW	To increase by 40% by 31.3.20	225	10	12	10		10		10		10	

6.0 CONCLUSIONS

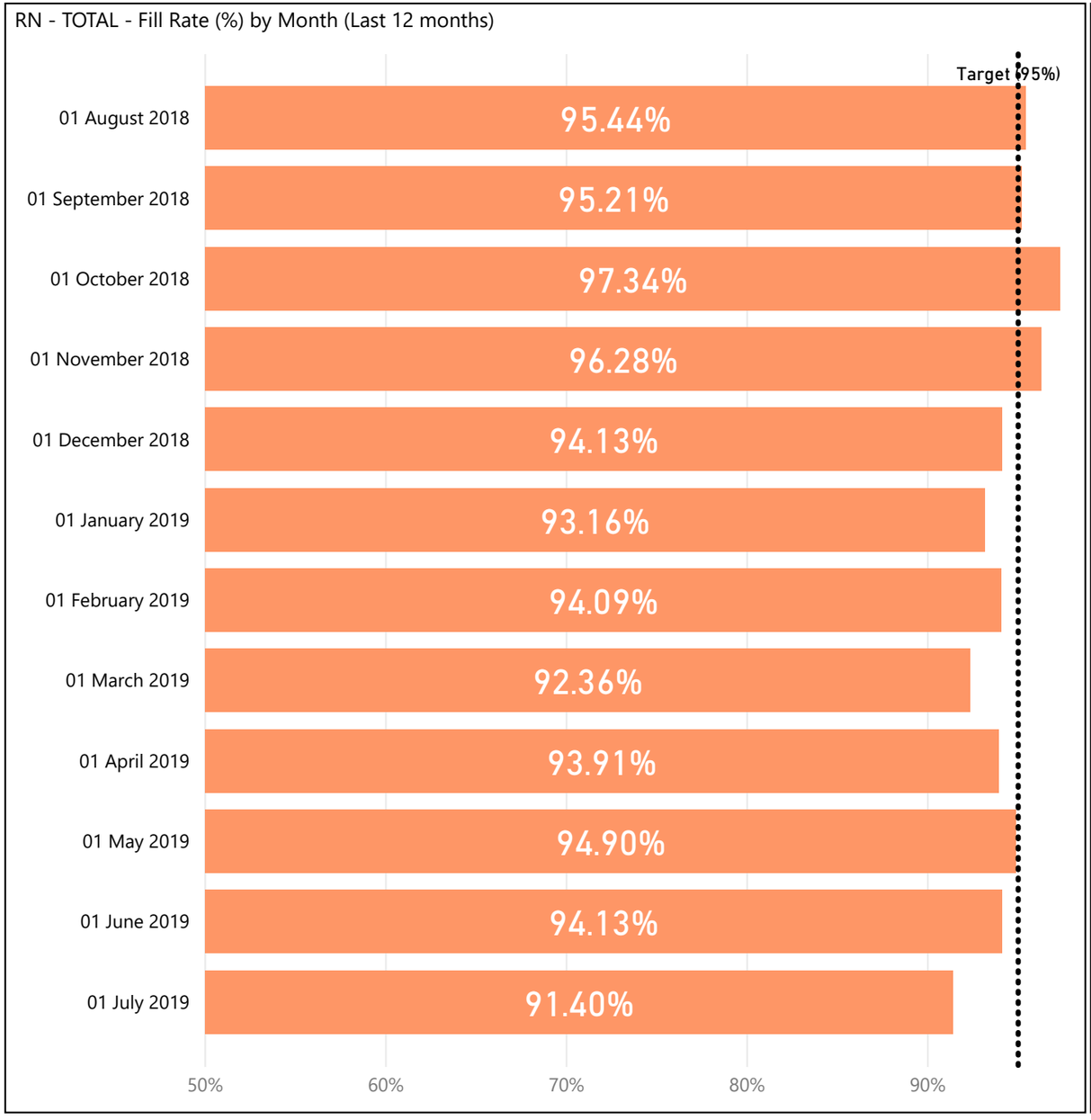
The report is presented to reflect the on-going nursing workforce transformation and will continue to reflect the progress being made and the improvements in grip and control across temporary staffing and rosters in particular but enhanced by workforce developments and agreed safe establishments according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

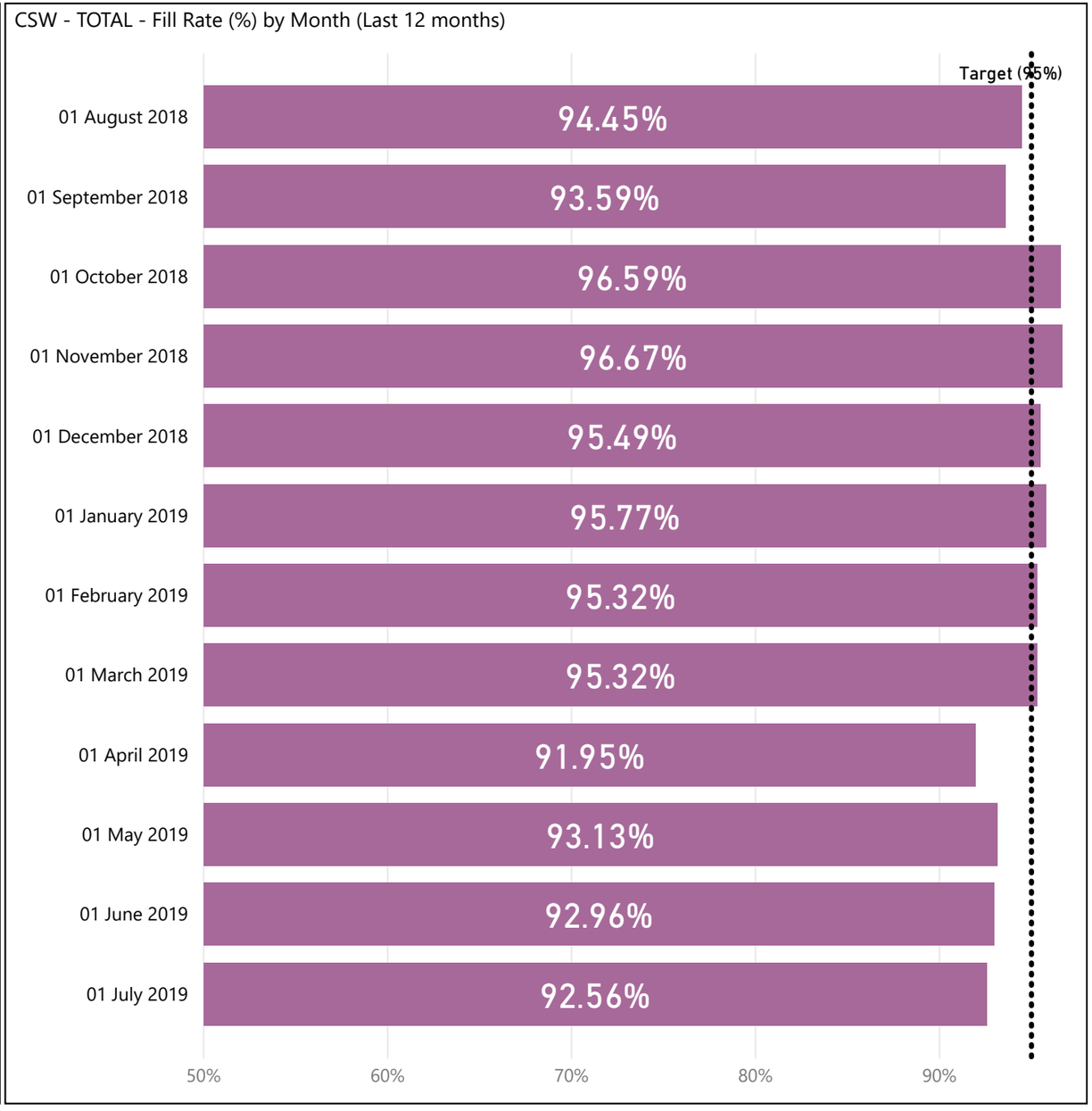
Appendix 1: Monthly overall fill rate data for RN/CSW
Appendix 2: NHS Digital Upload

0701 Safe Staffing Return - Fill Rate Trending

Split between RN & CSW

Walsall Healthcare NHS Trust





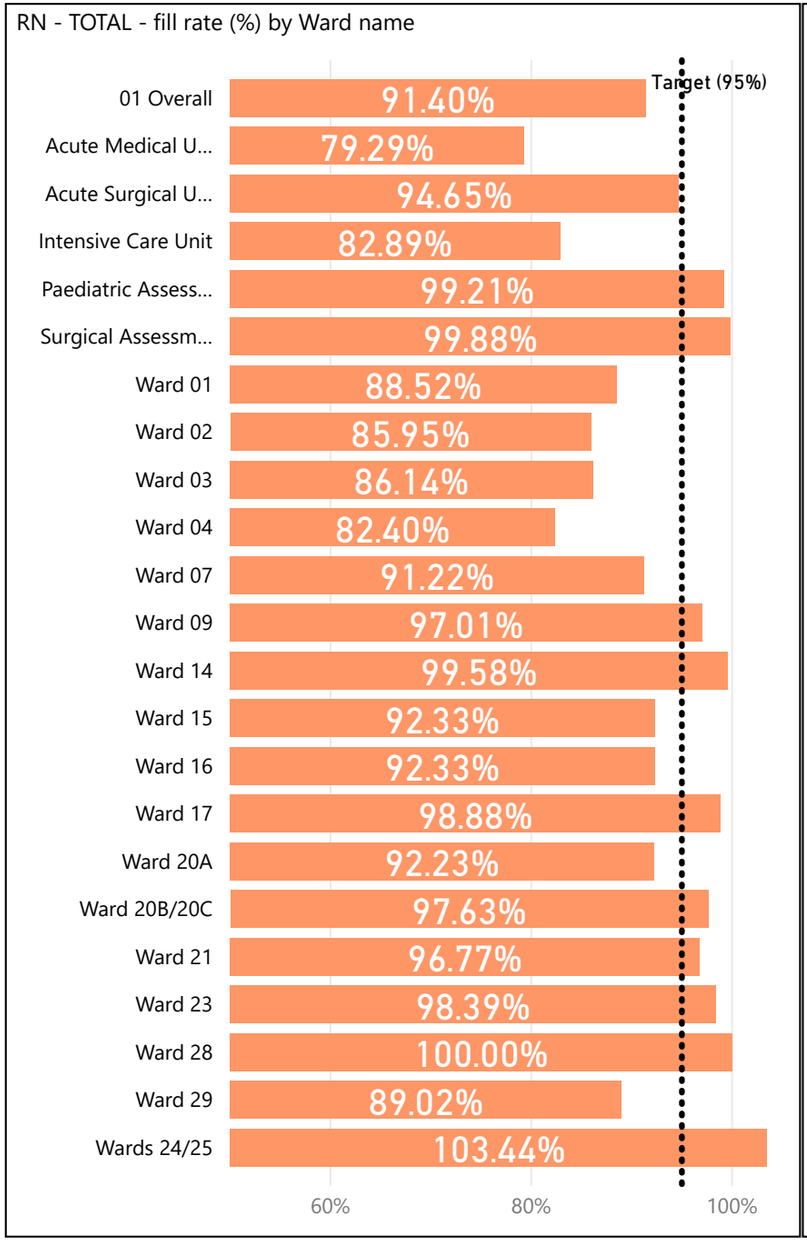
0701 Safe Staffing Return - Overall Fill Rate

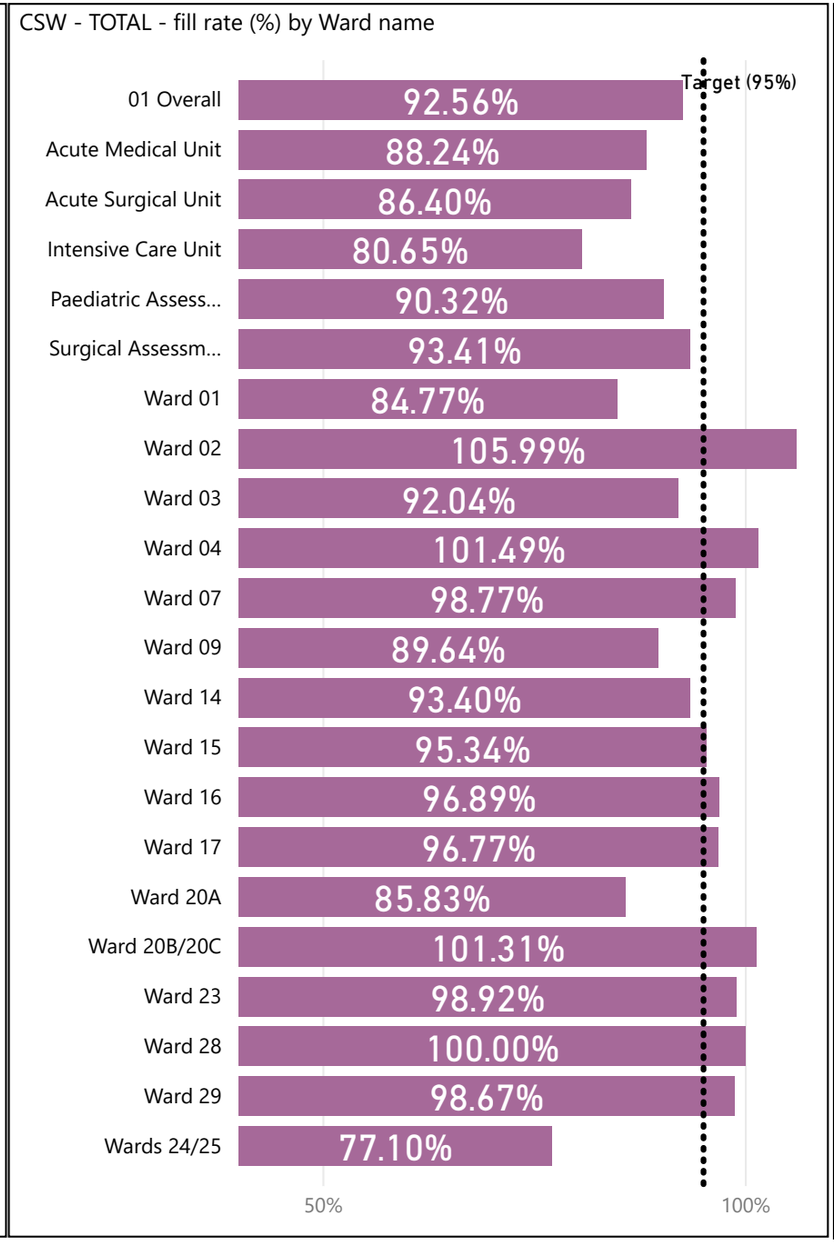
By Ward split between RN & CSW

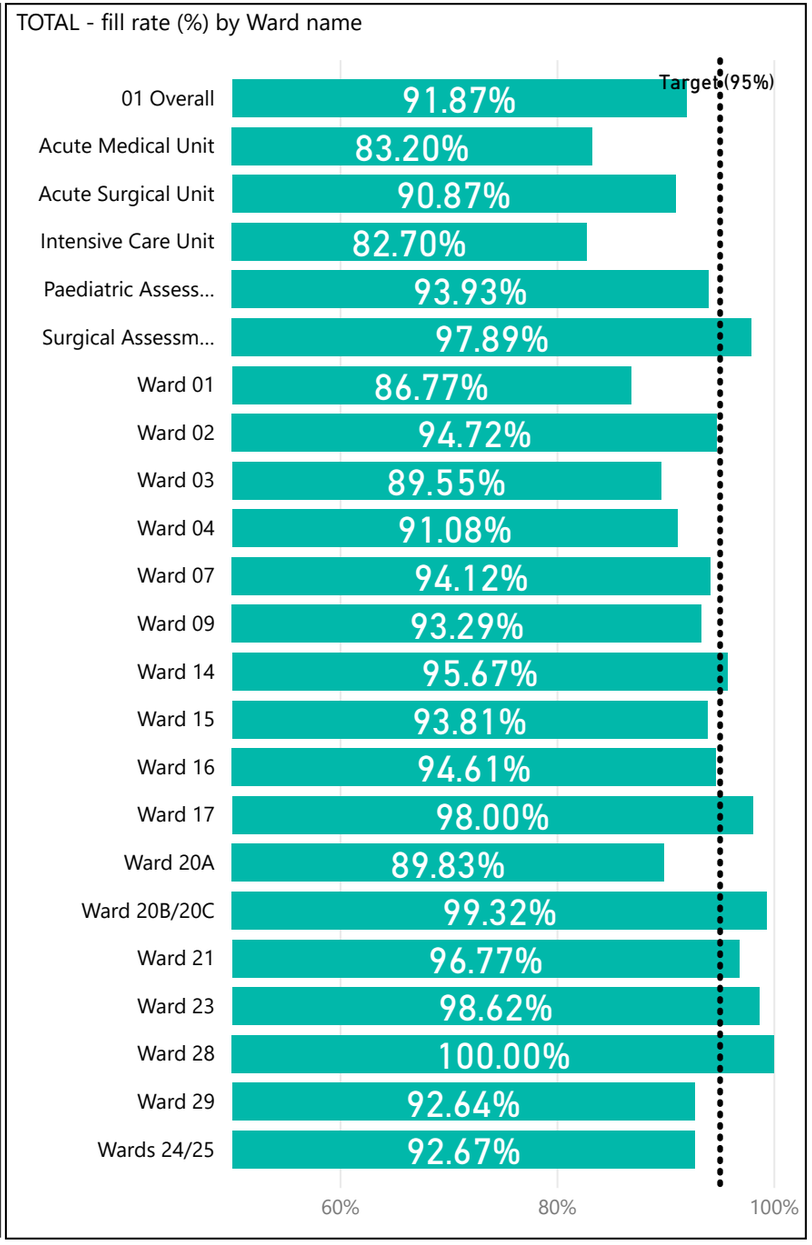
Month

01 July 2019

Walsall Healthcare NHS Trust







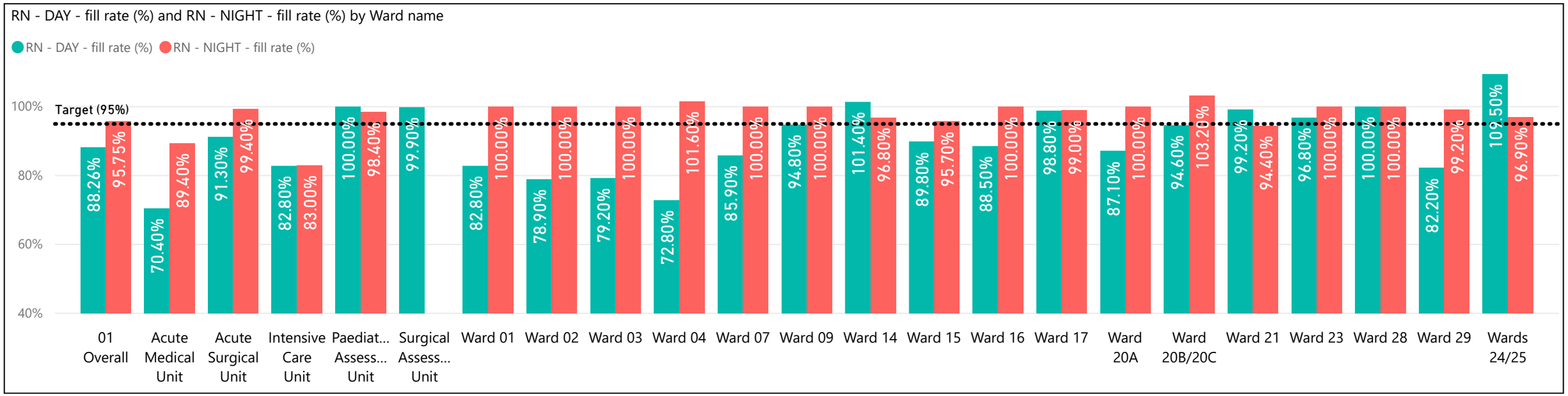
0701 Safe Staffing Return - Fill Rate for RN & CSW

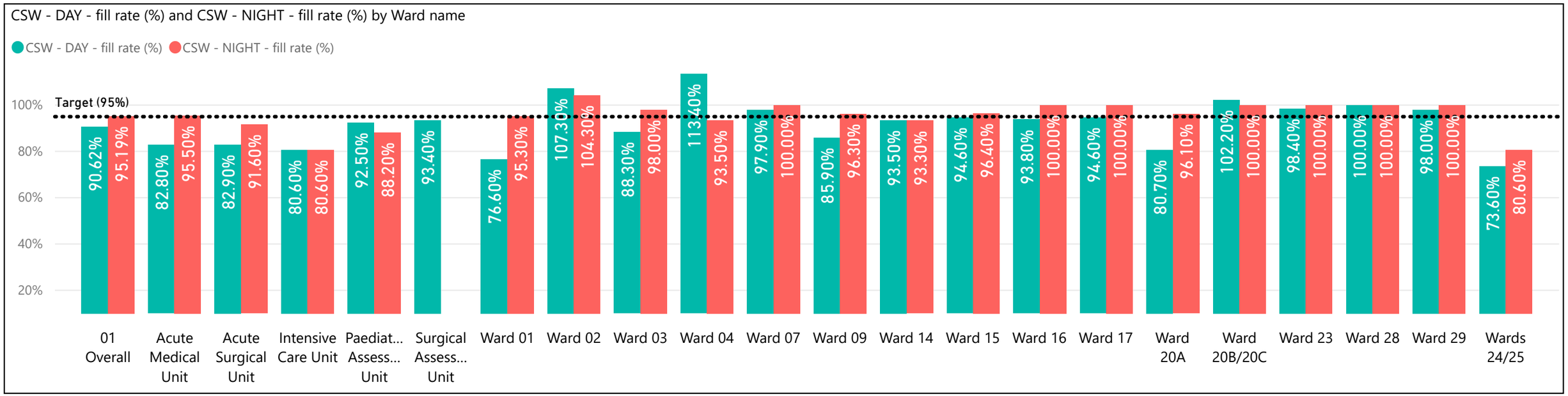
By Ward split between Day & Night

Month

01 July 2019

Walsall Healthcare NHS Trust





Safe Staffing (Rota Fill Rates and CHPPD) Collection

For any techincal queries or additional clarification relating to the collection please contact: NHSI.Returns@nhs.net

For any queries or additional clarification relating to submissions please contact: data.collections@nhs.net

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Please check that the data on this upload template is accurate before being submitted to SDCS. You are reminded that these figures will be published, and it is the responsibility of your organisation that these submitted figures are accurate and in line with national guidance. We will undertake basic validation checks on these figures post submission, and may come back to you with any queries we may have.

RBK Walsall Healthcare NHS Trust

Validations
Please correct all issues listed within the tables below. If the issues are not corrected then the pro forma will fail the validation stage in SDCS.

Control Panel

Trust - Frontsheet

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

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Allied Health Professionals				Care Hours Per Patient Day (CHPPD)						Day		Night		Allied Health Professionals	
					Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Registered allied healtH professionals		Non-registered allied health professionals													
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	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) (%)
RBK02	MANOR HOSPITAL	Acute Surgical Unit	100 - GENERAL SURGERY		2495.5	2278.1	2160	1790.5	1782.5	1771	1449	1327.5					1103	3.7	2.8	0.0	0.0	6.5	91.3%	82.9%	99.4%	91.6%		
RBK02	MANOR HOSPITAL	Paediatric Assessment Unit	420 - PAEDIATRICS	171 - PAEDIATRIC SURGERY	750.5	750.5	1069.5	989	713	701.5	1069.5	943					24	60.5	80.5	0.0	0.0	141.0	100.0%	92.5%	98.4%	88.2%		
RBK02	MANOR HOSPITAL	Ward 01	400 - NEUROLOGY	300 - GENERAL MEDICINE	2139	1770.6	1587	1215.5	1069.5	1069.5	1230.5	1173					1010	2.8	2.4	0.0	0.0	5.2	82.8%	76.6%	100.0%	95.3%		
RBK02	MANOR HOSPITAL	Ward 02	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	2139	1687.7	1426	1529.6	1069.5	1070	1069.5	1115.5					1039	2.7	2.5	0.0	0.0	5.2	78.9%	107.3%	100.0%	104.3%		
RBK02	MANOR HOSPITAL	Ward 03	300 - GENERAL MEDICINE		1426	1129.5	1794.5	1584	713	713	1138.5	1115.5					1008	1.8	2.7	0.0	0.0	4.5	79.2%	88.3%	100.0%	98.0%		
RBK02	MANOR HOSPITAL	Ward 04	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1426	1038.1	713	808.5	713	724.5	1069.5	1000.5					508	3.5	3.6	0.0	0.0	7.0	72.8%	113.4%	101.6%	93.5%		
RBK02	MANOR HOSPITAL	Acute Medical Unit	326 - ACUTE INTERNAL MEDICINE		2852	2009	2371.5	1963.55	2495.5	2231	1782.5	1702					1051	4.0	3.5	0.0	0.0	7.5	70.4%	82.8%	89.4%	95.5%		
RBK02	MANOR HOSPITAL	Ward 07	320 - CARDIOLOGY		1782.5	1532	1069.5	1047.5	1069.5	1069.5	713	713					626	4.2	2.8	0.0	0.0	7.0	85.9%	97.9%	100.0%	100.0%		
RBK02	MANOR HOSPITAL	Surgical Assessment Unit	100 - GENERAL SURGERY		806	805	356.5	333	0	0	0	0					5	161.0	66.6	0.0	0.0	227.6	99.9%	93.4%	-	-		
RBK02	MANOR HOSPITAL	Ward 09	110 - TRAUMA & ORTHOPAEDICS		1437.5	1362.5	1633	1403	1069.5	1069.5	920	885.5					785	3.1	2.9	0.0	0.0	6.0	94.8%	85.9%	100.0%	96.3%		
RBK02	MANOR HOSPITAL	Ward 14	300 - GENERAL MEDICINE		1069.5	1085	1705	1593.5	713	690	1380	1288					741	2.4	3.9	0.0	0.0	6.3	101.4%	93.5%	96.8%	93.3%		
RBK02	MANOR HOSPITAL	Ward 15	302 - ENDOCRINOLOGY	300 - GENERAL MEDICINE	1426	1280.5	1450	1372	1069.5	1023.5	966	931.5					857	2.7	2.7	0.0	0.0	5.4	89.8%	94.6%	95.7%	96.4%		
RBK02	MANOR HOSPITAL	Ward 16	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1426	1262	1069.5	1002.95	713	713	1069.5	1069.5					754	2.6	2.7	0.0	0.0	5.4	88.5%	93.8%	100.0%	100.0%		
RBK02	MANOR HOSPITAL	Ward 17	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1426	1409	1069.5	1012	1069.5	1058.5	713	713					765	3.2	2.3	0.0	0.0	5.5	98.8%	94.6%	99.0%	100.0%		
RBK02	MANOR HOSPITAL	Intensive Care Unit	100 - GENERAL SURGERY	192 - CRITICAL CARE MEDICINE	3910	3237	356.5	287.5	3921.5	3254.5	356.5	287.5					306	21.2	1.9	0.0	0.0	23.1	82.8%	80.6%	83.0%	80.6%		
RBK02	MANOR HOSPITAL	Ward 20a	110 - TRAUMA & ORTHOPAEDICS		1069.5	931	713	575.5	713	713	356.5	342.5					354	4.6	2.6	0.0	0.0	7.2	87.1%	80.7%	100.0%	96.1%		
RBK02	MANOR HOSPITAL	Ward 20b/20c	100 - GENERAL SURGERY		1345.5	1273.5	1046.5	1069.5	724.5	747.5	713	713					614	3.3	2.9	0.0	0.0	6.2	94.6%	102.2%	103.2%	100.0%		
RBK02	MANOR HOSPITAL	Ward 21	420 - PAEDIATRICS	171 - PAEDIATRIC SURGERY	1426	1414.5	0	0	1426	1345.5	0	0					451	6.1	0.0	0.0	0.0	6.1	99.2%	-	94.4%	-		
RBK02	MANOR HOSPITAL	Ward 23	502 - GYNAECOLOGY	100 - GENERAL SURGERY	713	690	713	701.5	713	713	356.5	356.5					276	5.1	3.8	0.0	0.0	8.9	96.8%	98.4%	100.0%	100.0%		
RBK02	MANOR HOSPITAL	Ward 24/25	501 - OBSTETRICS		1614.5	1767.5	1081.5	796	1495	1449	1069.5	862.5					944	3.4	1.8	0.0	0.0	5.2	109.5%	73.6%	96.9%	80.6%		
RBK02	MANOR HOSPITAL	Ward 28	501 - OBSTETRICS		2219.5	2219.5	126.5	126.5	2081.5	2081.5	230	230					289	14.9	1.2	0.0	0.0	16.1	100.0%	100.0%	100.0%	100.0%		
RBK02	MANOR HOSPITAL	Ward 29	300 - GENERAL MEDICINE		2139	1759	1426	1397.5	1426	1414.5	713	713					1018	3.1	2.1	0.0	0.0	5.2	82.2%	98.0%	99.2%	100.0%		

MEETING OF THE PUBLIC TRUST BOARD **5TH September 2019**			
CQC report outcome			**AGENDA ITEM: 8**
Report Author and Job Title:	Jenna Davies Director of Governance	**Responsible Director:**	Jenna Davies- Director of Governance
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This paper provides an update to the Board on the outcome of the Care Quality Commission inspection which was published in July 2019. Whilst this overall rating is the same as that given by the CQC inspection in December 2018, we were pleased to see that CQC have recognised the improvements we have made in many areas, and are especially proud if the rating of 'outstanding' for the caring domain. As part of this inspection, the Trust has been assessed for the first the first time against the use of resources framework and was rated as 'requires improvement' As a result of the improvements made in maternity, urgent care and improvements in culture of the Trust, the CQC recommended to NHSi that the Trust come out of Special Measures; a decision that was approved by NHSI. The Trust has celebrated improvements with staff, through regular communication and all staff have received a 'golden ticket' meal voucher to say thank you for supporting to Trust to come out of special measures. However CQC identified areas which still require further improvement including staffing in extra capacity areas, risk management, governance and Mental Health practices and processes. All of these areas had been identified by the Trust as areas of further improvement and plans were already in place to address a number of the issues raised. The core services and corporate areas are currently developing robust actions to address the must and should do recommendations, as well as the recommendations within the use of resources report. The plans developed will be added to the Trusts Patient Care Improvement Plan and been overseen through the Board Committees and the Board.		

Recommendation	The Board are asked to; • Note the CQC inspection report • Note the Use of Resources report and • Note the next steps to develop a robust action plans to address the recommendations contained with the report	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The CQC inspection process provides the Trust with external assurance and oversight of the effectiveness and implementation of improvements made within the Trust and has been added as a control against a number of Board Assurance Framework risks.	
Resource implications	Resource implications of meeting the recommendations contained within the report will be presented with the revised PCIP. Additional support as a result of coming of special measures is being provided by NHSi/NHSE.	
Legal and Equality and Diversity implications	The CQC report itself highlighted a number of improvements relating to equality and diversity and these will form part of the revised PCIP. If the Trust fails to deliver the necessary improvements as recommended within the report the Trust could be in breach of its NHSi and CQC licence	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☐	

1. PURPOSE OF REPORT

This paper provides an update to QPES on the outcome of the Care Quality Commission inspection which was published in July 2019.

2. BACKGROUND

The trust was placed into quality special measures by the Secretary of State for Health in February 2016 following a comprehensive inspection in September 2015, which the Trust received a rating of inadequate. The Trust was re-inspected in 2017 with the report issued in December of that year, at this time the Trust had made improvements and was rated as Requires Improvement.

The Trust was inspected in February 2019, and the following core services were visited

- Between 4 and 6 February 2019, CQC inspected the core services of critical care and medicine.
- Between 11 and 13 February 2019 CQC inspected urgent and emergency care, surgery and maternity.
- Between 25 and 26 February 2019 CQC inspected community sexual health services.
- NHSi carried out the Use of Resources Assessment on the 8th February 2019
- The CQC carried out the well led review from 19 March to 21 March 2019.

3. CQC Report

The CQC report was published in July 2019 during their inspection saw a number of areas of improvement and outstanding practice, and gave the Trust a rating of requires improvement, and recommended the Trust be removed from special measures.

3.1 Must do actions

The CQC found areas for improvement including seven breaches of legal requirement, the Trust was required to respond to these areas within 20 working days and a response was issued to the CQC on the 20th August. The seven breaches and high level actions have been presented to the Quality, Patient Experience and Safety Committee. These actions will be added to the PCIP.

3.2 Should do actions

The CQC also found 59 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of its services.

Each of the core services has received the report along with the evidence used to form the ratings about the services and have been tasked with developing an action plan to respond to the issues raised.

3.3 Use of Resources recommendations

NHSi identified 9 areas of improvements. Of the improvements a number of already being progressed through existing workstreams, for example temporary workforce, theatre and outpatients productivity improvements. The Trust is developing an action plan to meet the remaining improvements which will be monitored through PCIP.

4.0 Next Steps

The Trust Management Board has established a PCIP Task and Finish group to oversee each core service response to the must and should do recommendations and their inclusion on the PCIP, this includes the development of high level actions, KPIs/outcomes and the evidence to provide

assurance that not only the action has been completed, but the required action has been embedded and sustained.

5.0 RECOMMENDATIONS

The Board are asked to;

- Note the CQC inspection report
- Note the Use of Resources inspection report and
- Note the next steps to develop a robust action plans to address the recommendations contained with the report

Walsall Healthcare NHS Trust

Inspection report

Moat Road
Walsall
West Midlands
WS2 9PS
Tel: 01922721172
www.walsallhealthcare.nhs.uk

Date of inspection visits: 04 Feb to 6 Feb 201911- Feb to 13 Feb 201925 Feb to 26 Feb 201919 March to 21 March 2019
Date of publication: xxxx> 2017

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Outstanding**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas. The trust consists of one acute hospital site and a number of community sites. The trust's palliative care centre in Goscote is the trust's base for a wide range of palliative care and end of life services.

Walsall Manor Hospital has 408 acute inpatient beds. There is a separate three bedded midwifery-led birthing unit (MLU) situated a mile away from the main hospital site. This has remained closed for women to give birth there since September 2017 following safety concerns CQC identified in maternity services at our inspection of the service in June 2017.

The trust's sexual health service is part of the Walsall Integrated Sexual Health Services (WiSH). The service is run from the main hospital site and from a number of sexual health clinics in the Walsall area. This service includes sexual health, HIV, long-term contraception and family planning. The trust provides an outreach service following acquisition from the local authority and a contraception and sexual health (CASH) outreach service for young people.

The trust was placed into quality special measures by the Secretary of State for Health in February 2016 following our announced comprehensive inspection in September 2015. Following this inspection is has been recommended that the trust comes out of special measures.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

What this trust does

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas. The trust consists of one acute hospital site and a number of community sites. The trust's palliative care centre in Goscote is the trust's base for a wide range of palliative care and end of life services.

Walsall Manor Hospital has 408 acute inpatient beds.

There is a separate three bedded midwifery-led birthing unit (MLU) situated a mile away from the main hospital site. This has remained closed for women to give birth there since September 2017 following safety concerns CQC identified in maternity services at our inspection of the service in June 2017.

The trust previously had a cap on the number of births at the trust set at 4,200. This was imposed by the local clinical commissioning group in 2016 following safety concerns CQC identified in the maternity department at our 2016 CQC inspection of the service. This birth cap was lifted in April 2019 as improvements had been in the maternity department.

Facts and data about the trust:

- Total number of inpatient beds – 408 as at September 2018
- Total number of outpatient clinics per week - 1247
- 4158 staff as at September 2018
- A and E attendances from August 2017 to July 2018: 77,306 attendances
- Number of deliveries from April 2017 to March 2018: 3,379

Summary of findings

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 4 and 6 February 2019, we inspected the core services of critical care and medicine.

Between 11 and 13 February 2019 we inspected urgent and emergency care, surgery and maternity.

Between 25 and 26 February 2019 we inspected community sexual health services.

We carried out the well led review from 19 March to 21 March 2019.

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well led key question at trust level. Our findings are in the section headed 'Is this organisation well led?'

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- The acute site at Manor Hospital were rated as requires improvement.
- Overall community services were rated as good.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- Urgent and emergency care, medicine, surgery, critical care and maternity services were requires improvement and stayed the same. We rated it as requires improvement because:
- Services for children and young people, end of life care and outpatients were rated as good.
- Overall Community services were rated as requires improvement.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- Medicine, surgery, critical care and end of life services were rated as requires improvement.

Summary of findings

- Urgent and emergency care, maternity and services for children and young people were rated as good.
- Overall community services were rated as good for effective.

Are services caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- Surgery was rated as requires improvement for caring
- All remaining core services within Manor Hospital were rated as good.
- The overall rating for caring in community services was outstanding.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Critical care and outpatients were rated as requires improvement.
- All remaining core services within Manor Hospital were rated as good.
- Overall community services were rated as good for responsive.

Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Surgery and Critical Care were rated as requires improvement.
- All remaining core services within Manor Hospital were rated as good.
- Overall community services were rated as good for well led.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in urgent and emergency care, medicine and community sexual health services.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including seven breaches of legal requirements that the trust must put right.

We also found 59 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of its services.

Action we have taken

We issued requirement notices to the trust. Our action related to breaches of legal requirements at a trust-wide level and in urgent and emergency care, medical care, surgery and critical care services.

Summary of findings

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Urgent and Emergency Care

- The employment and integration of the new Advanced Clinical Practitioner role to improve patient target times for triage and treatment in urgent and emergency services.
- The award winning initiative to improve patient care for frequent attenders to the urgent and emergency department.

Medicine

- The ward manager of ward 2 had introduced innovatory "what matters to me" white boards at the head of each bed to facilitate individual care preferences for elderly patients.
- On ward 2 the introduction of the tea party club had been helpful in promoting normality among elderly patients and had helped in achieving optimum food and drink intake in patients with dementia.
- The development of "shout out boards" to allow staff to complement each other on work achievements as a form of morale boosting and peer emotional support was commendable
- The introduction of the communication clinic for patient relatives which operated from 3pm -5pm each day had helped improve family understanding of patient problems and progress and in offering emotional support to visiting relatives.

Community Sexual Health

- Safeguarding practices were fully embedded in all aspects of the service. Staff maintained up to date training and demonstrated advanced skills in the recognition of potential risk. The team was proactive in engaging with other agencies, including specialist organisations, to respond to patients with highly complex needs and in cases where multiple local authorities were involved. Staff ensured young people had access to high quality sexual health and sex education to develop skills to protect themselves from harm and exploitation.
- We observed excellent standards of safeguarding awareness during our inspection. For example, a patient booked into a future appointment at the satellite clinic visited and asked to be seen earlier. The patient was booked to attend with an interpreter and on this occasion attended with a relative translating for them. The clinical support worker (CSW) on duty recognised this as a safeguarding concern and explained discreetly and sensitively why they could not be seen with a relative interpreting for them. The CSW established the patient had no urgent or immediate clinical risk during this process, which ensured their safeguarding concern did not detract from clinical needs.
- The safeguarding team had adapted the existing clinical situation, background, assessment and recommendation (SBAR) tool for use by the security team when attending calls for help. The tool meant the security team could prepare themselves for the situation and plan a response based on what staff knew about the patient, such as mental health diagnoses or problems.
- The service was proactive in sharing the outcomes of audits and research broadly across the sector to improve understanding and practice. In April 2018 the service presented the outcomes of a project to identify how clinicians in

different departments treated the same condition. This was a collaborative project with other departments in the hospital and the team presented it at an international HIV and sexual health conference. The outcomes of the project meant patients received more consistent, evidence-based treatment wherever their condition was detected in the hospital.

- The CASH team provided an exemplary programme of sex and relationship education to young people in schools, colleges and the local community. This included a balanced approach to addressing the anxieties and worries of teenagers whilst supporting developing sexual interest in line with best practice guidance. The team used digital media to help communication and provided practical guidance on topics such as condom use and managing relationships.
- Young people in schools and colleges regularly presented with a wide range of questions about sex and sexual health and staff prided themselves on understanding different terminology and being able to provide specific information. This included on general sex and relationship education as well as on sexual behaviour and experimentation. Nurses kept up to date with sexual health information on social media, in current affairs and in popular culture to be able to effectively communicate with young people.
- There was a consistent focus on holistic care and staff strived to meet the needs of patients with complex health issues, including social care needs. The team had developed complex care pathways, such as for young people in vulnerable circumstances experimenting with alcohol and drugs. They provided coordinated care for people experiencing domestic abuse, sexual exploitation or coercion.
- Staff continually engaged with patients beyond the need for clinical contact to improve the service and develop specialist pathways. For example, the safeguarding team and sexual health team worked with a previous victim of sexual exploitation to arrange a trust event on the topic. The previous patient presented on their experience and reflection to staff from across the trust. More staff wanted to attend than could be accommodated in the venue and the presenter would return to repeat the presentations in the future.
- The senior sister distributed a ‘learning from excellence’ communication as part of the monthly quality and safety update. This was part of a strategy to identify and promote positive practice to balance information on incidents and risks. The communication included a rolling programme of peer-nominated awards.
- All members of the team demonstrated the importance of understanding new and emergency threats and trends to sexual health and HIV, at a local and population level. This included where international standards of care and treatment guidelines differed from the UK and patients were typically well-versed on both. For example, national and international guidance on the use of pre-exposure prophylaxis (PrEP) varied widely. This medicine was typically targeted at men who have sex with men (MSM) and as an additional preventative measure to avoid HIV infection alongside consistent condom use. However, the team recognised in practice many patients used PrEP instead of condoms, which had led to resistant strains of common STIs, including gonorrhoea and syphilis. As a result, the team coordinated care and treatment for more complex infections and for patients with more complex needs relating to psychosexual behaviour.

Areas for improvement

Action the trust MUST take to improve

For the overall trust:

- Ensure compliance with the requirements of the fit and proper person’s regulation. (Regulation 5)

Summary of findings

- Ensure the effectiveness of governance arrangements and the board is consistently informed of and sited on risks. (Regulation 17).

Urgent and Emergency Care

- Must improve mandatory and safeguarding training compliance for all urgent and emergency care staff. (Regulation 18).

Medicine

- The trust must ensure all staff have regard for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2010 when assessing patients and delivering care, including ensuring mental capacity assessments are detailed, compliant with legislation and best practice, and is undertaken in a way and at a time that recognises patient's abilities. (Regulation 11).
- The medical service must have systems in place to maintain safe staffing ratios and skill mix on medical wards. (Regulation 18).

Surgery

- The trust must ensure staffing levels on surgical wards are safe and reduce the risk of patient harm. This includes reviewing, monitoring and recording patient acuity (Regulation 18: Staffing)
- The trust must ensure the care and treatment provided to patients is safe. This includes keeping up to date patient care records, adherence to infection prevention and control practices and systems and processes which prevent never events (Regulation 12: Safe care and treatment)

Critical Care

- Must ensure the staffing cover provided by the critical care outreach team complies with required standards.

Action the trust SHOULD take to improve:

Urgent and Emergency Care

- Should improve waiting target compliance levels for triage and treatment in the urgent and emergency for all patients.
- Should consider replacing old or missing equipment in the urgent and emergency department.

Medicine

- The medicine service should ensure that all intravenous fluids are always securely stored in locked cupboards.
- The medicine service should monitor mandatory training and safeguarding rates to ensure that the trust targets are met.
- The medicine service should use audits to monitor and improve the quality of the service

Surgery

- The trust should ensure all staff are given an appropriate handover when starting or covering shifts.
- The trust should ensure any store room where medication is stored is locked and doors are closed.
- The trust should ensure all surgical staff comply with the World Health Organisation checklist and the five steps to safer surgery.
- The trust should ensure medical and nursing staff are compliant with all mandatory training.

Summary of findings

- The trust should ensure all patients receive care which protects their privacy and dignity.
- The trust should consider that all incidents are reported promptly.
- The trust should consider monitoring the performance in relation to sepsis management.
- The trust should consider recording all risks on the relevant risk registers and are understood and mitigated appropriately.
- The trust should consider improving the process of collecting, analysing, managing and using data in relation to the surgical assessment unit and surgical sterilisation unit to support and improve performance.

Critical Care

:

- Consider improving mandatory training compliance levels for medical staff to comply with trust targets.
- Consider improving ways to monitor and drive improvement for non-compliance with infection, prevention and control practices.
- Consider updating all critical care policies to ensure they are up-to-date.
- Consider providing follow-up clinics to suitable patients.
- Consider ways of improving the approaches to families regarding organ donation.
- Consider providing information to patients and those close to them in different languages.
- Consider giving patients the option to use patient diaries.
- Consider reporting data for all quality indicators to the Intensive Care National Audit and Research Centre (ICNARC).
- Consider auditing the performance of the critical care service against the Guidelines for the Provision of the Intensive Care Services (GPICS) standards to assess areas of compliance and non-compliance.
- Consider exploring the range of pathway options for patients requiring discharge from the critical care unit to expediate discharge.
- Consider supporting a patient forum group for the service to enable patients and their relatives to provide feedback and views on any aspect of their experience during their care and treatment.

Maternity:

- The maternity service should ensure all staff are fully compliant with infection prevention control procedures.
- The maternity service should ensure all inpatient staff have enough basic equipment such as fetal monitoring machines and thermometers to carry out their roles effectively.
- The maternity service should ensure all surgeons attend all crucial stages of the surgical safety checklist.
- The maternity service should ensure complaints are investigated and closed in line with their complaints policy.
- The maternity service should ensure the maternity risk register is kept up to date
- The maternity service should ensure they always follow best practice when prescribing, giving, recording and storing medicines.
- The maternity service should ensure it closes all complaints in the time frame set out in the service wide complaints policy.

Summary of findings

- The maternity service should encourage managers to utilise the mechanisms in place to manage risk.

Community Sexual Health service:

- Should ensure car parking at the sexual health satellite clinic is controlled in a way that does not present a safety risk to occupants of the clinic in an emergency evacuation.
- Should review health and safety monitoring and practices to reduce the risk of injury, abuse and violence to staff for community sexual health staff.
- Should improve monitoring of appointment cancellations for community sexual health to address trends.
- Should review arrangements for trust-level and senior management communication with community sexual health staff to ensure they feel supported and have access to managers during periods of change and high levels of pressure.
- Should address the negative views held by staff of the working culture and vision and strategy of the trust.

For the overall trust:

- The trust should ensure there are appropriate processes in place to investigate and learn from patient deaths.
- The trust should ensure that duty of candour processes are followed and that families have the opportunity to meet with representatives of the trust where there has been harm.
- The trust should ensure that there are suitable processes in place for patients detained under the Mental Health Act 1983 that ensure detentions are legal and their rights are protected.
- The trust should ensure that there are networks in place to support and promote staff equality and diversity.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well led at the trust as requires improvement. This stayed the same as the previous inspection. We rated as requires improvement because:

- Not all leaders had the necessary experience, knowledge or capability to lead effectively. Leaders were not always visible Where executives demonstrated the capacity and capability to deliver, required support structures were not always in place around them to ensure sustainable success.
- Structures below director level were not always sufficient to ensure accountability and the flow of information from leaders.
- Fit and Proper Person checks were not in place.
- The trust had a vision and strategy, however it had not kept pace with the trust focus on external systems strategy. Staff were engaged with and lived the trust vision and values every day.
- Staff networks were not in place to promote the diversity of staff.
- The trust did not always apply Duty of Candour robustly and appropriately.

Summary of findings

- The trust did not have effective governance structures, systems and processes in place to support the delivery of its strategy. We were not assured that the approach and the flow of information was always effective and were regularly reviewed.
- The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, the detail of controls and assurance of mitigations at board level were not always evident.
- The corporate risk register lacked necessary detail to give effective risk oversight at trust level.
- Appropriate governance arrangements were not in place in relation to Mental Health Act administration and compliance.
- Systems to identify and learn from unanticipated deaths were ineffective.

However:

- Leaders ensured the promotion of a positive culture across the trust. Staff felt supported and valued. We heard from all levels how the sense of pride to represent the organisation had significantly improved.
- The trust had appointed three Freedom to Speak Up Guardians and provided them with sufficient resources and support to help staff to raise concerns.
- The trust collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. The trust recognised where further improvement was needed to ensure accurate and reliable data sources.
- The trust engaged with patients, staff, the public and local organisations to plan and manage services. There had been a focus on increasing engagement with staff over the past 12 months however, engagement with patients was limited.
- Leaders were well engaged with external partnerships to secure experiences and quality across health and care.

Use of resources

www.cqc.org.uk/provider/RBK/Reports.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔	Requires improvement ➔➔	Outstanding ↑	Requires improvement ➔➔	Requires improvement ➔➔	Requires improvement ➔➔

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Manor Hospital	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community	Requires improvement	Good	Outstanding	Good	Outstanding	Good
Overall trust	Requires improvement	Requires improvement	Outstanding	Requires improvement	Requires improvement	Requires improvement

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Manor Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ➔🡐	Good ➔🡐	Good ➔🡐	Good 🡅	Good ➔🡐	Good 🡅
Medical care (including older people's care)	Requires improvement ➔🡐	Requires improvement 🡇	Good ➔🡐	Good ➔🡐	Good ➔🡐	Requires improvement 🡇
Surgery	Requires improvement ➔🡐	Requires improvement ➔🡐	Requires improvement 🡇	Good ➔🡐	Requires improvement 🡇	Requires improvement ➔🡐
Critical care	Good ➔🡐	Requires improvement ➔🡐	Good ➔🡐	Requires improvement ➔🡐	Requires improvement ➔🡐	Requires improvement ➔🡐
Maternity	Requires improvement ➔🡐	Good 🡅	Good 🡅	Good 🡅	Good 🡅	Good ➔🡐
Services for children and young people	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
End of life care	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Outpatients and Diagnostic Imaging	Good Dec 2017	N/A	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017
Overall*	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Outstanding Dec 2017	Good Dec 2017
Community health services for children and young people	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Community end of life care	Good Dec 2017	Good Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017
Community health sexual health services	Requires improvement	Outstanding	Outstanding	Good	Good	Good
Overall*	Requires improvement	Good	Outstanding	Good	Outstanding	Good

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Acute health services

Background to acute health services

The trust provides a full range of acute services at one site Manor Hospital site in Walsall.

During this inspection we inspected:

- Urgent and Emergency care
- Medical Care
- Surgery
- Critical Care

Further services we did not inspect include:

- Services for Children and Young People
- End of Life Care
- Outpatients
- Diagnostics

The report findings for these services were published in December 2017 and can be found on our website www.cqc.org.uk.

Summary of acute services

Requires improvement

Our overall rating for acute services provided by the trust at the Manor Hospital stayed the same at requires improvement. The summary of acute services inspected on this occasion can be found in the main report summary.

Manor Hospital

Moat Road
Walsall
West Midlands
WS2 9PS
Tel: <xxxx xxxx xxxx
www.walsallhospitals.nhs.uk

Key facts and figures

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas. The trust consists of one acute hospital site and a number of community sites. The trust's palliative care centre in Goscote is the trust's base for a wide range of palliative care and end of life services.

Walsall Manor Hospital has 408 acute inpatient beds.

There is a separate three bedded midwifery-led birthing unit (MLU) situated a mile away from the main hospital site. This has remained closed for women to give birth there since September 2017 following safety concerns CQC identified in maternity services at our inspection of the service in June 2017.

The trust previously had a cap on the number of births at the trust set at 4,200. This was imposed by the local clinical commissioning group in 2016 following safety concerns CQC identified in the maternity department at our 2016 CQC inspection of the service. This birth cap was lifted in April 2019 as improvements had been in the maternity department.

Facts and data about the trust:

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- Total number of outpatient clinics per week - 1247
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- A and E attendances from August 2017 to July 2018: 77,306 attendances
- Number of deliveries from April 2017 to March 2018: 3,379

Summary of services at Manor Hospital

Requires improvement ➔➔

Our rating of services stayed the same. We rated it them as requires improvement because:

Our rating of safe requires improvement overall. In medicine and surgery staffing levels were not always maintained in sufficient ensure patients received safe care and treatment. Patient records were not always up to date or sufficiently completed.

Summary of findings

Our rating of effective required improvement overall. The processes for ensuring patients capacity was assessed in line with the Mental Capacity Act 2005 were not robust. Some patients were deprived of their liberty without

Our rating of caring overall. Patients mostly received care which protected their dignity and privacy. Staff were kind and respectful and tried to get to know patients as individuals.

Our rating of responsive required improvement overall. Waiting times for triage and treatment in the urgent and emergency department did not meet national targets.

Our rating of well led required improvement overall. Not all required checks were in place to ensure directors were 'fit and proper persons'. The management of risks and governance did not always ensure a flow of information which demonstrated robust oversight and decision making.

Urgent and emergency services

Good ↑

Key facts and figures

Walsall Healthcare NHS Trust has a purpose built emergency department (ED) that is situated as part of the Manor Hospital. There is a four-bay resuscitation area, 23 cubicles, a separate waiting area for children that has three treatment rooms and two triage rooms, and new areas for other services that include the frailty team. There is an urgent care centre that is located on the same site and that shares an entrance and reception area with the ED.

From August 2017 to July 2018 there were 77,306 attendances at the trust's urgent and emergency care services.

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in most recent year compared to previous year. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from August 2017 to July 2018

* Discharged includes: no follow-up needed and follow-up treatment by GP

^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional

Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

The ED is part of the West Midlands Trauma Network of 33 hospitals in the area. The nearest major trauma centres for adults are the Royal Stoke University Hospital and the Queen Elizabeth Hospital in Birmingham. The nearest trauma centre for children is the Birmingham Children's Hospital.

We visited the ED as part of our unannounced comprehensive inspection of core services in February 2019. We spoke with seven patients and their relatives, friends or carers, and 29 staff across a range of roles. We tracked patient experience through their time at the ED, checked the quality of records, and observed staff practice.

During the last inspection in June 2017, we rated the ED as requires improvement for safe and responsive, good for effective, caring and well-led, and therefore requires improvement overall. This was because:

- There was unsatisfactory infection prevention and control practice.
- Medicines management was not satisfactory in all areas.
- Some patients were accommodated in a potentially unsafe environment.
- ED was not achieving target times for assessment, treatment and discharge of patients.
- ED was not achieving trust targets for mandatory training or appraisals.
- Improvements had been seen since the previous inspection in 2015 when the ED had been inadequate overall, with increased staff numbers, a dedicated paediatric area, and more equipment storage facilities and availability.
- Patient care had improved.
- Care and treatment were delivered in line with national guidance.

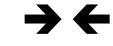
Urgent and emergency services

- Multi-disciplinary working was embedded and effective.
- Feedback was positive around staff care.
- The dementia nurse had contributed to significant awareness in staff
- The departmental managers were supportive and approachable.

Summary of this service

- Our rating of this service improved. We rated it as good because:
- There had been improvements in all areas from the previous inspection in 2017.
- Although there were still issues around safe, there had been improvements in both mandatory training compliance and triage and treatment targets. These areas, however, still required further improvement in order to reach targets.
- Staffing levels had increased since the last inspection.
- Risk management and incident reporting were improved since the last inspection and clear processes and learning were embedded.
- Infection prevention and control processes had developed since the previous inspection and recent audits were encouraging.
- Medicines management was safe and in line with guidance.
- New grades of staff had been introduced to the department and there was an upskilling of staff within the ED.
- There was a comprehensive audit programme, with performance data used to drive change.
- There was good multidisciplinary working and patient pathways.
- Feedback was positive regarding patient care.
- There were improving services for mental health and elderly patients.
- Leadership was responsive.
- Investment was signed off for the department to move into a purpose-built facility.
- There were good governance systems and embedded and improving clinical practice.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- There were delays regarding patients waiting to be seen for triage, and there were continuing black breaches for ambulance handover times. There were also delays in paediatric triage times, despite improvements in the previous year.
- Training targets were only being met for three out of the 10 mandatory training modules for nursing staff.

Urgent and emergency services

- No training targets were being met for any of the 10 mandatory training modules for medical staff.
- Safeguarding compliance had improved considerably since the previous inspection in 2017, but training targets were only met for two out of the six training safeguarding modules for both nursing and medical staff.
- The building was cramped, busy and there were occasional issues with capacity ratios for review rooms, contrary to trust policy.
- There were examples of a sparsity of some equipment – for example suction units.
- There were concerns regarding the age of some of the equipment and maintaining high cleanliness – for example commodes.
- There remained unfilled vacancies for staff, particularly medical staff.

However:

- There had been a large improvement in new staff and refresher training.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well, and there had been improvements since the last inspection. Staff kept themselves, equipment and the premises visibly clean. They used control measures to prevent the spread of infection, such as handwashing and use of personal protective equipment. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. There was now a dedicated lead for IPC. There was increased audit and improvements in audit results.
- Generally, staff coped well with the limited space and capacity, and adhered to safety processes and policy. The adult emergency department was generally fit for purpose, although there were issues with space and privacy for patients and staff - the service generally had suitable premises and equipment and looked after them well.
- For most patients, we found risks were managed and patients generally received assessments, treatment, and observations in a timely way. The service planned for emergencies and staff understood their roles if one should happen. The trust performed in line with other trusts for performance and risk. There was a clear and robust risk register and governance in place.
- The service had nursing staff levels that were improving since the previous inspection. Generally, most staff had the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment. Nurse staffing levels and skill mix were planned in line with guidance on safe staffing in emergency settings. There were still improvements to be made, but there was a risk assessment in place for competencies and relevant skill mix of all staff.
- There had been an innovative approach at the service to employ a new band of medical staff (Advance Clinical Practitioners) that were had the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment and to increase the staffing levels at the department.
- There had been improvements in waiting times in ED to be triaged and treated, despite there still being breaches and delays reported. This was a result of improved management and new initiatives. These initiatives including more staff grades and a system of rapid assessment triage for ambulance patients.
- There were appropriate records of patients' care and treatment. Generally, records were completed and included early warning score charts where appropriate. Audits were in place and led to increased compliance action plans.

Urgent and emergency services

- The service generally prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. There were incidents reported that had been dealt with in a timely manner with learning and action plans going forwards.
- The service managed patient safety incidents well and there was a robust and comprehensive electronic incident reporting system in place. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Information was clearly accessible to staff and there was a clear audit programme.
- There was a comprehensive programme of audits at both local and national level.
- There was improving reporting of audit results in the department, with staff noticeboard displays and presentations.
- Audit from 2016/17 showed failure to meet standards in asthma, consultant sign off and sepsis management. However, learning had been taken from these results to drive training and processes. Current audit data regarding trauma management, feverish children and vital signs in adults were showing more favourable audit results against national average.
- Staff generally gave patients enough food and drink to meet their needs while in the ED.
- Pain relief and recording of pain scores was good.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. While they did not generally meet national standards, performance was mostly comparable with national averages or just below. Where risk was perceived, this was added to the risk register.
- The service made sure staff were competent for their roles. Staff were encouraged and supported to develop their knowledge, skills and practice. Competency frameworks were in place to ensure staff gained the skills and experience relevant to their grade and to help formulate and manage risks for those who had not achieved all their competencies.
- There was a focus on improving training and on upskilling staff, particularly nursing staff and care support workers.
- There was a dedicated education officer for medical staff who ran effective training programmes in the department.
- There was good multidisciplinary working with specialist teams dedicated to improving patient outcomes, such as the frailty service.
- Both the adult and children's ED were operational 24 hours a day, seven days a week.
- Patients who used urgent and emergency care services were supported to live healthier lives and manage their own health, care and wellbeing.

Urgent and emergency services

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- Appraisal rates were below the trust target of 90%.
- Some patients stated that there was sometimes difficulty obtaining food and drink in the ED.
- There was a pressure on the service at night and weekends when staffing was lower and the urgent care centre and GP services were not necessarily available.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion, kindness and respect. Feedback from patients and those close to them was positive about the way staff treated them. Patients felt supported and cared for by staff.
- All staff were evidenced to be considerate and thoughtful to patients waiting to be seen. Staff provided emotional support to patients to minimise their distress. Patient's emotional and social needs were seen as being as important as their physical needs.
- Staff involved patients and those close to them in decisions about their care and treatment.
- There was a growing and embedded system of volunteers to provide non-medical assistance and emotional support.
- Patient feedback was gathered and communicated to staff to improve care and support.
- Mental health services were caring.
- End of Life feedback of experiences were positive. There were new initiatives to further improve this and designated dementia and end of life leads.
- Staff felt supported by colleagues and management with regard to emotional issues and dealing with incidents.

However,

- Friends and family feedback from 2017 showed that improvements needed to be made.
- Capacity issues did mean that on occasion there were issues with patient dignity and privacy.

Is the service responsive?

Good

Our rating of responsive improved. We rated it as good because:

- The trust was undertaking work to develop the local services. They planned and provided services in a way that generally met the needs of local people.
- There was easy access to interpreters and communication aids.

Urgent and emergency services

- The service generally took account of patients' individual needs. There was ongoing work with the local mental health and psychiatry teams.
- There were innovative pathways for patients, including the frailty team and the dementia support workers.
- There was a psychiatric service 24/7 provided by the local mental health trust.
- There were clear processes for the treatment, referral and escalation of all mental health patients to the ED.
- Flow through the department had improved since the last inspection, due to improved management and new staff roles. The Rapid Assessment Area was now more responsive to increase in capacity and there was a streaming service in the waiting room.
- The number of complaints had reduced since 2016/17 and there was a clear and comprehensive complaint process in place. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The number of successful claims against the ED was zero in 2018.
- Numerous compliments to the ED had been received and displayed around the department.
- There were improvements in some waiting times, for example in the paediatric department. Overall, the trust was improving and there were systems in place to encourage further improvements.

However:

- Not all patients could access the service promptly when they needed it. Waiting times to be seen for treatment were generally higher (worse) than the England average. More patients waited longer than four hours for a decision to admit, treat or discharge than the England average.
- The patient records did not have a flag system to alert staff to when patients had additional needs such as a learning difficulty.
- There were target breaches for the length that patients waited for admission or discharge.
- There were issues with discharge in other departments which did lead to capacity concerns in the ED at certain times.
- Some complaints were not always dealt with in a timely manner.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- The urgent and emergency care service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care, and there had been some recent appointments. Staff spoke positively about the senior management team and department managers and felt well supported and that there were noticeable recent improvements in staffing, management and morale.
- There was a clear staff structure and lines of oversight.
- Leadership was perceptive and responsive.
- There was a clear vision to improve patient experience which included the provision of a new purpose-built facility to be opened in 2021.

Urgent and emergency services

- Managers across the service promoted an improving and positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were committed to improving the quality of care and patient experience and worked together to do so. This was led by the clinical management team.
- There was a clear process of incident reporting, actions resulting and learning points.
- The service now used a systematic approach to continually improve the quality of its services and safeguard high standards of care. This was driven by both the senior management and the governance staff. Staff understood their roles and accountabilities.
- Governance was embedded and comprehensive.
- Innovation was encouraged and rewarded within the trust and the ED. The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. There had been a recent award for innovation.
- There was a new electronic risk register in place and a clear incident reporting form.
- Engagement with other stakeholders was evidenced to be a priority and there were initiatives in place to support this, such as the Walsall Together programme. The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.

However:

- Recruitment needed to be constantly revised going forwards and vacancies filled.
- Financing for new equipment needed to be considered going forwards.
- There needed to be further leadership input to improving flow, particularly regarding discharge in other departments in order to relieve pressure on the ED.

Outstanding practice

Areas where there was outstanding practice:

- The employment and integration of the new Advanced Clinical Practitioner role to improve patient target times for triage and treatment.
- The award winning initiative to improve patient care for frequent attenders to the department.

Areas for improvement

- **Action the hospital MUST take to improve:**
- The urgent and emergency service must improve mandatory and safeguarding training compliance for all staff.
- **Action the hospital SHOULD take to improve:**
- Should improve waiting target compliance levels for triage and treatment in the urgent and emergency for all patients.
- Should consider replacing old or missing equipment in the urgent and emergency department.

Medical care (including older people's care)

Requires improvement

Key facts and figures

The Medical division within Walsall NHS trust managed a number of medical wards,

Wards 1, 2, acute older adults

Ward 3 medically stable for discharge

Ward 4 Stroke rehabilitation

Ward 5/6 acute medical unit

Ward 7 cardiology

ward 10 Frail elderly service

Ward 14 medically stable for discharge

Ward 15 General medicine, diabetes and haematology

Ward 29 short stay acute care adults

The medical care service at Manor Hospital provides care and treatment for:

- General Medicine
- Acute older adult
- Cardiology
- Frail Elderly Service (Medicine)
- Diabetes, rental and haematology
- Gastroenterology
- Respiratory Medicine

Short stay acute care adults. There are 190 medical inpatient beds located across ten wards:

- Ward 1
- Ward 2
- Ward 3
- Ward 7
- Ward 10
- Ward 14
- Ward 15
- Ward 16
- Ward 17

Medical care (including older people's care)

- Ward 29

The trust had 31,532 medical admissions from July 2017 to June 2018. Emergency admissions accounted for 19,392 (61.5%), 142 (0.5%) were elective, and the remaining 11,998 (38.1%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 19,305
- Gastroenterology: 4,585
- Cardiology: 1,800

During the inspection visit the inspection team

- Spoke with 51 members of staff at different grades from ward domestic staff, health care assistants, registered nurses, ward mangers, doctors, consultants pharmacists, hospital managers, and discharge coordinators.
- Reviewed 13 patient's records.
- Observed staff interacting and caring for patients in all the wards visited.
- Spoke with 10 patients and 3 relatives.
- Reviewed performance information and data pertinent to care delivery within the medical wards. Attended ward and divisional huddles.

Summary of this service

We rated medicine at the trust as requiring improvement overall, we have judged the service as requires improvement for safe, and good for caring, requires improvement for effective, good for responsive and well-led care and noted some innovative practices.

However, improvements in safety were needed to ensure that services were responsive to people's needs. Although some elements of safety require improvement, the overall standard of service provided outweighs those concerns.

- Staff followed good hygiene procedures to reduce risks to patients.
- Incident reporting had improved since our last inspection and staff now knew what incidents to report and how to do so.
- The service now met national targets for referral to treatment times and had created a new winter pressure discharge ward discharge to free up beds when patients were ready to go home.
- The service treated concerns and complaints seriously. Managers investigated them and shared lessons learned with staff.
- Nurse staffing levels were determined using an acuity tool and were regularly reviewed and the trust was actively recruiting nursing staff

However:

- The service did not have enough nursing staff and there were high levels of sickness. The service was heavily reliant on bank and agency staff.
- Safe storage of medicines was compromised by unlocked intravenous fluid storage cupboards.

- Assessments of mental capacity were not always fully undertaken.

Is the service safe?

Requires improvement

We rated the medical service as requiring improvement for safe because

- The service did not have sufficient numbers of suitably qualified permanent nursing staff with the right qualifications, training and experience to keep people safe from avoidable harm and abuse at all times.
- The service provided mandatory training in key skills to all staff but not everyone eligible completed it.
- The cupboards used to store intravenous fluids were open on two of the wards despite having clear notices on the doors stating that they were to be locked at all times.
- There were deficiencies in the provision of suction apparatus on ward 1 to one bed space which posed a risk of delay in treating patients in an emergency.

However, we also found:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well and staff kept themselves, equipment and the premises visibly clean and they used control measures to prevent the spread of infection
- Resuscitation equipment, including emergency medicines, was readily available and regularly checked on all wards and equipment was available and could be utilised to safeguard patients from falls and pressure ulcers.
- Risks to patients were always managed positively within the service and staff used systems to identify deteriorating patients, and there was consistency in sepsis management.
- A major initiative to resolve the incidence of patient falls had been successfully implemented and the introduction of magnetic safety board's where safety huddles were held had improved all aspects of safety management.
- To help ease some of the nurse staffing issues the matrons attended meetings with the nurse bank managers twice a day to provide a weekly forward look at staffing requirements for the medical wards.
- The service had shortages in the acute medical workforce, but locum arrangements ensured that the service remained safe.
- Staff kept detailed records of patients' care and treatment and records were clear, up-to-date and easily available to all staff providing care and managed in a way that kept patients safe.
- The service followed best practice when prescribing, giving, recording and storing medicines.
- The service managed patient safety incidents well and staff recognised incidents and reported them appropriately. The service had a duty of candour policy available and laminated notices pertinent to the duty of candour were evident in staff areas of the medical wards.
- The service used safety monitoring results well and staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Medical care (including older people's care)

Is the service effective?

Requires improvement

Our rating of effective stayed the same and we rated it as requires improvement because:

- Managers monitored the effectiveness of care and treatment given to patients and used the findings to improve care delivery. However, outcomes for people who use services were sometimes below expectations compared with similar services.
- The 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 73.6%, which did not meet the audit minimum standard of 90%.
- The service was continuing to work towards seven-day services although had not yet achieved it.
- The rights of patient's subject to the Mental Capacity Act 2005 were not fully protected in all clinical areas as processes were not being robustly followed.
- Patients for whom DNRACPR processes were applied by doctors did not always have a mental capacity assessment to ensure they were not able to give consent.
- Applications which give the specific ward staff a two-week Deprivation of liberty safeguards holding period were out of date.

However, we also found:

- We saw that treatment and assessment was delivered in line with legislation, standards and evidence-based guidance including guidance from the National Institute of Clinical and Healthcare Excellence (NICE).
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools.
- Advanced nurse practitioners provided hospital at night cover for patient interventions and they handed over to a critical care outreach team every morning.
- The service made sure staff were competent for their roles and managers appraised staff's work performance.
- Nursing staff had the skills, knowledge and experience to identify and manage issues arising from patients suffering cognitive impairment.
- Staff throughout the service were supported to deliver effective care.
- Staff of different kinds worked together as a team to benefit patients and staff consistently told us that there was good multidisciplinary team working.
- Patients were supported to live healthier lives and manage their own care and wellbeing needs where appropriate.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

Medical care (including older people's care)

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion and feedback from patients confirmed that staff treated them well and with kindness. An initiative to improve call bell access by patients had been successfully implemented and patients told us that call bells were promptly answered by members of the care team.
- Most patients we spoke with told us that staff were busy but that there were enough staff on duty to care for them and they told us that there was strong positive feelings about Manor hospital in the Walsall community.

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- Staff provided emotional support to patients to minimise their distress and wards utilized "shout out boards" to allow staff to complement each other on work achievements as a form of morale boosting and peer emotional support.
- Staff involved patients and those close to them in decisions about their care and treatment and the service provided a wide range of information leaflets for patients and their families.

However, we also found:

- Staff told us that care for stroke patients on ward 4 was compromised by the high number of medical outliers who were being boarded on the ward, many of whom had complex needs.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The service took account of patients' individual needs and had reflected on the needs of the ageing population by introducing a frail elderly service.
- The trust had taken into consideration that people living with dementia needed additional facilities to function optimally within the hospital situation and the care environment had been adapted to include enhanced signage for washing and toilet facilities.
- The medical wards had access to Learning Disability support nurses who were able to work with patients with learning disabilities and the staff who cared for them.,
- People could access the service when they needed it and the service had a number of initiatives in place to improve flow and discharges within the division.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However, we also found:

- Although the division employed discharge coordinators who worked directly with staff and patients their heavy workload compromised their ability to respond to the challenges off the role.

Medical care (including older people's care)

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- Managers at all levels in the trust and across the medical division had the right skills and abilities to run a service providing high-quality sustainable care and managers promoted and upheld the overarching trust philosophy of caring for Walsall together and respect, compassion, professionalism and team work and ensured that they were fully embedded across the medical wards.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community and managers across the trust promoted a positive culture that supported and valued staff,
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The division had implemented band 6/7 professional development for nurses to help change the culture and accountability within the wards.
- The implementation of a patient centred improvement plan (PCIP) had successfully focused improvements in care delivery.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

However, we also found

That the service did not use information from audits effectively

Outstanding practice

- We found examples of outstanding practice in this service:
- The ward manager of ward 2 had introduced innovatory "what matters to me" white boards at the head of each bed to facilitate individual care preferences for elderly patients.
- On ward 2 the introduction of the tea party club had been helpful in promoting normality among elderly patients and had helped in achieving optimum food and drink intake in patients with dementia.
- The development of "shout out boards" to allow staff to complement each other on work achievements as a form of morale boosting and peer emotional support was commendable
- The introduction of the communication clinic for patient relatives which operated from 3pm -5pm each day had helped improve family understanding of patient problems and progress and in offering emotional support to visiting relatives.

Areas for improvement

Medical care (including older people's care)

Action the hospital MUST take to improve:

- The medical service must ensure that full mental capacity assessments are consistently carried out in accordance with the Mental Capacity Act 2005. (Regulation 11).
- The medical service must have systems in place to maintain safe staffing ratios and skill mix on medical wards. (Regulation 18).

Action the hospital Should take to improve:

- The medicine service should ensure that all intravenous fluids are always securely stored in locked cupboards.
- The medicine service should monitor mandatory training and safeguarding rates to ensure that the trust targets are met.
- The medicine service should use audits to monitor and improve the quality of the service.

Surgery

Requires improvement

Key facts and figures

Manor Hospital is the main site providing acute services for Walsall Healthcare NHS Trust. The surgical division provides adult elective and emergency services for a range of the following specialisms: trauma and orthopaedics (T&O), general surgery (including urology), bariatrics, breast care, colorectal surgery, outpatient vascular, upper gastrointestinal, ear, nose and throat service and day case cataract surgery (under local anaesthetic).

The surgical department is comprised of six surgical wards, arrivals and a discharge lounge. The service has 11 operating theatres; three of which have laminar flow and associated areas for anaesthetics and recovery. The hospital had 106 surgical inpatient beds and eight day-case beds.

There are usually 26 beds on the emergency trauma and orthopaedics ward (ward nine) but at the time of our inspection capacity had increased to 33 beds to accommodate seven additional patients due to escalation measures.

The acute surgical unit usually has 41 beds (wards 11 and 12) but at the time of our inspection capacity had increased to 53 beds to accommodate 12 medical patients due to escalation measures during the winter period. A breakdown of additional surgical wards visited are listed below:

- There are 16 beds on the elective trauma and orthopaedic surgery ward (ward 20a).
- There are 24 beds on the elective general surgery ward (ward 20b).
- The surgical assessment unit has 12 assessment chairs and a bay of three trollies.
- The day-case unit has eight trolley spaces and one side room.

The trust had 16,975 surgical admissions from July 2017 to June 2018. Emergency admissions accounted for 5,997 (35.3%), 8,745 (51.5%) were day case, and the remaining 2,233 (13.2%) were elective.

During the inspection visit, the inspection team:

- Spoke with 18 patients and 12 relatives.
- Reviewed 13 patient records.
- Observed staff caring for patients within scheduled care wards and theatres.
- Reviewed performance information and data from and about the trust.
- Spoke with 45 members of staff at different grades from band two to band eight including matrons, ward managers, nurses, physiotherapists, pharmacists, doctors, consultants, discharge coordinators, administration and housekeeping.
- Met with a director of operations, divisional director of nursing, clinical director for theatres, anaesthetics and critical care and care group managers for the surgical division.

The service was last inspected June 2017. At the last inspection of the surgery division we rated this as requires improvement overall including safe and effective. It was rated good in the caring, responsive and well led key questions. The surgery service was issued with one requirement notice and two recommendations for service improvement in the safe, effective and responsive domains. During our inspection, we looked at the changes the surgical directorate had made to address these concerns.

Surgery

Trust wide data is included within the surgery core service report for comparison with the core service data. Please refer to the provider level report for further information.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- Patient risk was not always assessed and responded too appropriately.
- Staff did not keep appropriate records of patients' care and treatment. The surgical division considered patient records a risk.
- Although staff had patient handovers before starting their shift, it was clear that temporary staff covering wards were not given appropriate handovers.
- Staff mandatory training was not always complete. Low compliance rates were seen across nursing and medical staff.
- The surgical division did not always control infection risk well. Shared facilities were not always clean and hygienic. For example, during our inspection we observed a piece of faeces soiled clothing in a shared area.
- Allied health professional staffing was not sufficient to deliver the services proposed by the division.
- People could not always access the service when they needed it. For example, there had been an increase in cancelled surgeries.
- Quality and sustainability challenges were understood by leaders but they could not always identify the actions needed to address them.
- The service had a system for identifying risks, planning to eliminate or reduce them but the risk register was not complete. There was a lack of assurance all risks associated with the surgical division had been recorded and mitigated.
- The service did not always collect, analyse, manage and use information well to support all its activities, using secure electronic systems with security safeguards.
- Service performance measures were not always collected, monitored or reviewed and it was unclear whether they were being effectively used to improve practice.
- There were some occasions where patients did not receive care which protected their privacy and dignity.
- Staff did not always respect confidentiality when conversations about patient care took place.

However:

- Medical staffing arrangements on surgical wards were safe.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- In general, the service had suitable premises and equipment and looked after them well.

Surgery

- Mandatory training was provided and compliance was monitored. The service made sure staff were competent for their roles.
- Nutrition and hydration met the needs of patients.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Most staff always cared for patients with compassion, privacy and dignity and supported patients to minimise their distress.
- Most staff always involved patients and those close to them in decisions about their care and treatment and respected confidentiality when conversations about patient care took place.
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- The service did not always ensure patient risk was assessed and responded to.
- Staff did not keep appropriate records of patients' care and treatment.
- Handover arrangements were not always safe. For example, staff temporarily covering patient care from other wards were not always given appropriate handovers.
- Staff mandatory training was not always complete. For example, staff within the surgical division had not all received sepsis training.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The surgical division did not always control infection risk well.
- Allied health professional staffing was not sufficient.

However:

Surgery

- Medical staffing arrangements on surgical wards were safe.
- In general, the service had suitable premises and equipment to provide safe care and treatment to patients. The maintenance and use of equipment kept people safe.
- Mandatory training compliance for nursing staff was monitored and the service provided mandatory training in key skills.
- The service mostly followed best practice when prescribing, giving, recording and storing medicines.

Is the service effective?

Requires improvement ➔➔

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not always provide safe care treatment and did not always follow national guidance.
- The service was not always monitoring the effectiveness of care and treatment or using the findings to improve outcomes. It was not possible to identify areas of concern or improvement due to poor and inconsistent data submissions.
- Patient outcomes were not always monitored due to high 'lost to follow up' patients.
- Compliance with required assessments was not always high.
- Patient outcomes were variable and some, specifically, re-admission rates for elective procedures were higher (worse) than the England average.
- The service was continuing to work towards seven-day services although were yet to achieve it.

However:

- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain.
- The service made sure staff were competent for their roles.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Performance was poor in relation to recording when patients were consulted and consented about their care.

Is the service caring?

Requires improvement ➔

Our rating of caring went down. We rated it as requires improvement because:

Surgery

- Staff did not always care for patients with compassion.
- Staff did not always ensure patients' privacy and dignity was respected.
- Staff did not always involve patients and those close to them in decisions about their care and treatment**.**

However:

- Staff provided emotional support to patients to minimise their distress.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided services in a way that mostly met the needs of local people.
- Services within the surgical directorate coordinated and delivered care to ensure they were accessible and responsive to patients with complex needs.
- Translation services were available to patients whose first language was not English.
- Surgical wards could accommodate patients in single sex areas.
- People could access the service when they needed it and received the right care promptly. Referral to treatment times for some surgical specialities were above (better) than the England average. Some specialities were below (worse) than the England average but not significantly so. The exception being oral surgery, which was significantly below (worse) than the England average.
- It was easy for people to give feedback and raise concerns about care received.

Is the service well-led?

Requires improvement

Our rating of well-led went down. We rated it as requires improvement because:

- Most managers had some skills and abilities to run the service but did not always act to ensure high-quality sustainable care was delivered.
- Leaders understood the challenges to quality and sustainability but could not always identify the actions needed to address them.
- There were extensive governance arrangements within the surgical division, but they were not always effective.
- The service had a system for identifying risks, planning to eliminate or reduce them but the service risk register was not used effectively. Significant care group risks were not always escalated and there were gaps where risks were not identified.
- The service did not always collect, analyse, manage and use information well to support all its activities, using secure electronic systems with security safeguards.

- Staff seemed committed to improving services, but we found limited evidence of this. Whilst there was a framework and governance and risk management systems they required work to ensure positive impact on improving patient care.

However:

- The service had a clear set of values, with quality and sustainability as the top priorities.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There were areas within the service where morale was mixed.
- The service engaged well with patients, staff and the public to plan and manage appropriate services.

Areas for improvement

Action the hospital MUST take to improve:

- The trust must ensure staffing levels on surgical wards are safe and reduce the risk of patient harm. This includes reviewing, monitoring and recording patient acuity (Regulation 18: Staffing)
- The trust must ensure the care and treatment provided to patients is safe. This includes keeping up to date patient care records, adherence to infection prevention and control practices and systems and processes which prevent never events (Regulation 12: Safe care and treatment)

Action the hospital SHOULD take to improve:

- The trust should ensure all staff are given an appropriate handover when starting or covering shifts.
- The trust should ensure any store room where medication is stored is locked and doors are closed.
- The trust should ensure all surgical staff comply with the World Health Organisation checklist and the five steps to safer surgery.
- The trust should ensure medical and nursing staff are compliant with all mandatory training.
- The trust should ensure all patients receive care which protects their privacy and dignity.
- The trust should consider that all incidents are reported promptly.
- The trust should consider monitoring the performance in relation to sepsis management.
- The trust should consider recording all risks on the relevant risk registers and are understood and mitigated appropriately.
- The trust should consider improving the process of collecting, analysing, managing and using data in relation to the surgical assessment unit and surgical sterilisation unit to support and improve performance.

Critical care

Requires improvement

Key facts and figures

The trust as one critical care unit based at Walsall Manor Hospital. We inspected the critical care service as part of the next phase of our inspection methodology. We conducted an unannounced inspection of the service from 4 to 6 of February 2019.

The critical care unit cares for adult patients needing intensive care (level three) or high dependency care (level two) as defined by the Intensive Care Society document Levels of Critical Care for Adult Patients (2009). The critical care unit accommodates male and female adult patients and does not have provision to care for children.

Patients are admitted to the critical care unit following medical and surgical emergencies and/or serious operations. Patients receive intensive treatment and monitoring on the unit until their condition has stabilised.

There were 357 admissions to the intensive care unit at Walsall Manor Hospital between April 2018 and September 2018, of which 73% (273) were non-surgical admissions, 15.8% (59) were emergency surgical admissions and 11.2% (42) were elective surgical admissions.

The unit provides support for all inpatient specialities and to the emergency department at Walsall Manor Hospital.

A consultant intensivist (a consultant specialising in intensive care medicine) leads the critical care service. They are supported by consultants, junior doctors, nursing staff and support staff.

The hospital opened a purpose built critical care facility on 1 December 2018. This combined the previously separated HDU and ITU into one unit. The unit had capacity for 16 intensive care beds, had nine side rooms and an isolation suite. Commissioners provided funding for 18 patients.

The new critical care unit has:

- An isolation suite with lobby area, en-suite bathroom facilities and a fixed track patient hoist
- Nine single bedded side rooms
- An open bay with capacity for eight beds
- A central monitoring station
- A clean and dirty utility room
- A kitchen to prepare patient food
- A consumable store room
- An interview room and handover office
- A housekeeping room
- A waste disposal hold
- A relative's room (Francoise Suite)

During the inspection, the inspection team:

- Spoke with five patients and seven relatives

Critical care

- Reviewed nine patient records
- Reviewed trust policies for critical care
- Reviewed performance information and data about the trust
- Spoke with 25 members of staff including nurses, pharmacists, consultants, administration staff and domestic staff
- Met with service leads and the matron for the service.

The Care Quality Commission last inspected the critical care service in June 2017. We rated the critical care service as requires improvement overall with safe, effective, responsive and well led rated as requires improvement and caring was rated as good.

We issued the critical care service with three requirement notices and six recommendations for service improvement.

During this inspection, we reviewed changes the critical care service had made to address these previous concerns.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Mandatory training compliance levels for medical staff were below the trust's target for seven of the 10 mandatory training modules.
- The cover provided by the critical care outreach team was insufficient to sufficiently

mitigate risk.

- The service did not always monitor infection risk well.
- The service did not always provide care and treatment based on national guidance and evidence of its effectiveness. Follow up clinics were not conducted to support patients after discharge from the unit. We had raised this as a concern at our previous inspection.
- Staff did not always deliver patient care and treatment seven days a week in accordance with national guidance.
- All staff had access to trust policies and procedures but they were not always up-to-date. Several guidelines had not been updated to reflect the patient pathway since relocating to the new unit.
- People could not always access the service when they needed it. Patients were not always admitted, treated and discharged patients in line with good practice and guidance.
- Discharges from the critical care unit did not always take place at appropriate times or place.
- The critical care service did not always use a systematic approach to continually improve the quality of the service and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The trust did not always collect, analyse, manage and use information well to drive improvement in the service.

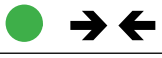
However;

- The service had suitable premises and equipment and looked after them well. The purpose-built unit met Health Building Note guidance for critical care units.

Critical care

- The service provided mandatory training in key skills to all nursing staff. The compliance rates were above the trust target for seven of the training modules and just below the trust target for the remaining three modules.
- The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- Physiotherapy staffing was sufficient to provide respiratory management and rehabilitation components of care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Nursing staff met the trust's target for all safeguarding and PREVENT training modules.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service exceeded the recommended levels of staff that had achieved their post registration qualification in critical care.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Nursing and medical staff compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was above the trust target.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The trust planned and provided services in a way that met the needs of local people. The purpose-built facilities and premises were appropriate for the critical care services delivered.
- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. The service had a clinical lead for critical care.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff morale had improved since relocating to the new critical care unit.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The trust was committed to improving services by learning from when things went well and when they went wrong. The service promoted specialist critical care training, research and innovation.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

Critical care

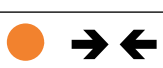
- The service had suitable premises and equipment and looked after them well. The purpose-built unit met Health Building Note guidance for critical care units.
- The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, clinical support worker provision for the unit was currently insufficient.
- The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, recruitment of middle grade consultants was a challenge for the department.
- The service provided mandatory training in key skills to all nursing staff. The compliance rates were above the trust target for seven of the training modules and just below the trust target for the remaining three modules.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Nursing staff met the trust's target for all safeguarding and PREVENT training modules. However, medical staff had met the trust target for three of the five modules.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However;

- Mandatory training compliance levels for medical staff were below the trust's target for seven of the 10 mandatory training modules.
- The service did not always monitor infection risk well.
- The cover provided by the critical care outreach team was insufficient to sufficiently

mitigate risk.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not always provide care and treatment based on national guidance and evidence of its effectiveness. Follow up clinics were not conducted to support patients after discharge from the unit. We had raised this as a concern at our previous inspection.
- Staff did not always deliver patient care and treatment seven days a week in accordance with national guidance.
- Physiotherapy staffing was insufficient to provide respiratory management and rehabilitation components of care. Routine physiotherapy cover was available Monday to Friday, and on-call cover was provided out-of-hours. However, physiotherapists should be available 24 hours a day to meet patient requirements.

Critical care

- All staff had access to trust policies and procedures but they were not always up-to -date. Several guidelines had not been updated to reflect the patient pathway since relocating to the new unit.
- The data contributed by the unit for the most recent reports was incomplete, as some quality indicators were not reported. For example, no data was submitted regarding a patient's physiology. The lack of some information reduced the extent the data could be reviewed and compared with other units.

However;

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service exceeded the recommended levels of staff that had achieved their post registration qualification in critical care.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good patient care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Nursing and medical staff compliance with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was above the trust target.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

However;

- The unit did not use patient diaries to help fill in gaps of a patient's memory.

Is the service responsive?

Requires improvement

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access the service when they needed it. Patients were not always admitted, treated and discharged patients in line with good practice and guidance.
- Discharges from the critical care unit did not always take place at appropriate times or place.

Critical care

However;

- Senior leaders of the critical care unit planned and provided services in a way that met the needs of local people. The purpose built facilities and premises were appropriate for the critical care services delivered.
- The service took account of patients' individual needs. Translation services were readily available to patients whose first language was not English. However, access to written information in other languages was limited.
- From October 2017 to September 2018, the service had not received any complaints and had seven compliments.

Is the service well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The critical care service did not always use a systematic approach to continually improve the quality of the service and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service had effective systems for identifying risks. However, the trust had not yet addressed a number of concerns we had raised at our previous inspection.
- The service did not always collect, analyse, manage and use information well to drive improvement in the service.

However;

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. The service had a clinical lead for critical care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action. Staff at all levels felt engaged with the future plans for the unit.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff morale had improved since relocating to the new critical care unit.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well and when they went wrong. The service promoted specialist critical care training, research and innovation.

Areas for improvement

Action the hospital MUST take to improve

The critical care unit must:

- Ensure the staffing cover provided by the critical care outreach team complies with required standards.

Action the hospital SHOULD take to improve

The critical care unit should:

- Consider improving mandatory training compliance levels for medical staff to comply with trust targets.

Critical care

- Consider improving ways to monitor and drive improvement for non-compliance with infection, prevention and control practices.
- Consider updating all critical care policies to ensure they are up-to-date.
- Consider providing follow-up clinics to suitable patients.
- Consider providing information to patients and those close to them in different languages.
- Consider giving patients the option to use patient diaries.
- Consider reporting data for all quality indicators to the Intensive Care National Audit and Research Centre (ICNARC).
- Consider auditing the performance of the critical care service against the Guidelines for the Provision of the Intensive Care Services (GPICS) standards to assess areas of compliance and non-compliance.
- Consider exploring the range of pathway options for patients requiring discharge from the critical care unit to expediate discharge.
- Consider supporting a patient forum group for the service to enable patients and their relatives to provide feedback and views on any aspect of their experience during their care and treatment.

Maternity

Good

Key facts and figures

The trust has 92 maternity beds across two sites:

- The Manor Hospital has 89 maternity beds, these beds are located within three wards and one unit.
- The Midwifery Led Unit has three maternity beds, these beds are located on one unit.

(Source: Trust Provider Information Request – Acute sites)

From July 2017 to June 2018 there were 3,348 deliveries at the trust. A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at Walsall Healthcare NHS Trust - comparison with other trusts in England

A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

. *(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)*

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at Walsall Healthcare NHS Trust by quarter.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service mostly had suitable premises and equipment and mostly looked after them well, although there were some shortages.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough nursing and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Maternity

- Staff mostly gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and could, if need be, offer supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Consultants, midwives and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Understanding and involvement of patients and those close to them.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service mostly treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. However, complaints were not investigated and closed in line with their complaints policy.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service mostly had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Maternity

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

However,

- The service did not always control infection risk well. Staff did not always keep themselves, equipment and the premises clean. They used control measures to prevent the spread of infection
- The service did not always follow best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up-to-date and easily available to all staff providing care.
- Managers did not close all complaints in the time frame set out in the service's complaint policy.
- Th risk register did not accurately reflect the current risks to the department.

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not always control infection risk well. Staff did not always keep themselves, equipment and the premises clean. They used control measures to prevent the spread of infection
- The service did not always follow best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up-to-date and easily available to all staff providing care.

However,

- The service provided mandatory training in key skills to all staff and made sure everyone completed it
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service mostly had suitable premises and equipment and mostly looked after them well, although there were some shortages.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough nursing and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Maternity

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff mostly gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and could, if need be, offer supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Consultants, midwives and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Is the service caring?

Good ↑

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Understanding and involvement of patients and those close to them.
- Staff involved patients and those close to them in decisions about their care and treatment.

Is the service responsive?

Good ↑

Our rating of responsive improved . We rated it as good because:

Service delivery to meet the needs of local people

Maternity

- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service mostly treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. However, complaints were not investigated and closed in line with their complaints policy.

Is the service well-led?

Good

Our rating of well-led improved . We rated it as good because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service mostly had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, the risk register was fully reflective of the current risks**.**
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Areas for improvement

Action the hospital SHOULD take to improve

- The maternity service should ensure all staff are fully compliant with infection prevention control procedures.
- The maternity service should ensure all inpatient staff have enough basic equipment such as fetal monitoring machines and thermometers to carry out their roles effectively.
- The maternity service should ensure all surgeons attend all crucial stages of the surgical safety checklist.
- The maternity service should ensure complaints are investigated and closed in line with their complaints policy.
- The maternity service should ensure they always follow best practice when prescribing, giving, recording and storing medicines.
- The maternity service should ensure it closes all complaints in the time frame set out in the service wide complaints policy.

Maternity

- The maternity service should encourage managers to utilise the mechanisms in place to manage risk.
- The maternity service should ensure the maternity risk register is kept up to date

Community health services

Background to community health services

The trust provides a range of community services across a range of site within the black country and wider area.

During this inspection we inspected:

- Sexual Health Services

Further community services that we did not inspect:

- Community health services for adults.
- Community health services for children, young people and families
- Community end of life services

The report findings for these services were published in December 2017 and can be found on our website www.cqc.org.uk.

Summary of community health services

Good ➔➔

Our overall rating of community health services remained the same. The summary of community services appears in the overall summary of this report.

Community sexual health services

Good

Key facts and figures

Information about the sites and teams, which offer community sexual health services at this trust, is shown below:

(Source: Universal Routine Provider Information Request (RPIR) – P2 Sites tab)

The sexual health service is part of the Walsall Integrated Sexual Health Services (WiSH), which includes sexual health, HIV, long-term contraception and family planning. The trust provides an outreach service following acquisition from the local authority and a contraception and sexual health (CASH) outreach service for young people, which is part of the team based at the locations listed above. The CASH team works from a hub offering a weekly appointment service on Thursdays from 2pm to 6pm. We included this service in our inspection and it operates from:

Willenhall Health Centre

Field Street

Willenhall

WV13 2NY

The main clinic is located adjacent to the trust's acute hospital and provides services at the following times:

Monday: 8am to 8pm

Tuesday: 9am to 8pm

Wednesday: 9am to 8pm

Thursday: 8am to 8pm (2pm to 7pm for under 25s only)

Friday: 9am to 4pm

WiSH operates a satellite clinic from Walsall town centre. At the time of our inspection it provided services at the following times:

Monday to Thursday: 9am to 5pm for pre-booked appointments

Friday: 9am to 12pm for pre-booked appointments

Friday: 12pm – 4pm for walk-in patients

Saturday: 9am to 4pm for walk-in patients (1pm to 3pm for under 25s only)

Summary of this service

We rated the service as good because:

- There was a culture of reporting near-misses and incidents openly and honestly and this demonstrably led to improvements in practice and care. Staff readily engaged in reflective practice and reviewed instances in which care or processes could have been better to inform service development.
- The team demonstrated a continual focus on improvement delivered through peer reviews, audits and research. This was in line with national and international trends and demonstrated the efforts made by staff to deliver care at the leading edge of sexual health and HIV knowledge and practice. Clinical and quality staff worked together to implement new care and treatment pathways to reflect new and emerging best practice.

Summary of findings

- Staff were audit and research-active and active in regional and national specialist networks. This demonstrably improved policies and practice and meant the team had access to advanced training and development opportunities.
- The young person's contraception and sexual health (CASH) team worked to broad key performance indicators aimed at improving sexual health literacy and improving vaccination uptake. The team delivered a comprehensive sex and relationship education programme that was tailored to the individual needs of young people they saw and led by population and epidemiological trends.
- Health promotion was a substantive element of the service's remit and staff worked in partnership with local organisations to plan and deliver campaigns and interventions to improve sexual health and literacy.
- Staff were persistent in identifying opportunities for development and growth and worked with colleagues across services to improve training. For example, the HIV specialist pharmacist was undertaking an independent prescriber's course and a member of the security team had undertaken training to become a dementia support worker.
- Staff went to great lengths and above and beyond their professional responsibilities in providing patients with compassionate care that included them in planning. The service saw a diverse patient group and staff had adapted communication and care delivery to individual needs, including those with highly complex needs.
- The senior team promoted a culture of reflection in which staff were supported to consider their practice as a tool to acknowledge good work and identify areas for improvement.
- Staff routinely and consistently engaged with patients, including through a user group. They acted on feedback, modified and updated the service and implemented new strategies as a result. A patient survey in 2018 had resulted in five key areas for change, all of which had been completed by 2019.
- Dedicated, experienced staff provided care and guidance to young people with a pragmatic approach to the age of consent and sexual experimentation. This was part of a broader approach to young people that was fluid and wholly focused on their safety and needs. The team had formalised communication standards with young people and their parents with the recent ratification of a standard operating procedure.
- Sexual health and safeguarding teams had worked with colleagues in the security team to help them support staff and patients experiencing mental health problems, dementia-related symptoms and those under the influence of alcohol or drugs. This had substantially increased the skill base of the security team to meet changing trends in the support they were called on to provide.
- Staff showed flexibility for patients accessing services. They adapted and extended clinic times to meet individual needs and changed the availability of testing during outreach sessions to meet demand.
- Services were delivered based on the needs of the population. Staff were proactive in identifying changing and emerging needs and adapting services to meet them. This was a multidisciplinary approach and staff worked with other teams to establish new care pathways and programmes.
- The service demonstrably improved facilities and access as a result of patient feedback and actively engaged with people when they expressed dissatisfaction. There was evidence from governance meetings and speaking with staff that feedback was taken seriously and used substantively in service planning.

However, we also found areas for improvement:

- In 2018 there were a series of incident reports relating to clinic cancellations and delays caused by persistent short staffing and turnover and sickness rates were significantly higher than trust targets. A new senior sister had begun to address the issues causing this although uncertainty in the service caused by funding cuts meant they were restricted in recruiting new staff.

Summary of findings

- There was a disconnect between what the trust told us about staff satisfaction and engagement, our discussions with staff and the results of a 'pulse check' survey. The survey in 2018 found areas of dissatisfaction amongst staff, including in relation to communication from the trust and with the senior management team. The senior sister in sexual health had addressed local issues but there was no evidence of improvement from the trust.

To come to our ratings, we inspected the main clinic, satellite clinic and the CASH service. We observed care being delivered, including at a school during an outreach session, and spent time with the reception team and single point of access (SPA) team in the course of their duties. We spoke with 13 members of staff reflecting a range of roles and responsibilities and spoke with four patients. We reviewed six sets of medical records and over 67 other pieces of evidence.

We had not previously inspected this service.

Is the service safe?

Requires improvement

We rated safe as requires improvement because:

- The service did not always have enough staff to provide the right care and treatment. Turnover and sickness rates were persistently higher than trust targets and staff frequently submitted incident reports regarding short staffing that led to clinic delays and cancellations.
- It was not evident the senior team always acted on health and safety incidents or audited local practices to keep staff safe.
- Robust systems and resources were not in place to keep reception staff safe from harm at the main clinic. Although staff reported instances of abuse and violence, the trust had failed to act on these.
- Fire safety standards were good in areas the trust had control over. However, there was a risk at the satellite clinic caused by uncontrolled parking, which meant a key fire exit was partially blocked.

However, we also found areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. We found proactive, timely and consistent safeguarding practices in line with trust policies and local best practice.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Clinics complied with Department of Health and Social Care guidance on infection control in clinical environments, in relation to waste management and the handling of sharps.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- Staff had the right qualifications, skills, training and experience to keep people safe from avoidable harm.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Staff had introduced dynamic templates to care plans, which enabled more coherent and individualised recording of assessments and consultations. A dedicated HIV administrator managed this patient group's records and these were maintained in line with national standards.

Summary of findings

- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time. Audits were in place to monitor safety standards and a dedicated HIV specialist pharmacist provided oversight and support.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Senior staff had acted on themes of incidents, including changes to practice following delayed communication with patients about test results.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Outstanding

We rated it as outstanding because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. The team worked proactively to implement strategies to meet new national guidance and where existing guidance changed and presented challenges.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Staff acted on learning from national incidents to review the effectiveness of processes and specific tests to ensure they could be confident with results.
- An extensive audit plan reflected the service's focus on meeting national standards while developing care in line with the local needs of the population, including reacting to changes in sexual behaviour.

The service operated an opt-out system for HIV testing and encouraged everyone who attended the main clinic to undertake a test. From February 2018 to January 2019 the service achieved an 82% uptake of HIV testing.

- Staff worked with colleagues in microbiology and other medical specialties to implement improvements to existing process within the requirements of national standards. This meant patients under the care of multiple teams, such as urology or gynaecology in addition to sexual health, received individualised, evidence-based care
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Staff coordinated care with other specialists and multidisciplinary working was clearly embedded in all aspects of the service. Nurses, clinicians, health advisors and outreach workers collaborated to deliver seamless pathways of care.
- The team had developed specialist clinics to improve patient outcomes, such as in dermatology, psychology and erectile dysfunction. Consultants worked with local GPs to improve sexual health services to patients in primary care.
- Staff worked in partnership with local organisations to plan and deliver health promotion campaigns and interventions. They targeted health promotion campaigns and interventions at specific population groups and provided patients with up-to-date guidance that reflected the latest national and international practice.

Is the service caring?

Outstanding

Summary of findings

We rated it as outstanding because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Patients consistently recommended the service in the NHS Friends and Family Test (FFT), with a 96% recommendation rate in 2018.
- During all our observations of interactions with patients, staff demonstrated kindness, empathy and reassurance. Patients gave us enthusiastic and positive feedback and gave a range of specific examples of how staff had supported and looked after them when they had needed it the most.
- Staff were acutely aware of the need for consistent standards of privacy and dignity and to manage patients confidentially. Staff adapted the service to maintain privacy and dignity based on where they delivered care.
- Staff provided emotional support to patients to minimise their distress**.** The team demonstrated an acute understanding of the differences in effective emotional support based on age and gender and adapted their approach accordingly.
- The whole team promoted a positive atmosphere to reduce the stigma and preconceptions of visiting a sexual health clinic They delivered this using communication adapted to specific age groups, in recognition of the different levels of comfort patients demonstrated in talking about their sexual health.
- Staff provided highly tailored support to patients based on their level of risk, understanding of the risks and broader health and social needs. The team was well equipped to provide care to patients with complex needs, such as sex addition.
- Staff involved patients and those close to them in decisions about their care and treatment. This included a very diverse patient group including commercial sex workers and those with complex psychosexual needs. Nurses kept up to date with sexual health information on social media, in current affairs and in popular culture to be able to effectively communicate with young people.
- The reception and single point of access (SPA) teams delivered a service with consistent attention to detail. They demonstrated an acute understanding of patient's needs and helped them understand why there were longer waits for some appointments.

Is the service responsive?

Good

We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people.
- The sexual health and multidisciplinary teams worked together to identify changes in population needs and behaviour. They used this information to identify potential gaps in screening and treatment and to implement additional care accordingly.
- Staff were proactive in adapting and delivering services to the emerging needs of specific population groups, which they accomplished through an acute understanding of behaviour and risk. Outreach staff targeted hard-to-reach groups that had higher risks of sexual infections and HIV and the contraception and sexual health (CASH) team spent time with new students during university fresher's weeks. In September 2018 the team carried out 189 chlamydia and gonorrhoea screens during fresher's events.

Summary of findings

- Staff had established relationships with other service providers to ensure they met the needs of patients with complex behaviours and problems. This included a long-standing reciprocal arrangement that enabled patients to access alcohol and drug cessation specialists.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Staff maintained up to date awareness of the services offered by other providers and clinics in the region to ensure they could meet demand and offer additional care where needed.
- Staff had increased the availability of testing for certain conditions during outreach sessions based on feedback and demand and were responsive in changing access times.
- Services were provided for an extensive range of people in the local population and staff worked collaboratively to ensure these were well coordinated. For example, the adult safeguarding team was developing a transition pathway for victims of sexual exploitation who were moving from childhood to adulthood.
- Staff demonstrated an acute understanding of the challenges and influences on local young people. The CASH team identified the impact of health inequalities on young people from lower socioeconomic groups and provided advice and guidance appropriate to their needs.
- Staff had adapted the Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients to the service, which ensured patients received continuity of care from named clinicians.
- Patients could order chlamydia testing kits online and arrange to collect these from any of the service's clinics. Staff implemented this process for patients who were unable to receive sensitive post at home, such as those with domestic safety concerns or those who were worried about confidentiality.
- The trust safeguarding team was working with the sexual health team to improve care for patients with learning disabilities through more advanced training. Staff adapted sex and relationship education sessions to meet the needs of young people living with autism and helped to make information more accessible.
- The CASH team used online resources to help discussions on topics such as consent, sex and the law and pornography to young people.
- During our inspection we observed staff worked together to ensure patients could access to service as conveniently as possible.
- The single point of access team had significantly improved access to the service. From January 2018 to January 2019 the team handled over 20,000 calls with a response time of less than two minutes.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However, we also found areas for improvement:

- From February 2018 to January 2019, the service cancelled 2204 appointments and patients cancelled 3156 appointments. The service did not monitor the reasons for cancellations or the time to re-booking.

Is the service well-led?

Good

We rated it as good because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. Staff spoke positively about recent changes in service leadership.

Summary of findings

- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improve quality and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Multidisciplinary governance structures enabled the local time to manage risks and performance. This included in safeguarding and medicines management.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards**.** Staff demonstrated a proactive approach to improving information management using methods that improved efficiency without creating risk.
- The service engaged well with patients, staff, the public and local organisations and collaborated with partner organisations effectively. We saw evidence of improvements to care as a result of patient feedback and a service user group.
- Staff continually engaged with patients beyond the need for clinical contact to improve the service and develop specialist pathways and worked with a user group to maintain regular discussions.
- The service was committed to improvement by learning from when things went well and when they went wrong, promoting training, research and innovation.

However, we also found areas for improvement:

- The single point of access team was routinely excluded from whole-team meetings because the phone lines could not be suspended. The CASH team could not always attend team meetings because they were often timed to coincide with planned outreach work. Although the senior sister provided briefings following meeting, the system meant a core group of staff did not have regular face-to-face meeting opportunities with the rest of the team.
- A pulse check staff survey in 2018 identified several areas in which staff were unhappy or dissatisfied.
- Although the trust promoted a positive culture and had a vision and strategy in place, staff feedback was variable.

Outstanding practice

- Safeguarding practices were fully embedded in all aspects of the service. Staff maintained up to date training and demonstrated advanced skills in the recognition of potential risk. The team was proactive in engaging with other agencies, including specialist organisations, to respond to patients with highly complex needs and in cases where multiple local authorities were involved. Staff ensured young people had access to high quality sexual health and sex education to develop skills to protect themselves from harm and exploitation.
- We observed excellent standards of safeguarding awareness during our inspection. For example, a patient booked into a future appointment at the satellite clinic visited and asked to be seen earlier. The patient was booked to attend with an interpreter and on this occasion attended with a relative translating for them. The clinical support worker (CSW) on duty recognised this as a safeguarding concern and explained discreetly and sensitively why they could not be seen with a relative interpreting for them. The CSW established the patient had no urgent or immediate clinical risk during this process, which ensured their safeguarding concern did not detract from clinical needs.

Summary of findings

- The safeguarding team had adapted the existing clinical situation, background, assessment and recommendation (SBAR) tool for use by the security team when attending calls for help. The tool meant the security team could prepare themselves for the situation and plan a response based on what staff knew about the patient, such as mental health diagnoses or problems.
- The service was proactive in sharing the outcomes of audits and research broadly across the sector to improve understanding and practice. In April 2018 the service presented the outcomes of a project to identify how clinicians in different departments treated the same condition. This was a collaborative project with other departments in the hospital and the team presented it at an international HIV and sexual health conference. The outcomes of the project meant patients received more consistent, evidence-based treatment wherever their condition was detected in the hospital.
- The CASH team provided an exemplary programme of sex and relationship education to young people in schools, colleges and the local community. This included a balanced approach to addressing the anxieties and worries of teenagers whilst supporting developing sexual interest in line with best practice guidance. The team used digital media to help communication and provided practical guidance on topics such as condom use and managing relationships.
- Young people in schools and colleges regularly presented with a wide range of questions about sex and sexual health and staff prided themselves on understanding different terminology and being able to provide specific information. This included on general sex and relationship education as well as on sexual behaviour and experimentation. Nurses kept up to date with sexual health information on social media, in current affairs and in popular culture to be able to effectively communicate with young people.
- There was a consistent focus on holistic care and staff strived to meet the needs of patients with complex health issues, including social care needs. The team had developed complex care pathways, such as for young people in vulnerable circumstances experimenting with alcohol and drugs. They provided coordinated care for people experiencing domestic abuse, sexual exploitation or coercion.
- Staff continually engaged with patients beyond the need for clinical contact to improve the service and develop specialist pathways. For example, the safeguarding team and sexual health team worked with a previous victim of sexual exploitation to arrange a trust event on the topic. The previous patient presented on their experience and reflection to staff from across the trust. More staff wanted to attend than could be accommodated in the venue and the presenter would return to repeat the presentations in the future.
- The senior sister distributed a ‘learning from excellence’ communication as part of the monthly quality and safety update. This was part of a strategy to identify and promote positive practice to balance information on incidents and risks. The communication included a rolling programme of peer-nominated awards.
- All members of the team demonstrated the importance of understanding new and emergency threats and trends to sexual health and HIV, at a local and population level. This included where international standards of care and treatment guidelines differed from the UK and patients were typically well-versed on both. For example, national and international guidance on the use of pre-exposure prophylaxis (PrEP) varied widely. This medicine was typically targeted at men who have sex with men (MSM) and as an additional preventative measure to avoid HIV infection alongside consistent condom use. However, the team recognised in practice many patients used PrEP instead of condoms, which had led to resistant strains of common STIs, including gonorrhoea and syphilis. As a result, the team coordinated care and treatment for more complex infections and for patients with more complex needs relating to psychosexual behaviour.

Areas for improvement

We told the trust they SHOULD:

Summary of findings

- Ensure car parking at the satellite clinic is controlled in a way that does not present a safety risk to occupants of the clinic in an emergency evacuation.
- Review health and safety monitoring and practices to reduce the risk of injury, abuse and violence to staff.
- Improve monitoring of appointment cancellations to address trends.
- Review arrangements for trust-level and senior management communication with staff to ensure they feel supported and have access to managers during periods of change and high levels of pressure.
- Address the negative views held by staff of the working culture and vision and strategy of the trust.

Click or tap here to enter text.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 5 (Registration) Regulations 2009 Registered manager condition

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Our inspection team

Our team was led by Victoria Watkins , Head of Hospital Inspection.

The team included on inspection manager, seven inspectors (including a pharmacy inspector and a mental health inspector), one executive reviewer, and 14 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

Walsall Healthcare NHS trust

Use of Resources assessment report

Moat Road
Walsall
West Midlands
WS2 9PS

Tel: (01922) 721172
www.walsallhospitals.nhs.uk

Date of publication: 25 July 2019

This report describes our judgement of the Use of Resources and our combined rating for quality and resources for the NHS trust.

Ratings

Overall quality rating for this NHS trust	Choose a rating
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Outstanding**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Our overall quality rating combines our five NHS trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this NHS trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RBK/reports)

Are resources used productively?	**Requires improvement** ●

Combined rating for quality and use of resources	Requires improvement

We award the Use of Resources rating based on an assessment carried out by NHS Improvement.

Our combined rating for Quality and Use of Resources summarises the performance of the NHS trust taking into account the quality of services as well as the NHS trust's productivity and sustainability. This rating combines our five NHS trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Use of Resources assessment and rating

NHS Improvement are currently planning to assess all non-specialist acute NHS trusts and foundation NHS trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively NHS trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of NHS trust performance against a selection of initial metrics, using local intelligence, and other evidence. This analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the NHS trust.

Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five NHS trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating, using the ratings principles included in our guidance for NHS trusts.

This is the first time that we have awarded a combined rating for Quality and Use of Resources at this NHS trust. The combined rating for Quality and Use of Resources for this NHS trust was requires improvment, because:

- We rated safe, effective, responsive, and well-led as requires improvement; and caring as outstanding.
- We took into account the current ratings of the core services and community services not inspected at this time.
- The overall rating for the trust's acute locations remained the same.
- The trust was rated requires improvement for use of resources. Full details of the assessment can be found on the following pages.

Walsall Healthcare NHS trust

Use of Resources assessment report

Date of site visit:
8th February 2019

Tel: 01922 721172
www.walsallhealthcare.nhs.uk

Date of publication:
<xx.MONTH.201x>

This report describes NHS Improvement's assessment of how effectively this NHS trust uses its resources. It is based on a combination of data on the NHS trust's performance over the previous twelve months, our local intelligence and qualitative evidence collected during a site visit comprised of a series of structured conversations with the NHS trust's leadership team.

The Use of Resources rating for this NHS trust is published by CQC alongside its other NHS trust-level ratings. All six NHS trust-level ratings for the NHS trust's key questions (safe, effective, caring, responsive, well-led, use of resources) are aggregated to yield the NHS trust's combined rating. A summary of the Use of Resources report is also included in CQC's inspection report for this NHS trust.

How effectively is the NHS trust using its resources?	**Requires improvement**

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the NHS trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the NHS trust, and the NHS trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework.

We visited the NHS trust on 8th February 2019 and met the NHS trust's executive team (including the chief executive), the chair and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

Is the NHS trust using its resources productively to maximise patient benefit?	Requires improvement

We rated the use of resources at this NHS trust as Requires Improvement. The NHS trust's performance is variable across the areas covered by this assessment and although it has demonstrated improvement in some it continues to have key workforce challenges, in particular high levels of sickness absences and high use of temporary staffing, which has contributed to a deterioration in its financial performance. Whilst the NHS trust has implemented productivity improvement initiatives, the impact is yet to be reflected in its financial position.

- Performance against clinical services productivity metrics is variable. The NHS trust compares well in respect to Delayed Transfers of Care (DTOCs), 30-day emergency readmissions and elective pre-procedure bed days. This indicates better discharge processes and utilisation of elective bed capacity. Performance for non-elective pre-procedure bed days and Did Not Attend (DNAs) rates, though on an improving trend, remain worse than other NHS trusts, indicating that there is scope to improve utilisation of outpatient services and emergency bed capacity.
- The NHS trust also has variable performance against the constitutional operational standards. It is meeting the diagnostic and cancer standards and whilst it is not meeting the 18-week standard, performance is in line with its improvement trajectory. Further work is required to achieve sustained improvement against the 4-hr Accident and Emergency standard.
- The NHS trust has an overall cost per weighted activity unit (WAU) of £3,587 compared with a national median of £3,486 for 2017/18 (the most recent data), placing the trust in the second highest cost quartile nationally. This means the NHS trust spends more per unit of activity than most other trusts.
- Workforce productivity does not compare well in most areas. The NHS trust's cost per WAU is in the highest cost quartile nationally, which means that it spends more on pay to

deliver activity when compared with other NHS trusts. The key contributors being nursing and temporary workforce costs. Sickness absence rates are also above the national median, and although the NHS trust achieved a reduction in agency costs in 2017/18, this has not been fully sustained, and the NHS trust expects to breach the 2018/19 agency ceiling by 23%. However, the NHS trust's overall retention rates compare well.

- A number of clinical service and workforce productivity improvement initiatives are being implemented by the NHS trust. They include nursing, medical and temporary workforce reviews to identify opportunities for better workforce deployment and cost reduction, and utilisation improvement programmes for theatre and outpatient services, which are supported by an external management consultancy. The NHS trust is also progressing some of the 'Getting It Right First Time' (GIRFT) improvement initiatives, in specialities such as orthopaedics. The full financial impact of these improvement programmes has not yet been modelled, however the NHS trust was able to demonstrate some in year financial benefits, such as reduced temporary agency nursing costs and improved income generation.
- The NHS trust's costs in pathology compare well and it has started working collaboratively with neighbouring NHS trusts in a pathology network, which is in line with the national strategy for sustainability of pathology services.
- Pharmacy costs also compare well, with the NHS trust benchmarking in the best quartile nationally. This is contributing to the NHS trust's low non-pay cost per WAU, which benchmarks lower than most NHS trusts. The NHS trust has pharmacy staff working on wards to support medicines optimisation and other various initiatives in place to reduce medicines wastage. The NHS trust has progressed well in delivering against the national top ten medicines programme, with savings performance that is better than target.
- There is more use of reporting radiographers for plain x-ray film reporting, which is the preferred operating model in imaging services as it releases consultant workforce capacity for more complex work. Other improvement initiatives in imaging services, include improving workforce capacity and improving utilisation of facilities through working with third parties. Outsourcing and agency costs, however, remain high.
- Estates and Facilities management costs are relatively lower than most NHS trusts, and the NHS trust is maintaining its estate well with a low maintenance backlog and critical infrastructure risk. This is partly due to the PFI arrangements in place for some of the estate, however the NHS trust also demonstrated a more proactive approach to maintenance of its retained estate. There is scope for further improvement in respect to waste management and PFI costs, which benchmark worse than most NHS trusts.
- Supplies and services costs compare well, however the NHS trust's performance against the NHS Improvement procurement metrics indicates that further cost reduction may be achieved through more effective procurement processes. Whilst the NHS trust is in a procurement collaboration, it is yet to optimise savings from this arrangement.
- The cost of running the finance function is lower than most NHS trusts and further improvements are planned for its sub-functions where the costs are outliers. The function has also recently taken over the programme management office to support productivity and financial improvements. Further work is required to ensure that financial modelling is embedded in early stages of developing productivity improvement initiatives, to allow for better understanding and delivery of financial benefits.
- The NHS trust did not agree its control total for 2017/18, and its performance was worse than plan. The NHS trust had a plan of £20.7 million against which it reported a deficit of £24.08 million. However, as a percentage of turnover (9.6%) this performance was in line with the previous year. The NHS trust agreed to its control total for 2018/19, but is not on track to deliver this, and the latest forecast position is £28.5 million deficit before PSF

(11.48% of turnover) against a control total and plan of £15.5 million. The main contributors to the adverse position are a higher than expected pay bill driven by premium agency costs, and slippage against the cost improvement plan.

- For 2018/19, the NHS trust's cost improvement plan aimed to deliver a higher target of £15.5 million (5.61% of operating expenditure), which was the level of savings required to deliver the control total. Slippage against this plan was identified early in the year and the NHS trust strengthened its cost improvement delivery structures, however it has not achieved full recovery (against its plan) and is forecasting delivery of £13.7 million (4.71% of operating expenditure).

How well is the NHS trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?

The NHS trust's performance for clinical services productivity is variable, however it has demonstrated improvements in areas where it does not compare well.

- At the time of the assessment in February 2019, and based on November 2018 data, the NHS trust was meeting the cancer and diagnostics constitutional operational standards. It was not meeting the 18 -week Referral to Treatment (RTT) standard but was delivering above its recovery trajectory for this standard. The NHS trust was also not delivering the 4-hour Accident and Emergency standard. An improvement plan had been developed for the NHS trust (and wider Walsall system), however this is not being delivered. The Emergency Care Intensive Support Team has been working with the NHS trust to make sustained improvements in performance against this standard, and as part of the 2019/20 operational planning round, a revised trajectory is being developed by the NHS trust.
- Patients being treated at the NHS trust are less likely to require additional medical treatment for the same condition when compared with other NHS trusts. For the period October 2018 to December 2018, the emergency readmission rate at 7.14% is below the national median of 7.86%, an improvement on the previous year (8.79%). Improvements have been achieved through initiatives which ensure that there is appropriate monitoring of patients after discharge. For instance, virtual surgery and fracture clinics are held for patients who have been discharged and may require further surgery. Further work is also planned in conjunction with health commissioners (as part of a Walsall Together Programme) to support patients manage long-term conditions better at home, with an initial focus on respiratory and cardiology conditions.
- Delayed Transfers of Care (DToC) at 3.5% (October 2018) are in line with the national median. Opportunities exist for further improvement as the NHS trust identified that there are delays in the discharge process, which result from inefficiencies in the current approach to utilising therapy interventions. There is a heavy reliance on therapy interventions to mobilise patients, and this drives unnecessary referrals for therapy services, generating longer waiting times. Work has commenced to review current practice against best practice models.
- The NHS trust's average Length of stay for elective admissions benchmarks better than the national median and the NHS trust has achieved a reduction in the average Length of stay for non-elective admissions over the last 12 months, though this remains above (worse than) the national median. There has also been a reduction in the percentage of beds occupied with long stay patients, from an average of 22.6% in 2017/18 to 21.4% as at November 2018.
- The NHS trust has integrated teams for discharge planning which include therapists and social workers, who work with wards to support prompt discharge of patients. There is an

intermediate care service (a joint venture through Walsall Together) which further supports elective patient flow through provision of a facilitated discharge service. The NHS trust has also engaged with the national programmes which aim to improve patient flow, such as SAFER, Red 2 Green and MADE events.

- Fewer patients are coming into hospital prior to the day of their surgery compared to other hospitals in England, as indicated by the pre-procedure bed days for elective care which benchmarks well nationally. Performance for the period October to December 2018 is 0.03 days compared to the national median of 0.13. This is an improving position and puts the NHS trust in the best quartile nationally, with only six other NHS trusts reporting a better position. The NHS trust attributes this performance to changes in practice (driven by clinicians) which led to more patients being admitted on the day of surgery. The aim was to ensure continuity of elective work by reducing the planned surgery cancellations as a result of bed capacity constraints.
- The NHS trust is above the national median and in the worst quartile for the pre-procedure non-elective bed days, which for period October to December 2018 were 0.83 days compared to a national median of 0.65 days. This indicates that patients are waiting longer in hospital for emergency procedures, when compared to other NHS trusts. The NHS trust has identified that this performance is largely driven by delays to hip fracture pathway and has appointed a dedicated consultant lead to implement the improvements.
- The NHS trust has undertaken work to make improvements in theatre utilisation, which was one of the workstreams established as part of the Financial Improvement Programme. This is a programme of support, introduced by NHS Improvement, through which NHS trusts are supported in materially reducing their costs to improve their financial positions. The programme ended in March 2018, but the NHS trust has maintained this workstream and for the period April 2018 to December 2018, its income performance is reported to be £1 million better than plan, with £0.6 million of this attributed to improved theatre utilisation. Further significant improvements however remain to be made as the NHS trust continues to experience inconsistent theatre performance and high cancellations rates.
- The Did Not Attend (DNA) rate for the NHS trust, though improved, remains in the worst quartile nationally. For October 2018 to December 2018, the DNA rate was 9.09%, compared to a national median of 7.32%. This is however an improvement on the previous year, when the NHS trust's performance was 11.76% for the same quarter. The reduction has been delivered through an Outpatients Service Improvement Plan. Further improvements are being made with patient text and voice call reminders. The NHS trust is also considering triage of Trauma and Orthopaedics and Colorectal patients, prior to offering a first outpatient appointment.
- There is strong clinical engagement with the national 'Getting It Right First Time' programme, and the NHS trust has commenced work eight specialties to identify areas for productivity improvements. For instance, in orthopaedics, an action plan has been developed with the aim of delivering improved utilisation through increasing the number of joint replacement operations on a standard all-day theatre list during February 2019. The NHS trust has not yet quantified any benefits expected from these initiatives.

How effectively is the NHS trust using its workforce to maximise patient benefit and provide high quality care?

The NHS trust has a high pay bill with nursing and temporary workforce costs as the main contributors. To address this, the NHS trust has embarked on a review of its workforce skill mix, costs and deployment processes. It is also working to reduce the high sickness absence rates.

- For 2017/18 the NHS trust had an overall pay cost per WAU of £2,392 compared with a national median of £2,180, placing it in the highest cost quartile nationally. This means that it spends more on staff per unit of activity than most NHS trusts. However, the NHS trust is in the lowest cost quartile for medical cost per WAU.
- Nursing and midwifery staff cost per WAU for 2017/18 is £852 compared to a national median of £710. A nurse staffing review of all in-patient areas identified a relatively high number of higher graded nursing posts within the NHS trust, which was contributing to this high cost per WAU. These posts were previously created to enhance recruitment and retention of nursing staff. The NHS trust is addressing this high cost through its nursing transformation program, which will deliver changes in the nursing skill mix, with expected savings of £0.5 million.
- The NHS trust has identified that there is insufficient capability in its current e-rostering software to attain optimisation of substantive staff in workforce deployment processes. A business case for procuring a more effective e-rostering software solution has been developed. The NHS trust has a process in place to monitor patient acuity and dependency, however this is largely manual. Electronic collation of patient acuity and dependency data would provide more accurate monitoring information and further improve effectiveness of staff deployment.
- Medical staffing cost per WAU at £478 is lower than the national median of £533 and in the lowest cost quartile nationally. The NHS trust is working to improve deployment of medical workforce through achieving consistency in job planning approach across specialities, and electronic capture of job plans (with the NHS trust reporting 78% compliance). Further work is required to ensure alignment with the NHS trust demand and capacity plans. The NHS trust has commissioned external consultancy support to address this and to also identify other productivity improvement opportunities, through the review of medical agency spend.
- The NHS trust achieved a reduction in overall agency spend for 2017/18 compared to the previous year, with the spend reported to be marginally above the agency ceiling set by NHS Improvement. However, the improvement has not been fully sustained in 2018/19, and agency spend is expected to rise above 2017/18 levels and exceed the agency ceiling (2018/19) by 23%. Drivers of agency spend remain, cover for vacancies and sickness absences, as well temporary capacity during periods of high emergency demand.
- The NHS trust has strengthened its controls for agency booking and is working to proportionately increase the bank staff fill rates. Evidence provided by the NHS trust demonstrated that since October 2018, there has been a reduction in monthly spend on overall temporary nurse staffing, mainly driven by a reduction in use of agency staff. The NHS trust has also been successful in eliminating use of care support agency workers in December 2018. The NHS trust is part of the Black Country collaboration where NHS trusts are working together to drive down the medical agency prices and is in early stages of developing a bank collaborative with a neighbouring NHS trust.
- The NHS trust is progressing the use of alternative roles in its workforce model. Examples of the new roles established include advanced clinical practitioners in the emergency department to support assessment and streaming of patients to the right care settings, advanced physiotherapy practitioners working in the community to support GP's as well as improvements in the Musculoskeletal pathway, and advanced practitioners in imaging services who have improved reporting times and patient flow.
- The overall staff retention rate is 86.9% for November 2018, placing the NHS trust above the national median of 85.9%, and in the second-best quartile nationally. However, there

are staff groups with high turnover rates, for instance AHPs, which is driving high agency use. Improvement actions implemented include, better performance reporting (on staff retention and turnover) to support management address areas with lower retention rates and working with the National NHS Leadership Academy to identify ways to enhance talent management and succession planning.

- At 5.43% in September 2018, overall sickness absences rate is worse than the national median of 4.00% and places the NHS trust in the worst quartile nationally. Sickness absence cover is one of the drivers of agency use and the NHS trust is taking a range of actions to address this. For instance, improved reporting to support monitoring and management of absences and use of Health and Wellbeing initiatives, focused on improving attendance. A new attendance policy has been developed which focuses on the health and well-being of staff and is linked to delivery of a revised sickness absence target of 3.75%.

How effectively is the NHS trust using its clinical support services to deliver high quality, sustainable services for patients?

The NHS trust has started working collaboratively with partners to deliver sustainable services in pathology, which is in line with the national strategy for this area. The cost of pharmacy services is relatively lower than most NHS trusts, and it is progressing well in delivering against the nationally identified savings in the top ten medicines programme. The NHS trust is utilising reporting radiographers in its imaging services, however further work is required to reduce high outsourcing and agency costs.

- The overall cost per test in pathology benchmarks in the second lowest quartile nationally mainly due to a very low cost per test in microbiology. Cost per test in cellular pathology is high and in the highest cost quartile nationally.
- The NHS trust has recently transferred its pathology services to the Black Country Pathology Service Network. This development is in line with the national strategy for delivering sustainable Pathology services, however it's too early to assess delivery of benefits.
- The imaging department has a high rate of radiographer reporting for plain x-ray films, when compared with other NHS trusts. Radiographer reporting for plain x-ray films releases consultant capacity to undertake more complex work. The NHS trust also has dedicated radiographer support for the emergency department. There is real time information on diagnostics requests from ED, which is available to staff, allowing for better monitoring and management of patient waiting times and patient flow.
- There is collaboration in providing some of the imaging services, to support better utilisation of workforce and improvements in pathways and patient experience. The NHS trust works with a neighbouring NHS trust to provide breast screening services, with whom they also share consultant resource in Neurophysiology and Clinical Measurement. This has resulted in standardised practice across two organisations. The NHS trust has contracted an external service provider to undertake MRI examinations, which allows it access to new equipment, improved utilisation and better turnaround times.
- The NHS trust has a number of vacancies in the imaging department (which is driving agency and outsourcing costs), with their current vacancy rate being 7.34%. The high vacancy rate is partly due to increased number of posts, which have not yet been filled. The NHS trust undertook a demand and capacity review which identified a requirement

for additional capacity in radiology. There has been some recent success in recruiting to senior roles such as sonographers and senior radiographers, but recruitment to lower graded roles remains a challenge.

- DNA rates in radiology are high, in particular for plain x-ray films, non-obstetric ultrasound and nuclear medicine. The NHS trust has identified delays is communicating appointment slots to patients as the key driver and is addressing this through prompter communication of appointments and confirming patient attendance via telephone.
- The NHS trust's medicines cost per WAU is relatively low when compared nationally and places the NHS trust in the best performing quartile. As part of the Top Ten Medicines programme, the NHS trust is progressing well in delivering against the nationally identified saving opportunities, achieving 122% of the savings target to date. The NHS trust has progressed switching to most of the biosimilars, but there are further opportunities to pursue in respect to Trastuzumab and Adalimumab.
- The NHS trust has other cost improvement initiatives in place, most of which aim to reduce drug wastage. For instance, pharmacists ensure patients are transferred with their medicines between wards which reduces the need for re-dispensing. The NHS trust also has a pharmacy robot to support stock control and tracking of medicines. Evidence of savings delivered to date through these initiatives was however not provided.
- The NHS trust compares well in respect to prescribing pharmacists providing support on wards. Prescribing pharmacist support medicines optimisation practice, which drives safety efficiency and cost reductions.
- The NHS trust provides IT services to other NHS organisations in its locality, through hosting IT network and support service provision. Its clients include clinical commissioning groups and GP practices.
- There is some progress in implementing electronic prescribing for chemotherapy, however all other prescribing is paper based. The NHS trust is developing a business case for an electronic prescribing system.

How effectively is the NHS trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?

The NHS trust's non-pay costs compare well. However, there is opportunity for further improvement through more effective procurement processes, and reduction in the estates PFI and waste disposal costs. The NHS trust also needs to investigate and address the high Human Resources (HR) function costs.

- For 2017/18 the NHS trust had an overall non-pay cost per WAU of £1,194 compared to a national median of £1,307, placing it in the second lowest cost quartile nationally. A breakdown of the cost categories shows that supplies and services costs per WAU also benchmarks better than the national median, however there is scope to further improvement this non-pay cost through more effective procurement processes.
- The NHS trust is 68 out of 136 on the procurement league table for period July to September 2018, and its Procurement Process and Price Performance at 61, benchmarks slightly better than the national median. This indicates that there is scope to improve the effectiveness of the NHS trust procurement processes in driving down the cost of purchases.

- This NHS trust is part of the Black Country procurement Collaborative but is yet to optimise the procurement benefits from this arrangement. Evidence provided by the NHS trust demonstrated improvement in the value of savings delivered through this arrangement, but with scope for further savings.
- For 2017/18, the cost of running the Finance function is in line with most NHS trusts, whereas the Human Resources benchmarks in the highest cost quartile. The Finance function cost is £0.68 million per £100 million of turnover compared to the national median of £0.7 million. The HR function cost is £1.24 million per £100 million of turnover compared to a national median of £1.09 million. The NHS trust has undertaken actions to reduce its finance function costs in future years, for instance, it has retendered its audit services, where costs benchmark higher than most NHS trusts. The NHS trust needs to further investigate and address the drivers of the high running costs for the HR function.
- The NHS trust's estates and facilities cost per square metre is £338, which places it below its peer benchmark value of £345. The NHS trust's maintenance backlog and critical infrastructure risk metrics also compare well against the peer benchmarks. The NHS trust has a PFI arrangement in place for part of its estate, however it also demonstrated a more proactive approach to maintenance of its retained estate, with 62% of the maintenance work being planned.
- The NHS trust has undertaken developments of estates to improve clinical services productivity, for instance expansion of an emergency ward to create more additional bed capacity for seasons of high demand, expansion of Emergency department to reduce congestion in peak times and relocation of ITU and HDU, into one area. The NHS trust has not provided the quantified benefits realised or expected from these improvements.
- There is scope to further reduce the cost of running the estate in respect to waste management and PFI costs, which are above peer benchmarks and in the highest cost quartile when compared with peers. The NHS trust has appointed a sustainability and waste manager to support improvements in waste management, which include re-tendering of contracts and enhanced NHS trust wide training in waste segregation. To date the NHS trust has not secured savings against its PFI contact costs but intends work with papers to identify potential savings opportunities.

How effectively is the NHS trust managing its financial resources to deliver high quality, sustainable services for patients?

The NHS trust did not achieve its financial plan in 2017/18 mainly due to underperformance against its income plan. Whilst it has improved the income performance in 2018/19, it will not achieve the control total due to under performance against its CIP target and cost pressures associated with additional emergency capacity and temporary staffing.

- For 2017/18, the NHS trust did not agree its control total of £10.9 million deficit (excluding STF). The NHS trust had a plan of £20.7 million against which it reported a deficit of £24.08 million (9.6% of turnover). This was in line with the reported position in the previous year, as a percentage of turnover.

- A combination of factors contributed to the adverse outturn including under achievement against income plan, cost pressures arising mainly from use of medical agency staffing, and costs of additional capacity, created in response to the rise in emergency demand. The NHS trust also attributes the loss of income to displacement of elective activity as a result of emergency demand pressures and the national request to cancel inpatient elective activity during the winter of 2017/18.

- For 2018/19, the NHS trust agreed its control totals of £15.5 million deficit before PSF and £10.5 million with PSF. The NHS trust is not on track to achieve its control total for 2018/19, and at the time of the assessment, was forecasting a deficit of £24.5 million deficit before PSF (9.6% of turnover) and £20.0 million with PSF. The main contributors to the adverse position being a higher than expected pay bill driven by premium agency costs and slippage against the cost improvement plan. The NHS trust put in place a financial recovery plan aimed at strengthening expenditure controls and driving improved productivity and income generation, however since the assessment, the position has further worsened with the forecast deficit increased to £28.5 million before PSF (11.48% of turnover) in February 2019.
- The NHS trust delivered marginally below its cost improvement plan for 2017/18. It reported delivery of £10.9 million (3.9% of operating expenditure) against a plan of £11 million. 70% of delivered CIP was reported as recurrent and 20% as delivered through improved income generation.
- For 2018/19, the NHS trust's cost improvement plan aimed to deliver a higher target of £15.5 million (5.61% of operating expenditure), which was the level of saving required to deliver the control total. Slippage against this plan was identified early in the year and the NHS trust strengthened its cost improvement delivery structures. This included realignment of the programme management office to the finance directorate and appointment of an interim Chief Operating Officer to drive reductions in capacity costs and productivity improvements in theatres and out patients. In addition, the NHS trust has undertaken workforce reviews to identify opportunities for reduction in the pay bill. The NHS trust has not achieved full recovery (against its plan) and as at December 2018 was reporting delivery of £7.2 million against a plan of £8.9 million, with 44% of this reported as recurrent. The NHS trust is forecasting delivery of £13.7 million (4.71% of operating expenditure).
- The NHS trust assessed its underlying deficit position as £19 million. A breakdown of this deficit was not provided by the NHS trust. We were not able to assess whether the drivers are within the NHS trust's control.
- Due to the historical deficit position, the NHS trust is reliant on additional cash support in the interim to consistently meet its financial obligations and maintain its positive cash balance. The NHS trust's cash position has been further adversely impacted by delays in commissioners' payments, as a result of disputes. This together with the NHS trust's decision to prioritise its PFI contractual and pharmaceutical suppliers' payments, has contributed to the increase in average creditor days, meaning the NHS trust's performance against the better payment practice code remains poor at 21% by number of invoices.
- The NHS trust uses service line reporting to support the identification of efficiencies at speciality level. Reports are published on quarterly basis and show the contribution levels for each speciality. The NHS trust is using its workforce cost information to assess opportunities for cost reduction. The NHS trust has not yet developed patient level costing systems.
- The NHS trust does not have any material commercial income streams, however it is actively exploring opportunities to maximise its NHS clinical income through; improving utilisation of facilities and workforce in theatres and outpatients, repatriation of activity such as births and improving quality of activity coding to support income billing.
- The NHS trust is not routinely reliant on management consultants. However, it has commissioned external management consultants to provide support in areas where the NHS trust has had insufficient capabilities, for instance development of financial sustainability programmes and high value business cases. The NHS trust is working to

ensure transfer of these skills to its substantive staff. Total spend on management consultants in 2017/18 was £2.3 million (0.8% of operating expenditure), and this is expected to reduce to £1.6 million (0.6% of operating expenditure).

Areas for improvement

We have identified scope for improvement in the following areas:

- The NHS trust should continue working towards improving its outpatients and theatres services utilisation, including reduction in DNAs and cancelled operations.
- The NHS trust's Finance team should support the quantification of GIRFT initiatives and ensure appropriate cost/benefit monitoring of these programmes
- The NHS trust should work at pace to implement the more effective software for deployment of the nursing workforce.
- The NHS trust should continue working to reduce temporary staffing costs.
- The NHS trust should investigate and address the high costs of the Human Resources department.
- The NHS trust should work towards improving its creditor payment performance.
- The NHS trust should continue working to reduce waste management and PFI costs.
- The NHS trust should identify the drivers of its underlying deficit and develop a plan to return to financial balance.

Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term 'allied health professional' encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows NHS trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24-hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all NHS trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which NHS trust boards, governing bodies and chief executives of NHS trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.

Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the NHS trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the NHS trust's annual financial plan and its actual performance. NHS trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows NHS trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the NHS trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of NHS trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR)	This metric shows the annual cost of the NHS trust's HR department for each £100 million of NHS trust turnover. A low value is preferable to a high value but

cost per £100 million turnover	the quality and efficiency of the department's services should also be considered.
Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which NHS trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives NHS trusts information on key performance metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.
Non-pay cost per WAU	This metric shows the non-staff element of NHS trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the NHS trust spends less per standardised unit of activity than other NHS trusts. This allows NHS trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows NHS trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of NHS trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the NHS trust spends less on staff per standardised unit of activity than other NHS trusts. This allows NHS trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the NHS trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs

Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the NHS trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other NHS trusts (the performance element). A high score indicates that the procurement function of the NHS trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Single Oversight Framework (SOF)	The Single Oversight Framework (SOF) sets out how NHS Improvement oversees NHS trusts and NHS foundation NHS trusts, using a consistent approach. It helps NHS Improvement to determine the type and level of support that NHS trusts need to meet the requirements in the Framework.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables NHS trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at NHS trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Sustainability and Transformation Fund (STF)	The Sustainability and Transformation Fund provides funding to support and incentivise the sustainable provision of efficient, effective and economic NHS services based on financial and operational performance.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets NHS trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report NHS trusts' %

	achievement against these targets. NHS trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit (WAU)	The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.

Walsall Healthcare NHS
NHS Trust

Performance Report

August 2019

(July 2019 Results)

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Walsall Healthcare NHS
NHS Trust

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Walsall Healthcare NHS
NHS Trust

Quality, Patient Experience and Safety Committee

Caring for Walsall together

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

- There were no reported MSA breaches in July. However, there remains a risk of breaches occurring on the wards in the West Wing due to the ward layout and availability of bathroom facilities, this has been escalated to the corporate risk register and is reviewed daily by the matrons
- FFT "would recommend" scores were above the Trust target across all 4 areas in maternity
- Safeguarding Adults and Safeguarding Children's Level 2 and 3 training was achieved. Level 2 Safeguarding Children Training compliance target was previously below the Trust target but has been achieved for the last 3 months.

Key Areas of Concern

- The total number of C.diff cases reported in July was 2 cases against a target of no more than 26 in 2019-2020, this means the Trust is currently 2 cases above trajectory at this point in the year with 11 cases overall since April 2019.
- Performance for the MCA stage 2 tracking declined in July and remains below the Trust target. The Deteriorating Patient Group is co-ordinating improvement work around MCA Stage 2 testing supported by the Medical Director and Director of Nursing
- VTE compliance improved in July but still remains below the Trust target. The committee received a deep dive into actions been undertaken to achieve compliance with VTE screening.
- Dementia screening declined in July to 62.3% against the 90% target. The Trust has seen improvements in screening but this is not yet embedded.
- The number of complaints responded to within 30 days increased in July to 31% but is well below the 80% target. This will be a focus for the next committee
- The percentage of EDS completed within 48 hours deteriorated in July to its lowest since April 2019.

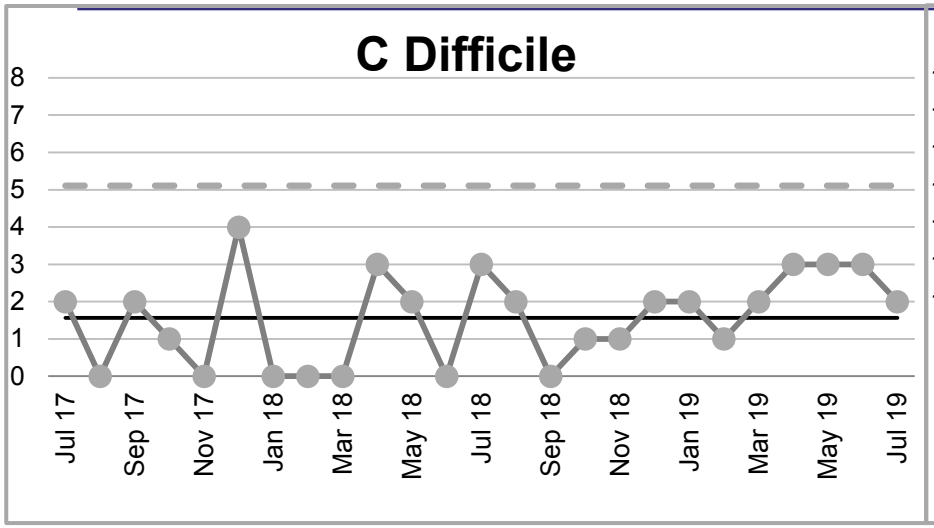
Key Focus for Next Committee

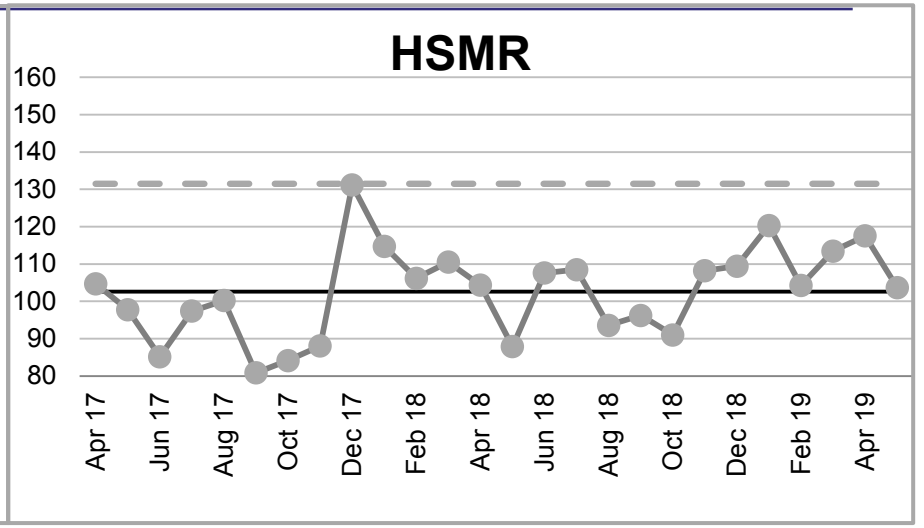
- The committee continues to focus on complaints since the introduction of additional metrics
- The Director of Nursing raised concerns about falls and although there has been a reduction in falls per 1000 bed days, there were 2 falls resulting in moderate harm. Falls is a key priority for the committee and will be focus
- Pressure ulcers in the community setting is a focus for the committee
- VTE will be a focus for the next committee

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 July there were 2 C Diff cases attributed to the Trust.

The Trust has had a total of 11 cases YTD against a target of 26 cases for the year this is 2 cases over the trajectory for this point in the year. The 2 C Diff cases in July were on ward 3 (unavoidable), and AMU (unavoidable).

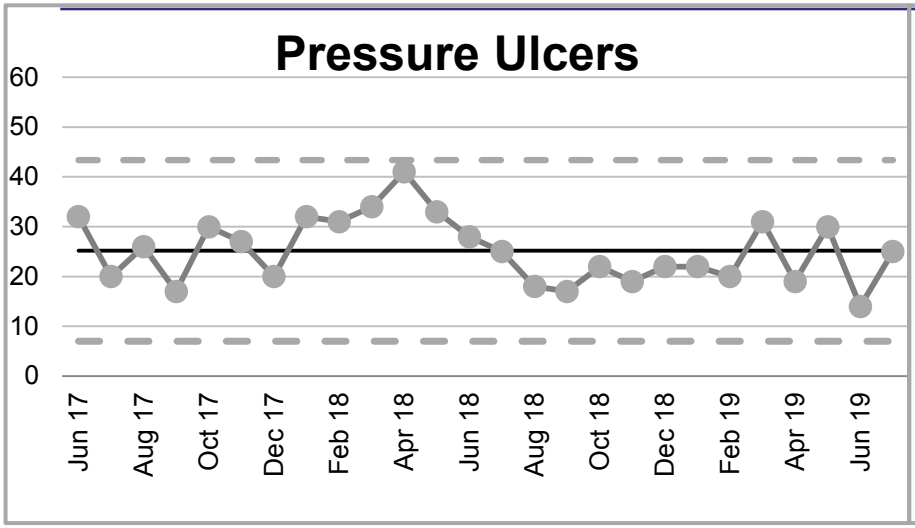
Narrative (Supplied by Medical Director)

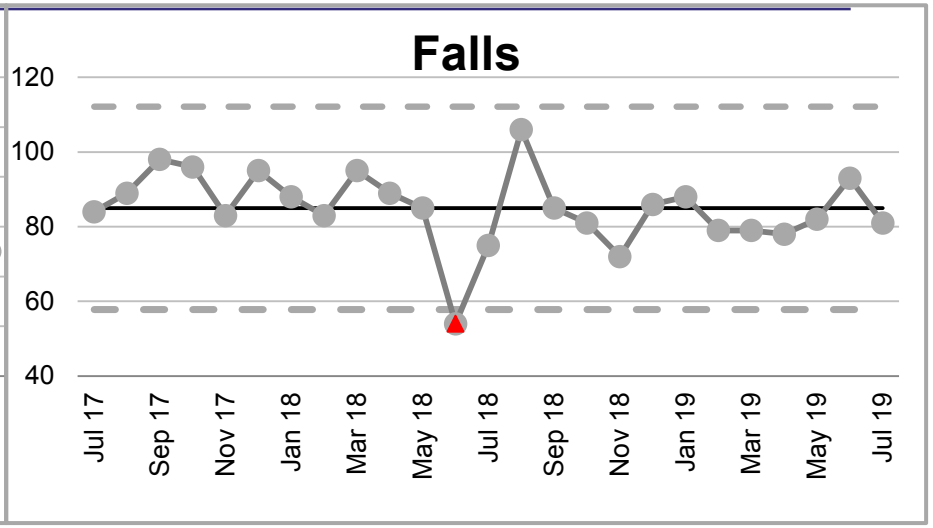
HSMR performance continues to be within expected parameters and compares favourably with CCG right care peers
Improvement plans to assure patient safety continue including the implementation of the ME process, responding to peer advise and undertaking qualitative reviews of groups of patients in response to data indicators.
SHMI for further updates has not currently been published.

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)

Across the Trust in July 2019 there was a total of 25 acquired pressure ulcers reported for the hospital and community compared to 14 reported in the previous month; a significant increase. This increase was due to an increase in the number of category 3,4 or unstageable acquired pressure ulcers in July. RCAs are currently being undertaken on these pressure ulcers. The committee will be focusing on the acute and community themes at its next meeting. An external review is will also be commissioned

Narrative (supplied by Director of Nursing)

The number of falls decreased in July 2019 with 81 falls reported compared to June 2019 when 93 falls were reported which was the highest number of falls reported since August 2018.
The number of falls remains high despite various interventions undertaken and supported at ward level. The Director of Nursing is leading specific work in this area
The ratio of falls per 1000 bed days reduced to 5.01 in July, this was a decrease from the ratio of 6.05 reported in June
There were 2 falls which resulted in moderate harm to the patients.

Walsall Healthcare NHS Trust

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE 2019-2020

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no..	HSMR (HED) nationally published in arrears	104.41	113.74	117.55	103.69				100.00		N
no..	SHMI (HED) nationally published in arrears	107.28							100.00		BP
no	MRSA - No. of Cases	0	0	0	0	0	0	0	0	2	N
no	Clostridium Difficile - No. of cases	1	2	3	3	3	2	11	26	19	N
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays	0.77	1.09	0.82	0.93	0.53	0.59				
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population	0.34	0.55	0.31	0.59	0.21	0.55				
no..	Falls - Rate per 1000 Beddays	5.19	4.82	5.02	5.17	6.05	5.01		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	0	0	4	1	0	0	5	0	13	BP
%..	VTE Risk Assessment	93.61%	91.94%	91.01%	92.02%	92.29%	93.20%	92.16%	95.00%	94.90%	N
no	National Never Events	0	0	0	0	0	0	0	0	17	N
no..	Midwife to Birth Ratio	1:25.2	1:28.1	1:24.2	1:26.9	1:27.3	1:31.5		1:28	1:28.1	N
%..	C-Section Rates	33.70%	26.33%	29.20%	27.55%	28.01%	34.77%	30.04%	30.00%	28.46%	BP
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	10.27%	11.56%	11.12%	12.22%	10.13%			10.00%	10.73%	L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	82.68%	83.65%	85.23%	85.72%	85.04%	83.65%	84.92%	100.00%	84.47%	N/L
%..	Compliance with MCA 2 Stage Tracking	46.15%	66.67%	68.97%	59.26%	69.57%	61.76%	64.42%	100.00%	62.44%	BP
%..	Friends and Family Test - Inpatient (% Recommended)	97.00%	95.00%	96.00%	96.00%	96.00%	96.00%		96.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	93.63%	93.62%	93.72%	92.69%	93.28%	92.73%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	88.73%	88.65%	89.12%	85.74%	84.92%	85.11%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	94.33%	96.27%	97.04%	96.21%	96.32%	96.65%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	91.60%	92.23%	92.67%	92.85%	93.10%	91.61%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	90.58%	89.50%	89.16%	84.75%	85.68%	87.37%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	95.20%	95.48%	95.37%	95.08%	95.45%	94.26%		95.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	82.08%	83.42%	83.38%	85.12%	89.64%	90.89%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	89.05%	90.81%	88.98%	90.37%	89.96%	90.24%		85.00%		L

Walsall Healthcare NHS
NHS Trust

Integration

Caring for Walsall together

Integration – Highlight Page

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

Key Areas of Success

SPA (Single Point of Access):

There has been a positive response from the Community Nurses delivering the SPA in terms of support from other community teams.

During July, access to the Rapid Response Team was closed 3 times due to being unable to meet the increase in new referrals, an additional nurse was recruited to the team during the month to support.

The aim is to increase referrals from WMAS by 10% (based on the numbers we have seen in the first 4-6 weeks). At WMAS request the SPA start time is 08.00 from the 1st August.

Stroke unit: continues to have mixed occupancy of medical outliers and stroke rehab patients. Currently 16 beds occupied with 25% stroke patients and rest medical. Average occupancy rate for July is 8 (47%) stroke patients & 9 (53%) medical outliers. The challenges of continuing as a mixed unit remains, particular for nursing staff, but this is not currently impacting greatly on therapy staff input.

Nursing Home Enhanced Case Management: Through out July there was a consistent 3 Nursing home patients in Acute at any one time. There has also been a 31% increase throughout Q1 of Advanced Care Plans to support this patient group to remain in their own home.

Key Actions Taken

Quality and assurance team for care homes to be launched within Q2 2019/ 20. Their base will be Hollybank house for both Health and Social Care team members. Dates to be confirmed.

Community Cardiology: Moving towards a launch date of the 2nd September for IV Furosemide with Heart Failure pathways to avoid hospital admission with Clinical Intervention Team and Dr.Gupta as lead. On target.

Key Focus

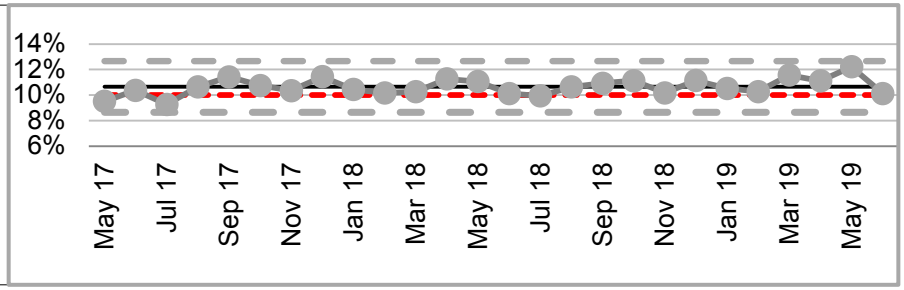
- ***ICS:*** MFFD list is 10 less patients on average in July 2019 compared to July 2018, demand for Bed based service remains high.

Integration

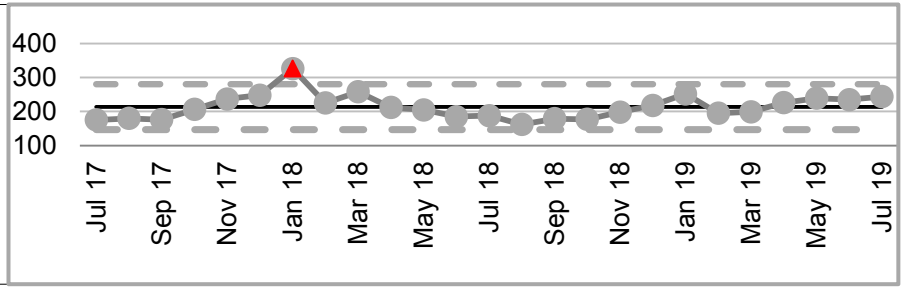
SPC Key

Mean | Process limits - 3σ | High or low point | Special cause - improvement
Special cause - concern | Target | 0

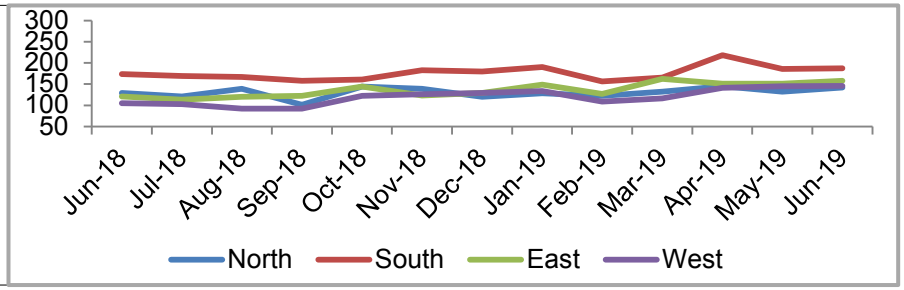
Emergency Readmissions



Rapid Response – Avoidable Att / Adm



Readmissions by Locality



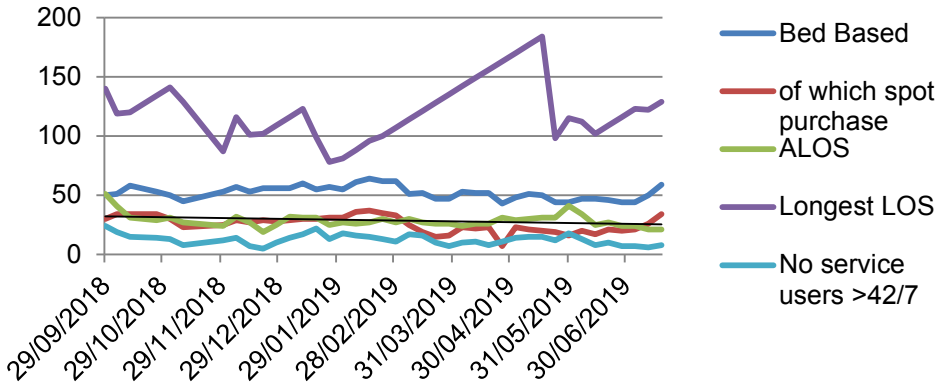
Narrative (supplied by Director of Strategy & Improvement)

Service delivery improvement plans (SDIP) investment have been approved, recruitment and service redesign is progressing with the aim of having all schemes in place by Q3 2019.
Proactive budget management has provided further opportunity to recruit to additional pharmacist capacity to support redesign of medication directives and enhanced management of discharge medication and additional therapy support.

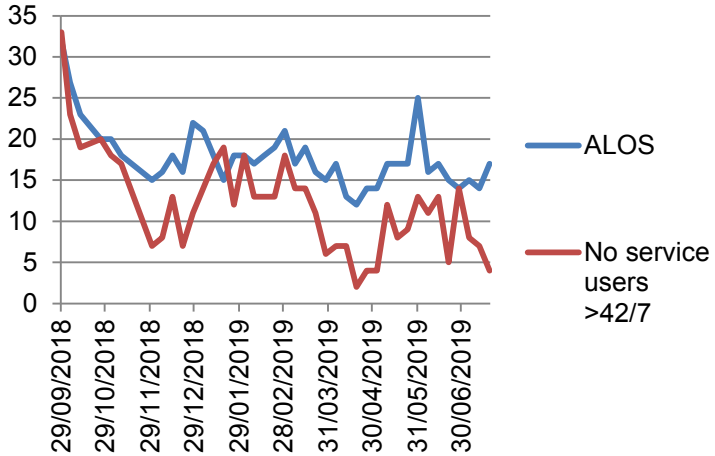
Adult Community Divisional structure under review as additional services are transferred to Division i.e. Therapies and Integrated Equipment loans. Plans to change from 4 Care Groups to 4 Localities groups and 2 Care Groups for Urgent Intermediate Care and Palliative care

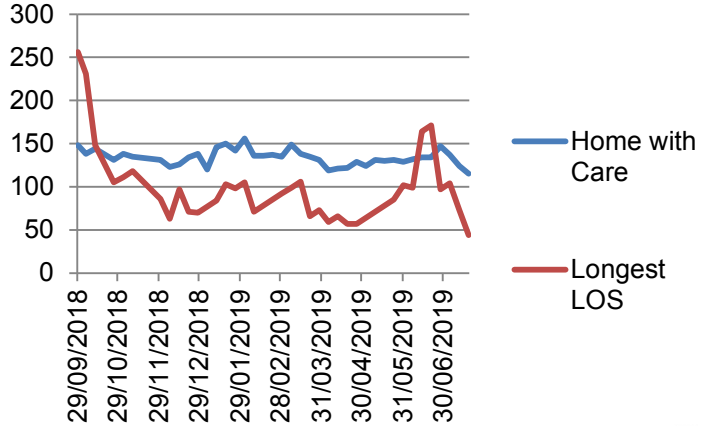
Partners under Walsall Together Alliance have moved to Blakenall Village which will enhance our interdisciplinary partnership between health and social care providers. East 1 and East 2 place based health and social care locality teams have also moved to Blakenall Village.
Transformation funding initiatives in Diabetes services are beginning to demonstrate outcomes including a 37% reduction in patients requiring limb amputations when comparing 2017 and 2018 and a 15% increase in patients receiving multidisciplinary support.
Recurrent funding for MDT coordinator approved and out to recruitment.

Community Pathways: Bed Based & Home with Care



- The service continues to use more than the funded beds (59 versus 40 commissioned) with some block beds remaining empty as the care homes concerned are unable to meet patients' needs
- Commissioners are reviewing the efficiency of the current block providers





- This reflects the LOS of patients currently on pathways
- Average LOS has remained significantly below 20 for June & July

Walsall Healthcare NHS
NHS Trust

INTEGRATION
2019-2020

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-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)	10.27%	11.56%	11.12%	12.22%	10.13%		11.17%	10.00%	10.73%	L
no	Rapid Response Team - Total Referrals	228	221	273	276	269	270				L
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission	195	199	226	239	235	244				L
%	Rapid Response Team - % of patients referred requiring a 2 hour response who are subsequently seen within 2 hours	46.62%	91.04%	71.08%	66.28%	63.44%	72.73%				L
%	Histopathology - % of Diagnostic Biopsies reported within 7 days of sample received	62.00%	64.00%	44.00%	45.00%				90.00%		L
%	Histopathology - % of Histopathology test reported within 10 days of sample received	42.00%	50.00%	19.00%	25.00%				90.00%		L
%	Histopathology - % of Gynae tests reported within 10 days of sample received	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	7.31%	7.13%	7.18%	7.79%	7.89%	7.84%	7.69%	7.00%	7.43%	BP
	RESOURCES										
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only (Mon&Thurs)	34	36	36	31	35	31				
no	Average Number of Medically Fit Patients - Trust (Mon&Thurs)	37	40	25	30	32	25				
	PARTNERS										
Rate	Occupied Beddays per Locality - Rate per 1000 GP Population (GP Caseload)	34.99	37.49	37.88	36.26	35.94	37.25				L
no	Nursing Contacts per Locality - Total	16944	18784	18619	19182	18447	19638	75886		205571	L
Rate	Emergency Readmissions per Locality - Rate per 1000 GP Population (GP Caseload)	1.70	1.90	2.16	2.03	2.09	2.30				L
no	No. of patients on stroke pathway in partnership with Wolverhampton (one month in arrears)	10	10	3	4	6					L

Walsall Healthcare NHS
NHS Trust

People and Organisational Development Committee

Caring for Walsall together

Walsall Healthcare NHS
NHS Trust

People and Organisational 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

- A Health & Wellbeing Action Plan has been developed, aimed at engaging colleagues with support which promotes a healthy lifestyle, the Hub also provides a visible safe space for a colleague to seek advice.
- The HR Operations Team has prepared training packages to support partnership working and address high sickness levels.
- Learning and Development have worked with national and internal partners to address long-standing issues in regards to the accurate recording of completed training. Whilst the root cause lies with system design controlled externally, internal workarounds have secured greater assurance regarding compliance data.

Key Areas of Concern

- Retention – Retention remains 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.
- Sickness Absence – Absence levels within the MLTC division remains a concern, with SPC analysis highlight a rising trajectory within this area.
- Mandatory Training – The Committee noted major improvements for Information Governance compliance, but also expressed concern that despite efforts a sizeable number of colleagues have failed to comply.
- Appraisals – Compliance continues to rise steadily, but there remain concerns that the current improvement approach is not sufficient to achieve target.

Key Actions Taken

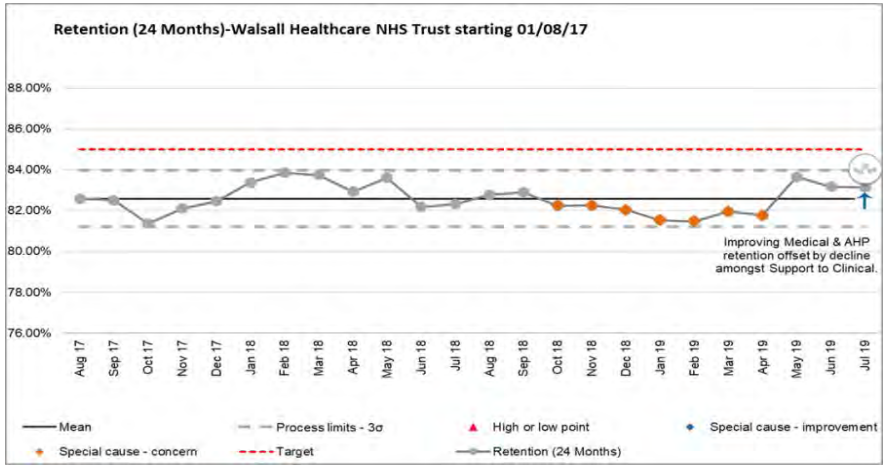
- As part of the Nursing Workforce Strategy, finance ledger and ESR establishment information have been reconciled, to assist the Trust in gaining a full picture of vacancy gaps.
- The Health & Wellbeing Team have surveyed male colleagues within the Trust and will be using the intelligence gathered to inform targeted support services. This builds upon research which has indicated disproportionate cases of mental illness within the male population.
- Preventative schemes, such as the Weight Loss Challenge and Health Checks have been commissioned to continue until at least 2020.
- The Governance Team have worked in collaboration with Learning & Development to target key areas and improve IG compliance.
- A root and branch review of both mandatory and statutory training compliance has begun. This review will aim to simplify access to learning within the Trust, improve performance management through the adoption of user-friendly self-service tools, and provide the foundations for robust training-needs-analysis.

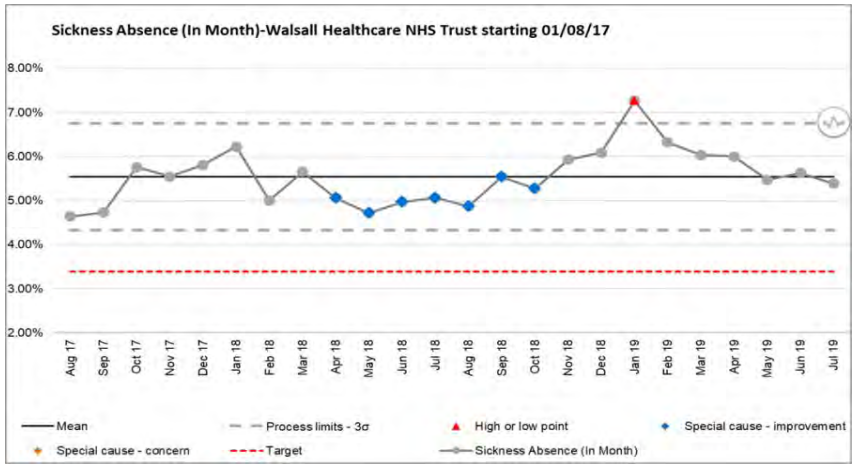
Key Focus for Next Committee

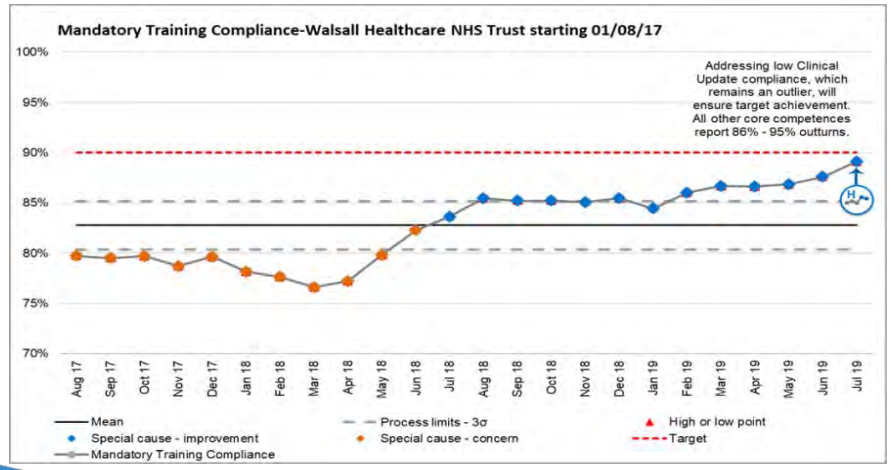
- Equality, Diversity & Inclusion
- Finance-related Workforce KPIs

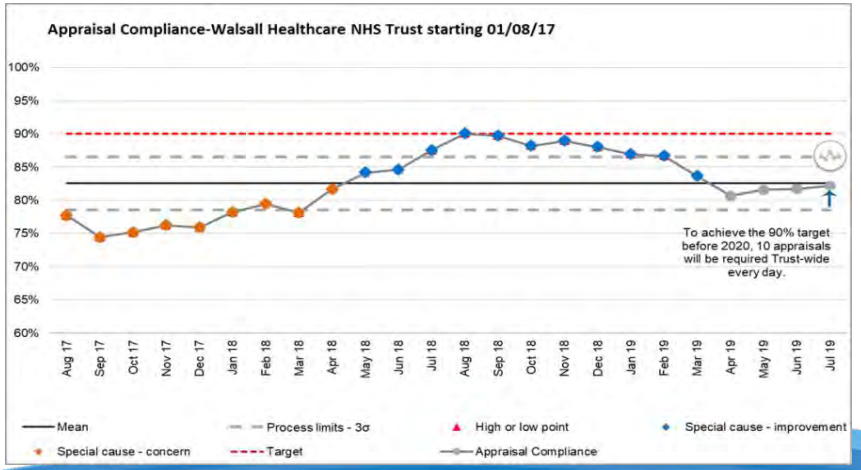
Walsall Healthcare NHS
NHS Trust

People and Organisational Development Committee









Walsall Healthcare NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 2019-2020

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	% of RN staffing Vacancies	8.11%	8.44%	8.52%	9.65%	10.84%	11.28%				BP
%..	Mandatory Training Compliance	86.01%	86.67%	86.62%	86.84%	87.60%	89.09%		90.00%	86.67%	L
%..	PREVENT Training - Level 1 & 2 Compliance	93.63%	93.62%	93.72%	92.69%	93.28%	92.73%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	88.73%	88.65%	89.12%	85.74%	84.92%	85.11%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	94.33%	96.27%	97.04%	96.21%	96.32%	96.65%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	91.60%	92.23%	92.67%	92.85%	93.10%	91.61%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	90.58%	89.50%	89.16%	84.75%	85.68%	87.37%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	95.20%	95.48%	95.37%	95.08%	95.45%	94.26%		95.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	82.08%	83.42%	83.38%	85.12%	89.64%	90.89%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	89.05%	90.81%	88.98%	90.37%	89.96%	90.24%		85.00%		L
	VALUE COLLEAGUES										
%..	Sickness Absence	6.32%	6.04%	6.00%	5.47%	5.63%	5.38%		3.39%	6.04%	L
%..	PDRs	86.71%	83.66%	80.67%	81.60%	81.73%	82.20%		90.00%	83.66%	L
	RESOURCES										
%..	Bank & Locum expenditure as % of Paybill	9.29%	9.12%	4.61%	7.37%	7.96%	6.97%		6.30%	9.14%	L
%..	Agency expenditure as % of Paybill	5.23%	4.46%	2.76%	4.83%	4.49%	4.41%		2.75%	4.90%	L
no	Staff in post (Budgeted Establishment FTE)	3981	3981	3871	3905	4022	4033				L
%..	Turnover (Normalised)	11.55%	11.58%	11.65%	11.92%	11.68%	11.07%		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

- July has seen a step improvement in emergency access standard performance, continued improvement in Cancer Waiting Times (June Validated) including delivery of 62-day performance above national 85% standard, and improvement in Diagnostic waiting times back to delivering above the national standard of 99% of patients waiting less than 6 weeks.
- Trust has attained plan at a £3.3m deficit at month 4, though has an operational deficit of £1.4m year to date 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 £1.4m operational deficit to plan at month 4 (£3.3m deficit as per plan). The Trust will need to mitigate the 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 in the early months of the financial year this risk has not been mitigated, the result being for a risk to delivery of the outturn to total £6m (£8m deficit with lost quarter 4 Provider Sustainability Funding)

Key Actions Taken

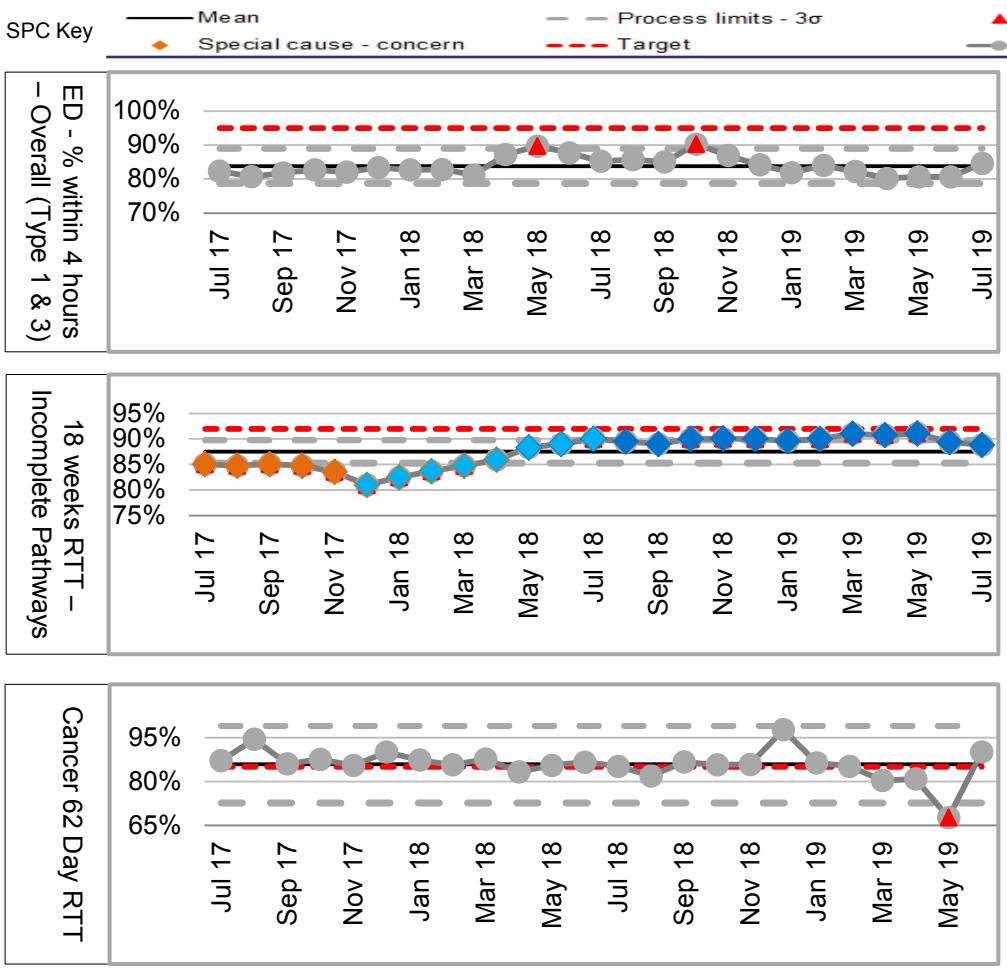
- Strengthened Site Safety Meeting structure to support improved flow.
- Implementation of the Executive led measures to improve run rate (endorsed at Extra-ordinary Trust Board) with further reviews on-going to assure full mitigation of the £0.5m monthly run rate risk (improved patient flow, reduction 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) 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 to indicate risk to delivery of the financial plan

Key Focus for Next Committee

- Receipt of Winter Plan to support safe access to emergency care.
- Review of the forecast deficit, key to attainment of the financial plan for 2019/20 being oversight within the 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
- PFIC to monitor implementation of the run rate improvements, delivery of the Financial Plan
- Board Development session arranged to review Medically Fit for Discharge

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee



Narrative (supplied by Chief Operating Officer)

Emergency/Urgent Care

Despite a continued increase in Type 1 ED attendances, (July 7.7% increase compared to the same period in 18/19), performance met trajectory agreed with NHSI and achieved 84.6% against the emergency access 4 hour standard. The ED department saw a significant improvement against the 4 hour target during the last 2 days of the month, not only achieving above the national target of 95% for Types 1&3, but also achieving 96.45% for type 1 alone on 30th July with only 8 breaches in total. This has been the best single day of EAS performance since August 2015.

RTT

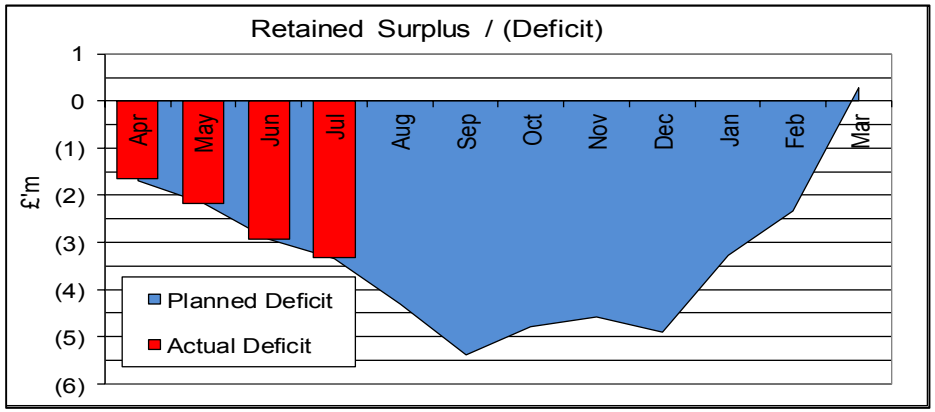
The Trust RTT incomplete pathway performance for July was 88.79% (un-validated). This was a deteriorating position, with increasing patients waiting > 18 weeks (predominantly in the Division of Surgery). Patients waiting 18 to 26 weeks in particular increased. There was an admitted 52 week breach in the Division of Surgery, identified following data quality checks. An RCA has been commissioned and the patient will be subject to clinical harm review in line with Trust process. Actions are in place to reduce long waits in Pain Management and bring deteriorating services back in line to meet the Trust Trajectory.

Cancer (Please note: June validated)

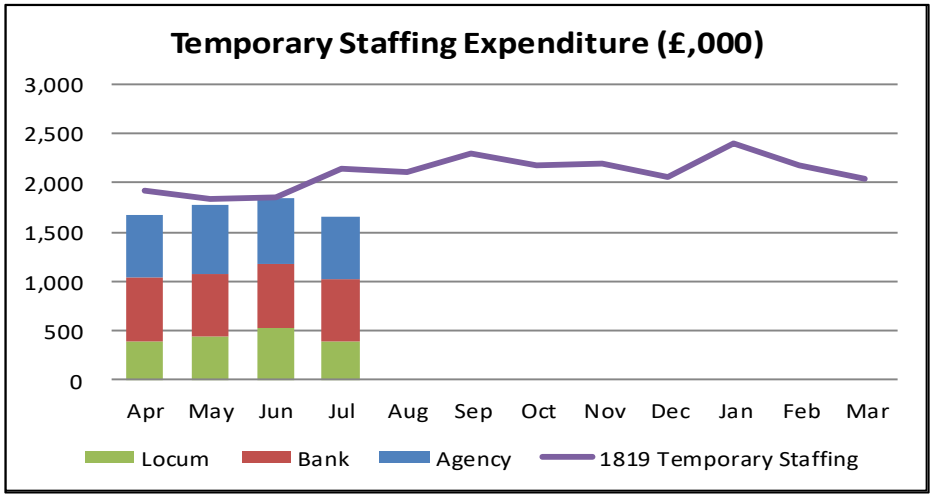
The Trust achieved the 2WW GP constitutional measure for the 2nd month and as predicted Breast Symptomatic failed the constitutional measure but did achieve a significant improvement.

The Trust failed to achieved the constitutional measures for 62 day RTT screening. Diagnostic waiting times, reporting times and histopathology remain a challenge. Histology reporting times in June have improved in line with the recovery plan. On-going monitoring is in place. The Trust achieved the constitutional measure for 62 day RTT with a performance of 90.1% and 62 day RTT consultant upgrade performance of 86.7%

Financial Performance to July 2019 (Month 4)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.5	0.9	1.3	1.6	1.6	1.7	1.7	1.7	1.7	1.7	1.7	1.7
DELIVERED RECURRENTLY	0.3	0.5	0.9	1.2	1.3	1.4	1.4	1.5	1.6	1.7	1.8	1.9
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	2.2	2.8	3.5	4.3	5.3	6.3	7.2	8.1	9.0	9.9



Financial Performance

- Trust remains at an operational deficit of £1.4m, though has attained plan following a movement in reserves.
- Overspending on pay is reflective of the cost overruns within MLTC (sickness and use of unfunded capacity)
- Medical & Long Term Conditions Division remains in escalation for financial performance off plan as part of the Trust's Accountability Framework, Women's Children's & Clinical Support Services escalated owing to the income risk in regards to birth numbers.
- The Executive have adopted 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 (against CCG contracts), largely as a consequence of reduced births (£0.5m) in the first 4 months of the year and A&E coding underperformance (£0.4)

CIP Delivery

- The Trust's Annual Cost Improvement Programme requirement is £8.5m (£10.5m stretch) .
- The CIP has delivered £2.8m YTD, which is over plan but under the stretch target of £3.2m, an under achievement of £0.4m YTD. In addition, £1.6m of the total is delivered non-recurrently and focus is being placed on attainment of sustainable improvements using model hospital and other relevant benchmark data.

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding is £2.6m, due to receipts exceeding plans from Commissions.
- Failure to deliver mitigating actions will result in increased spending, as such will place additional pressure on management of cash flow.

Financial Performance - Period ended 31st July 2019

Description	Annual Budget	Budget to Date	Actual to Date		Variance
	£'000	£'000	£'000		£'000
Income					
CCGs	211,296	71,323	70,484		(839)
NHS England	18,396	6,260	6,411		151
Local Authorities	8,865	2,980	3,021		41
DoH and Social Care	18,380	4,144	4,144		0
NHS Trusts/FTs	1,008	336	379		43
Non NHS Clinical Revenue (RTA Etc)	980	353	356		3
Education and Training Income	6,834	2,265	2,274		8
Other Operating Income (Incl Non Rec)	7,498	2,685	2,893		209
Total Income	**273,256**	**90,346**	**89,961**		**(385)**
Expenditure					
Employee Benefits Expense	(178,342)	(58,670)	(59,267)		(596)
Drug Expense	(9,368)	(5,974)	(6,118)		(144)
Clinical Supplies	(15,365)	(5,539)	(5,896)		(357)
Non Clinical Supplies	(17,805)	(6,158)	(6,125)		33
PFI Operating Expenses	(5,444)	(1,815)	(1,833)		(19)
Other Operating Expense	(30,036)	(9,900)	(8,483)		1,417
Sub - Total Operating Expenses	**(256,360)**	**(88,057)**	**(87,721)**		**335**
Earnings before Interest & Depreciation	**16,896**	**2,289**	**2,240**		**(49)**
Interest expense on Working Capital	51	17	27		10
Interest Expense on Loans and leases	(10,387)	(3,462)	(3,580)		(118)
Depreciation and Amortisation	(6,560)	(2,187)	(2,015)		172
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(16,896)**	**(5,631)**	**(5,568)**		**64**
Total Expenses	**(273,255)**	**(93,688)**	**(93,289)**		**399**
RETAINED SURPLUS/(DEFICIT)	**0**	**(3,342)**	**(3,328)**		**14**

Use of Resources Ratings (M4)

Finance and use of resources rating	03AUDITPY	03PLANYTD	03ACTYTD	03PLANCY	03FOTCY
i	Audited PY 31/03/2019 Year ending Number	Plan 31/07/2019 YTD Number	Actual 31/07/2019 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 July 2019

	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	390
Depreciation and Amortisation	2,015
Donated Assets Received credited to revenue but non-cash	0
(Increase)/Decrease in Trade and Other Receivables	(5,229)
Increase/(Decrease) in Trade and Other Payables	(4,076)
Increase/(Decrease) in Stock	40
Interest Paid	(3,580)
Net Cash Inflow/(Outflow) from Operating Activities	**(10,440)**
Cash Flows from Investing Activities	
Interest received	**27**
(Payments) for Property, Plant and Equipment	**(2,503)**
Net Cash Inflow/(Outflow)from Investing Activities	**(2,476)**
Net Cash Inflow/(Outflow) before Financing	**(12,916)**
Cash Flows from Financing Activities	11,353
Net Increase/(Decrease) in Cash	**(1,563)**
Cash at the Beginning of the Year 2018/19	4,186
Cash at the End of the July	**2,623**

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending July 2019

	Balance as at 31/03/19	Balance as at 31/07/19	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Total Non-Current Assets	**141,208**	**141,273**	**65**
Current Assets			
Receivables & pre-payments less than one Year	16,532	21,219	4,687
Cash (Citi and Other)	4,186	2,623	(1,563)
Inventories	2,362	2,322	(40)
Total Current Assets	**23,080**	**26,164**	**3,084**
Current Liabilities			
NHS & Trade Payables less than one year	(29,461)	(23,836)	5,625
Other Liabilities	(1,445)	(2,020)	(575)
Borrowings less than one year	(15,590)	(15,053)	537
Provisions less than one year	(117)	(117)	-
Total Current Liabilities	**(46,613)**	**(41,026)**	**5,587**
Net Current Assets less Liabilities	**(23,533)**	**(14,862)**	**8,671**
Non-current Assets			
Non-current liabilities			
Borrowings greater than one year	(202,939)	(214,370)	(11,431)
Total Assets less Total Liabilities	**(85,264)**	**(87,959)**	**(2,695)**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	64,190	64,823	633
Revaluation	15,925	15,925	-
Income and Expenditure	(165,379)	(165,379)	-
In Year Income & Expenditure	-	(3,328)	(3,328)
Total TAXPAYERS' EQUITY	**(85,264)**	**(87,959)**	**(2,695)**

Walsall Healthcare NHS
NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2019-2020

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-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)	84.02%	82.21%	80.22%	80.68%	80.68%	84.57%	81.54%	95.00%	85.90%	N
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	64.71%	65.43%	62.49%	66.92%	60.93%	63.65%	63.48%	100.00%	72.20%	BP
no	Ambulance Handover - No. of Handovers completed over 60mins	44	22	35	16	21	5	77	0	155	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	92.67%	87.38%	82.46%	94.48%	95.61%	90.71%	90.95%	93.00%	93.59%	N
%..	Cancer - 62 day referral to treatment of all cancers	85.23%	80.37%	80.90%	67.71%	90.10%	78.95%	79.59%	85.00%	85.35%	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	90.01%	91.02%	90.72%	91.04%	89.37%	88.83%		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	0.31%	0.12%	3.15%	6.50%	4.13%	0.33%	3.59%	1.00%	0.32%	N
no	No. of Open Contract Performance Notices	8	9	10	11	11	11	11	0	9	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	7.31%	7.13%	7.18%	7.79%	7.89%	7.84%	7.69%	7.00%	7.43%	BP
	RESOURCES										
%..	Outpatient DNA Rate (Hospital and Community)	9.87%	9.94%	10.63%	10.35%	9.93%	10.57%	10.38%	8.00%	10.44%	L
%..	Theatre Utilisation - Touch Time Utilisation (%)	80.05%	92.73%	89.54%	86.70%	86.99%	86.94%		75.00%		L
%..	Delayed transfers of care (one month in arrears)	2.85%	2.86%	3.51%	2.65%	3.27%	3.45%		2.50%	3.46%	L
no	Average Number of Medically Fit Patients (Mon&Thurs)	93	99	85	80	87	75				
no	Average LoS for Medically Fit Patients (from point they become Medically Fit) (Mon&Thurs)	10.15	11.35	12.34	10.46	12.57	11.23				
£	Surplus or Deficit (year to date) (000's)	-£27,159	-£27,669	£45	£3	£4	£14	£14		-£27,669	L
£	Variance from plan (year to date) (000's)	-£14,393	-£17,038	£45	£3	£4	£14	£14		-£17,038	L
£	CIP Plan (YTD) (000s)	£12,000	£15,500	£900	£1,600	£2,500	£3,200	£3,200		£15,500	L
£	CIP Delivery (YTD) (000s)	£9,500	£11,100	£800	£1,400	£2,200	£2,800	£2,800		£11,100	L
£	Temporary Workforce Plan (YTD) (000s)	£17,700	£19,400	£1,300	£2,700	£4,200	£6,000	£6,000		£19,400	L
£	Temporary Workforce Delivery (YTD) (000s)	£23,100	£25,200	£1,700	£3,500	£5,300	£6,900	£6,900		£25,200	L
£	Capital Spend Plan (YTD) (000s)	£7,300	£12,200	£500	£800	£1,600	£2,400	£2,400		£12,200	L
£	Capital Spend Delivery (YTD) (000s)	£11,700	£13,100	£700	£1,200	£1,300	£1,700	£1,700		£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 5th September 2019			
The review of the winter plan for 18/19			**AGENDA ITEM: 13**
Report Author and Job Title:	Ned Hobbs, Chief Operating Officer Ian Billington, Head of EPRR Dan Hodgkiss, Patient Safety Manager (MLTC) 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. Iterations of this review have been presented and discussed at People & Organisational Development Committee, Quality, Patient Experience & Safety Committee and the Urgent & Emergency Care Operational Group during May 2019. It has been presented to the Performance, Finance & Investment Committee in July 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 only 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 too during Winter 2018/19. Delivery of this incurred more costs than budgeted for, however. Lessons learnt are included in the report, and have informed the planning for Winter 19/20. The Full Winter Plan (19/20) will be presented to Trust Board on 3rd October 2019.	
Recommendation	1. 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. 2. Members of the Trust Board are asked to note findings and lessons learnt which will be used to inform the Winter Plan for Winter 2019/20.	
Does this report mitigate risk included in the BAF or Trust Risk Registers?	Risk implications are outlined within the document	
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 July 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 Urgent & Emergency Care Operational Group during May 2019. It has been presented to Performance, Finance & Investment Committee in July 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

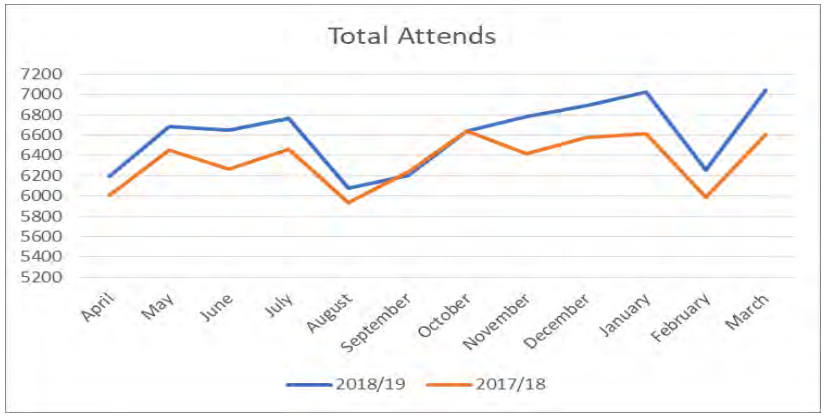
- An Annual budget of £1m was assigned in 18/19 to support the winter plan, the Trust net expenditure totalled £2.1m on winter.
- The additional expenditure over plan (£1.1m) centred upon the early opening of bed capacity (the summer ward) that was only partially off-set by generating elective income (£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 the thematic review
- Patient Safety
- Operational Performance
- Finance Review

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

Walsall Healthcare NHS
NHS Trust

Patient Safety Review

Caring for Walsall together

Patient Safety

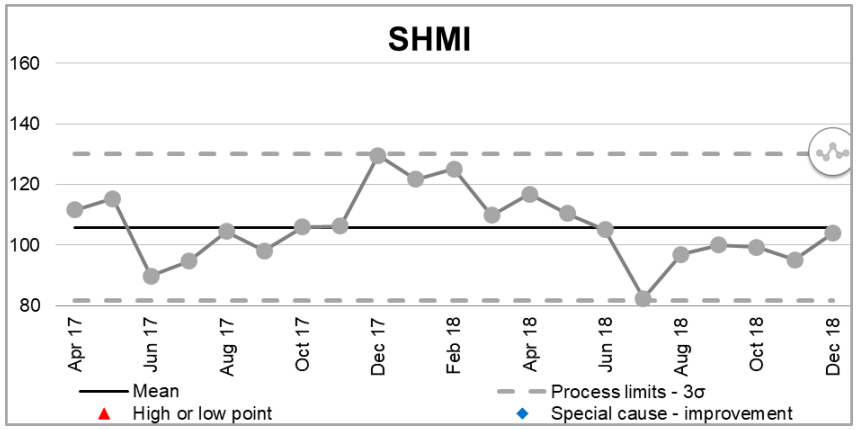
- To establish how safely patients were managed during the winter 18/19 period we have chosen to test the following hypothesis:

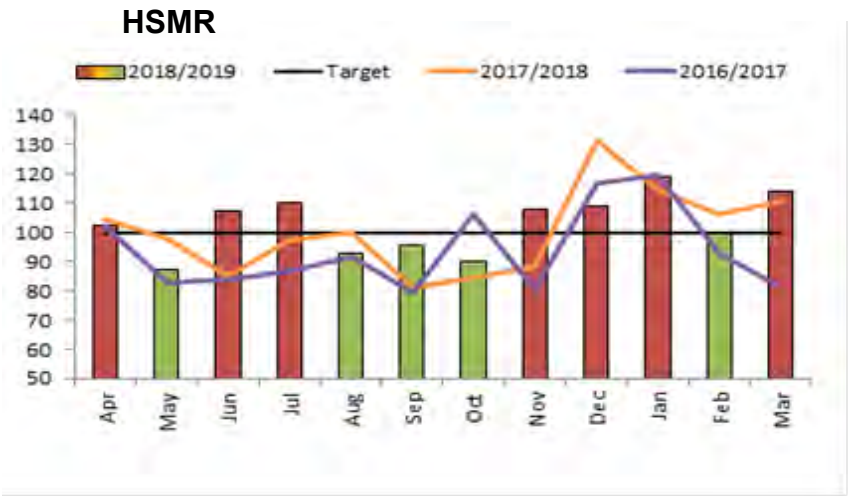
Increased bed occupancy, due to reduction in escalation beds open during the winter period, led to increased operational pressure which resulted in **increased harm or risk of harm** to patients

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

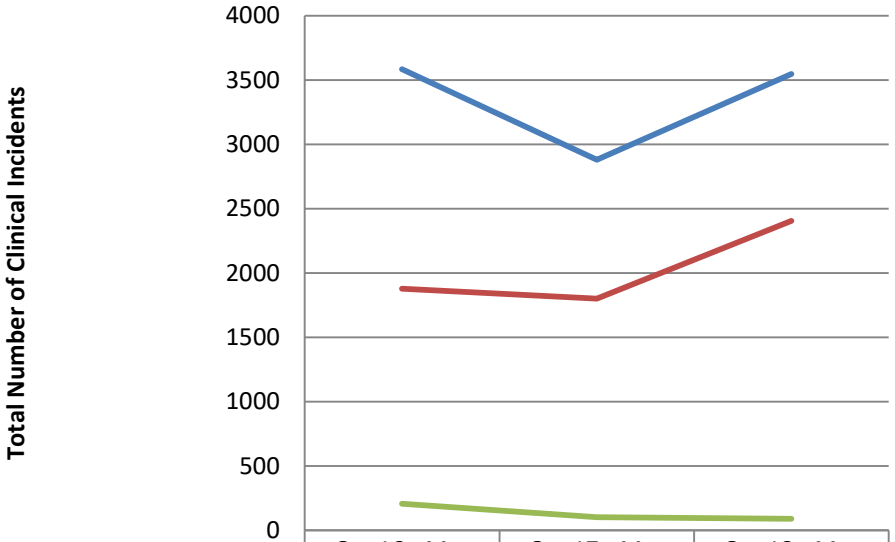
- Between Oct 18 – Mar 19 there were a greater number of clinical incidents reported totalling 6043 which is a 26% increase when comparing to Oct 17 – Mar 18; and a 7% increase for Oct 16 – Mar 17. In the same period however Moderate to Death incidents fell YoY

- 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.

A comparison of the total number of clinical incidents reported across three consecutive years between Oct - Mar



	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.

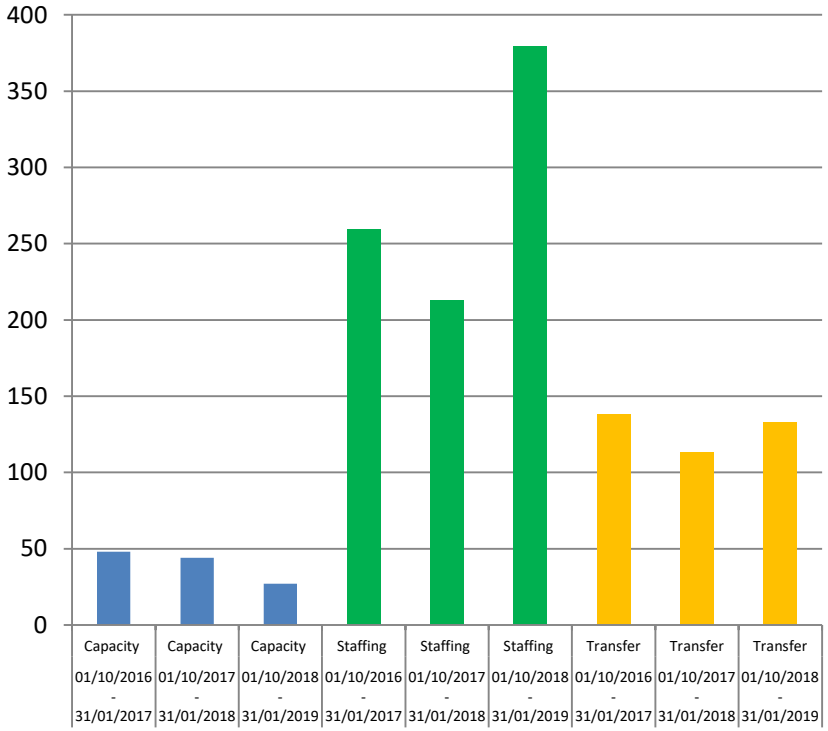
- Serious Incidents – Suboptimal Care of Deteriorating Patient
- **Oct 16 - Mar 17 - 7**
- **Oct 17 - Mar 18 - 3**
- **Oct 18 - Mar 19 – 2**

- 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)

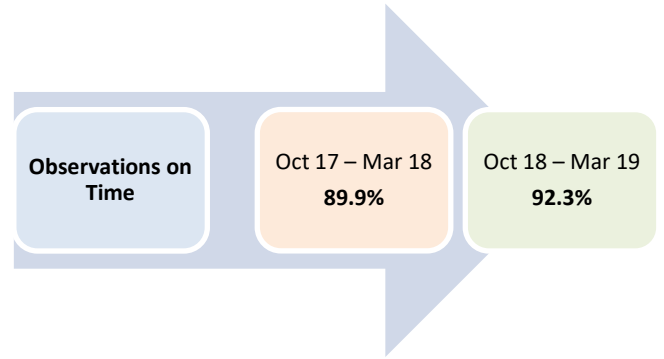
Comparison of Capacity / Staffing and Transfer Incidents from 0ct - Mar across three consecutive years

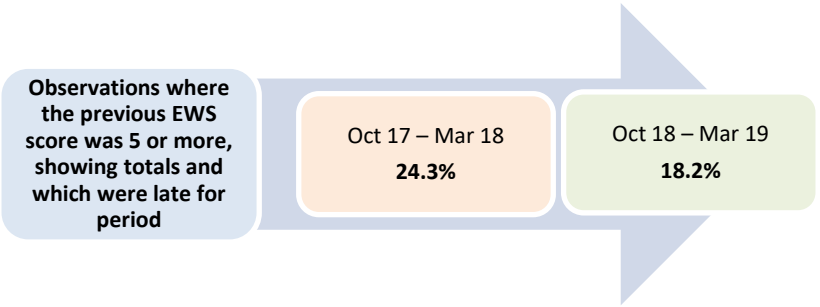


Safety continued - Timeliness of patient observations

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.

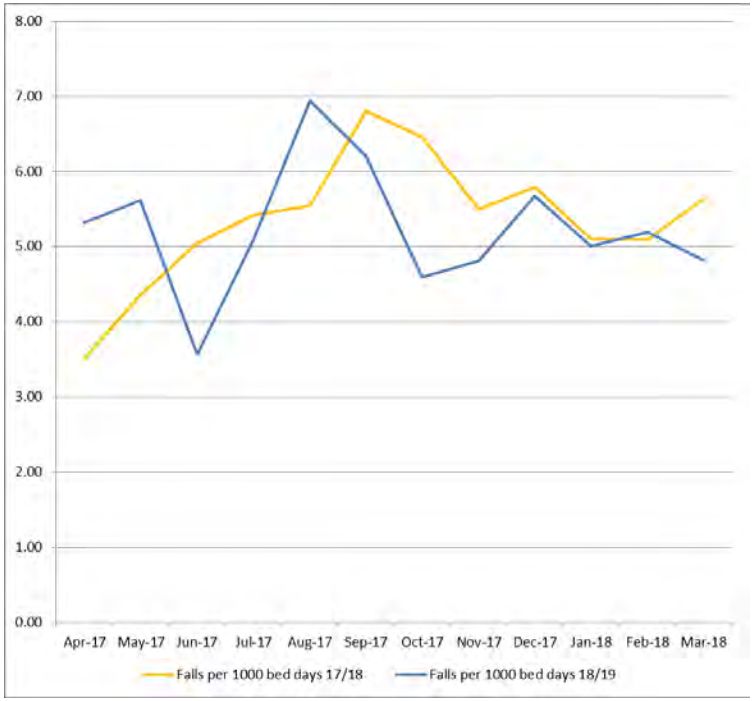




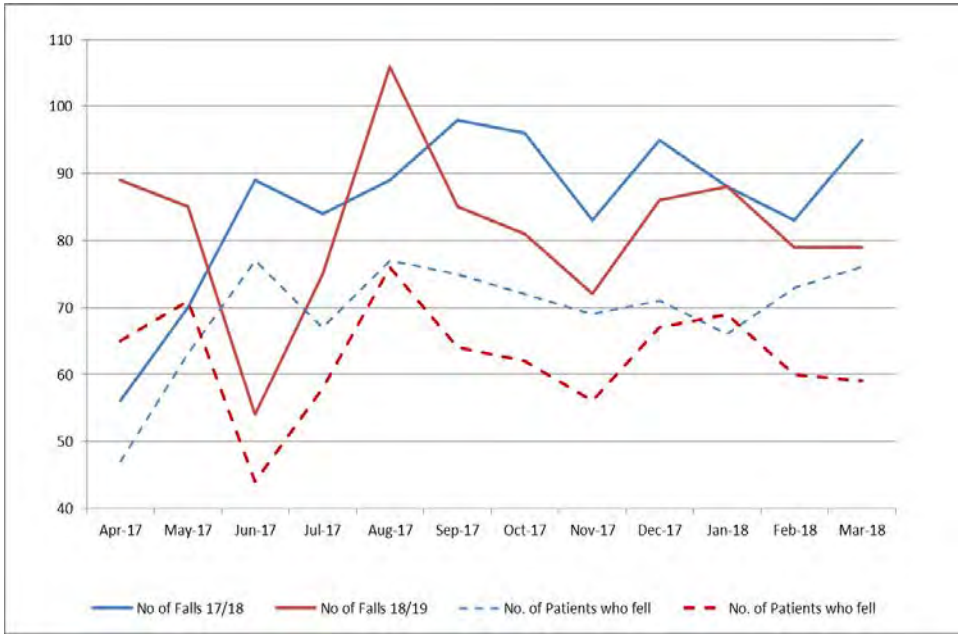
Safety – Falls

- 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

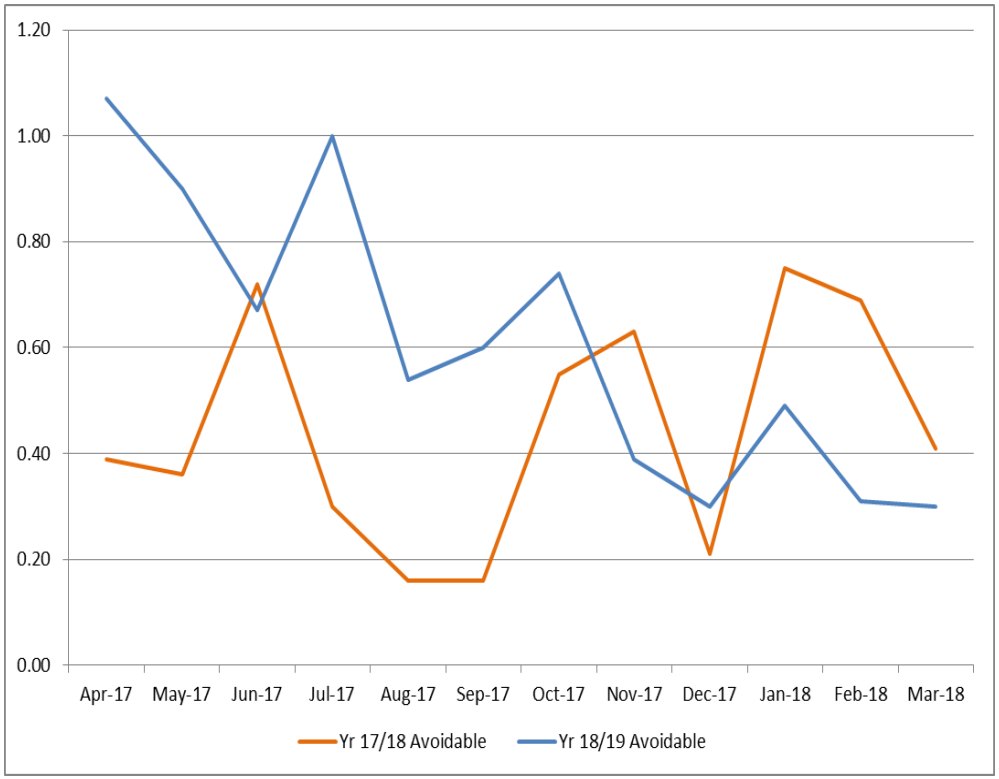


Total Falls



Safety – Pressure Ulcers

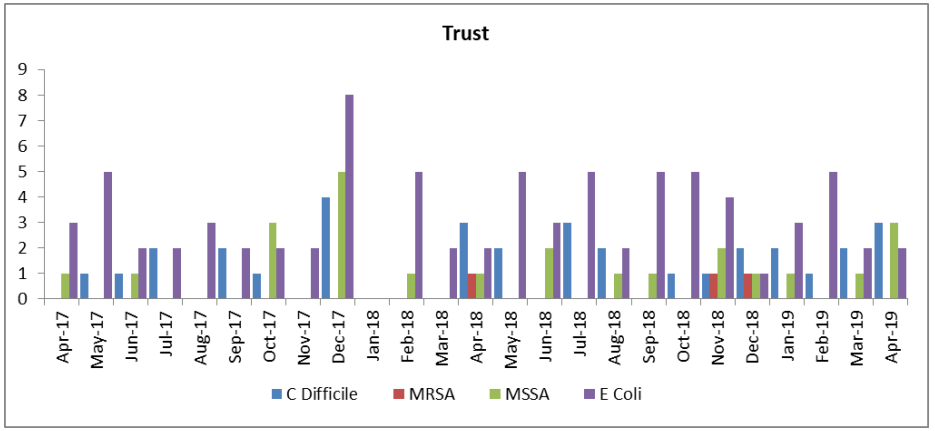
- Pressure Ulcers were higher in 2018/19 Q1-Q3 than 2017/18.
- Pressure Ulcers reduced significantly in Q4 of 2018/19, and indeed when compared to Q4 2017/18.

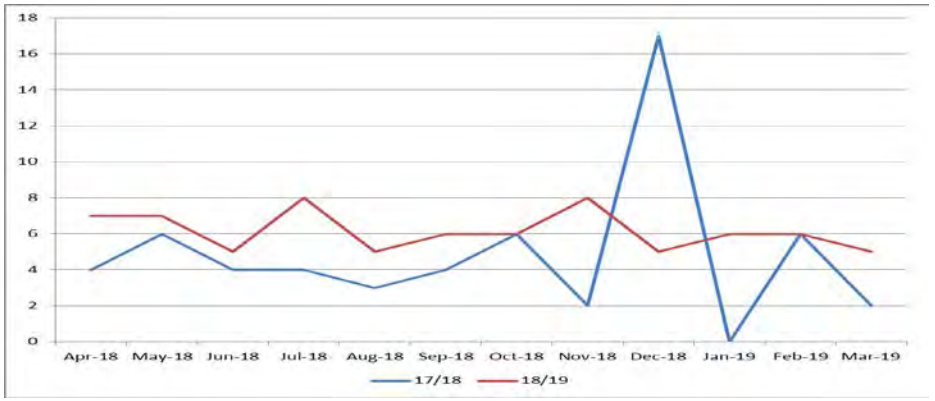


Safety – Infection Control

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

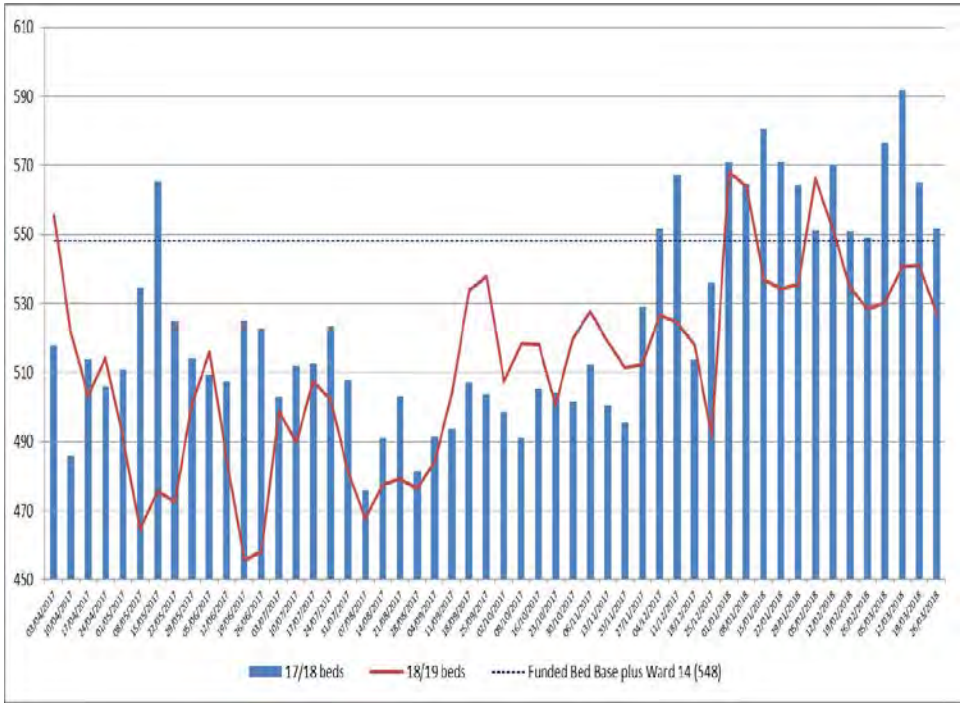
Performance Review

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.

Occupied bed days rose sharply over the Festive and New Year period.



Walsall Healthcare NHS
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Key Performance Indicators

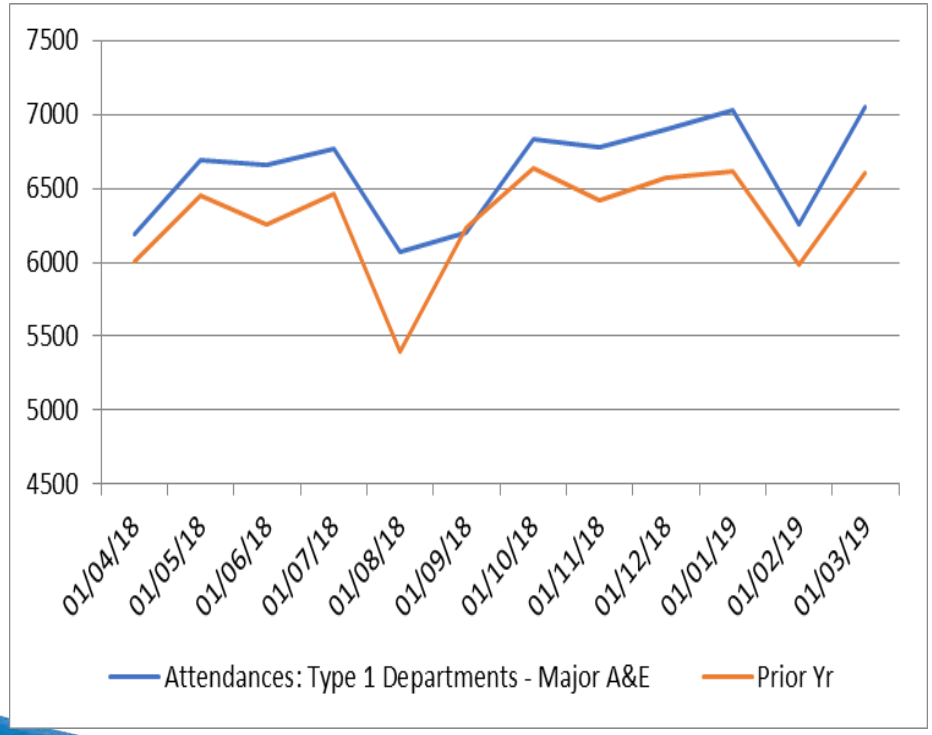
	2018/19	2017/18	2016/17
KPI	Winter (Nov 1st - Mar 31st)	Winter (Nov 1st - Mar 31st)	Winter (Nov 1st - Mar 31st)
4 hour standard (all types activity (Type 1, Types 3 (Mat Triage, FAU, UCC, WiC))	83.86%	82.45%	79.44%
Ambulance turnaround times	67.52%	65.73%	58.78%
Triage times in ED (Average - minutes- 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

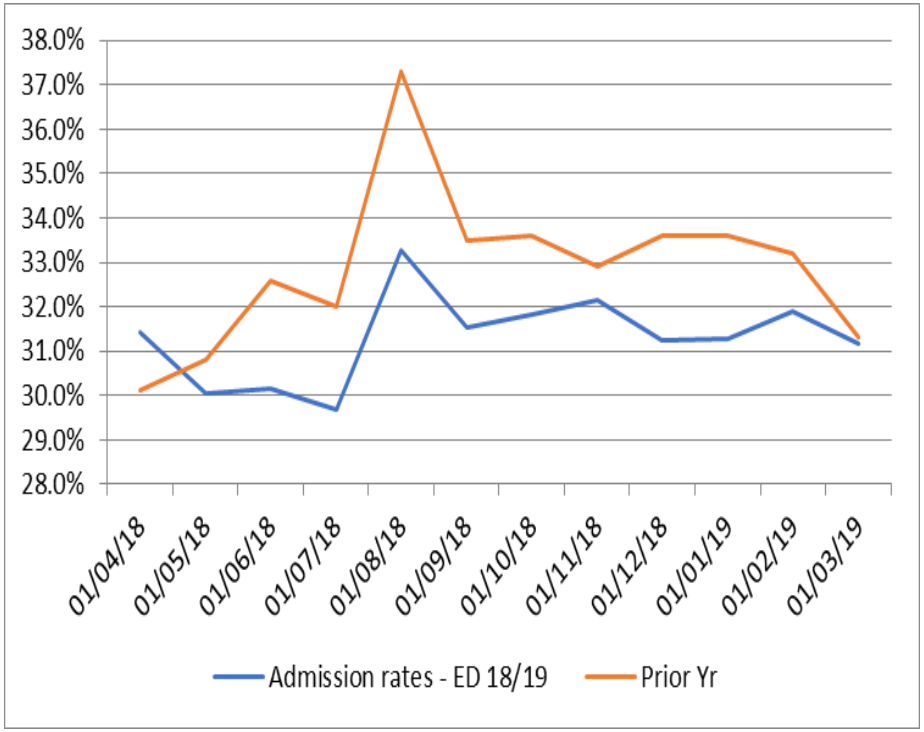
ED attendances 2017/18 and 2018/19

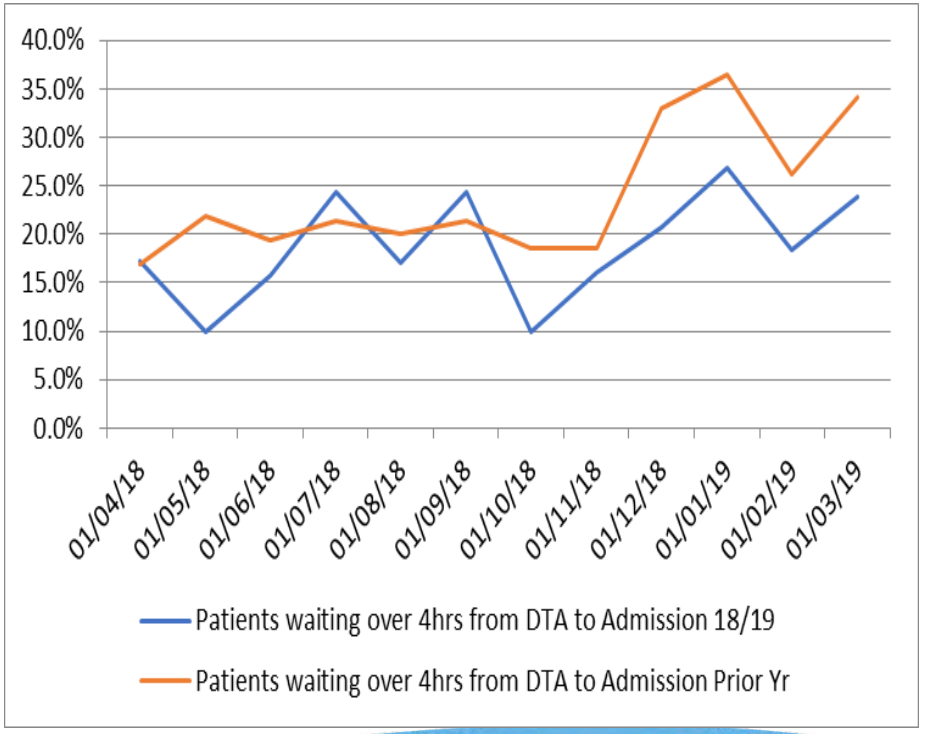


4hr Emergency Access Standard (Type 1) performance 2017/18 & 2018/19

Other ED performance metrics

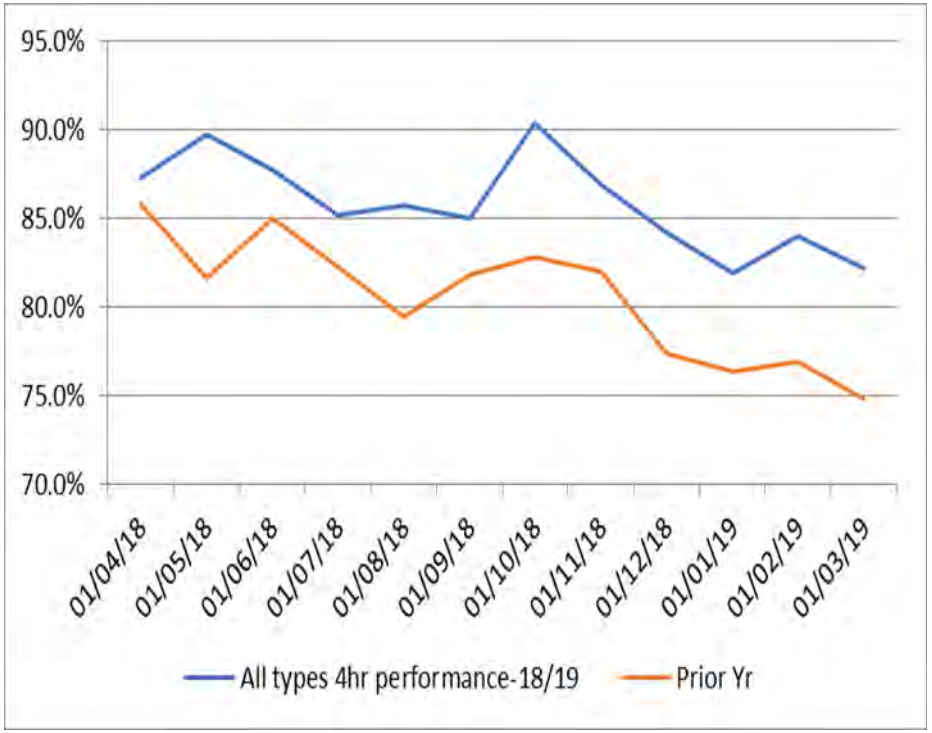
Despite the additional pressure of attendances the Trust managed to sustain lower admission rates and also reduced waiting times following a decision to admit





All Type 4hr Performance

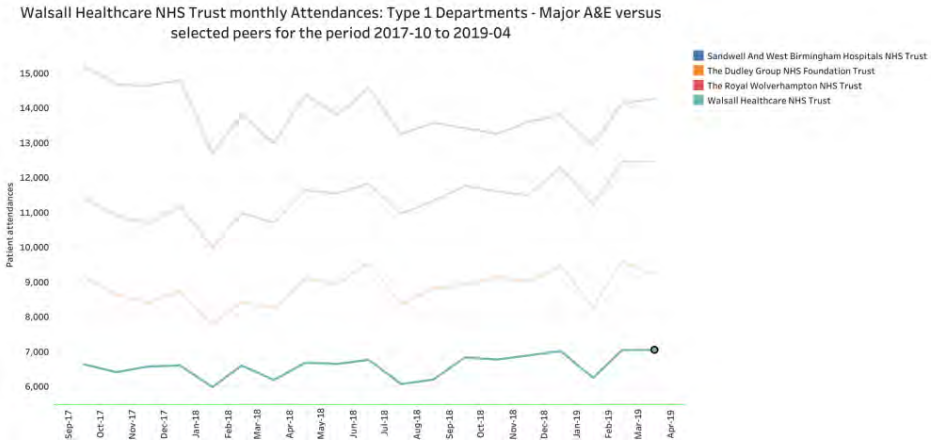
A significant (as high as 16%) reduction in type 3 – UCC patients over the winter period has meant All type performance has not improved in line with Type 1 but has, nevertheless, improved year on year.

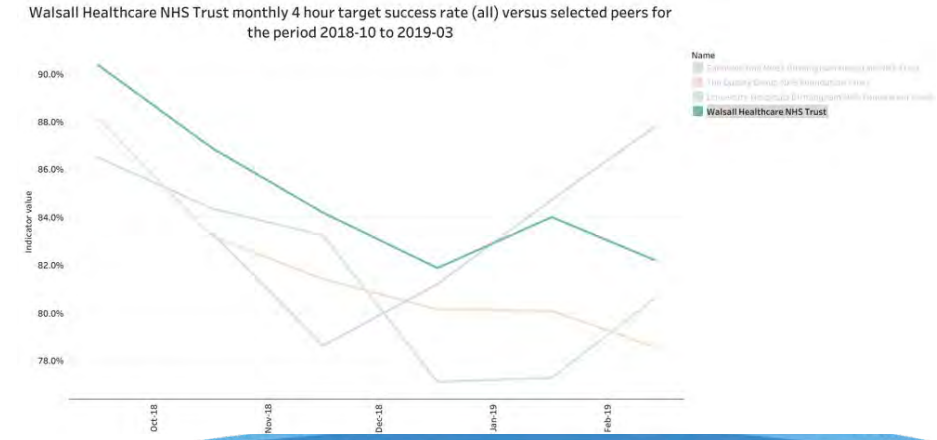


Our performance compared to regional peers

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

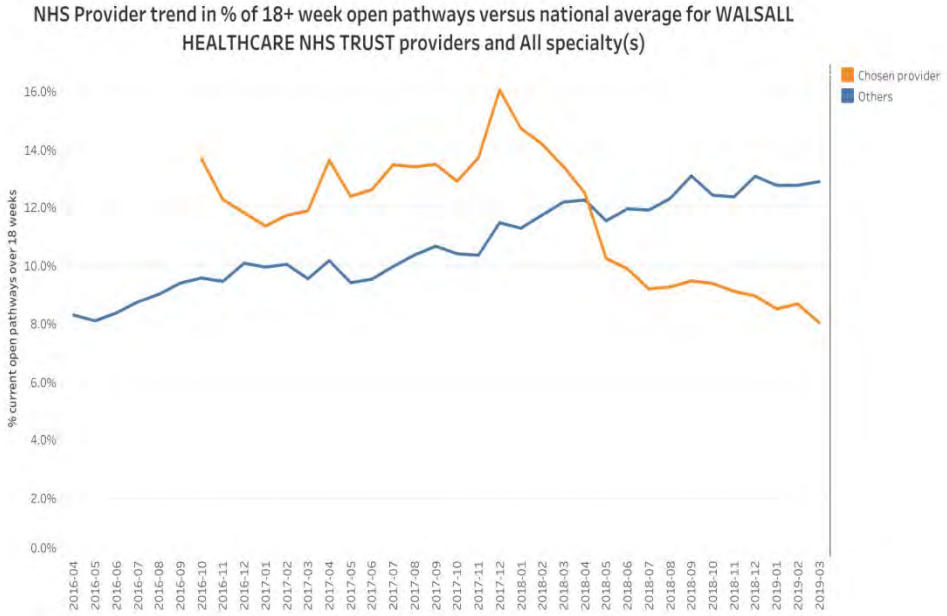




RTT Performance

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



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 only partially off-set by generating elective income (£0.8m) and additional expenditure over the winter period beyond plan (£0.3m).

Walsall Healthcare NHS
NHS Trust

Lessons Learnt

Caring for Walsall together

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

Lessons Learnt

- Careful planning of additional inpatient bed capacity, using an evidence-based forecast demand on the bed base is valuable.
- Planning should include scenarios to stress-test inpatient bed demand (e.g. assuming 1 or 2 standard deviations of variance above mean demand).
- Deployment of clinical interventions to enable rapid access to senior clinical decision-makers (e.g. additional Emergency Department Middle Grade cover, and additional Consultant Acute Physician cover in the Emergency Department) is associated with positive performance and patient safety metrics.
- Bed occupancy rose significantly over the Christmas and New Year Festive period in Winter 2018/19. Interventions to minimise this rise would result in a lower bed occupancy in January.
- Costings need to reflect all associated costs to use of additional inpatient bed capacity (e.g. Estates costs), and reflect scenarios including stress-tested increased demand.
- Provision of safe, timely emergency care over the Winter Period is a whole-Trust endeavour.

MEETING OF THE PUBLIC TRUST BOARD – Thursday 5th September 2019			
Walsall Together Report			**AGENDA ITEM: 15**
Report Author and Job Title:	Michelle McManus Walsall Together Programme Manager	**Responsible Director:**	Daren Fradgley Interim Walsall Together Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	This paper updates the Board Members on the key Walsall Together work undertaken this month: A working group has been established to take forward implementation of the Section 75 agreement between Walsall Healthcare and Walsall Council. A Briefing is currently being developed and will be circulated to all Walsall Together partners in September. The Clinical Operating Model (COM) Group met for the first time in July and agreed a number of specific responsibilities that will form the basis of the Terms of Reference; We have passed through to the next stage of assessment in our application for development of the Family Safeguarding Model; a detailed mobilisation plan is being developed whilst we await the outcome of our application; The Walsall Together Partnership (WTP) has resolved to undertake a series of developmental workshops between September and November 19 with key themes including systems thinking, strengths based practice and co-production; The Walsall Together Director has met with Directors of Strategy and Commissioning across a number of STP partners to start to share thinking across the wider Black Country. A number of issues have been were presented to the WTP Board in August including: • A delay in the scoping of the specialist community services projects • Risks associated with achieving the commissioned model for the Intermediate Care Service; • Costs associated with shifting the stroke rehab service into the community.		

Recommendation	Board members to NOTE and discuss the contents of this paper.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This paper outlines the progress in relation to the Walsall Together programme of work and 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; BAF004 Failure to progress the delivery of the Walsall Integrated model for health and social care.	
Resource implications	There are no new resource implications associated with this report.	
Legal and Equality and Diversity implications	The Walsall Together Programme Plan will include an EDI assessment overall and individual assessments for each project.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

WALSALL TOGETHER REPORT
SEPTEMBER 2019

1. PURPOSE OF REPORT

This report provides the board with an update on the Care at Home strategic objective which is coordinated by Walsall Together.

2. GOVERNANCE ARRANGEMENTS

The following additional Board papers reference in more detail the progress made in respect of the governance arrangements for Walsall Together:

- A Highlight Report is included in the Committee section;
- There is a specific paper presenting the Alliance Agreement and the revised Walsall Together Partnership (WTP) Board Terms of Reference.

A working group has been established to develop the proposed Section 75 agreement between Walsall Healthcare NHS Trust and Walsall Council. A high-level Implementation Plan has been agreed and there is a series of meetings in the diary over the coming months. An outline briefing document will be shared with board members during September to help shape further thinking.

The Clinical Operating Model (COM) Group met for the first time on 23rd July 19 and was well attended. Additional representation from health commissioning, Public Health and Children's Services was agreed and members have since been engaged. The Group has been established as the overarching clinical and professional group that will mandate, oversee and ensure effective engagement for the system to enable better integrated working in the interests of citizens. A number of specific responsibilities were agreed and will form the basis of the Terms of Reference that will be presented for approval at the next meeting.

3. FAMILY SAFEGUARDING MODEL

A paper was presented to the WTP Board in July that outlined Walsall's application for implementation of the Strengthening Families, Protecting Children Programme. We have since passed through to the next stage of assessment and have submitted a statement of readiness, which details our suitability and commitment to the Family Safeguarding Model.

Walsall Together Partners fully support the application for the Family Safeguarding Model and have agreed to proceed with implementation notwithstanding that we are still waiting to hear the outcome of our application. Further details in respect of a mobilisation plan and the implications for the Walsall Together programme are being worked through.

4. SPACE UTILISATION

A Walsall Together Space Utilisation Group has been established to tackle the number of estates challenges faced in delivering the Walsall Together vision. The group will ensure that the space currently occupied is correctly aligned to meet the needs of the services. Where this is not the case they will work to identify suitable premises across the borough. The group will endeavour to ensure that if a team is moved a cost pressure is not incurred by partners. The group is looking at the entire partnership estates portfolio and not just at the Trust or the Council.

From 1st September, full co-location of the East Locality teams will be achieved at Blakenall Village Centre. The teams previously occupying space at Parkview Medical Centre, Anchor Meadow Medical Centre and the Civic Centre comprise of community health services and adult social care and will be fully integrated alongside the operational management team for the services in scope. The next priority for the Space Utilisation Group is to confirm a plan to co-locate the South Locality teams; a number of options have already been identified and the Group expects to achieve co-location by the end of October 19.

5. WORKFORCE AND ORGANISATIONAL DEVELOPMENT

In July 19, the WTP Board confirmed the adoption of Strengths Based Practice as a standout feature of Walsall Together. An application has since been submitted to the Skills for Care Workforce Development Innovation Fund to support a learning and development project which will train the health, social care and voluntary sector workforce in Walsall in deploying a Strengths Based Approach to assessment across all pathways of care.

We have secured £20,700 from Skills for Care and an additional £22,700 from the Better Care Fund, which will allow us to deliver full training for strength-based approaches, co-production with service users and personalisation to around 350 members of staff across place based teams between September and March 2019/20.

Wider workforce development is being led through the Walsall Together programme team. A Programme Manager has been assigned responsibility to lead this work to include scoping of opportunities for training and development of existing staff and future workforce roles that deliver the clinical operating model.

In the context of delivering an ambitious programme of transformation across the health and care system, the WTP Board has resolved to undertake a series of developmental workshops between September and November 19 with key themes pertinent to delivery of an ICP. The development will include systems thinking and specific themes for Walsall Together e.g. strengths-based practice and co-production. A more detailed proposal for this development will be considered by the WTP Board in September.

6. IT & DIGITAL

Discussions and strategic principles for the Shared Care Record and Population Health have been agreed and include having a combined infrastructure to underpin true partnership and integration from a data and technology point of view. Awareness Events and Workshops are being scheduled during October and November to gain views, ideas and opportunities. The product of all this will be an agreed Walsall strategy for all partners.

In July, the Walsall Together Director met with other ICP digital leaders and the CEO of NHSX. It was apparent that some of the best technological progress has been made in places that are bringing together IT services as one provider. The clearest example of this was in Buckinghamshire where they have a shared local authority and health IT service. Conversations are already underway in Walsall to explore how a data warehouse could be hosted by one partner on behalf of the partnership.

7. STP ALIGNMENT

As part of the STP Place Based Workstream, the Walsall Together Director has met with Directors of Strategy and Commissioning across a number of STP partners to start to share thinking across the wider Black Country System. More information is expected to emerge from ongoing conversations over the next few months that will provide support and perspective to the strategic thinking within Walsall Together.

8. DELIVERY OF THE TRANSFORMATION

To provide assurance on delivery of the transformation, the programme office now produces a suite of documents to the WTP Board on a monthly basis. This includes:

Document	Detail
Programme Structure and RAG Ratings for Horizon 1	A high-level view of all live projects, their associated RAG ratings and any necessary exception reporting.
Programme Status Report	A high level status summary of every project within the programme.
Individual Workstream/ Project Reports	When relevant within the agreed governance processes, individual Workstream and Project level documentation will be presented to the WTP Board for assurance and approval.

The following exception reporting was presented to the WTP Board in August against 'amber' (defined as off track but recoverable) and 'red' (defined as off track, intervention required) projects:

- Pathway redesign, establishment of GPs with Special Interests and virtual outpatient clinics are currently 'amber' rated. Work in some specialties has commenced via the Right Care programme, however a workshop is required to understand the full scope of these projects. It has been agreed that various models for the delivery of outpatients in the community are to be explored in more detail with the clinical teams. The final Workstream Plan is expected to be submitted for approval in October.

- The Intermediate Care Service (ICS) Improvement Plan is 'amber' rated due to the risks associated with achieving the commissioned model (therapies establishment and funding). A full review of therapies is currently underway and follows the transfer of all therapy services at WHT from the Women's and Children's division into Adult Community Services.

- The Stroke/Neuro Rehab Pathways project is 'red' rated due to the current challenges around the financial model. Intervention is required in respect of the costs associated with catering, cleaning and medical cover.

The following workstream/project documentation has been approved by the WTP Board:

- Workstream Plan for Tier 3 – Intermediate, Unplanned and Crisis Services;
- Workstream Plan for Tier 4 – Acute and Emergency Services;
- Therapies Project Brief.

9. RECOMMENDATIONS

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

WALSALL TOGETHER PARTNERSHIP BOARD

TERMS OF REFERENCE: Version 0.10

RATIFIED BY THE TRUST BOARD ON:

NEXT REVIEW DUE:

1. CONSTITUTION

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

2. PURPOSE

2.1. The Committee will be responsible for decision making and strategic direction, including responsibility for the delivery of the Walsall Together Business Plan.

2.2. The Committee will have responsibility for the oversight of service integration contractually in scope for the system integration and transformation.

2.3. The Committee is authorised by the board to investigate any activity within its terms of reference. The Committee is authorised by the Board to obtain outside legal or independent advice and to see the attendance of outsiders with relevant experience and expertise if it considers necessary.

3. MEMBERSHIP

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

3.2. The Membership of the Committee shall consist of:

- A Non-Executive Director to be appointed by the Chairman;
- Two Non-Executive Directors (one from each provider Trust);
- Executive Director of Walsall Together;
- 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 Executive, One Walsall;
- Primary Care Network Clinical Directors;
- Director of Governance, Walsall Healthcare Trust;
- Corporate Director, Walsall Housing Group representing Housing.

3.2 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.

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 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. DECISION MAKING

6.1. A quorum shall be 2 Non-Executive Directors and one representative from each partner organisation.

6.2. It is recognised that each of the partners has their own regulatory and statutory responsibilities and partners have their own internal governance arrangements. There may be some matters where partners respective Boards/Governing Bodies need to retain the ability to reserve the approval of some decisions for that Board/Governing Body. The limits of that authority will be recorded in partner's respective Schemes of Delegation. Partners therefore acknowledge that the relevant individuals may not have the appropriate levels of delegated authority to make decisions at meetings of the Walsall Together Partnership Board. Accordingly, some decisions will need to be considered and approved by partner's individual Boards/Governing Bodies before final resolution by the Walsall Together Partnership Board.

6.3. All decisions will be made by consensus of the partnership.

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 WTP Board are a matter reserved to the Trust Board.

9. ADMINISTRATIVE ARRANGEMENTS

9.1. The Chair of the WTP Board will agree the agenda for each meeting with the Executive Director of Walsall Together. The WTP Board 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 Board members.

9.2. All papers presented to the WTP Board should be prefaced by a summary of key issues and clear recommendations setting out what is required of the WT Boards.

10. ANNUAL CYCLE OF BUSINESS

10.1 The Walsall Together Partnership Board will develop an annual cycle of business for approval by the Trust Board meeting at its first meeting of the financial year. The Walsall Together 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 WTP Board will on behalf of the Trust 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 All WTP Board meetings 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 WT Board and details of assurance provided

14. DUTIES

14.1 The primary responsibility of the Walsall Together Partnership 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 Walsall Together Partnership Board would be to:

- Provide strategic leadership and oversight of service delivery for in-scope services and for Walsall Together 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 Walsall Together partners to account for upholding the commitments made in the Business case, and the Alliance Agreement;
- To provide assurance that needs of the community and patients are best serviced by the proposed partnering arrangements.

14.5 To review the risk implications of the partnership arrangements.

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

MEETING OF THE PUBLIC TRUST BOARD – Thursday 5th September 2019			
Walsall Together Alliance Agreement			**AGENDA ITEM: 16**
Report Author and Job Title:	Michelle McManus Walsall Together Programme Manager	**Responsible Director:**	Daren Fradgley Interim Walsall Together Director
Action Required	Approve ☒ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	As part of the development of the Walsall Together Business case, partners agreed to develop an alliance agreement which would outline the formal mechanism which the partners will work together to deliver the objectives of Walsall Together Partnership The alliance is not a separate legal entity and as such is unable to take decisions separately from or bind the partners. Any arrangements that will require more formal contractual arrangements such as directly commissioned services within the partnership or transfers will have bespoke legal frameworks such as a Section 75. Where governance arrangements are written and agreed elsewhere e.g. in Terms of Reference, these are appended and not duplicated in the document. The focus of the document is on an agreed set of behaviours and how the Partners will work together. The Terms of Reference have been updated in the following areas: • The name of the Board has been changed to the 'Walsall Together Partnership Board' to reflect branding aspirations and to reduce the confusion caused by using different terminology; • Quoracy has been updated. These changes reflect the comments received during the review process, which is now complete.		
Recommendation	The Board is asked to; • Approve the Alliance Agreement and • Approve updated Terms of Reference for the Walsall Together Partnership Board.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This paper outlines the progress in relation to the Walsall Together programme of work and 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; BAF004 Failure to progress the delivery of the Walsall Integrated model for health and social care.	
Resource implications	There are no new resource implications associated with this report.	
Legal and Equality and Diversity implications	The Walsall Together Programme Plan will include an EDI assessment overall and individual assessments for each project.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☐	Care at home ☒
	Partners ☐	Value colleagues ☐
	Resources ☐	

Walsall Together

Walsall Together
Alliance Agreement

Walsall Council

whg

NHS
Dudley and Walsall
Mental Health Partnership
NHS Trust

One Walsall
Inspiring and supporting social action

Walsall Healthcare NHS
NHS Trust

NHS
Walsall
Clinical Commissioning Group

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THIS AGREEMENT is made on the day of 2019

BETWEEN the parties listed in Schedule 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 agreement is an integral part of the vision to promote integrated services that deliver personalised care and it is anticipated that this agreement will facilitate the objectives of Walsall Together as more fully described in this agreement.

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.

Over the period of this agreement, the partners will work together positively and in good faith in accordance with the alliance principles to achieve the alliance objectives. The partners also envisage that this agreement will endeavour to provide flexibility to their relationship as may be required, from time to time, to implement the changes required either nationally or any subsequent changes to the Health or Social Care functions

This agreement is referred to in, supplements and works alongside the Services Contracts. It is designed to supplement and work alongside the Third Party Service Contracts. In other words, this agreement is the overarching agreement that sets out how we will work together in a collaborative and integrated way and the Service Contracts, the Service Operations Manual and Third Party Service Contracts respectively set out how we will provide the Services.

IT IS AGREED AS FOLLOWS:

1. PURPOSE

1.1. The partners have agreed to form an alliance with a primary aim to improve the health and wellbeing outcomes for the population of Walsall. In addition the alliance will be established to improve the financial, governance and contractual framework for the delivery of the services within the Walsall Together scope.

1.2. We recognise that the successful implementation of the alliance will require strong relationships and the creation of an environment of trust, collaboration and innovation. This agreement provides a formal mechanism in which the partners will work together to deliver the agreed governance arrangements and objectives of Walsall Together through a set of behaviours that are described in this agreement.

1.3. This Alliance Agreement supports the wider Black Country Sustainability and Transformation Plans (STP) memorandum of understanding.

2. TERM

2.1. This agreement shall be deemed to have come into force on the Commencement Date and, subject to Clause 3.2 and the provisions for earlier termination set out in this agreement, will expire on 31 March 2021 ("Initial Period").

2.2. It is the intention of the partners that this agreement will be extended beyond the Initial Period. Accordingly, unless the Walsall Together Partnership Board agrees otherwise, the partners shall not less than six (6) months prior to the expiry of the Initial Period consider extension of this agreement.

3. EXCLUSIONS

3.1. Each one of the partners agrees that:

3.1.1. Each one of the partners is a sovereign organisation;

3.1.2. The alliance is not a separate legal entity and as such is unable to take decisions separately from or bind the partners.

3.2. This agreement is referred to in, supplements and works alongside the Services Contracts. It is designed to supplement and work alongside the Third Party Service Contracts. In other words, this agreement is the overarching agreement that sets out how partners will work together in a collaborative and integrated way and the Service Contracts, and Third Party Service Contracts respectively set out how the partners will provide the Services.

3.3. We recognise that each partner has its own regulatory and statutory responsibilities and that there will be some decisions that will need to be reserved for consideration and determination by individual Boards/Governing Bodies. The limits of that authority will be recorded in partners' respective Schemes of Delegation.

3.4. The partners shall support each other to achieve compliance with each of our statutory responsibilities. Accordingly, nothing in this agreement will require any of the partners to do anything which is in breach of legal obligations (including procurement and competition law) or which breaches any regulatory or provider licence requirements.

3.5. The partners acknowledge that commissioning arrangements remain unchanged.

4. AIMS AND OBJECTIVES

4.1. The intention of the partners is that the alliance will deliver sustainable, effective and efficient services with significant improvements over the term of the agreement. The partners have agreed to work collaboratively to:

4.1.1. Improve the health and wellbeing outcomes for the Walsall population;

4.1.2. Improve care delivery and quality standards in the provision of care;

4.1.3. Meet the statutory financial duties of all partner partners.

4.2. The alliance objectives will enable delivery of commissioner partners' key objectives so to be able to meet demand from changing levels of need, changing funding levels, new legislation and/or policy imperatives.

4.3. The provider partners acknowledge and accept that the partners may seek to shift activity and service specifications under the respective services contracts in order to achieve the alliance objectives.

4.4. The Walsall Together Business Case describes a Clinical Operating Model (COM) and a number of activity shifts that will contribute to the Triple Aim. Implementation of the COM will contribute to the following:

4.4.1. Increase in community contacts;
4.4.2. Increase in population self-care and self-management;
4.4.3. Increase in social care contacts;
4.4.4. Increase in VCS contacts;
4.4.5. Increase in outpatient appointments in the community;
4.4.6. Reduced length of stay;
4.4.7. Reduced inappropriate A&E attendances;
4.4.8. Reduced admissions from ambulatory care sensitive conditions;
4.4.9. Reduced DNAs and length of outpatient appointments;
4.4.10. Reduced number of outpatient appointments;
4.4.11. Reduced outpatient referrals;
4.4.12. Reduce the burden on Primary Care GP appointments through enhanced activity in the community.

4.5. Walsall Together will impact on the health and wellbeing of the population and will develop an Outcomes Framework with the following themes:
4.5.1. A healthy population;
4.5.2. Accessible, coordinated and responsive care;
4.5.3. Strong communities;
4.5.4. System enablers.

5. BEHAVIOURS

5.1. It is agreed that Walsall Healthcare Trust shall be the Host Partner.

5.2. As Host Partner, Walsall Healthcare Trust will engage with partners in a coordinated and integrated way, establishing an environment that encourages collaboration and integration.

5.3. Accordingly, we have agreed a set of behaviours that the partners will work to in delivering our alliance objectives:

5.3.1. Work towards a shared vision of integrated service provision;

5.3.2. Commit to delivery of system outcomes;

5.3.3. Commit to common processes, protocols and other system inputs for those in-scope services;

5.3.4. Take responsibility to make unanimous decisions on a 'Best for Walsall' basis, understanding population needs and predicting demand;

5.3.5. Always demonstrate that service users' best interests are at the heart of our activities, ensuring the partnership promotes prevention and overall health and wellbeing;

5.3.6. Adopt an uncompromising commitment to trust, honesty, collaboration, innovation and mutual support;

5.3.7. Establish an integrated collaborative team environment to encourage open, honest and efficient sharing of information, whilst complying with data protection laws;

5.3.8. Co-produce with others, especially service users, families and carers, in designing and delivering the services;

5.3.9. Communicate openly about major concerns, issues or opportunities relating to the programme and the achievement of the outcomes;

5.3.10. Share appropriate information, experience and knowledge so as to learn from each other and develop effective working practices;

5.3.11. Work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

5.3.12. Adopt a positive outlook by behaving in a positive, proactive manner.

5.3.13. Communicate with each other and all relevant staff in a clear, direct and timely manner to optimise the ability for each of partner, the Walsall Together

Partnership Board and the supporting Governance Groups to make effective and timely decisions to achieve the alliance objectives.

5.4. Delegated Authority

5.4.1. We shall strive to give as much advance notice of Walsall Together Partnership Board business as is reasonably possible so as to allow each partner to seek views and any necessary approvals or authority from their individual organisation.

5.4.2. We shall seek to ensure that partners have appropriate levels of delegated authority in order to consider and determine issues at meetings of the Walsall Together Partnership Board.

5.4.3. Where there are limits on the delegated authority of partners (as confirmed in the relevant Scheme of Delegation), each partner shall advise the other partners of those limits and what additional approvals or authorisations will be required to participate in and make decisions at meetings of the Walsall Together Partnership Board.

5.5. Workforce

5.5.1. All partners understand that we each have certain responsibilities to each other in the way we deal with staff and employment law issues. For example, we need to manage the risk that some staff could transfer from one partner to another under the Transfer Regulations contained in the relevant Service Contract.

5.5.2. We agree that we will each have responsibility for our own staff and that, where internal reorganisation or redeployment of staff is needed, each partner shall be individually responsible for any costs of that reorganisation or redeployment.

5.5.3. In respect of staff that manage and run services in pursuant to this Agreement, each partner commits to each of the others that we shall co-operate and negotiate, acting reasonably and in good faith, to agree how we will manage the financial, operational, legal and other consequences of such staff transfers.

6. PROCESSES

6.1. Any partner that becomes aware of any actual or potential conflict of interest, which is likely to have an adverse effect on the partners ability to properly perform the obligations under this agreement, must immediately notify the Walsall Together Partnership Board. The Walsall Together Partnership Board shall determine how best to manage any actual or potential conflict of interest.

6.2. The Walsall Together Partnership Board may resolve to terminate this agreement if an Event of Force Majeure renders the continuation of the agreement impossible.

6.3. The Walsall Together Partnership Board may resolve to terminate this agreement if a dispute cannot be resolved.

6.4. The partners acknowledge and confirm that the host shall be entitled to be reimbursed for the agreed management and administrative costs reasonably incurred by the host in connection with the fulfilment of the hosting obligations.

6.5. New partners shall be admitted on terms which are fair, reasonable and non-discriminatory. Where a partner or partners wish to admit a new organisation to be a partner under this agreement, such a proposal shall be considered at the Walsall Together Partnership Board.

6.6. Partners may be removed by resigning to the Walsall Together Partnership Board.

6.7. Partners may submit a proposal to the Walsall Together Partnership Board to recommend the removal of another partner. The proposal shall outline the reasons for removal. Any removal will be considered will on terms which are fair, reasonable and non-discriminatory.

6.8. The provisions of this agreement may be varied at any time by a partner submitting a Notice of Variation to the Walsall Together Partnership Board. All Variations must be agreed by all partners.

7. STRUCTURE

7.1. Walsall Together Partnership (WTP) Board

7.1.1. Partners agree to establish the WTP Board, which is to be established as a sub-committee of the host partner.

7.1.2. The WTP Board will be responsible for decision making and strategic direction, including responsibility for the delivery of the Walsall Together Business Case.

7.1.3. The WTP Board will have responsibility for the oversight of service integration contractually in scope for the system integration and transformation.

7.1.4. The WTP Board will have other duties and the authority and accountability as defined in its Terms of Reference (Appendix 1).

7.2. Senior Management Team (SMT)

7.2.1. Partners agree to establish the Walsall Together SMT to provide assurance to the WTP Board that the objectives of the programme are being delivered. The SMT will be responsible for the delivery of system integration and transformation for in-scope services as per the clinical operating model.

7.2.2. The SMT will have other duties and the authority and accountability as defined in its Terms of Reference as approved by the WTP Board.

7.3. Executive Director of Walsall Together

7.3.1. We agree that the partners will engage an individual to undertake the role of the Executive Director of Walsall Together. The Director will be responsible for the oversight of the transformation and integration of services, as well as the operational management of the Walsall Together partnership services.

7.3.2. The Director of Walsall Together will be an Executive Director of the host partner, however their appointment will be confirmed and apply to all partners. The Walsall Together Director will work closely with all partners as a system integrator.

7.4. Risk Management

7.4.1. Risk implications of the partnership arrangements will be managed according to the host's Risk Management Policy. Where relevant, each partner will transfer all or part of a risk to individual organisation Risk Registers in accordance with individual Risk Management Policies.

7.4.2. Clinical and operational risks for the services in scope will continue to be reported and managed by the individual service providers and in accordance with the obligations under the Services Contracts.

APPENDIX 1 – WALSALL TOGETHER PARTNERSHIP BOARD TERMS OF REFERENCE

MEETING OF THE PUBLIC TRUST BOARD 5th September 2019			
Revalidation Annual Report & Statement of Compliance 2018/19			**AGENDA ITEM: 17**
Report Author and Job Title:	Mark Read – Medical Revalidation & Job Planning Manager	**Responsible Director:**	Dr. Matthew Lewis – Medical Director
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	**Appraisal & Revalidation Performance 1 April 2018- 31 March 2019** • **90%** of connected doctors had an appraisal between 1 April 2018 - 31 March 2019; • **87% (52)** of doctors due for revalidation were recommended for revalidation between 1 April 2018- 31 March 2019, a significant improvement from 55% in the previous year; • **13% (8)** of doctors due to be revalidated were deferred owing to insufficient supporting information, or owing to them being subject to an ongoing process - a significant improvement from 45% in the previous year; **Key Actions undertaken since 1 April 2018** An increased emphasis on monitoring key quality elements of appraisal, including quality of the appraisal summary, evidence of reflection and the associated Personal Development Plan (PDP) outputs. This has included monitoring and improving Medical Appraiser performance through the Medical Professional Standards Group (PSG) (formerly Revalidation Steering Group) and Appraiser Support Group meetings and the development of a new Medical Appraisal and Revalidation Policy (yet to be ratified by the Local Negotiating Committee). • **1 April 2018**, new software system for governing Medical Revalidation and electronic Appraisal for all 251 doctors connected to this designated body (Allocate – Health Medics Optima); • **January 2019** - Monthly reporting to the MPSG on performance metrics to embed a Clinically Led culture of ownership and accountability. Monitoring performance with regards to appraisal and revalidation and identifying actions owned at care group level will help mitigate risks of non-compliance. • **April 2019** – new Trust Lead Medical Appraiser appointed, Dr. Riaz Bavakunji, Nephrology Consultant. • **June 2019** – 17 new Trust Medical Appraisers trained, increasing the total Trust Medical Appraisers to 61; **Key Actions Planned for 1 April 2019 - 31 March 2020**		

	Creating a culture focused on reflection and application to clinical performance, robust PDP's that are effective and objectives that are aligned to both Trust, service and individual needs. • The Revalidation Team will be rolling out monthly 'drop in sessions' for Doctors to attend that will provide training on the elements as well as technical support and advice. • MPSG to continue to monitor appraisal compliance; • Complete a programme of refresher training for existing Medical Appraisers in November 2019 and April 2020. • Revise Disciplinary and Management of Performance Procedure for Medical Staff. • Completion of Medical Appraisal Checklist for all connected Doctors (to commence 12 weeks prior to anniversary date) • Deliver Medical Appraisal Refresher Training. • Lead Appraiser to meet all Medical Appraisers during Appraisal Year on 1-1 basis to discuss Appraisal Feedback, performance and development. • Target of 0 late recommendations to the GMC. • Ensure positive recommendations are confirmed in writing. • Arrange 1 further NHS Resolution Case Investigator Workshop. • *Involve a Non-executive Director or Lay Member in the MPSG.* **Risks and Issues** Identified risks include: • New Policy yet to be ratified; • Improving overall Trust Appraisal Performance; • ESR Appraisal Data Accuracy; • Revalidation Team Resources –the Medical Revalidation & Job Planning Administrator role has been vacant since May 2018), having not been appointed to following 2 separate recruitment processes. Temporary Bank support has been in place intermittently since 23/07/2018. **A permanent post holder is due to commence 02/09/2019.**
Recommendation	Members of the Trust Board are asked to: • Note and receive the Annual Report for Revalidation • Approve the 'Statement of Compliance' confirming that the organisation, as a designated body, is compliant with the regulations (Section 7) A *Statement of Compliance with the regulations* **(Section 7)** should be signed by the Chairman or Chief Executive Officer of the designated body's Board or management team and submitted to Dr David Levy, Regional Medical Director and Higher Level Responsible Officer, NHS England Midlands and East by **30 September 2019**

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Failure to deliver consistent standards of care to patients' across the Trust results in poor patient outcomes and incidents of avoidable harm. BAF Risk 001	
Resource implications	N/A	
Legal and Equality and Diversity implications	N/A	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☒	

A Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published by NHS England in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes was undertaken by NHS England, with the priority redesign of the three annexes below:

1. **Annual Organisational Audit (AOA):**

The AOA captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included. **See Appendix 1**

2. **Board Report:**

The Board Report is presented to support Walsall Healthcare NHS Trust (hereafter referred to as the Trust) as a 'designated body' in reviewing progress over time. Whereas the previous version of the Board Report template addressed the Trusts compliance with the responsible officer regulations, the revised version now contains items to help the Trust assess its effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This handbook describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

The over-riding intention of this Board Report is to guide the Trust by setting out the key requirements for compliance with regulations and key national guidance. It provides a format to review these requirements, so that the Trust can demonstrate not only basic compliance but continued improvement over time. The Board Report will:

a) help the Trust in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

3. Statement of Compliance:

The Statement Compliance (in Section 7) is now combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The Board of Walsall Healthcare NHS Trust can confirm that:

1. **The Annual Organisational Audit (AOA) for this year has been submitted.**

Date of AOA submission: 01/04/2019

Actions from last year: *No action.*

Comments: ***Trust Appraisal Compliance***

Figure 1 demonstrates the Trust's overall Appraisal Compliance rate fell by 7% from 97% on 31 March 2018 to 90% on 31 March 2019. It should be noted that 90% compliance remains consistent with Same Sector Average (89.6%) in 2019.

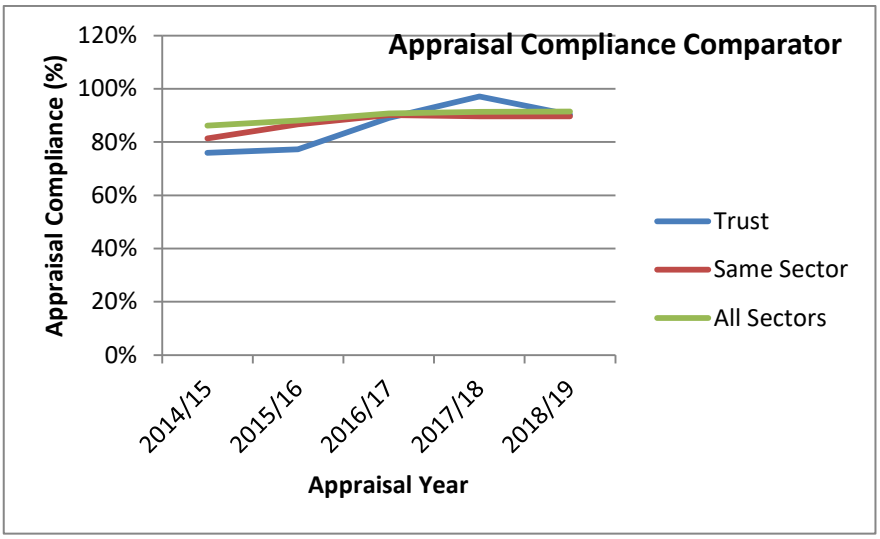

Figure 1- Appraisal Compliance Comparator

Trust Unapproved Missed Appraisals

Figure 2 demonstrates the number of missed appraisals where there is no 'approved' reason (approved by the Responsible Officer (RO)) increased in 2018/19 by 5% and was also higher than the same sector average. The number of 'approved' missed appraisals was *lower* than the same sector average (Trust: 3.7% Sector: 6.7%), suggesting fewer doctors sought/obtained an approval from the RO and poorer engagement in the appraisal process, leading to more late appraisals.

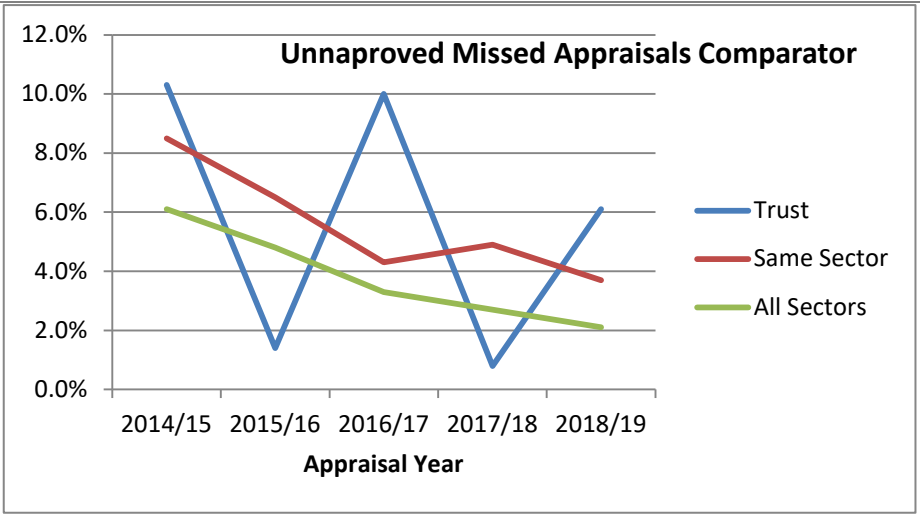

Figure 2 – Unapproved Missed Appraisal Comparator

The monthly Maintaining Professional Standards Group (MPSG) chaired by the Medical Director/Responsible Officer reviews progress of the appraisal and revalidation programme, discusses any concerns and identifies potential non-engagement early. Actions are agreed to encourage ownership for appraisal compliance at Divisional Level.

Action for next year: *MPSG to continue to monitor appraisal compliance;*

2. **An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.**

Dr Matthew Lewis joined Walsall Healthcare NHS Trust on 22/10/2018 as Medical Director and Responsible Officer, replacing the previous post holder Mr. Amir Khan.

3. **The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.**

Yes.

Action from last year: *Appoint to the post of Medical Revalidation and Job Planning Administrator, Vacant since May 2018;*

Comments: Medical Revalidation and Job Planning Administrator will commence in post 02/09/2019. On 22/10/2018, the Trust also appointed a new Medical Director and Responsible Officer (RO), Dr Matthew Lewis and in then in April 2019, a new Lead Medical Appraiser, Dr Riaz Bavakunji was also appointed. The Trust's Appraisal & Revalidation Programme has therefore undergone a period of significant change during the last appraisal year.

Action for next year: *Complete a programme of refresher training for existing Medical Appraisers in November 2019 and April 2020.*

4. **An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.**

Action from last year: *No action.*

Comments: In April 2018, the Trust transitioned to a new system for governing Medical Revalidation and electronic Appraisal for all 251 doctors connected to this designated body. Doctors with a prescribed connection are managed and updated through GMC Connect online, by the Medical Revalidation and Job Planning Manager who has delegated access, on behalf of the Trust's Responsible Officer. The Manager is notified by the Recruitment Team of new starters once an unconditional offer of employment is made to a doctor, to ensure the system is updated in a timely manner.

Action for next year: *No actions identified.*

5. **All policies in place to support medical revalidation are actively monitored and regularly reviewed.**

Action from last year: *Develop a New Medical Appraisal & Revalidation Policy.*

Comments: The *Medical Appraisal & Revalidation Policy was agreed at the Medical Advisory Committee (MAC)* but is yet to be agreed at the Local Negotiating Committee (LNC) and so is not yet ratified. It is anticipated that this will be presented at LNC in September 2019. The existing *Appraisal Policy for Senior Medical Staff* remains in place, with a review date of August 2017.

The Trust also has a Policy in place to manage concerns: *Disciplinary and Management of Performance Procedure for Medical Staff,* which is due to be reviewed in 2019.

Action for next year: *Ratify the Medical Appraisal & Revalidation Policy and a revised Disciplinary and Management of Performance Procedure for Medical Staff.*

6. **A peer review has been undertaken of this organisation's appraisal and revalidation processes.**

Action from last year: *No action.*

Comments: Last Independent Verification Visit was undertaken by NHS England in 24/11/ 2016;

The Trust appointed a new Medical Appraisal Lead in April 2019 will quality assure a random selection of 60 appraisals each appraisal year and meet all 61 Medical Appraisers on an annual basis to provide peer support and feedback on their performance, using Appraisal

Feedback data from doctors and calibrate performance of appraisers. Points of learning and general feedback will be provided to appraisers through bi-monthly Appraiser Support Group Meetings (ASG), facilitated by Lead.

The MPSG also reviews training needs, performance and quality of appraisal and ensures consistency through a review of 5 random appraisal PDP's and summaries.

Action for next year: *No action.*

7. **A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.**

Action from last year: *Improve timely identification of newly connected doctors*

Comments: It was identified in the 2017/18 Board Report that a key area to improve was the timely identification of newly connected doctors, particularly on short term placements with the Trust (often recruited via Trust Bank), and this issue contributed to some of the late revalidation submissions in 2017/18. Furthermore, Medical Training Initiative (MTI) doctors, who now undertake annual Medical Appraisal.

Now, the Medical Revalidation Manager offers 1-2-1 support for all new starters to the Trust.

Action for next year: *No action.*

Section 2 – Effective Appraisal

1. **All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.**

Action from last year: *No action.*

Comments: Confirmed, information regarding complaints and significant events are all documented within the Complaints and Significant Events Report which is a mandatory element of medical appraisal. This includes a report obtained from other healthcare organisations including private hospitals.

Action for next year: *No action.*

2. **Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.**

Action from last year: *No action.*

Comments: All 'missed appraisals' have a recorded reason. Since April 2018, the Allocate system provides a live "RO Dashboard", for tracking and monitoring the key performance indicators pertaining to the Medical Appraisal Programme. This includes, 'Approved Missed Appraisals' where the RO has agreed to a postponement (i.e. sickness absence, maternity leave, sabbatical). The RO dashboard is managed and maintained by the Medical Revalidation Manager.

For audit purposes, the Revalidation team will now maintain a 'Medical Appraisal Checklist' for all doctors, documenting and tracking all contact and support offered to doctors through in the 12 weeks leading up to their appraisal anniversary date. Where risks or issues are identified or a lack of engagement in the appraisal process, there is a procedure of escalation. This includes a meeting with the Trust Lead Appraiser 6 weeks before the doctors appraisal due date and, if required, the development of an action plan to ensure appraisal completion on time.

Action for next year: *Completion of Medical Appraisal Checklist for all connected Doctors (to commence 12 weeks prior to anniversary date)*

3. **There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).**

Action from last year: *Develop New Medical Appraisal & Revalidation Policy.*

Comments: The *Medical Appraisal & Revalidation Policy* was drafted and agreed at the Medical Advisory Committee (MAC), but is yet to be agreed at the Local Negotiating Committee (LNC) and so is not yet ratified. It is anticipated that this will be presented at LNC in September 2019. The existing *Appraisal Policy for Senior Medical Staff* remains in place, with a review date of August 2017.

Action for next year: *Ratify Medical Appraisal & Revalidation Policy (Target Date November 2019).*

4. **The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.**

Action from last year: *Deliver New Medical Appraiser Training.*

Comments: 17 new Medical Appraisers trained in June 2019, increasing the Medical Appraiser cohort to 61. The ratio of appraisers to doctors is now 1: 4, down from 1: 5.7 in the previous year. Refresher Training will be delivered on 06/11/2019 and 24/04/2020 to existing Medical Appraisers (excluding those recently trained/appointed in June 2019).

Action for next year: *Deliver Medical Appraisal Refresher Training.*

5. **Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).**

Action from last year: *Re-launch Appraiser Support Group (ASG) meetings.*

Comments: All Medical Appraisers are members of the Appraiser Support Group (ASG) which will be chaired by one of the Trust's Lead Appraiser. These meetings will be held bi-monthly. It is a requirement that all Medical Appraisers attend a minimum of 3 ASG meetings per appraisal year. The meetings will cover any issues and concerns to be addressed, the appraiser allocations for the forthcoming year, any training and development needs and Quality Assurance through reviews of anonymised appraisal outputs (to demonstrate good and poor practice) to ensure calibration of practice.

Action for next year: *Lead Appraiser to meet all Medical Appraisers during Appraisal Year on 1-1 basis to discuss Appraisal Feedback, performance and development.*

6. **The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.**

Action from last year: *Present Annual Board Report and return the Statement of Compliance to NHS England by 30 September.*

Comments: The Annual Board Report is presented to the Board each year and provides a quality review framework.

Action for next year: *Present Annual Board Report and return the Statement of Compliance to NHS England by 30 September.*

Section 3 – Recommendations to the GMC

1. **Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.**

Action from last year: *A target of 0 late recommendations to the GMC*

Comments: 1 late recommendation in 2018/19 owing to Trust administrative delay. This figure is an improvement on the previous year, when 5 recommendations were late in 2017/18.

Since April 2019, the Trust Lead Medical Appraiser supported by the Medical Revalidation Manager, has delegated responsibility for reviewing the Doctors Revalidation Portfolio

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

(typically the last 5 years of Medical Appraisals). The Medical Revalidation Manager records the decision on GMC Connect and Allocate. Where concerns arise i.e. insufficient supporting information, or where unresolved local/GMC concerns exist, these cases are escalated to the RO to discuss with their GMC Employee Liaison Officer (ELA)

Action for next year: *Target of 0 late recommendations to the GMC.*

2. **Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.**

Action from last year: *No action.*

Comments: The Trust Medical Appraisal Lead reviews the doctor's appraisal portfolio once the doctor is 120 days away from their revalidation due date ('under notice'). If there are any likely causes for delay these are considered in advance by the Lead with an appropriate plan put in place with the Doctor, e.g. deferral if necessary.

Action for next year: *Ensure positive recommendations are confirmed in writing.*

Section 4 – Medical governance

1. **This organisation creates an environment which delivers effective clinical governance for doctors.**

Action from last year: *No action.*

Comments: Confirmed.

Action for next year: *No action.*

2. **Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.**

Action from last year: *No action.*

Comments: Confirmed. Trust Teams and systems provide information data as follows: Clinical Audit attendance (Departmental Clinical Audit Lead/Facilitator); Mandatory and in-house Training (ESR), complaints and significant events (Patient Safety/PALS - Safeguard) and e-360 feedback (Revalidation Team); Consultant Appraisal Summary Reports (Health Evaluation Data) to provide Consultants with an overview of their individual performance, Trust specialty performance and National specialty performance.

Current safeguards are in place as well as ongoing discussions between the Medical Director and GMC Employee Liaison Advisor (ELA). When there are concerns regarding conduct or capability, the Trust implements the framework set out in 'Maintaining High Professional Standards in the Modern NHS' (MHPS). This forms the basis of the medical disciplinary Policy. There have also been 7 further medics trained as Case Investigators this year.

Action for next year: *No action.*

3. **There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.**

Action from last year: *Arrange NHS Resolution Case Investigator and Case Manager Workshop(s);*

Comments: NHS Resolution delivered Case Investigator Training and Case Manager Training (May - July 2019). The Trust now has 20 trained Investigators, and 5 trained Case Managers.

To ensure this was delivered in a cost effective manner, the Medical Revalidation manager arranged for a total of 24 external paying delegates to attend across the 3 sessions.

Action for next year: *Arrange 1 further NHS Resolution Case Investigator Workshop.*

4. **The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].**

Action from last year: *No action.*

Comments: The Trust is currently reviewing the Policy for raising and dealing with concerns. This will follow the 'Maintaining High Professional Standards' framework and NCAS 'Back on Track' framework. All concerns about doctors are managed under the framework of 'MHPS' within the Medical Disciplinary Procedure. All cases that reach the threshold for GMC referral are discussed at a monthly meeting between the Medical Director and the GMC ELA.

Since January 2019, the Trust's Maintaining Professional Standards Group (MPSG) replaced the Revalidation Steering Group (RSG). The number of doctors in remediation and disciplinary processes are reported on and reviewed on a monthly basis at the MPSG. Terms

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

of Reference are in place, and the Group reports directly to the Trust's Quality, Patient Experience and Safety Committee.

Action for next year: *Involve a Non-executive Director or Lay Member in the MPSG.*

5. **There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].**

Action from last year: *No action.*

Comments: The Medical Practice Transfer of Information Form (MPIT) supports the appropriate transfer of information about a doctor's practice to and from the doctor's Responsible Officers (RO). When recruiting, handover information received is forwarded to the Trusts RO. Requests for information received are processed by the Medical Revalidation Manager.

Action for next year: *No action.*

6. **Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).**

Action from last year: *No Action.*

Comments: Confirmed. All Trust Policies are subject to Equality Impact Assessments.

Action for next year: *No Action.*

Section 5 – Employment Checks

1. **A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.**

Action from last year: *No action.*

Comments: Standard Trust Recruitment Policy pre-employment checking process includes references, DBS checks, right to work checks and Occupational Health Assessment for new starters. Also, the Medical Practice Transfer of Information form (MPIT) is requested by the Trust's Recruitment Team once a final offer of employment is confirmed. This applied to all

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

substantive, short-term contract holders. Doctors employed through an Agency are subject to checks by the Agency.

As part of the Recruitment process, candidates are expected to demonstrate that they are up-to-date with their practise and that they have an up-to-date Medical Appraisal. This requirement is incorporated into the local Medical Recruitment procedures.

Action for next year: *No action.*

Section 6 – Summary of comments, and overall conclusion

1. General review of 2018/19

- Appraisal rates have shown a decline from 2017/18, with 90% of all doctors eligible for appraisal completing the process. There were 9 doctors exempt from appraisal attributed to long term sickness and maternity leave. These are all approved reasons for exemption. Reassuringly, there were no recommendations of non-engagement sent in 2018/19.

Appraisal Year	% of doctors with a prescribed connection who have had an appraisal
2014 - 2015	76%
2015 - 2016	77.3%
2016 - 2017	89.1%
2017 - 2018	97.1%
2018 - 2019	90.2%

- A continued challenge in 2018/19 was meeting the target set by NHS England of returning completed appraisal documentation within 28 days of the appraisal meeting.

Appraisal Year	% of doctors submitting the completed documentation within 28 days
2018 – 2019	84%

- All reasons for delay in appraisal completion are clearly recorded on Allocate and must be provided to NHS England as part of the Annual Organisational Audit. The overwhelming reason cited for delays were workload pressures and appraiser unavailability.

- Following a change to reporting requirements in 2016/17, doctors are now required to have their appraisal by the same 'due date' each year, rather than within a designated quarter. Those that fall beyond 12 months are considered a missed appraisal. The relevant changes in reminders issued through Allocate at 12 weeks, 8 weeks and 4 weeks, and reporting has now been embedded and is working well. There has not

been any notable adverse impact on how our appraisal figures are reported externally. The priority for the appraisal team remains ensuring that all doctors have an annual appraisal.

- Doctors who have recently undertaken appraisal but completed it late have been issued with a letter from the MD/RO to remind them of their professional and employee responsibilities and the requirement to undertake appraisal on time next year;

2. Actions still outstanding

- Ratify the Medical Appraisal & Revalidation Policy at LNC.

3. Current Issues

- The reduction in appraisal compliance is largely attributable to the absence of a dedicated full time Medical Revalidation Administrator since May 2018. The Medical Revalidation & Job Planning Manager has had limited support during this time, through several short-term bank employees.

- There has been an on-going issue with medical appraisal rates being under-reported on the ESR system. The recording of annual appraisal has been an area of significant focus by external bodies, and therefore the presentation of incorrect data has not been helpful. It has been agreed that given the Medical Revalidation Team, which already reports direct to NHS England and the Trust Board will ensure that on a monthly basis ESR is updated at month end. This causes minor duplication of recording but ultimately ensure accurate reporting statistics.

4. New Actions:

- The Revalidation Team will be rolling out monthly 'drop in sessions' for Doctors to attend that will provide training on the elements as well as technical support and advice;
- MPSG to continue to monitor appraisal compliance;
- Complete a programme of refresher training for existing Medical Appraisers in November 2019 and April 2020;
- Revise Disciplinary and Management of Performance Procedure for Medical Staff;
- Completion of Medical Appraisal Checklist for all connected Doctors (to commence 12 weeks prior to anniversary date);
- Develop a 'web page' for Medical Revalidation to include guidance and resources;
- Deliver Medical Appraisal Refresher Training;
- Lead Appraiser to meet all Medical Appraisers during Appraisal Year on 1-1 basis to discuss Appraisal Feedback, performance and development;
- Target of 0 late recommendations to the GMC;
- Ensure positive recommendations are confirmed in writing;
- Arrange 1 further NHS Resolution Case Investigator Workshop;
- *Involve a Non-executive Director or Lay Member in the MPSG.*

Section 7 – Statement of Compliance:

The Board of Walsall Healthcare NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Walsall Healthcare NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Appendix 1 – Annual Organisational Audit Comparator (AOA)

2018-19 Walsall Healthcare NHS Trust

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD **5th September 2019**			
Infection Prevention and Control Annual Report 2018/19 and Annual plan of work 2019/20.			**Agenda item: 18**
Report Author and Job Title:	Joanne Taylor Deputy Director of Infection Control	**Responsible Director:**	Dr Karen Dunderdale Director of Nursing
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	This is the Infection Prevention and Control Annual report for 2018/19. This gives details of the mandatory HCAI data for the year and the work undertaken to reduce the risk of HCAI acquisition. The report also gives the plan of work and audit programme for 2019/20.		
Recommendation	Members of the Board are asked to approve the report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Annual audits relate to risk 764 on the Trust risk register and 350, 351, 354, 355 and 361 on the department risk register.		
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

Infection Prevention and Control

Annual Report 2018-19, and Infection Control Annual Plan 2019-20

Dr K Dunderdale - Director of Infection Prevention & Control and Director of Nursing
Joanne Taylor - Deputy Director of Infection Prevention & Control

Infection Prevention & Control Annual Report 2018-19

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1. Executive Summary

- The Trust has achieved the planned infection control activities outlined in the annual programme 2018/19
- The Trust experienced 2 case of MRSA bacteraemia during 2018-19.
- On *C.difficile*, there were 19 toxin positive reportable cases against a trajectory of no more than 17 cases, ending the year 2 cases over trajectory.
- Mandatory Surgical site surveillance was completed in elective Orthopaedic Hip and knee replacements.

2. Introduction

Healthcare Associated Infections can cause harm to patients, compromising their safety and leading to a suboptimal patient experience and increased length of stay in hospital. Maintaining low rates of HCAI remains a cornerstone of the Trusts approach to patient safety and experience.

3. Reporting arrangements

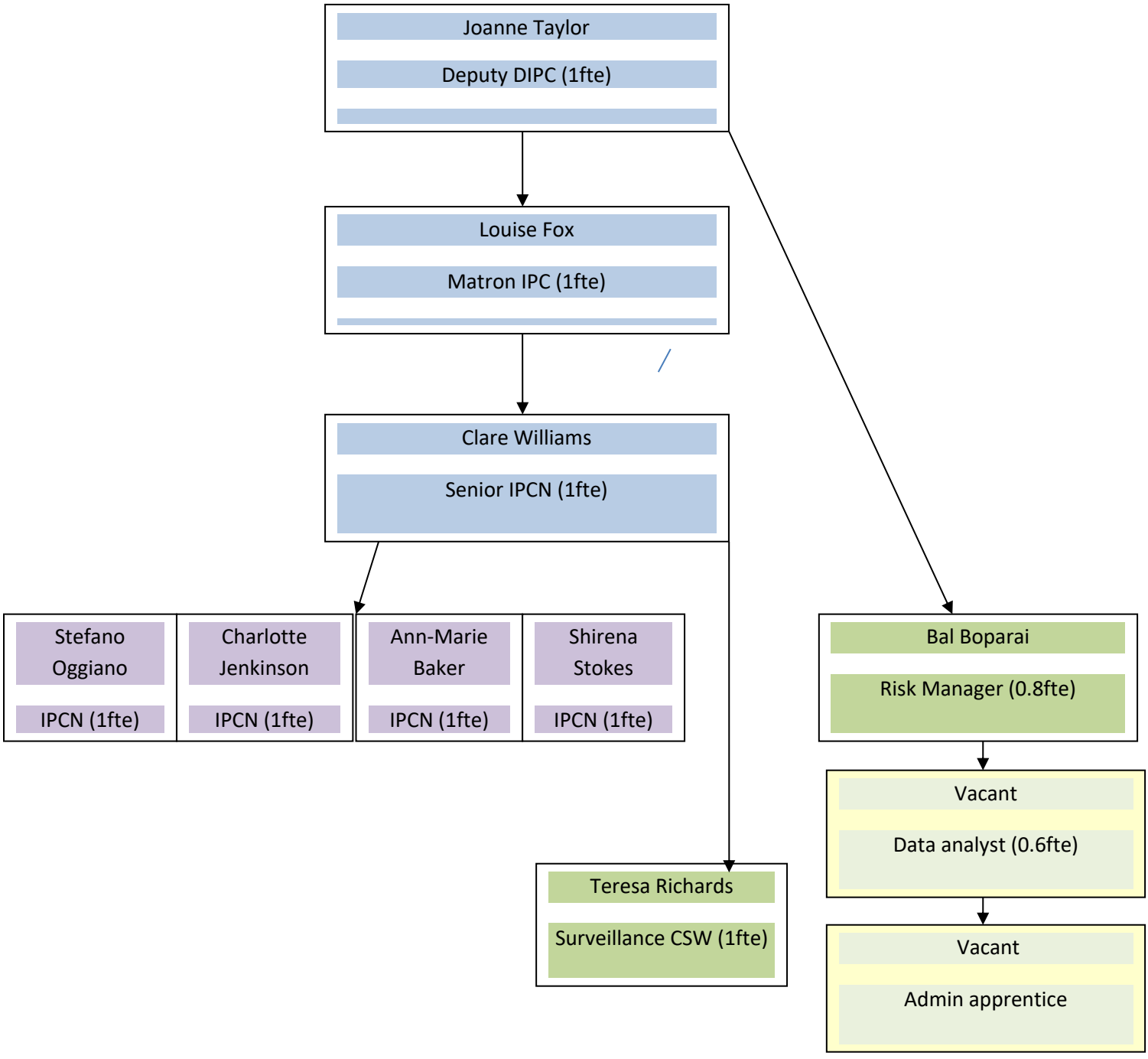
The Infection Prevention & Control Team (IPCT) based at the Manor Hospital site.

The IPCT continues to work closely with the Consultant Microbiologists, Antimicrobial Pharmacist, Walsall Public Health and Public Health England.

The role of Director of Infection Prevention and Control (DIPC) was undertaken by the Medical Director until 2018. From October 2018 the role of Director of Infection Prevention and Control (DIPC) changed to the Director of Nursing. Both directors report directly to the Chief Executive on matters pertaining to infection prevention and control.
The role of Deputy DIPC post is undertaken by Head of Infection Prevention and Control.

The Infection Prevention and Control Committee (IPCC) is chaired by the DIPC or Deputy DIPC and met monthly during 2018-19.

4. IPC team structure 2019/20



Links to Clinical Governance/Risk Management/Patient Safety

The DIPC is a member of the Quality, patient experience and Safety Committee and Infection Control regularly attends the Health and Safety Committee and Divisional quality boards..

Monthly reports are prepared by the IPCT and presented to the IPCC, and the Quality, patient experience and safety Committee and the Board. Ad hoc reports and audit requests are also presented to meet service requirements.

5. **Infection Prevention and Control Committee (IPCC)**

The role of the IPCC is to provide strategic direction for the prevention and control of Healthcare Acquired Infections in Walsall Healthcare Trust. It performance manages the organisation against the Trust's Infection Prevention and Control Strategy and ensures that there is a strategic response to new legislation and national guidelines. In addition the committee seeks assurance from the divisions and ensures compliance with the Health and Social Care act. Membership of the committee is detailed in Appendix 1.

Compliance with The Health and Social Care act is measured using the hygiene code. A full assessment of this was undertaken in November 2018. And an action plan developed for improving compliance. This was presented to the Quality, patient experience and safety board in January 2019. Ongoing monitoring of this is undertaken at IPCC. A summary of compliance at the end of the financial year 2018/19 can be seen in Appendix 2.

There are a number of standing groups that report into IPCC:-

<u>Decontamination Group</u>

The HSDU is a purpose built building that is situated opposite the main hospital. This is a standalone building and provides its own steam to run all critical services. HSDU is an ISO accredited service and provides a service to Walsall Healthcare and the Community. HSDU is audited on a yearly basis by our external auditors (SGS) and also internal audits on a monthly basis by our own internal auditors which have been trained by SGS.

In 2014 the Trust invested £1.2 million in the HSDU department which included critical equipment like new sterilisers and washer disinfectors and a general overall/refresh of the department.

HSDU provides decontamination services throughout the Trust with our main customers being Theatres. In 18/19 we produced approx. 34,841 trays and 36,466 supplementary items. HSDU provides a 7 day service. HSDU also provides an endoscope decontamination service for Endoscopy, ENT, Urology and Theatres. HSDU provides this 6 day service and was awarded JAG accreditation in April 2019.

The decontamination group meetings take place quarterly and cover all aspects of decontamination, including yearly management review meetings which we discuss non-conformances, supplier failures, quality performance, education & training, customer feedback, MRHA alerts, water safety and any new legislation. We also discuss any departmental changes and improvements we can make for our service, this is all reported to our external auditors and quarterly to IPCC.

Antimicrobial Group

In November 2018 the Trust announced its' first annual antimicrobial strategy, providing a work schedule for the antimicrobial stewardship team (AMST). Prior to this announcement, the Trust had limited formal AMST activity. The fundamental principles of the strategy are to provide the basics in prescribing antibiotics well (an evidenced-based formulary) with tools and processes in place to ensure antibiotic prescriptions are the best they can be (education, audit with feedback, dosing calculators, etc), and methods to ensure patients are discharged as quickly as possible (e.g. outpatient parenteral antibiotic therapy (OPAT) and new 'discharge enabling' antibiotics). To support the AMST in these goals, the Antimicrobial Management Group (AMG) has been newly reformed, reporting to both the Infection Control Committee and Medicines Management Group. To achieve the strategy, the AMST plan of work is:

- Praising well performing units – a recent example being NNU.
- indication, duration and 72h review.
- Teaching and training of junior doctors, medical consultants, pharmacists.
- Better antibiotic use: a new formulary to be announced, IV infusion of antibiotics on ITU, lower dosing of carbpenems, improved confidence in gentamicin with a desktop calculator.
- Ongoing visibility of the AMST on the wards, and supported by colleagues in pharmacy.
- Supporting discharge: OPAT – this will ensure patients discharged on OPAT remain safe; a formulary request for the addition of fosfomycin as an oral discharge enabling drug.
- Closer attention by AMST on those units using high volumes of high risk antibiotics: cephalsporins, carbapenems, quinolones and Tazocin.

Water Safety group

The Water Safety Group provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring water related hazards are assessed and monitoring/control measures developed and instigated.

The aim of the Water Safety Group is to ensure the safety of all water used by patients, visitors, relatives and staff, to minimise the risk of infection associated with waterborne pathogens.

The Group meet on a monthly basis and work closely with the Infection Prevention Team.The groups remit is to:-:

- Ensure the Water Safety Plan is reviewed
- Review and action risk assessments and other associated documentation
- Review new builds, refurbishments, modifications and equipment are designed, installed, commissioned and maintained to the required standards
- Ensure maintenance and monitoring procedures are in place
- Surveillance of environmental monitoring, specifically in respect of determining water sampling requirements and agreeing location of augmented areas. En
- Ensure augmented units within the Trust are tested monthly and results are reviewed and actioned as required.

The remit will include all elements as per Section 6.9 of Health Technical Memorandum 04-01 Part B 2016

Sharps safety group

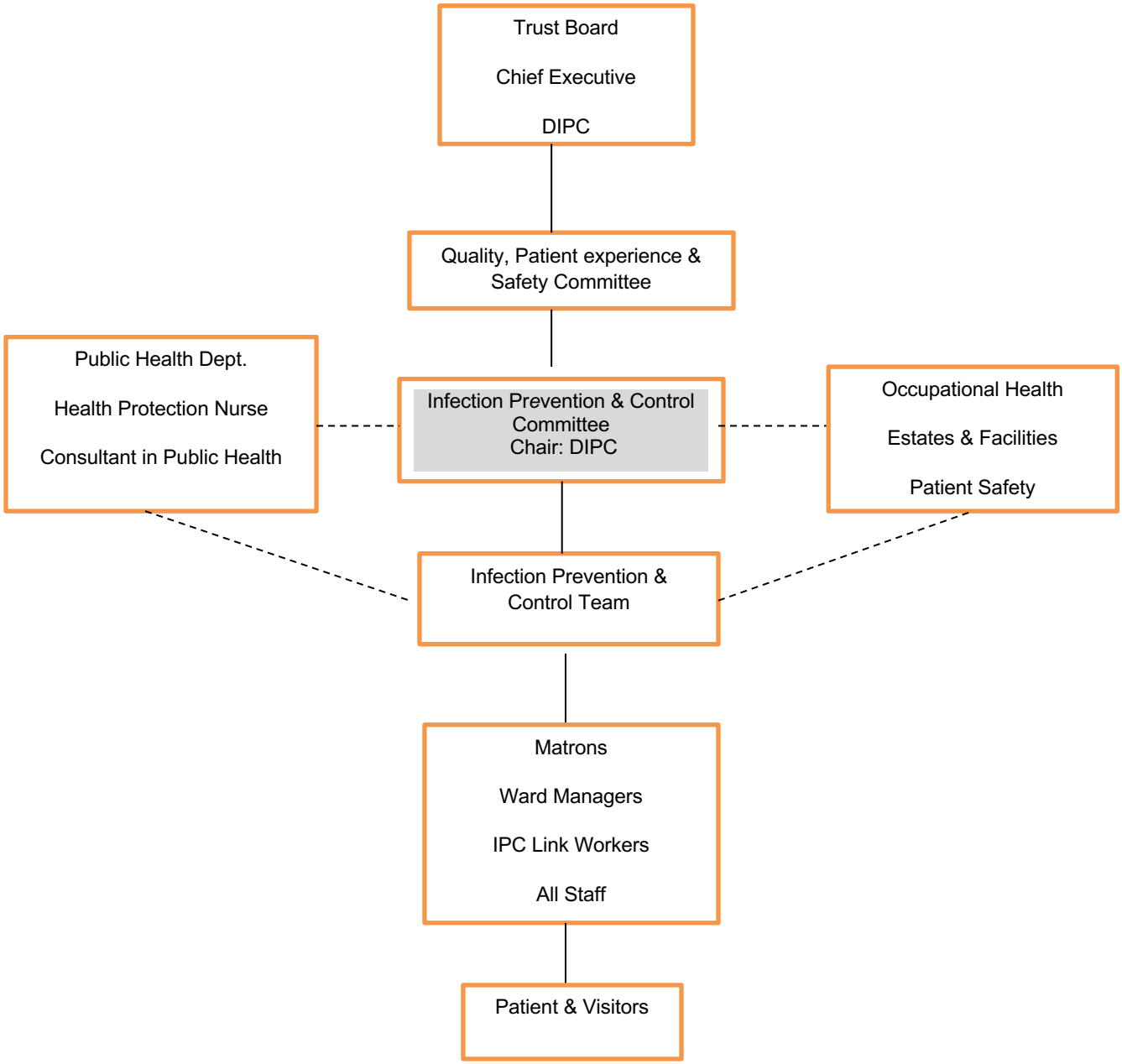
The Sharps safety group meets quarterly. The group reviews any incidents relating to sharps inoculation and monitors the trends in incidents by both staff groups and place of work. The findings from this support the education of staff and the drive to ensure safe practices take place, including implementation of safety devices. The sharps safety group report is taken to IPCC by the Lead Occupational health Nurse.

Annual work plan

An annual work plan runs from April to March; it is prepared by the IPCT, and agreed each year by the IPCC and approved by the Board. (See appendix 3).

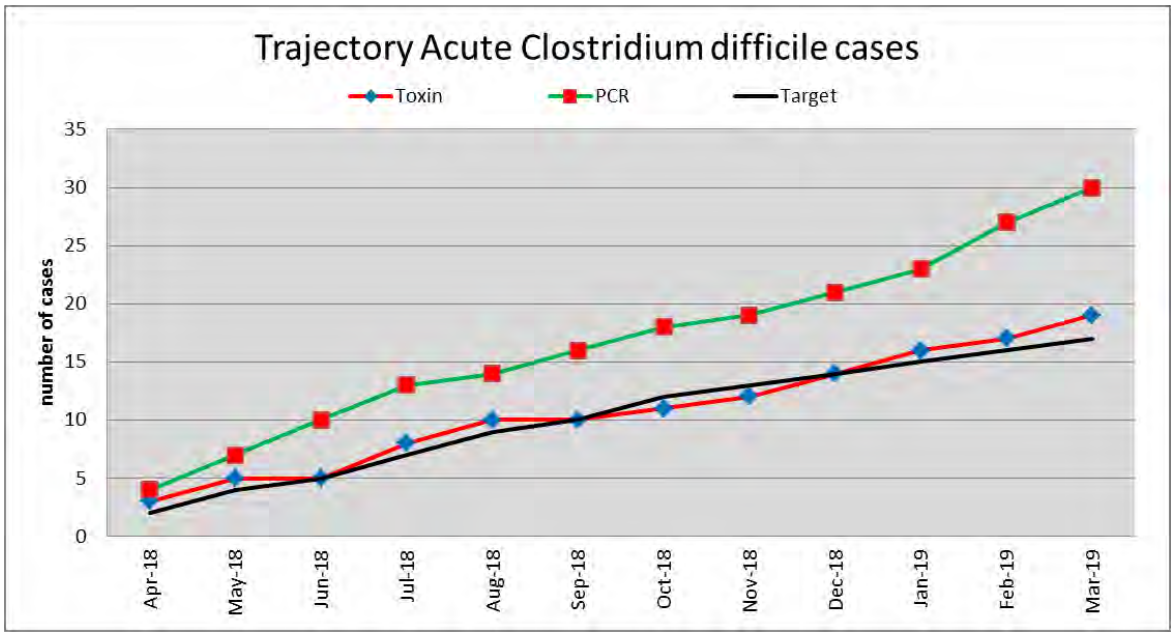
6. The Assurance Framework for Infection Prevention & Control

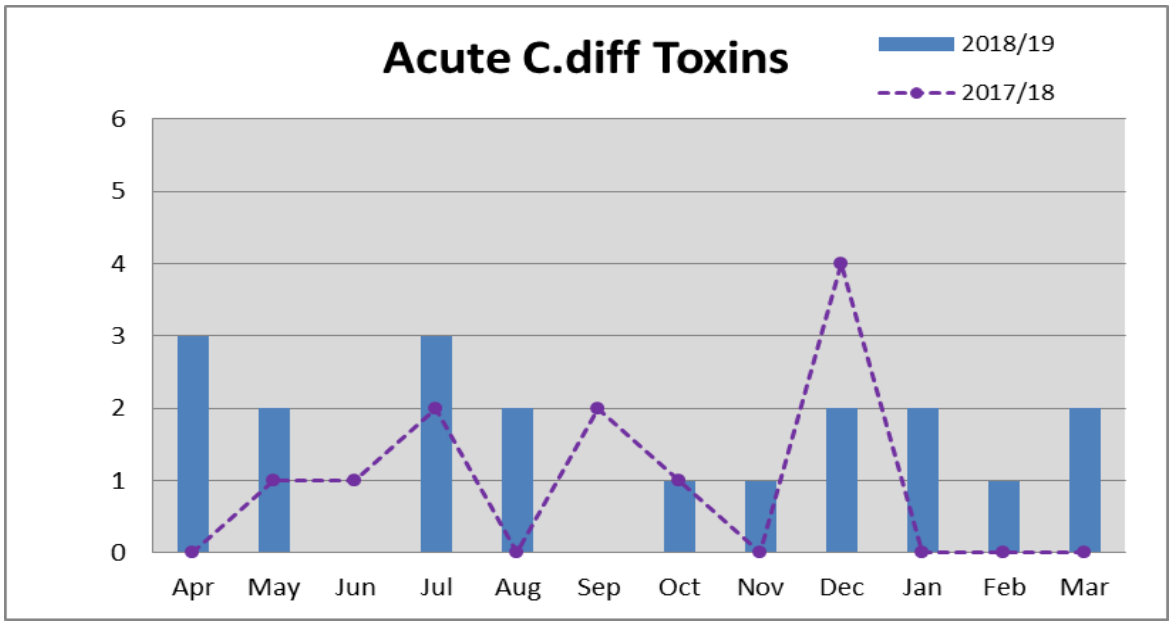
The Assurance Framework for Infection Prevention & Control and reporting arrangements for the Infection Control Committee for Walsall Healthcare NHS Trust are as follows:



7. *Clostridium difficile*

The graphs below identify *Clostridium difficile* hospital attributed toxin positive specimens at the Manor Hospital between April 2018 and March 2019.





The Trust carries out root cause analysis table tops on all Trust apportioned *Clostridium difficile* cases. These are reported to the divisional quality meetings and at IPCC.

During 2018-19 the plan included:

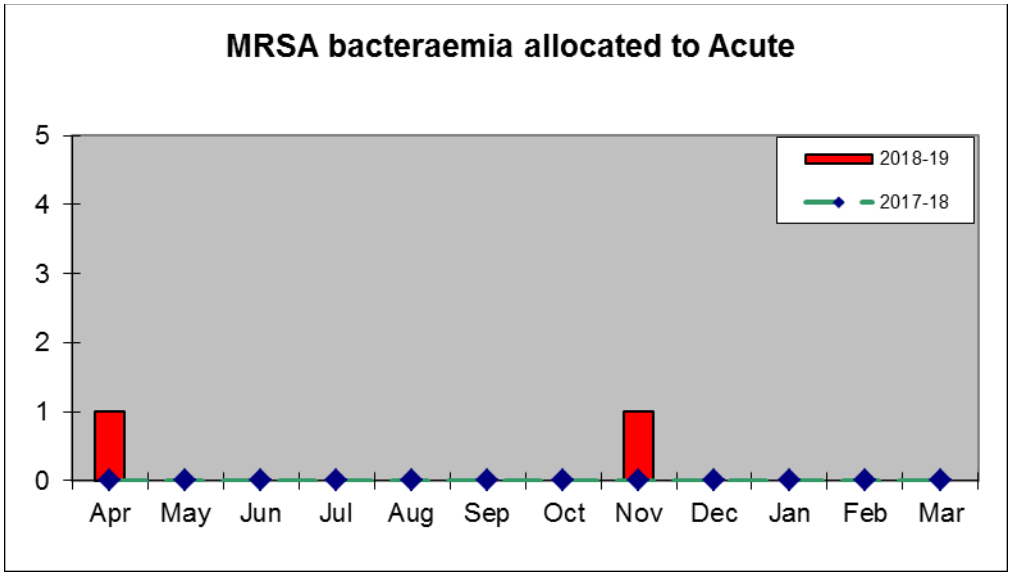
- Isolation of patients within 2 hours of a positive result

- Antimicrobial stewardship given that antimicrobials are also a key risk factor for the development of *Clostridium difficile*. An Antimicrobial Management Group has been formulated and oversees a programme of audit of antimicrobial prescribing across the Trust with feedback directly to Medical Consultants and the Medical Director. These audits assess the appropriateness of antibiotic choice and that prescribing is within both within the Trust's 'Antimicrobial Prescribing' policy and Trust medicines management guidelines.
- Continued review and education of guidance regarding when to send stool specimens including revised flowcharts
- Inclusion of actions required to reduce risks of Clostridium difficile at mandatory updates
- RCA of Clostridium diifficlie cases. Toxin positive cases were all then reviewed quarterly to determine if avoidable/unavoidable. Of the 19 cases during 2018-19, 12 were agreed as unavoidable and 7 avoidable.

8. Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

MRSA at the Manor Hospital

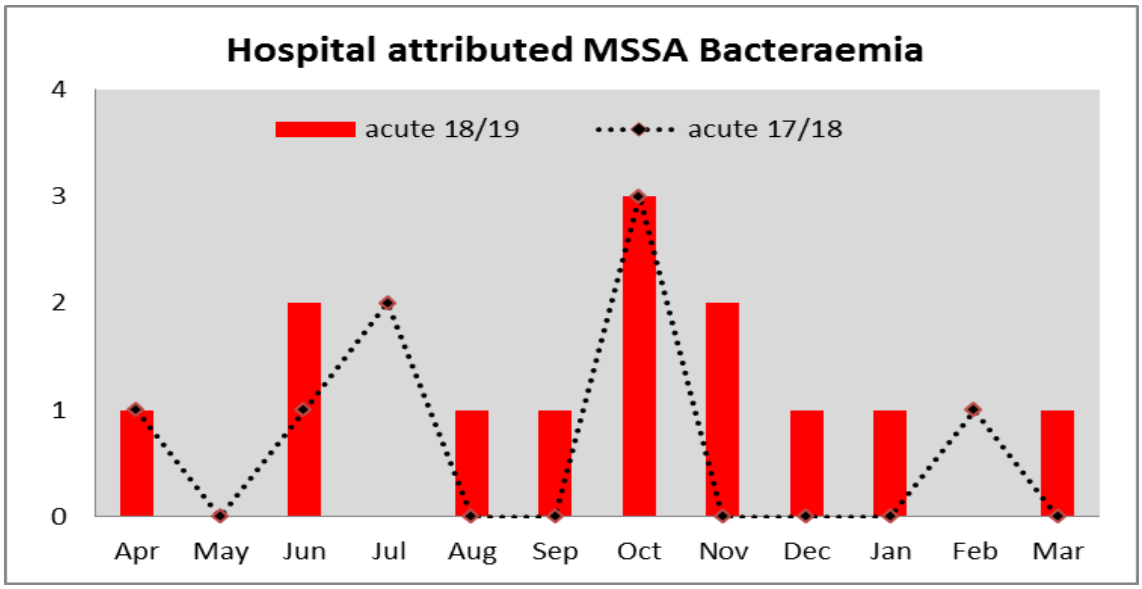
There were 2 cases of MRSA bacteraemia (blood-stream infection) attributed to the Manor Hospital during 2018-19.



Both of these cases had a full review undertaken and following this 1 was deemed avoidable and 1 unavoidable.

9. Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

There have been a total of 13 hospital attributed cases of MSSA bacteraemia during 2018-19. This represents an increase of hospital cases from 8 in 2017-18.



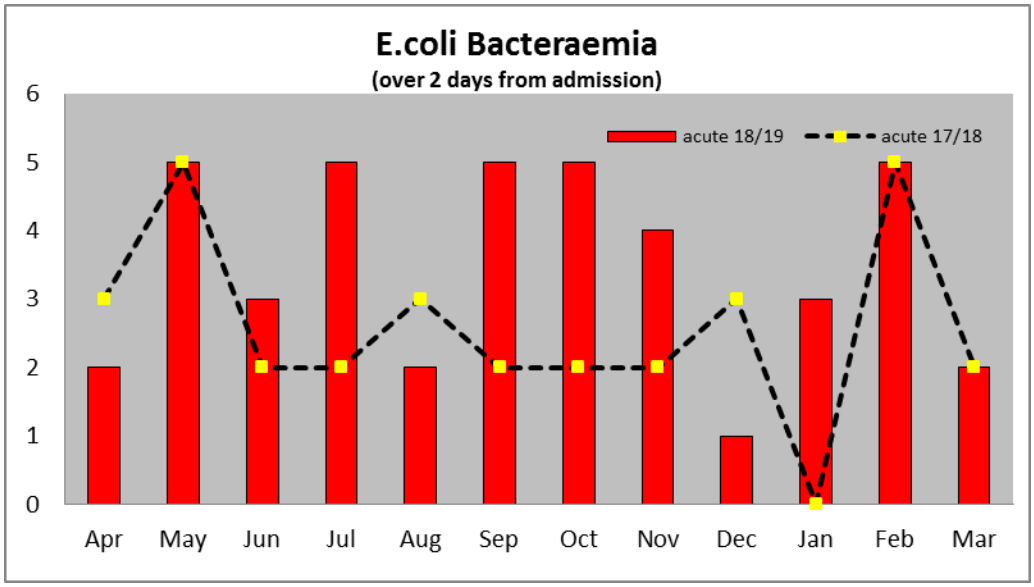
There continues to be no local or national mandatory reporting trajectories for MSSA. It is not anticipated that there will be any national trajectories for 2019-20.

However, the Infection Prevention & Control Team aims to maintain low rates of MSSA and investigate all cases to ascertain if there are further actions that can be taken. Performance of MSSA bacteraemia continues to be monitored at Infection Prevention and Control Committee.

Work for MSSA bacteraemia prevention is the same as for MRSA; and includes the ongoing work to improve and maintain best practice in intravenous line care.

10. E.coli bacteraemia

There were a total of 42 hospital attributed cases of *E.coli* bacteraemia in 2018-19. All cases are reviewed on an individual basis regarding cause and if there are any lessons regarding avoidance. In addition there is a Walsall wide working group to reduce the gram negative infections across Walsall. This group has representation from Walsall Healthcare NHS Trust, Walsall CCG, Walsall Health protection unit and Dudley and Walsall Mental Health Trust. This work is feedback through the governance structures of each organisation including the Infection prevention and Control committee at the Trust.

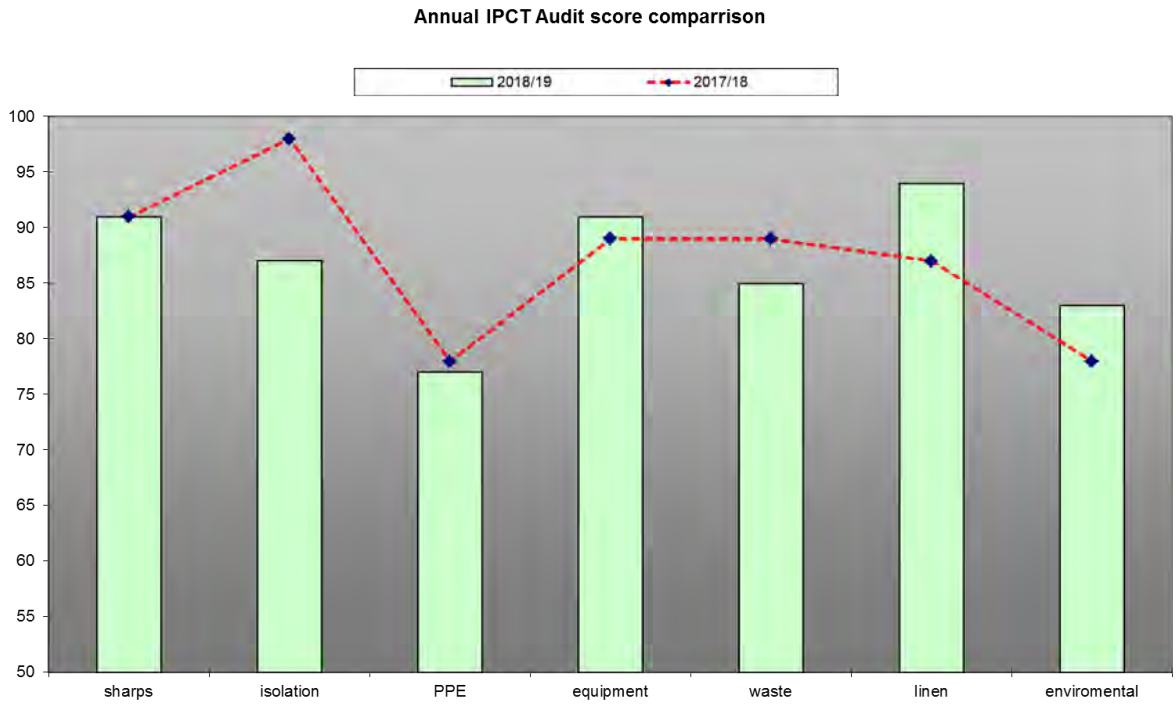


11. Acute Services Infection Prevention audits

The following infection prevention audits were undertaken during 2018-19 covering the Manor Hospital site. A comparison to similar audits undertaken during the previous year 2017-18 is provided in the table below.

Audit results are shared with Heads of Service and are reported to and discussed at Infection Prevention and Control Committee and Divisional Quality team meetings. Any non-compliance is fed back to the area at the time of audit. These annual audits are in addition to monthly observational audits for all ward areas which were undertaken monthly by the Infection Prevention & Control Team during the year with Matrons.

Audit	2018/19	2017/18
Sharps	91	91
Isolation	87	98
PPE	77	78
Patient Equipment	91	89
Waste	85	89
Linen	94	87
Environmental	83	78



12. Root Cause Analysis and actions

A Root Cause Analysis ensures that improvements in care are identified and results in action plans or changes in practice that are agreed and monitored at the appropriate Divisional Quality Team meetings and by the Infection Prevention and Control Committee.

Hospital Associated *Clostridium difficile*

RCA's undertaken for the 19 reported cases of toxin positive *Clostridium difficile* during 2018-19 the outcome from these are given below:-

Total Acute Toxin cases	19
Total Acute PCR cases	30
Period of increased incidence	0
Avoidable	7
Unavoidable	12

Methicillin-Susceptible *Staphylococcus aureus* (MSSA) Bacteraemia

A total of 13 hospital associated cases were reported in 2018-2019 compared to 8 reported 2017-2018.
All cases are reviewed on an individual basis regarding cause and if there are any lessons regarding avoidance.

Peripheral cannulas are a known risk for MSSA and therefore work has been ongoing regarding education and patient safety.

13. Outbreaks of Infection

The IPCT recognises and responds to any significant episode, incident or outbreak of infection. Incidents and outbreaks may be reported in several different ways. All are included in the IPCT monthly reports and reported via the Infection Prevention and Control Committee.
Outbreaks of Healthcare Associated Infection are reported via the Trust's reporting arrangements as serious incidents. An outbreak report is also prepared for the Infection Prevention and Control Committee for significant outbreaks to ensure any relevant lessons are learnt. An outbreak committee is usually convened to manage and monitor the situation.

Outbreaks of infection for example Norovirus, influenza or periods of increased incidence of *Clostridium difficile* are classified as serious incidents and reported on the serious incident reporting system STEIS.

Norovirus

The following table identifies outbreaks of Norovirus at the Manor hospital between April 2018 and March 2019.

Total number of patients affected = 60
Total number of confirmed cases = 11

Full ward Closures norovirus = 0

Bay closures norovirus = 15

Ward	Date closed	Total number patients	Number of confirmed cases	Total number of days closed
17	1.4.18	5	3	8
29	2.4.18	1	0	1
AMU	2.4.18	3	0	2
29	8.4.18	2	0	2
7	12.4.18	5	1	3
4	12.4.18	1	1	3
9	15.4.18	3	1	3
7	17.4.18	1	1	3
AMU	24.4.18	2	1	3
7	28.4.18	1	1	3
9	30.4.18	3	1	3
17	4.10.18	4	0	1
9	18.10.18	5	0	1
ASU	24.10.18	3	0	1
7	14.12.18	3	1	2

Influenza

Where a positive Flu has been identified in a bay the positive patient has been isolated and the bay has been closed for observation for minimum of 48 hours for signs of any spread. Patients in the bays have also been assessed regarding their vaccination status and need for prophylactic Tamiflu.

Bay closures influenza

Ward	Type	Date closed	Date opened
17	Observation following positive Flu in bay	28.9.18	30.9.18
AMU	Observation following positive Flu in bay	21.12.18	23.12.18
AMU	Observation following positive Flu in bay	25.12.18	27.12.18
AMU	Observation following positive Flu in bay	24.12.18	25.12.18
AMU	Observation following positive Flu in bay	30.12.18	31.12.18
AMU	Observation following positive Flu in bay	4.1.19	7.1.18
16	Observation following positive Flu in bay	6.1.19	9.1.18
AMU	Observation following positive Flu in bay	8.1.19	10.1.19
2	Observation following positive Flu in bay	9.1.19	11.1.19
AMU	Observation following positive Flu in bay	9.1.19	11.1.19
16	Observation following positive Flu in bay	10.1.19	12.1.19
1	Observation following positive Flu in bay	11.1.19	13.1.19
16	Observation following positive Flu in bay	13.1.19	14.1.19
17	Observation following positive Flu in bay	15.1.19	19.1.19
AMU	Observation following positive Flu in bay	15.1.19	17.1.19
1	Observation following positive Flu in bay	16.1.19	19.1.19
2	Observation following positive Flu in bay	16.1.19	18.1.19
17	Observation following positive Flu in bay	18.1.19	24.1.19
AMU	Observation following positive Flu in bay	18.1.19	20.1.19
AMU	Observation following positive Flu in bay	22.1.19	25.1.19
29	Observation following positive Flu in bay	23.1.19	27.1.19
1	Observation following positive Flu in bay	23.1.19	25.1.19
7	Observation following positive Flu in bay	26.1.19	28.1.19
AMU	Observation following positive Flu in bay	4.2.19	6.2.19
AMU	Observation following positive Flu in bay	5.2.19	7.2.19
AMU	Observation following positive Flu in bay	6.2.19	7.2.19
AMU	Observation following positive Flu in bay	7.2.19	9.2.19
ASU	Observation following positive Flu in bay	7.2.19	9.2.19
17	Observation following positive Flu in bay	8.2.19	12.2.19
AMU	Observation following positive Flu in bay	9.2.19	11.2.19
AMU	Observation following positive Flu in bay	10.2.19	10.2.19
AMU	Observation following positive Flu in bay	11.2.19	13.2.19
15	Observation following positive Flu in bay	12.2.19	14.2.19
AMU	Observation following positive Flu in bay	14.2.19	16.2.19
29	Observation following positive Flu in bay	20.2.19	22.2.19
AMU	Observation following positive Flu in bay	21.2.19	23.2.19
AMU	Observation following positive Flu in bay	22.2.19	24.2.19
AMU	Observation following positive Flu in bay	23.2.19	24.2.19
AMU	Observation following positive Flu in bay	4.3.19	6.3.19
AMU	Observation following positive Flu in bay	5.3.19	7.3.19
29	Observation following positive Flu in bay	7.3.19	8.3.19

17	Observation following positive Flu in bay	7.3.19	12.3.19
7	Observation following positive Flu in bay	10.3.19	12.3.19
7	Observation following positive Flu in bay	12.3.19	14.3.19
7	Observation following positive Flu in bay	13.3.19	14.3.19
25	Observation following positive Flu in bay	15.3.19	16.3.19
17	Observation following positive Flu in bay	18.3.19	21.3.19
AMU	Observation following positive Flu in bay	27.3.19	29.3.19
AMU	Observation following positive Flu in bay	29.3.19	31.3.19

Ward flu closures influenza

Ward	Date closed	Date opened	Number of confirmed cases	Total number of days closed
16	14.1.19	18.1.19	4	4
7	14.3.19	18.3.19	0	4

Other closures

Full ward closures

Ward	Date closed	Total number patients	Number of confirmed cases	Total number of days closed	Reason for closure
1	29.9.18	0	0	2	Possible scabies

14. Surgical Site Surveillance

In 2004 it became a mandatory requirement for all trusts undertaking orthopaedic surgery to conduct surveillance of surgical site infections, using the Surgical Site Infection (SSI) Surveillance Service of Public health England, (PHE). The data set collected as part of the surveillance is forwarded to HPE for analysis and reporting. Surveillance is divided up in to quarters (Jan-Mar, Apr-Jun, July-Sept and Oct-Dec) and each site is required to participate in at least one surveillance period every 12 Months in at least one orthopaedic category. In 2018 we participated in 2 quarters. During April – June 2018, Walsall Healthcare participated in mandatory surveillance for Total Hip Replacements and Total Knee Replacements. 1 Knee replacement was reported as surgical site infection.

Category	Total no of records submitted	No of SSI inpatient	No of SSI readmission	Total SSI
Hip Replacement	45	0	0	0

Knee Replacement	59	0	1	1

During October 2018 – December 2018 there was a reduction in the number of cases identified where no surgical site infections were identified.

Category	Total no of records submitted	No of SSI inpatient	No of SSI readmission	Total SSI
Hip Replacement	47	0	0	0
Knee Replacement	51	0	0	0

This is an improvement from 2017/18 where in the 1 quarter we participated we had 1 hip and 2 knee surgical site infections.

15. Education

Education remains a core element of the work of the Infection Prevention & Control Team in both hospital and community settings. The IPCT contribute to the Trust Induction and Mandatory Updates and a range of planned and bespoke education sessions whenever a specific need arises, including for blood cultures and intravenous line care.

The IPCT continued to support a Link worker scheme both within Walsall healthcare trust.

IPCT held awareness events during the year these included:

World hand hygiene day 5th May

As part of Hand Hygiene Day 2018 (5 May) and Royal College of Nursing's Glove Awareness Week (30 – 4 May), the Infection Prevention and Control team completed ward based training and awareness sessions during the week. A total of 110 staff signed attendance sheets for ward based teaching sessions.

On Friday 4 May the team promoted Hand hygiene, glove awareness and Prevention Sepsis in Healthcare at a stand in the main atrium. A total of 136 staff signed the attendance sheets for stand in main atrium.

ANTT events

Two event days were held on 18th September in the community at Pinfold Health Centre (28 staff) and 21st September in MLCC (40 staff attended) and covered a range of topics during the events including:

- The real harm of health care associated infection
- An introduction to the ANTT clinical practice framework
- Group work to define and overcome barriers to principles of ANTT
- An interactive key part and key site exercise and an exercise with the practical clinical guidelines
- Hand hygiene principles
- Decontamination principles in relation to standard and surgical ANTT
- Wound infection management
- Catheter associated urinary tract infection and introduction to the “HOUDINI” approach
- Management of peripheral vascular cannulas

On the acute focus day the service also arranged a selection of information stalls during lunch for all Trust staff to attend with invites for submission to a competition; over 100 staff attended the stalls which included:

- Infection Prevention and Control Stall and the ANTT framework
- Hand hygiene products with Gojo industries
- Sharps safety at disposal with Sharpsmart
- Cannula management and vessel health preservation from professional development nurses
- Sepsis recognition and management from professional development nurses
- Pre-filled syringes and skin preparation from BD
- Decontamination of devices from Gama healthcare.

The events were highly interactive with very positive feedback; 96% of delegates who attended evaluated the day as excellent. The team shared resources for delegates to take away and highlighted the updated infection prevention page on Trust intranet to access further resources

LiA mouth care event

On 24th October, IPCT, Speech and Language Therapists and LiA Leads hosted the Trust’s first mouth care events. There was a total attendance of 45 attendees and the event included:

- Background of hospital acquired pneumonia. Prevalence and the association with dental plaque and pneumonia.
- The cost of hospital acquired pneumonia at Walsall Healthcare.
- An introduction to quality improvement with a driver diagram group work exercise to identify methods to reduce incidence of respiratory tract infections
- Measurement for improvement and reviewing baseline data
- An introduction to the mouth care matters initiative and introduction to oral cavity assessments and care planning
- How to deliver different methods of mouth care based on risk assessment

Christmas Events

During December ward based teaching focusing on hand hygiene and other basic infection control principles was provided using a Christmas advent calendar. This involved windows for staff to open with questions, scenarios and practical step by step technique assessment.
Staff who completed the calendar were asked to wear a sticker with the IPC hand logo “ask me about the 5 moments” to encourage questions from staff, patients and relatives, be able to reiterate the standard effectively and promote positive conversations regarding hand hygiene.
Hand hygiene posters in clinical areas were also refreshed

In addition to the advent calendar educational support across wards and departments was completed by nurse educator from Clinell. This included decontamination of patient equipment and promotion of the standard of using the green “I am clean” tape on equipment following decontamination.

A total of 345 staff were captured using the advent calendar plus an additional 106 staff in the decontamination education.
The campaign was also supported via daily dose and Director of nursing blog.

There was a prize draw out of all the attendees of the advent calendar training. The winner was Trainee Nurse Associate Carl Limbaga on Ward 16 who won an Amazon gift card.

Infection control “12 days of Christmas”

Following on from the advent Calendar campaign which ended on 25th December IPCT formulated their own “12 days of Christmas” with some top messages being shared each day between 26th December and 6th January via the daily dose.
These included:

1. Urinary Catheters
2. PPE
3. Equipment decontamination
4. Prevention of surgical site infection
5. Antibiotic prescribing

6. CPE screening
7. Environmental cleanliness
8. Peripheral cannula care
9. Hand decontamination
10. Influenza
11. Prevention of Gram negative bacteria
12. Management of patients with diarrhoea

The full PowerPoint which was shared in daily dose and made available on the intranet and was sent to clinical areas.

16. Bibliography

Department of Health (2008) *Clostridium difficile* infection: How to deal with the problem. Department of Health, London.

Department of Health. (2010). *The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance*. London: Department of Health. Available at: www.dh.gov.uk

Department of Health (2012) Updated Guidance on the diagnosis and reporting of *Clostridium difficile.* Department of Health, London.

Health Protection Agency (2012) Guidelines for the management of Norovirus outbreaks in acute and community health and social care settings. Health Protection Agency.

Appendix 1

Membership of the Infection Prevention and Control Committee (IPCC)

The IPCC meets monthly and the membership consists of:-

- Director of Nursing/ Director of Infection Prevention and Control (DIPC) (Chair)
- Lead Nurse for Infection Prevention (Deputy Director of infection prevention)
- Consultant Microbiologists
- Associate Medical Directors
- Chief Operating Officer
- Director of Public Health
- Health Protection Nurse – Local Authority
- Public Health Consultant – Local Authority
- Divisional Directors of Nursing (Acute & Community) – Walsall Healthcare NHS Trust
- Antimicrobial Pharmacist
- Occupational Health Service Manager
- Divisional Director Estates & Facilities
- Decontamination Lead
- CCG Lead for quality

Appendix 2

Hygiene Code Compliance Summary

(Updated March 19)

Criterion 01:	**Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.**	**Partial Compliance**
Criterion 02:	**Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.**	**Partial Compliance**
Criterion 03:	**Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk if adverse events and antimicrobial resistance .**	**Partial Compliance**
Criterion 04:	**Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.**	**Partial Compliance**
Criterion 05:	**Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**	**Fully Compliant**
Criterion 06:	**Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**	**Fully Compliant**
Criterion 07:	**Provide or secure adequate isolation facilities.**	**Partial Compliance**
Criterion 08:	**Secure adequate access to laboratory support as appropriate.**	**Fully Compliant**
Criterion 09:	**Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections.**	**Partial Compliance**
Criterion 10:	**Providers have a system in place to manage the occupational health needs of staff in relation to infection**	**Fully Compliant**

Appendix 3

Infection Prevention and Control (IPC) Service April Annual Plan 2019 – March 2020

R	**= Work not completed**	**A**	**= Work behind schedule**	**G**	**= Work completed**	**NA**	**= Work on target to be completed**

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Compliance Criterion 1. **Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.**					
Reporting • Produce Infection Prevention and Control (IPC) reports (including cleanliness), which inform the organisation of progress and exceptions via appropriate governance structures/processes including: ○ Monthly ICC Committee ○ Quality, patient experience strategy group ○ Divisional Quality meetings ○ Annual IPC report • The Deputy DIPC will attend and provide assurance reports to the quarterly Walsall borough-wide HCAI forum and the CCG HCAI forum	From April 2019, • Attend Community divisional meetings to discuss issues arising and disseminate information directly to divisions specific to team needs, as already in place for Medicine, Surgery, Womens and Childrens and Clinical support services.		31.03.2020	• Reports • Action plans • Meeting minutes	Criterion 1 1.1, 1.5

Staff Training • Deliver sessions on the various clinical update and Trust induction sessions • Bespoke sessions for non-hands on staff (Skanska, facilities) or where practice/audit identify department gaps.	IPCT deliver these sessions currently For areas where there are practice/policy gaps the IPCT will work with the ward Manager/Matron/DDoN/M to develop an improvement plan. • Improvement plans to be taken to ICC by the divisions.		31.03.2020	Attendance records ICC minutes	Criterion 1 1.1 Criterion 6 Criterion 10.1
Hand hygiene (HH) Compliance • Ensure that all front facing staff i.e. with patient contact, receive annual training about the 5 moments for hand hygiene. • Non patient facing staff receives information on the importance of hand hygiene and bare below the elbows in clinical environments.	Hand hygiene included in all training session.		31.03.2020	Training records on ESR	Criterion 1.1.5 NICE QS 61.3
Water Safety • A water safety plan and water safety group are in place	Facilities Director has a Water plan in place for WHT •Regular water safety meetings need to take place quarterly (or more frequently if actions required)		31.03.2020	Report to ICC on water safety ICC minutes	Criterion 1.1.6
Annual report is available to the public	Annual report is produced. Need to ensure this is made a public document		31.07.19	Annual report accessed via WHT Internet page	Criterion 1.3..9, 4.2.3

Post Infection Review (PIR)/Root Cause Analysis (RCA) investigations (in accordance with national/mandatory • IPCT take the lead on any WHT PIR/RCA • IPCT to arrange quarterly meetings with CCG to review cases and agree if any lapse in care has occurred. IPCT to ensure shared learning from cases is incorporated into the divisional quality reports	No of cases during 2019/20 against a target of zero MRSA bacteremia and 26 C.difficile toxin cases:- MRSA: CDI: Escalation to QPES if trajectory breached. Monthly report to ICC Monthly reporting to divisional DQT Quarterly report to Walsall HCAI forum and Walsall CCG HCAI forum		31.03.2020	• RCA report to ICC • ICC minutes • Walsall HCAI minutes • Walsall CCG HCAI minutes • QPES minutes	Criterion 1 1.5

Monitoring and reporting of infections • Maintain and further develop robust surveillance systems using ICNet reporting facility to ensure prompt reporting of infections and appropriate actions are taken by clinicians to prevent cross infection or avoidable harm to service users, staff or the general public • Ensure that incidence of infection and/or outbreaks are reported through the appropriate governance streams • Ensure reporting of outbreaks to relevant bodies e.g. Public Health England.	• IPC Team notify clinical teams of alert organisms and support patient management for the patient and to reduce the risk to others. • IPC team check isolates reports routinely and cross reference any reported infections through ICNet, taking account of reported sensitivities and resistance. • IPCT identify periods of increased activity and/or trends for enhanced surveillance, support or training needs for staff teams		31.03.2019	• Electronic alerts from IcNetEmail • Incident/ exception reporting • Meeting minutes/ reports • Daily Side room review • Post outbreak report/review	Criterion 1.1, 1.5

Clinical Incidents • Lead on any IPC clinical incidents: ○ Work with staff on shared learning/ improve practice/service delivery (as required) ○ Report/Escalate in a timely manner (as appropriate) through governance processes	• IPCT to co-ordinate on specific and themed aspects of IPC affecting numerous sites • IPCT act on incident forms to support patient safety • IPCT to be a member of the Health and Safety committee • IPCT to be a member of the Sharps safety group • IPCT to lead on infection related serious incidents		31.03.2019	ICC minutes Incident reports Serious incident report Serious incident meeting minutes	Criterion 1.1, 1.5, 1.7

Patient Movement and discharge For patients to have a safe transfer between departments which reduces the risk of cross infection For patients to have a safe discharge and ongoing care.	• The patient transfer policy needs updating by Corporate Nursing • For patient infection status and details of any HCAI and treatment to be documented in EDRs		31.03.20	In date policy EDR	Criterion 1.8. 1.9, 4.2

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Compliance Criterion 2. **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection.**					

IPC Audit Programme • To develop an annual audit plan; which forms part of the annual report. • To Carry out a planned IPC audit programme across WHT to assess IPC standards/ practices in accordance with national guidance/legislation • To support Estates and Facilities during monthly and annual PLACE audits • To Carry out a planned IPC audit programme across WHT to assess IPC standards/ practices in accordance with national guidance/legislation (appendix 1) • To support Estates and Facilities during annual PLACE audits	The IPC team will • Conduct a rolling IPC audit programme to all relevant areas where clinical practice takes place. • To provide the completed audit tool back to the area, Matron and DDoN/M within 2 weeks of audit • Areas to complete action plans which will be compiled and reported on by DDoN/M at ICC • IPCT will support areas in rapid improvement if scores under 80% • IPCT will re-audit areas where a score of below 80% in line with audit plan		31.03.2020	•Audit tools • Audit programme • Audit reports • Action plans and updates • Annual audit report	Criterion 2.1

Decontamination • To ensure safeguards are in place to ensure the appropriate decontamination of medical devices and equipment across WHT • To ensure cleaning schedules are in place for both facilities and nursing staff.	• There is a decontamination group at WHT, lead by the decontamination lead. These need to have agreed TOR, increased attendance and take place quarterly in order for assurance to be in place. Issues to be escalated by Decontamination lead at ICC • 50 cleaning standards have been reviewed, new cleaning schedules need to be implemented April 2019		31.3.20	•Decontamination group minutes •ICC minutes •Cleaning schedules in place	Criterion 2.5, 2.6
Capital Planning/Refurbishment • Ensure that premises where care is delivered are fit for purpose from an IPC perspective through walkthrough visits/ audits/reports of: • New Builds - From early development stages to commissioning • At the time of relocation/refurbishment of premises Liaise with colleagues e.g. Site managers and H&S (as appropriate) on identified actions	Activity is reported at ICC and any potential infection control issues escalated.		31/3/20	•ICC minutes •Plans •Project meeting minutes	

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Compliance Criterion 3. **Ensure appropriate antimicrobial use to optimise inpatient outcomes and to reduce the risk of adverse events and antimicrobial resistance.**					
• IPC team to support Pharmacy as leads for to antimicrobial stewardship to ensure that appropriate antimicrobial use is continued according to national and local guidelines such as NICE, guidance on PGDs and Start Smart, Then Focus guidance.	• The Deputy DIPC to work in collaboration with the Antimicrobial group to review the antimicrobial strategy for the Trust. • The Antimicrobial Pharmacist to carry out an antibiotic audit which will be reported to ICC • Work collaboratively within the Trust and as part of the wider health economy to raise the profile of antimicrobial stewardship Trust wide. New priority will be given to promoting antimicrobial stewardship to all clinicians. • To ensure the importance of IPC forms part of the antimicrobial plan and staff training in line with the Department of Health (2019) Antimicrobial plan		31.03.2020	• ICC minutes • Antimicrobial plan • Training records	Criterion 3.2 NICE QS. 61.1 9.L.2

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Compliance Criterion 4. **Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.**					
Communication • Ensure that sufficient information and instruction is provided for service users and others in order to limit the spread of infection • Ensure there are policies in place in line with the Health and Social Care code. • Inform via Trust Daily Dose	The IPCT will: • Provide and signpost to up to date, standard and rolling information for staff, service users and visitors • Provide and signpost to local, national and international campaign materials through daily dose and local campaign events • Update as and when required e.g. Pandemic flu, MERS, Zika, vaccination schedules, Public health		31.03.2020	• Daily dose • Hand hygiene day • Infection control week	Criterion 4.3
Objective	**Actions required/Progress To Date**	**Status**	**Completion Date**	**Evidence of Completion**	**Reference**
Compliance Criterion 5. **Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.**					
MRSA screening • Provide evidence of clear and robust processes in place for screening on admission and proactive monitoring to identify likely sources of infection and the spread thereof	The IPCT will: • Review the current MRSA policy to take account of patient demographic and patient flow • Work with inpatient teams to close gaps in compliance with protocol		31.03.2019	• MRSA policy	Criterion 5.1, 5.2

Patient risk assessment • Ensure process for assessing infection risk for patients is robust both on admission and following admission.	The IPCT will: • Monitor the IT systems in place to alert staff of previous infection risk • Work with teams to ensure that any omissions are addressed in a timely manner and breaches safeguarded • Carryout side room reviews to provide an updated system to capacity to allow timely isolation • Explore IPCT tools for risk assessment		31.010.2019	• ICNet side room allocation system • Safeguard incidents	Criterion 5.1, 5.2

Patient influenza vaccination campaign 2019/20 • That flu vaccination is accessed by inpatients that require it during the campaign period. This will include facilitation by the Trust for inpatients as well as encouraging patients to access the vaccine via their GP if they are considered to be in a risk category	Admitting teams will: • Actively seek out patients who need vaccination and inform the clinicians on the ward • Work with public health and pharmacy to ensure supplies of vaccines are available for in-patients		31.03.2020	• Need for vaccination documented in patient notes	Criterion 5.1, 5.2
Patient alert system • A system is available to alert clinicians and prescribers to significant patient IPC issues such as previous history of: o MRSA history o Clostridium Difficile history o MDR organisms	The IPC team will: • Be responsible for ensuring alerts are added to the ICNet system, and therefore displayed on Fusion		31.03.2019	• Fusion alert • Reports on ICNet	

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Compliance Criterion 6. **Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.**					
Link Practitioner Network • Ensure a network of link practitioners are embedded within teams	• The IPCT will coordinate link practitioners within clinical teams. This will include: • Chairing quarterly link practitioner meetings and disseminating minutes in a timely manner ○ Disseminating up to date IPC information to the link practitioners for cascade to teams as and when they arise ○ Encourage link practitioner activity ○ around campaigns ○ Extend membership further to non-inpatient areas Ward Managers/Matrons and DDoN/Ms will support these meetings through release of staff to attend.		31.03.2020	• Link meeting minutes • Link meeting attendee list • Campaigns	Criterion 6.1
Induction • **For IPC to continue to be a part of induction for all staff groups**	The IPCT to ensure that • Induction continues to highlight IPC issues and direction to resources such as IPC page on Intranet • For IPC to be included in all staff job descriptions		31.03.2019	• Training compliance • Staff job descriptions	Criterion 6.2

Compliance Criterion 7. Provide or secure adequate isolation facilities.					
Objective	**Actions required/Progress To Date**	**Status**	**Completion Date**	**Evidence of Completion**	**Reference**
• That all staff have access to the information on who to isolate and the actions to take if support is needed • That staff providing support to those providing direct care are aware where the information is available on reasonably practicable isolation facilities to inpatient areas.	• Ensure an up to date isolation policy is available to all staff • Provide guidance and support to staff managing patients in isolation as and when the situation arise • Update the ICNet side room isolation weekdays		31.03.2019	• Isolation policy • ICNet side room system	Criterion 7.1, 7.2, 7.3
Compliance Criterion 8. Secure adequate access to laboratory support as appropriate					
Objective	**Actions required/Progress To Date**	**Status**	**Completion Date**	**Evidence of Completion**	**Reference**
Specimen collection • That timely and good quality specimens are collected and sent to laboratory correctly and within acceptable timeframes • To provide out of hours point of care testing for peak times of Influenza	• Provide guidance and education on specimen collection for in-patient units as required through link practitioners network, • Business case and implementation plan required in order to implement by September 2019		31.03.2020	• Specimen rejection figures • POC testing in place out of hours	Criterion 8.1, 8.2.1, 8.2.2, 8.2.3

Compliance Criterion 9. **Have and adhere to policies designed for the individuals care and Provider organisations that will help to prevent and control infections.**					
Objective	**Actions required/Progress To Date**	**Status**	**Completion Date**	**Evidence of Completion**	**Reference**
IPC Policies • That WHT have all relevant, up to date, evidence based IPC policies • They are easily accessible to all staff at all times via Trust intranet • That department audit shows compliance with policies above 80% in all categories	• The IPCT to maintain a database of current and new IPC policies and review dates required • Review and update the policies as required within the agreed timeframes • Ward Manager/Matron/DDoN compile action plan for any areas with less than 80% compliance and report action plan progress through ICC		31.03.2020	• Policies on Intranet • ICC minutes • Action plans	Criterion 9.1, 9.2, 9.3
Departmental Policies • Staff will have all relevant and up to date information on medical devices and Endoscopy (including device tracking)	• There is a Endoscopy policy but it is not on the Trust intranet		31.07.19	• Policy on Intranet	Criterion 9.j.5, 9.j.6

Outbreak Management • That arrangements are in place for the management of outbreaks of infection (known/ suspected)	• IPCT to ensure the outbreak policy is up to date in light of any updated guidance and information. • IPCT to ensure that outbreak pack is readily available to all staff at all times		31.03.2019	• Updated outbreak management pack and RTI is available to all staff	
Compliance Criterion 10. **Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.**					
Post Exposure Incident Management • That review of post exposure incident management is carried out (e.g. needle-stick injury) to ensure: o Quality and patient safety o Compliance with Health and Safety, Occupational Health and IPC legislation and guidance	• The IPC team will be a member of the Sharps safety group and Health and Safety committee • Occupational health will bring incidents in their report to ICC		31.03.2019	• Datix reviews • Investigation reports • ICC minutes	Criterion 10.3
Annual Flu Campaign for Frontline Healthcare Workers • That WHT have a robust approach and plan to ensure that frontline HCW have the opportunity to access flu vaccination to protect themselves and patients from the potential serious complications of influenza	• Occupational health will Lead on the 2019/20 annual flu programme • The programme will be shared at ICC no later than August 2019 • The IPCT will be a member of the internal flu group and the Walsall CCG Flu group		31.03.2019	•	

IPCT ANNUAL AUDIT PLAN 2019/20

Audit completed	Action plan completed	improvement support under 80%	Re audit under 80%

	April	May	June	July	August	September	October	November	December	January	February	March
Ward 1												
Ward 2												
Ward 3												
Ward 4												
AMU												
Ward 7												
ward 14												
ward 15												
Ward 16												
Ward 17												
Ward 29												
SAU												
Ward 9												
Ward 10												
ASU												
ICU												
20a												
20b												
20c												
Ward 23												
Ward 24												
Ward 25												
NNU												

Delivery												
Ward 21												
PAU												
Hand Hygiene												
Cannula												
Trust wide Waste												
Ward kitchens												
Support services cupboards												
A&E												
Endoscopy												
Cardiac intervention unit												
peadiatric audiology												
CMU												
CMU OPD 103												
Antenatal												
MLU												
Ward 26												
Maternity theatres												
Sexual health - GUM												
Sexual health - WISH												
Chemotherapy												
Medical day case												
Discharge lounge												
FHD theatres												
West wing theatres												
DTC theatres												
Imaging OPD 005												
Imaging A												
Mortuary												
Phlebotomy 002												

HSDU												
OPD 003												
OPD 004												
OPD 006												
OPD 007 (opthalmolgy)												
OPD 008												
OPD 105												
OPD 107												
OPD 108												
Pre-assessment 104												
Adult audiology OPD												
Arrivals												
Fracture clinic												
OPD 126 Gynae												
OPD 126 haemotology/oncology												
OPD 126 breast screening/imaging												
Community Podiatry										3	3	2
Community physio										2	2	2
Wound Clinics										2	1	1
Continence										1	2	1
Health Visitors	3	3	2									
Child dev. Centre												
Shortheath Clinic												
Urgent Care centre												
ambulatory care												
Paediatric outpatients												
OPD physio												
009 Outpatient Dental												

Palliative care centre												
Chemo - Palliative C Centre												
IV clinic CIT at Hollybank												

MEETING OF THE PUBLIC TRUST BOARD			
Quality, Patient Experience and Safety Committee Highlight Report			**AGENDA ITEM: 19**
Report Author and Job Title:	Karen Dunderdale Director of Nursing	**Responsible Director:**	Phil Gayle- Non Executive Director.
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	**<u>Hospital Acquired Infections</u>** At the date of the committee meeting there has been a total of11 hospital acquired C. Diff infections and 0 MRSA bacteraemia to July 2019. **<u>Performance report</u>** The committee continues to ask for development of the performance report using SPC charts to enable a more robust discussion. **<u>CQC Update</u>** The committee wishes to formally congratulate the organisation for all their work which lead to the Trust coming out of special measures and achieving Outstanding for caring **<u>Update in VTE</u>** The committee received a deep dive into actions been undertaken to achieve compliance with VTE screening. There have been no episodes of hospital acquired thrombosis directly attributable to non-assessment of VTE risk status or the administration of prophylaxis. The committee received reassurance regarding mitigations and priority actions. **<u>Gosport Independent Review Gap analysis</u>** The Committee received assurance that the organisation has key mechanisms in place to gain assurance. **<u>Diagnostic backlog</u>** The committee received a report from the division regarding delays in diagnostic imaging reporting. The committee were reassured about the mitigating actions to reduce the back log to 2 weeks by October 2019. However, the committee were not assured about the level of harm as 3 Sis have been raised in this regard. The committee has asked for a review of the QIA process and the individual QIAs for each scheme this year. **<u>Annual Infection Prevention & Control report</u>** The committee receive this annual report and recommend it for		

	approval to the board **<u>Medical Revalidation Annual Organisational Audit</u>** The committee received the report and recommend for approval the Statement of Compliance Regulations (Section 7) **<u>Delivery of Seven Day Services</u>** • The committee received a report on the four priority standards and recommend to the board that the Trust supports the medical workforce programme	
Items for escalation	The Trust Board is asked to note the report and support any further action required.	
Recommendation	Members of the Trust Board are asked to NOTE the business of the Highlight Report.	
Risk in the BAF or Trust Risk Register	None	
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 ☐	

MEETING OF THE PUBLIC TRUST BOARD			
Integrated Care Partnership (ICP) Board Highlight Report			**AGENDA ITEM: 22**
Report Author and Job Title:		**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 August 2019: • Patient story from One Walsall, which demonstrated significant positive impacts on the patient along with crisis prevention for local Healthcare providers. • The Directors report outlined the following updates; o Family Safeguarding Model had been submitted and a detailed mobilisation plan is being drafted whilst we await the outcome of our application. o Space Utilisation Group had been implemented with co-location moves in progress and challenges being reviewed with co-locating the South, as recognised to not be possible in the current Estate. o Workforce development innovation fund was approved. o Board and SMT development recommendation to source external coaching following approval from ICP Board. o IT and Digital conversations were underway in Walsall to explore how a data warehouse could be hosted by one partner on behalf of the partnership. o STP Alignment strategic thinking within Walsall Together conversations are live with more information anticipated over coming months. • The ICP Board endorsed Hexitime. • The ICP Board supported the resilient communities cabinet briefing. • Lessons learned from the Peabody visit was shared with the ICP Board. • ICP Board agreed the Alliance Agreement, Board Terms of Reference and SMT Terms of Reference. Within the Board Terms of Reference the name of the Board has been changed to the 'Walsall Together Partnership Board'. • ICP Board approved the inclusion of Housing representation to future meetings.		

	• ICP Board members agreed support of the Programme overview, which was endorsed by SMT.	
Items for escalation	No items for escalation were highlighted at this meeting.	
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 AUGUST 2019

1. INTRODUCTION

The Integrated Care Partnership (ICP) Board met in August 2019. The ICP Board will continue to meet monthly in line with the approved Terms of Reference.

This report provides an overview of the key items discussed at the meeting held in August 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 Mr Richard Beeken, Chief Executive, 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:

- Mr Mark Axcell, Chief Executive, Dudley and Walsall Mental Health Partnership NHS Trust
- Mrs Anne Baines, Non-Executive Director, Walsall Healthcare NHS Trust
- Ms Jenna Davies, Director of Governance, Walsall Healthcare NHS Trust
- Mr Sukhbinder Heer, Non-Executive Director, Walsall Healthcare NHS Trust
- Mr Paul Tulley, Director of Commissioning, NHS Walsall Clinical Commissioning Group

3.2. Minutes of last meeting and matters arising

Members agreed the minutes from the previous meeting, following minor changes to the attendee list. No matters arising were escalated therefore the Chair confirmed she was happy to proceed with the agenda items.

3.3. Patient Story

Comments were received and noted, highlighting the demonstration of excellent care and crisis prevention in the community. Members discussed the importance of understand the impact on prevention and if the patient is now a lesser user of services. Members also agreed that it was important to produce a log of all patient reports provided to the Board, to complete long term reviews on impact and trends.

3.4. Walsall Together Director Report

A report from the Interim Walsall Together Director was received, outlining the subjects named above. The report was taken as read and members were asked for any comments or queries. A discussion was held regarding OD support for colleagues working across Walsall Together. The OD programme was agreed and supported by ICP Board. It was noted that significant progress had been made with relocation of East Teams in to Blakenall Village Centre. This was also now being used for Walsall Together Leadership teams and quickly becoming Walsall Together HQ.

3.5. Hexitime

Board members endorsed the use of Hexitime, acknowledging however the importance of communications around the launch and engagement. The Interim Walsall Together Director advise that with support from the Board and SMT there was scope to fund Hexitime for the first year, then seeking commitment from partner to budget set for future years Board members confirmed that they were happy to support this. A draft plan is to be taken to SMT for approval.

3.6. Clinical Operating Model (COM) Group Highlight Report

Mrs Furnival presented the highlight report shared with members ahead of the meeting. Mrs Furnival confirmed that COM Group was well attended with positive engagement from Walsall Clinical Commissioning Group and Public Health.

3.7. Resilient communities cabinet briefing

ICP Board received the briefing which was taken as read. Members agreed that there was a requirement for the Walsall Housing Group to be included moving forward as key providers for the community.

3.8. Peabody visit

The report circulated to members ahead of the meeting was taken as read and the Interim Walsall Together Director highlighted the positive learning that was obtained through this visit.

The Interim Walsall Together Director advised that Peabody stated they recognised if they invested in the community the benefits would be a reduction in pressure on Health and Care services. Peabody invest significant sums annually in to the

community, which had proven to be successful investment for their Health and Care services.

It was agreed that it would be beneficial to understand how much, across all partners had been and was planned to be invested in Walsall Together projects collectively.

Board members recognised the importance of including a Walsall Housing Representative in discussions for Walsall Together, as they are a key resource for the community.

3.9. Alliance Agreement

Board members reflected on comments received and agreed following minor amendments;

- Reformat to remove unnecessary capitals.
- Terms of reference refer to alliance contract, which needed to be changed to agreement.
- PCNs to be taken out of brackets.
- Remove/amend accountability and contractual section from within the agreement.

Board members agreed the documents provided, following the amendments outlined above. Documents to be provided on the same cycle to all partners Board meetings for approval. It has been confirmed that WHCT and CCG would present in September and WMB and DWMHPT in October as dictated by governance cycles.

3.10. Proposal for membership – Walsall Housing Representative

ICP Board members welcomed and approved the proposal to invite a Housing Representative to future Board meetings.

3.11. SMT Action Log

The Interim Walsall Together Director presented the SMT action log which was shared with members ahead of the meeting. No comments or queries were received; therefore the action log was accepted as read.

3.12. Matters for escalation

No items were raised for escalation to the Trust Board.

4. RECOMMENDATION

The Board is recommended to NOTE the content of the report for information and to formally approve the decisions made.

MEETING OF THE PUBLIC TRUST BOARD			
AUDIT COMMITTEE HIGHLIGHT REPORT			**AGENDA ITEM: 23**
Report Author and Job Title:	Jenna Davies- Director of Governance	**Responsible Director:**	Mr S Heer- Non Executive Director- Chair of Audit Committee
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	The Audit Committee meet on the 22nd July 2019, and was quorate. The following items were discussed • Charitable funds Annual Report and Accounts • Annual committee effectiveness review • Review Losses and Special Payments • Report on single source Tenders • Internal Audit Report and Internal Audit Plan progress The Audit Committee highlighted a number of areas for the Board to have sight of.		
Recommendation	Member of the Board are asked to; • Note the report and the areas of escalation		
BAF or Trust Risk Register	None		
Resource implications	Not Applicable		
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 ☒		

Audit Committee highlight report

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 Heer, Non-executive Director, and Committee Chair.

2.2 The Audit Committee received and reviewed the Charitable Funds Annual Report & Accounts. The Committee approved the accounts and they have now been submitted. The Audit Committee thanked the finance team for their work in developing the Annual Report and Accounts

2.3 The Audit Committee reviewed the outcome of the Annual Review of Effectiveness of Board Committees. The Committee noted that this was the first time the Trust had undertaken the review, and felt it was a good process and be undertaken each year. The Committee reviewed the terms of reference agreed by each committee and will be making a recommendation to the Board for approval as part of the wider governance framework due to be presented to the Board in November.

2.4 The Audit Committee received a number of Internal Audit reports;

- Management of Controlled Drugs
- Mortality
- Well Led
- Board Assurance framework

The Committee noted the recommendations and the management response for each report.

2.5 The Committee asked for the following actions be referred to other Committees;

- Post Implementation Reviews to PFIC
- Losses and special payments to be reviewed through POD

3. RECOMMENDATION

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